Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
Shady Grove Adventist Hospital Emergency Center at Germantown, (CCN: 21-0057),	)	Date: May 8, 2008
Petitioner,	)	Docket No. C-07-371 Decision No. CR1783
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Shady Grove Adventist Hospital (Petitioner or Shady Grove), and the Shady Grove Adventist Hospital Emergency Center at Germantown (Germantown Emergency Center),[1] met the requirements for provider-based status established by 42 C.F.R. § 413.65(d)(1), as of the time of Petitioner's application or provider-based attestation on July 27, 2006.

I. Background

On April 11, 2007, Petitioner requested a hearing by an administrative law judge (ALJ) to challenge the March 1, 2007 reconsideration decision of the Centers for Medicare & Medicaid Services (CMS) to deny Petitioner provider-based status. The case was assigned to me for hearing and decision on April 24, 2007. I held a hearing in Washington, D.C., on December 11, 2007, and the proceedings are recorded in a transcript (Tr.) with pages numbered 1-101. The parties offered, and I admitted as evidence, CMS Exhibits (CMS Exs.) 1-19, and Petitioner's Exhibits (P. Exs.) 1-19. Tr. at 12-15. CMS called no witnesses. Petitioner elicited testimony from: Robert Jepson, Associate Vice President for Government Relations and Public Policy at Adventist

[1] The real party in interest in this case is Shady Grove Adventist Hospital, which seeks provider-based status for the Germantown Emergency Center.

Healthcare (Tr. 40-54); Rebecca Vasse, Nursing Director of Emergency Services at Petitioner and Germantown Emergency Center (Tr. 54-74); Angelo Falcone, M.D., CEO of Montgomery Emergency Physicians (Tr. 75-86); and John Cook, Ph.D., former chief rate analyst for the Maryland Health Services Cost Review Commission (HSCRC) (Tr. 87-97). Both parties submitted pre-hearing briefs, post-hearing briefs, and post-hearing reply briefs.[2]

II. Discussion

A. Findings of Fact

The following findings of fact are based upon the joint stipulations of fact of the parties dated August 6, 2007, the transcript of the hearing, and the exhibits admitted. Where pertinent, citations to exhibit numbers related to each finding of fact may be found in the Analysis section of this decision if not indicated here.

1. Shady Grove Adventist Hospital, Medicare provider number 21-0057, is the correct Petitioner and the main provider in this case.

2. On July 27, 2006, Shady Grove submitted a provider-based attestation to CMS for the Germantown Emergency Center, which was a newly-constructed facility that the hospital was opening in Germantown, Maryland. CMS Ex. 2.

3. Shady Grove is located at 9901 Medical Center Drive, Rockville, Maryland 20850.

4. The Germantown Emergency Center is located at 19735 Germantown Road, Germantown, Maryland 20874, approximately nine miles from the campus of Shady Grove.

5. On November 6, 2006, Shady Grove was notified of CMS's decision denying the hospital's request for provider-based status for the Germantown Emergency Center. CMS Ex. 3, at 28-31.

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[2] Petitioner requests in its post-hearing brief that I take judicial or administrative notice of a January 15, 2008 article in the *Washington Post*. Petitioner Post-Hearing Brief (P. Brief) at 7 n.5. The request is denied. CMS has not denied that there was a need for a facility to provide emergency care in the area as asserted by Petitioner.

6. CMS advised Shady Grove that its request for provider-based status was denied based on CMS's determination that the Germantown Emergency Center failed to meet the requirements of the provider-based regulation at 42 C.F.R. § 413.65(d)(1). CMS Ex. 3, at 28.

7. Shady Grove filed a request for reconsideration of CMS's denial of provider-based status on December 28, 2006. CMS Ex. 3.

8. CMS advised Petitioner by letter dated March 1, 2007, that it affirmed the November 6, 2006 decision denying provider-based status for the Germantown Emergency Center. CMS Ex. 4.

9. The State of Maryland contracted with the Social Security Administration in 1977 and thereafter to have Medicare reimburse its hospitals under a waiver of the usual Medicare hospital reimbursement system, as currently authorized by section 1814(b)(3) of the Social Security Act (Act).[3] CMS Exs. 5-11, 14-16; CMS Post-Hearing Brief (CMS Brief) at 2.

10. Maryland hospitals are reimbursed for the inpatient and outpatient services they provide to Medicare beneficiaries under rates established by a state rate-setting authority, the HSCRC. CMS Exs. 5-11; CMS Brief at 2.

11. No state other than Maryland has opted out of the national Medicare hospital reimbursement system in favor of a reimbursement scheme developed by a state. CMS Brief at 2.

12. CMS determined that, at the time of its application, the Germantown Emergency Center met all requirements at 42 C.F.R. § 413.65 for provider-based status as a remote location of Petitioner, except for the requirement contained in the last sentence of 42 C.F.R. § 413.65(d)(1), which states that, "[i]f a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, CMS will determine that the facility or organization does not have provider-based status." CMS Ex. 4; Tr. 37-38.

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[3] Effective July 1, 1985, the arrangement changed from a demonstration project reimbursement system governed by a contract between the state and the federal agency to a waiver of application of the national payment system pursuant to section 1814(b)(3) of the Act. CMS Ex. 10.

13. CMS denied the Germantown Emergency Center provider-based status based upon its determination that the Maryland HSCRC did not consider the Germantown Emergency Center part of Shady Grove, the main provider, for state rate-setting purposes. CMS Ex. 4, at 1; Tr. 23-24.

14. In 2005, Maryland law was amended to recognize freestanding medical facilities that are physically separate from a hospital or hospital grounds but that are an administrative part of a hospital or related institution, including facilities that provide emergency care. MD. Code Ann., Health-Gen. §§ 19-3A-01-19-3A-03 (2007); P. Ex. 12.

15. The jurisdiction of the Maryland HSCRC is established by MD. Code Ann., Health-Gen. § 19-211 (1999).

16. The HSCRC determined that its rate-setting authority over outpatient services provided by a hospital is limited to such services provided "at the hospital," citing MD. Code Ann., Health-Gen. § 19-201(d). P. Ex. 12; CMS Ex. 18.

17. The HSCRC determined that because the Germantown Emergency Center is not physically located at Shady Grove or on its campus, the HSCRC had no authority under its enabling act to regulate rates paid to the facility. P. Ex. 12; CMS Ex. 18.

18. The HSCRC specifically made no finding as to whether or not the Germantown Emergency Center was "part of" Shady Grove within the meaning of the federal regulation. P. Ex. 12; CMS Ex. 18.

19. On June 5, 2007, the HSCRC advised CMS that the HSCRC makes findings as to its jurisdiction over outpatient services in accordance with Maryland law and that the HSCRC takes no position on whether a facility is "provider-based" under federal regulations. CMS Ex. 18.

B. Conclusions of Law

1. Petitioner timely requested a hearing and I have jurisdiction.

2. The Maryland HSCRC determined that it did not have jurisdiction or authority to set rates to be charged by the Germantown Emergency Center.

3. The Maryland HSCRC did not determine that the Germantown Emergency Center was not a part of Petitioner, Shady Grove, as it had no jurisdiction or authority to do so.

4. The Germantown Emergency Center is administratively a part of Petitioner, Shady Grove, as a matter of Maryland law, thus precluding a Maryland HSCRC decision to the contrary even if the HSCRC had jurisdiction. MD. Code Ann., Health-Gen. §§ 19-3A-01-19-3A-03 (2007).

5. CMS erred in denying provider-based status for the Germantown Emergency Center based upon the last sentence of 42 C.F.R. § 413.65(d)(1) and the action of the Maryland HSCRC.

6. Petitioner met the requirements for provider-based status for the Germantown Emergency Center as of the date of its application.

C. Issues

The only issue in this case is whether Petitioner met the requirements for provider-based status established by 42 C.F.R. § 413.65(d)(1).

D. Analysis

Petitioner seeks a determination that its Germantown Emergency Center has "provider-based status." Although generalizations are dangerous in so complicated a system as Medicare, the parties attempted to explain simply for me at hearing their perspective upon why obtaining provider-based status is important to Petitioner. Counsel for CMS explained that if it is determined that there is provider-based status between Petitioner and the Germantown Emergency Center, Petitioner can recover some overhead costs through Medicare that would not be recovered if the Germantown Emergency Center is not treated as provider-based but rather as a "free-standing facility," such as a physicians' office building.[4] Tr. 20-21. Pursuant to the applicable regulation, a "free-standing

[4] I agree with counsel for CMS that whether or not an entity or facility recoups more or less through Medicare based upon whether it is characterized as "free-standing" or "provider-based" is not material to the determination of the appropriate status of the facility or entity – at least not in this case. CMS Brief at 5-6 n.3. Of course, the same might be said when considering whether Petitioner can recoup more under the Maryland reimbursement scheme authorized under the waiver of section 1814(b)(3) or the federal scheme under section1814(b)(1) and (2) – both are authorized by Congress. I also note that CMS arguments that the Germantown Emergency Center might be entitled to recoup some overhead expenses from Medicare under other provisions of the Act (CMS Brief at 5-6 n.3) or that Petitioner could ask the Maryland legislature to change the jurisdiction of the HSCRC (CMS Reply Brief (CMS Reply) at 2) are also not material to the determination I am required to make in this case regarding whether or not the

facility" is an "entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity." 42 C.F.R. § 413.65(a)(2). A "main provider" is a provider of services "that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control." *Id.* A "provider-based entity" is a provider of services created or acquired by a "main provider" to deliver health care services of a different type from the main provider but under the ownership, administrative, and financial control of the main provider. *Id.* The regulation specifies that a "provider-based entity" includes the physical facility and the personnel and equipment needed to deliver the services at the facility. "Provider-based status" is the relationship between the main provider and the provider-based entity. *Id.* Petitioner is the "main provider" in this case. Petitioner seeks recognition of provider-based status with the Germantown Emergency Center.

There is no dispute that Petitioner built, staffed, and equipped the Germantown Emergency Center. Petitioner argues that the Germantown Emergency Center should be treated as a "provider-based entity," with "provider-based status" between Petitioner and the Germantown Emergency Center being recognized by CMS. Petitioner states that, if provider-based status is not recognized, overhead costs associated with the Germantown Emergency Center operating every day, all day, cannot be recouped from Medicare (P. Brief at 2 n.2, and 10; Tr. 24-26); that if Petitioner cannot recover the substantial overhead expense associated with operating the Germantown Emergency Center it may not be economically viable to continue to offer emergency services at that facility (Tr. 26; P. Brief at 22); and that if emergency services are no longer offered at the Germantown Emergency Center, the community will be deprived of undisputedly necessary emergency health care (Tr. 26-29).

Petitioner filed its application or attestation of provider-based status on July 27, 2006. CMS Ex. 2; P. Ex. 1. The first notice to Petitioner that provider-based status would not be recognized between Petitioner and the Germantown Emergency Center was the notice from the CMS fiscal intermediary, Highmark. The Highmark-notice advised Petitioner that provider-based status would not be recognized because the Maryland HSCRC "does not consider a facility which is not physically adjacent to a hospital to be part of the hospital." CMS Ex. 3, at 28. Highmark noted that a facility not considered by the HSCRC to be part of the hospital is not eligible to be paid under the Maryland system for Medicare reimbursement. The Highmark notice goes on to state that "CMS has concluded that the Commission has found that the facility is not providing 'hospital'

Germantown Emergency Center qualifies for provider-based status.

services and therefore it does not meet the 42 CFR § 413.65(d)(1) requirement."[5] In its March 1, 2007 notice denying Petitioner's request for reconsideration of the denial from Highmark, CMS states:

> It has long been the position of CMS that it would be inappropriate for a facility to be considered separate from the main provider, i.e. not provider-based, for state rate-setting purposes in those states that have a cost review commission or other agency that has the authority to regulate facility reimbursement while, at the same time, claiming provider-based status for Medicare purposes.

CMS Ex. 4, at 1. My translation of this statement by CMS in the terms of 42 C.F.R. § 413.65(a)(2), is that CMS considers it inappropriate for a "main provider" to receive Medicare reimbursement for services provided to Medicare eligible beneficiaries based upon a state rate scheme, while the "provider-based entity" with which the "main provider" has "provider-based status" receives reimbursement for services provided to Medicare eligible beneficiaries under the federal rate scheme. CMS states in its notice that authorizing such a practice would permit providers to adjust their structure to obtain the most advantageous rate of reimbursement. CMS does not state in its notice that it determined that Petitioner in this case was attempting to maximize its return in this way. CMS also does not state that maximizing return violates the Act or the regulations, but, rather, the CMS rationale is that it wants to avoid increasing costs to Medicare without benefit to Medicare beneficiaries or the Medicare system. CMS Ex. 4, at 1.

Although not specifically stated in either the Highmark notice or the March 1, 2007 CMS reconsideration denial, the intermediary and CMS decisions apparently turned on a September 15, 2005 letter from Robert Murray, the Executive Director for the Maryland HSCRC, that was included in Petitioner's application for provider-based status.[6] CMS

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[5] Unless read quickly, the Highmark notice makes little sense. The notice states as grounds for denial of recognition of provider-based status that: (1) the HSCRC determined that the Germantown Emergency Center was not part of the hospital because it was not adjacent; and (2) that the Germantown Emergency Center was not providing "hospital" services. Highmark does not cite the evidence it relied upon. Neither ground cited by Highmark is pursued by CMS before me.

[6] I note with passing interest that Highmark initially recommended that Petitioner's application for provider-based status be granted. However, by letter dated November 2, 2006 (P. Ex. 2), CMS notified Highmark that its recommendation was not accepted and provider-based status would not be granted. In its letter, CMS states that "[w]e have been in contact with the Maryland Heath (sic) Services Cost Review Commission and they have advised us that they do not consider the Emergency Center

Brief at 2. The September 15, 2005 letter from Robert Murray to Petitioner states it is in response to Petitioner's inquiry to the HSCRC regarding the status of the Germantown Emergency Center. The letter advised Petitioner that in 2005 the Maryland legislature authorized the establishment of an "emergency care" facility that is physically separate from a hospital and the hospital grounds but that is an administrative part of the hospital. Mr. Murray stated his understanding that CMS would not grant provider-based status if the HSCRC finds that a particular facility is not part of a provider. Mr. Murray also stated that pursuant to Maryland law the HSCRC's rate-setting authority extended only to hospital outpatient services furnished at the hospital and, therefore, the HSCRC would not regulate rates paid to the facility.[7] Mr. Murray stated that the HSCRC made no finding that the Germantown Emergency Center is "not part of" Petitioner within the meaning of the federal regulations. P. Ex. 12, at 1.

In his June 5, 2007 letter to CMS, Mr. Murray attempted to explain the determination of the Maryland HSCRC that it had no jurisdiction to set rates for the Germantown Emergency Center:

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facility to be part of the Shady Grove Adventist Hospital for purposes of rate regulation . . . ." P. Ex. 2, at 2. CMS did not disclose in its letter to Highmark who was involved in its contact with the Maryland HSCRC or when the contact occurred. CMS presents no evidence to me of such a contact. The only evidence CMS relies upon regarding the position of the Maryland HSCRC are the two letters at P. Ex. 12 and CMS Ex. 18.

[7] I note that "hospital services" within the jurisdiction of HSCRC includes "emergency services" with no language suggesting a proximity requirement such as that specified for the provision of outpatient services. MD. Code Ann., Health-Gen. § 19-201(d)(1)(ii). Mr. Murray was not called by either party to explain to me why the HSCRC would not regulate rates at the Germantown Emergency Center based upon the fact that its existence and operation was, according to him, specifically made possible by new Maryland legislation to permit the establishment of "emergency care" facilities separate from a hospital or its grounds. *See also* Tr. 45-46; P. Brief at 8. Unless there is some different meaning under Maryland law accorded the phrases "emergency care" and "emergency services," it seems to me that any emergency services provided at the Germantown Emergency Center would clearly be within the jurisdiction of the HSCRC. My task, however, is not to review the action of the HSCRC, and I give deference to Mr. Murray's interpretation of the enabling statutes for the HSCRC given his position as Executive Director for that state agency. However, the evidence shows that rates for reimbursement set by the HSCRC are actually higher than those recoverable through CMS. Tr. 72; CMS Brief at 6. Thus, it would seem in Petitioner's best interest to encourage HSCRC to assume jurisdiction or to seek a legislative change in Maryland to permit HSCRC jurisdiction, if it has not done so already.

> When I indicated in the 2005 letter that the HSCRC "has made no finding that the Germantown facility is not part of Shady Grove Adventist Hospital, as those terms are used in the federal regulation," I was attempting to make the point that while the Commission makes findings as to its jurisdiction over outpatient services in accordance with its own statutory law, it takes no position on whether the facility is "provider-based" under applicable federal regulation. The HSCRC leaves that determination, or finding, up to CMS.

CMS Ex. 18, at 1.

The parties have identified at least three possible ways to treat the Germantown Emergency Center for purposes of Medicare reimbursement:

- A freestanding facility for which Medicare reimbursement might be made for physician and related services, but would result in minimal or no reimbursement for overhead expenses relative to what Petitioner might recoup under either of the following classifications;

- A facility that is subject to the waiver provided by section 1814(b)(3) of the Act and reimbursement pursuant to the Maryland state reimbursement system under the Maryland HSCRC; or

- A provider-based entity with provider-based status relative to Petitioner and reimbursement through CMS and its contractors at the federal rate.

The first option will result if the CMS decision stands.

The second should be the preferred treatment for Petitioner. According to evidence Petitioner adduced at hearing, the state rates set by the Maryland HSCRC are actually more favorable than the federal rate. Tr. 72; CMS Brief at 6. However, the Maryland HSCRC, which is charged with setting rates for the Maryland reimbursement system, has determined that the Germantown Emergency Center is not within its jurisdiction. Thus, Petitioner is precluded from claiming the most favorable Maryland rates for Medicare reimbursement for the services provided to Medicare eligible beneficiaries at the Germantown Emergency Center.

Petitioner's next best option or fall-back is to seek reimbursement at the federal Medicare reimbursement rates for services provided to Medicare eligible beneficiaries at its Germantown Emergency Center. To be eligible for reimbursement at the federal hospital rate and recover some of its overhead expenses, Petitioner must show that the Germantown Emergency Center is provider-based. The requirements for a determination that a facility has provider-based status with a main provider are set forth at 42 C.F.R.

§ 413.65. CMS does not dispute that as of the time of its application for provider-based status, Petitioner and the Germantown Emergency Center met all requirements for provider-based status with one exception that caused CMS to deny recognition of provider-based status. Tr. 37-38. CMS denied provider-based status based upon the last sentence of 42 C.F.R. § 413.65(d)(1). CMS Ex. 3, at 28; 4. The sentence in question states:

> If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, CMS will determine that the facility or organization does not have provider-based status.

The provision has two prongs: (1) there must be a cost review commission in a state with the authority to regulate rates; and, (2) that body must find that a particular facility or organization is not part of a provider. The CMS application of this provision to deny provider-based status for the Germantown Emergency Center is an error of both fact and law.

The parties do not question that the Maryland HSCRC is a "cost review commission." However, CMS seems oblivious to the fact that the HSCRC ruled that it did not have authority to regulate the rates charged by Petitioner at the Germantown Emergency Center. CMS has not explained why it should not defer to the HSCRC's interpretation of its enabling statutes. Because HSCRC has determined that it has no authority to regulate rates at the Germantown Emergency Center, then as a matter of fact, the first prong of the last sentence of section 413.65(d)(1) is not satisfied and that sentence is not a basis upon which to deny provider-based status. Further, as a matter of unrebutted fact, Mr. Murray has stated that the Maryland HSCRC did not find that the Germantown Emergency Center was not part of Petitioner. The fact that the HSCRC made no finding that the Germantown Emergency Center was not part of Petitioner, means that the second prong of the last sentence of 42 C.F.R. § 413.65(d)(1) is also not satisfied because it requires a specific finding by the state agency. Finally, CMS has not addressed the presumption that arises that the Germantown Emergency Center is part of Petitioner because the Maryland statutes, enacted to permit a facility such as the Germantown Emergency Center, require that such a facility be an administrative part of a hospital. MD. Code Ann., Health-Gen. §§ 19-3A-01-19-3A-03 (2007). Section 19-3A-01 defines a freestanding medical facility, such as the Germantown Emergency Center, as being a facility where medical and health services are provided, that is physically separate from a hospital or hospital grounds, and is an administrative part of a hospital or related institution. A Maryland HSCRC

determination that the Germantown Emergency Center was not "part of" Petitioner would be contrary to Maryland law. Thus, as a matter of law, the second prong of the last sentence of 42 C.F.R. § 413.65(d)(1) is not met. Neither prong of the last sentence of 42 C.F.R. § 413.65(d)(1) is satisfied and its invocation by CMS to deny provider-based status to the Germantown Emergency Center is in error.

While I appreciate the CMS concern that a main provider might attempt to "game" the system to get the best recovery for services provided at a provider-based entity, that concern is not implicated in this case. Here Petitioner does not qualify for reimbursement by the Maryland reimbursement scheme and Petitioner has no choice in the matter. Certainly, if Petitioner subsequently qualifies under the Maryland reimbursement scheme, CMS may then act to ensure Petitioner is not reimbursed more than is permitted or required by law. I have no trouble accepting the CMS position that it must protect the Medicare trust fund and no exploration of the legislative history of 42 C.F.R. § 413.65 is necessary to convince me. However, the weakness of the CMS position in this case is highlighted by the fact that CMS has to resort to arguing that the regulation it was responsible to promulgate is poorly drafted. CMS asserts that from the moment it published its notice of proposed rule-making (NPRM) on the provider-based regulation in the Federal Register in 1998, CMS has consistently taken the position that "it would be inappropriate for a facility or organization to be considered freestanding for State ratesetting purposes but [to seek] provider based status under Medicare." CMS Brief at 8, citing "63 Fed. Reg. at 47590 (September 8, 1998)." One can only wonder why, if that is true, CMS did not clarify its regulation at the time.

In its reply brief CMS makes the argument that because Petitioner is reimbursed for hospital services under the Maryland rate system authorized by section 1814(b)(3) of the Act, that is the only avenue available for Petitioner to recover Medicare reimbursement for outpatient hospital services provided at the Germantown Emergency Center. CMS Reply at 9. CMS does not cite a provision of the Act or a regulation of the Secretary in support of this assertion. Rather, CMS cites language from "65 Fed. Reg. at 18530" (CMS Ex. 13, at 27). The language cited by CMS is taken from the required "regulatory impact analysis" section of the rule-making document. When read in context, it is clear that the point of the passage cited by CMS was to summarily state the impact of the new regulation rather than to provide a legal interpretation of the Act or the new regulatory provisions that followed. Further, the passage states that Maryland hospitals that are reimbursed under the Maryland scheme authorized by section 1814(b)(3) of the Act are excluded from the outpatient prospective payment system (PPS) (the federal rate scheme), but it does not say that all Maryland hospitals, main providers, or provider-based entities are excluded from PPS if not covered by the Maryland scheme. Certainly the language of

section 1814(b)(3) suggests that not all providers in a state with a scheme subject to that section need participate in or be covered by the state scheme. The section begins "if some or all of the hospitals in a State . . . ." No one suggests that section 1814(b)(3) was not drafted with the State of Maryland in mind as it was, and is, the only state with a reimbursement scheme subject to that provision. I conclude the CMS argument is unfounded.

III. Conclusion

I conclude that CMS should not have denied Petitioner provider-based status for the Germantown Emergency Center based on 42 C.F.R. § 413.65(d)(1).

/s/
Keith W. Sickendick
Administrative Law Judge