DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Decision of the Administrator

IN THE CASE OF:	*	**MGCRB Case No. 24C0101**
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Mercy Hospital Joplin	*	
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Provider No. 26-0001	*	**Date: January 31, 2023**
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This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision entered by the Medicare Geographic Classification Review Board (MGCRB). The review is during the 90-day period in § 1886(d)(10) of the Social Security Act (Act), as amended.[1] The Hospital requested that the Administrator reverse the MGCRB's denial of its reclassification application. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND MGCRB DECISION

The issue involves whether the MGCRB properly denied the Hospital's requests for reclassification. The Hospital, geographically located in the urban Joplin, Missouri (MO) Core-Based Statistical Area (CBSA) but classified as rural under §412.103, made a primary request for reclassification to the urban Fayetteville-Springdale-Rogers, Arkansas (AR) CBSA for purposes of using the area's wage index to determine its payment rate under the Medicare inpatient prospective payment system (IPPS) for the Federal Fiscal Years (FFY) 2024 through 2026. The MGCRB denied the primary request, noting that the requested area is required to be no farther than 35.00 miles under the proximity requirements. The MGCRB measured the distance as 49.2 miles. The MGCRB stated that the Hospital incorrectly mapped to McDonald County, which is not a part of the Fayetteville-Springdale-Rogers, AR CBSA. The MGCRB also denied the Hospital's secondary request for reclassification to the Joplin, MO CBSA, finding that the pre-reclassified average hourly wage (AHW) for the requested area was lower than the pre-reclassified AHW for the area in which the Hospital is located; the AHW for the requested area is 35.7269 and the AHW for the Hospital's home area is 36.1724.

HOSPITAL'S COMMENTS

The Hospital commented, requesting review by the Administrator. The Hospital noted that it in its denial, the MGCRB did not take into account the fact that as the Hospital is approved as a Rural Referral Center, it should receive special treatment under 42 C.F.R. § 412.230(a)(3)(i) and (ii). Under these provisions, hospitals that are approved as a rural referral center do not have to meet

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[1] 42 U.S.C. § 1395ww(d).

the proximity requirements, but can be redesignated to either the closest urban area or the hospital's geographic home area. The Hospital argued that the requested Fayetteville-Springdale-Rogers, AR CBSA is the closest, at 42.2 miles, compared to the Springfield, MO CBSA, which is 52.0 miles away. At it met all of the other requirements for redesignation to the Fayetteville-Springdale-Rogers, AR CBSA, the Hospital argued that it should be approved under the special access rules.

Regarding the secondary request, the Hospital noted that it is geographically located in the Joplin, MO CBSA to which it sought redesignation, thus, the pre-reclassified AHW of the requested area would be the same as the pre-reclassified AHW of the area in which the Hospital is located. The Hospital noted that in the FY 2022 Final Rule[2], CMS clarified that it would allow hospitals to reclassify to an area with an AHW that is higher than the AHW of either the hospital's geographic home area or the rural area.

DISCUSSION

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

Section 1886(d)(10)(C)(iii)(II) of the Social Security Act and the Medicare regulations at 42 C.F.R. § 412.278 provide for the CMS Administrator's review of the MGCRB decisions. In exercising its authority under § 1886(d)(10) of the Act, the MGCRB must comply with all of the provisions of Title XVIII of the Act and the regulations issued there under, including the regulations at 42 C.F.R. § 412.230, *et seq*. Likewise, the regulations promulgated by the Secretary establishing procedures and criteria for the MGCRB are binding on the agency and on the Administrator in reviewing MGCRB decisions.

Section 1886(d)(10) of the Act provides for the MGCRB to consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year its wage index. Further, § 1886(d)(10)(D)(i)(I) requires the Secretary to publish guidelines for comparing wages, taking into account to the extent the Secretary determines appropriate, occupational mix in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

With respect to MGCRB reclassification, the Medicare regulations at 42 C.F.R. § 412.230 *et seq*., set forth the criteria an individual hospital seeking redesignation to another rural or urban area must meet for purposes of using that area's wage index. Except for sole community hospitals and rural referral centers, which have the option of applying under special access rules, an individual hospital must meet the proximity criteria at 42 C.F.R. § 412.230(a)(2), which states:

> *Proximity*. Except as provided in paragraph (a)(3) of this section, to be redesignated to another rural area or an urban area, a hospital must demonstrate a close proximity to the area to which it seeks redesignation by meeting the criteria in paragraph (b) of this section, and submitting data requested under paragraph (c) of this section.

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[2] 86 Fed. Reg. 44,774, (Aug. 13, 2021)

The regulation at 42 C.F.R. § 412.230(a)(3) provides special access rules for sole community hospitals and rural referral centers, stating:

> (3) *Special rules for sole community hospitals and rural referral centers*. To be redesignated under the special rules in this paragraph, a hospital must be a sole community hospital or a rural referral center as of the date of the MGCRB's review.
>
> (i) A hospital that is a approved as a rural referral center or a sole community hospital, or both, does not have to demonstrate a close proximity to the area to which it seeks redesignation.
>
> (ii) If a hospital that is a approved as a rural referral center or a sole community hospital, or both, qualifies for urban redesignation, it is redesignated to the urban area that is **closest** to the hospital or to the hospital's geographic home area. If the hospital is closer to another rural area than to any urban area, it may seek redesignation to either the closest rural or the closest urban area. (Emphasis added.)

The proximity criteria at 42 C.F.R. § 412.230(b) provides that:

> *Proximity criteria*. A hospital demonstrates a close proximity with the area to which it seeks redesignation if one of the following conditions applies:
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> (1) The distance from the hospital to the area is no more than 15 miles for an urban hospital and no more than 35 miles for a rural hospital.
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> (2) At least 50 percent of the hospital's employees reside in the area.

In order to demonstrate proximity, 42 C.F.R. § 412.230(c) requires that a hospital submit appropriate data relating to its proximity to an area. To demonstrate proximity to the area, the hospital must provide evidence of the shortest route over improved roads to the area and the distance of that route.

In addition, hospitals must meet certain wage criteria at 42 C.F.R. § 412.230(d)(1) supported by wage data that is consistent 42 C.F.R. § 412.230(d)(2)(ii) in order to be redesignated.

The regulation at 42 C.F.R. § 412.230(d)(3) provides that an exception for hospitals that were "ever" approved as an RRC:

> (3) *Rural referral center exceptions.* (i) If a hospital was ever approved as a rural referral center, it does not have to demonstrate that it meets the average hourly wage criterion set forth in paragraph (d)(1)(iii) of this section.
>
> (ii) If a hospital was ever approved as a rural referral center, it is required to meet only the criterion that applies to rural hospitals under paragraph (d)(1)(iv) of this section, regardless of its actual location in an urban or rural area.

Thus, a hospital that was "ever" approved as an RRC does not have to meet the 106/108 percent of the AHW of hospital in the area in which the hospital is located, and only has to meet the 82 percent of the AHW of hospitals in the area to which it seeks redesignation.

In 1999, Congress enacted §401 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999[3], which established a separate procedure from the MGCRB process whereby urban hospitals can be reclassified from urban to rural status if they meet certain criteria. This provision was set forth at § 1886(d)(8)(E) of the Act and promulgated at 42 C.F.R. § 412.103. Consistent with the statute, the Medicare regulations at 42 C.F.R. § 412.103, provides special treatment for hospitals located in urban areas that apply for reclassification as rural. When the Secretary implemented 42 C.F.R. § 412.103, the Secretary also initially amended the MGCRB process at 42 C.F.R. § 412.230(a)(5)(iii) to prohibit hospitals with § 412.103 rural status from also being redesignated under the MGCRB process based upon this acquired rural status and for a year in which such status was in effect and provided certain limitations. In addition, hospitals were required to meet the reclassification proximity criteria for its geographic location verses its rural classification under § 412.103 at the time of the MGCRB decision.

However, the U.S. Court of Appeals for the Second Circuit, in *Lawrence + Memorial Hospital* v. *Burwell*[4], and Third Circuit, in *Geisinger Community Medical Center v. Secretary, DHHS*[5], respectively held the limiting language of the regulation contrary to the statute and, thus, held that a hospital with "401" rural status pursuant to 42 C.F.R. § 412.103 could reclassify based on the acquired 401 rural status and retain the rural status for the same period as the MGCRB reclassification. So as to not have different policies for different jurisdictional regions, CMS removed the limitation in the reclassification regulation that was invalidated by the courts in *Geisinger* and *Lawrence*.[6] CMS also revised the regulation text at § 412.230(a)(5)(ii) to allow more than one reclassification for those hospitals redesignated as rural under § 412.103 and simultaneously seeking reclassification through the MGCRB. Therefore, for applications due to the MGCRB on September 1, 2016, for reclassification first effective for FY 2018, a hospital could apply for a reclassification under the MGCRB while still being reclassified from urban to rural under § 412.103, and such hospitals would be eligible to use distance and average hourly wage criteria designated for rural hospitals at § 412.230(b)(1) and (d)(1).

CMS reiterated in the August 22, 2016 Final Rule[7] that while hospitals designated as rural under § 412.103 may use the distance (35 miles for a rural hospital, compared to 15 miles for an urban hospital) and average hourly wage *criteria*, the average hourly wage *data* are to be compared to the average hourly wage of the hospital's actual urban geographic location. Thus, CMS previously allowed hospitals classified as rural under § 412.103 to use the 106 percent AHW criteria (rather than the 108 percent for an urban hospital) but still compared the hospital to the geographic area in which it was located, rather than to the rural area.

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[3] Pub. Law 106-113
[4] 812 F.3d 257 (2d. Cir. 2016)
[5] 794 F.3d 282 (3d Cir. 2015).
[6] 81 Fed. Reg. 23,428, 23,433-35 (Apr. 21, 2016).
[7] 81 Fed. Reg. 56,762, 56,925.

Subsequently, the United States District Court for the District of Columbia held in *Bates County Memorial Hospital, et al., v. Azar*[8] that:

> A key MGCRB regulation, in turn, requires the MGCRB to compare the hospitals' hourly wage rates with others "in the area in which [they are] located." 42 C.F.R. § 412.230(d)(1)(iii)(C). But in doing so, the Secretary interpreted Section 401 to allow him to use other hospitals in the urban area in which applicant hospitals are geographically located, instead of the rural area to which they were reclassified under Section 401. Plaintiffs sued, arguing that Section 401's command that they be treated as located in the rural areas of their states forecloses the Secretary's application of the MGCRB regulation to them in this way. The Secretary argues, to the contrary, that the statute is vague, his interpretation is reasonable, and it is entitled to Chevron deference. Not so. The Court agrees with Plaintiffs that the text of the statute requires it to enter summary judgment on their behalf, and it will remand the case to the Secretary for action consistent with this opinion.

As a result of the *Bates* court's decision, CMS revised its policy in the May 10, 2021 interim final rule with comment period (IFC)[9] so that the redesignated rural area, and not the hospital's geographic urban area, are considered the area a § 412.103 hospital is located in for purposes of meeting MGCRB reclassification criteria. Similarly, CMS revised the regulations to consider the redesignated rural area, and not the geographic urban area, as he area a § 412.103 hospital is located in for the prohibition at § 412.230(a)(5)(i) on reclassifying to an area with a pre-reclassified average hourly wage lower than the prereclassified average hourly wage for the area in which the hospital is located.

These changes implemented the *Bates* court's interpretation of the requirement at section 1886(d)(8)(E)(i) of the Act that ''the Secretary shall treat the hospital as being located in the rural area.'' Thus, effective with the May 10, 2021 IFC, a § 412.103 hospital would be considered to be located in the rural area of the state for all purposes of MGCRB reclassification, including the average hourly wage comparisons required by § 412.230(a)(5)(i) and (d)(1)(iii)(C). For example, for purposes of § 412.230(d)(1)(iii)(C), the § 412.103 hospital compares its average hourly wage to the average hourly wage of all other hospitals in the state's rural area. In addition, for purposes of § 412.230(a)(5)(i), a § 412.103 hospital may not be redesignated to another area if the pre-classified average hourly wage for that area is lower than the prereclassified average hourly wage of the rural area of the state in which the hospital is located (thus, a § 412.103 hospital could potentially reclassify to any area with a pre-reclassified average hourly wage that is higher than the prereclassified average hourly wage for the rural area of the state, if it meets all other applicable reclassification criteria).

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[8] 464 F.Supp. 3d 43 (D.D.C. 2020).
[9] 86 Fed. Reg. 24,735.

In the FY 2022 Final Rule[10], a commentor noted that the IFC stated that a hospital reclassified under § 412.103 "could" potentially reclassify to any area with a prereclassified average hourly wage that is higher than the pre-reclassified average hourly wage for the rural area of the state for purposes of the regulation at § 412.230(a)(5)(i). The commenter asserted that CMS' use of the word ''could'' in this context suggested that CMS would allow the hospital to use either its home average hourly wage or the rural average hourly wage for purposes of the regulation at § 412.230(a)(5)(i). The commenter suggested that CMS allow both comparison options, because the rural average hourly wage may occasionally be higher than the hospital's home urban area's average hourly wage, such as in the state of Massachusetts. CMS responded:

> The commenter's interpretation of our policy is correct. While the court's decision in *Bates* requires CMS to permit hospitals to reclassify to any area with a prereclassified average hourly wage that is higher than the pre-reclassified average hourly wage for the rural area of the state, we do not believe that we are required to limit hospitals from using their geographic home area for purposes of the regulation at § 412.230(a)(5)(i). Therefore, we are clarifying that **we would allow hospitals to reclassify to an area with an average hourly wage that is higher than the average hourly wage of either the hospital's geographic home area or the rural area.** (Emphasis added).[11]

In this case, the MGCRB found that the Hospital, which is geographically located in the urban Joplin, MO CBSA but classified as rural under § 412.103, met all the criteria to be reclassified to the urban Fayetteville-Springdale-Rogers, AR CBSA, except for the 35 mile proximity requirement. The MGCRB found that the distance as 49.2 miles. The MGCRB stated that the Hospital incorrectly mapped to McDonald County, which is not a part of the Fayetteville-Springdale-Rogers, AR CBSA.[12] The Hospital argued that under the special access rules for RRCs, the Fayetteville-Springdale-Rogers, AR CBSA is the closest CBSA. The Administrator notes that the Hospital did not apply under the special access rules, but rather, under proximity. The Administrator has previously allowed several hospitals to reclassify despite inadvertently selecting the wrong application method.[13] The Administrator notes that the Hospital should be

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[10] 86 Fed. Reg. 44,774, (Aug. 13, 2021).

[11] Id. at 45,189.

[12] The Administrator notes that McDonald County was previously part of the Fayetteville-Springdale-Rogers, AR CBSA. Compare "List 1. CORE BASED STATISTICAL AREAS (CBSAs), METROPOLITAN DIVISIONS, AND COMBINED STATISTICAL AREAS (CSAs), AUGUST 2017" Available online at https://www2.census.gov/programs-surveys/metro-micro/geographies/reference-files/2017/delineation-files/list1.xls to the more recent "List 1. CORE BASED STATISTICAL AREAS (CBSAs), METROPOLITAN DIVISIONS, AND COMBINED STATISTICAL AREAS (CSAs), MARCH 2020" Available online at https://www2.census.gov/programs-surveys/metro-micro/geographies/reference-files/2020/delineation-files/list1_2020.xls.

[13] See, e.g., Administrator's Decisions in *Geisinger Lewistown Hospital*, MGCRB Case No. 21C0219; *Hays Medical Center*, MGCRB Dec. No. 21C0053l; *Mary Lanning Healthcare*, MGCRB Case No. 21C0001*;* and *Park Ridge Health*, MGCRB Case No. 21C0009.

on notice going forward that it is imperative to select the correct method during the application process, or risk having the application rejected.

In light of the foregoing and based on the record presented by the Hospital for this reclassification period, the Administrator reverses the MGCRB decision. As the Hospital also met the other necessary criteria, including the wage comparison criteria for redesignation, the Hospital qualifies for redesignation to the urban Fayetteville-Springdale-Rogers, AR CBSA, for purposes of using that area's wage index to determine its payment rate under the Medicare inpatient prospective payment system (IPPS) for the Federal Fiscal Years (FFYs) 2024 through 2026.[14]

[14] As the Administrator is reversing the MGCRB's decision regarding the primary request, the Administrator is not ruling on the Hospital's secondary request to the Joplin, MO CBSA.

DECISION

The Administrator reverses the MGCRB's decision in this case.

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

Date: April 14, 2023

/s/
Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services