United States Court of Appeals
For the Eighth Circuit

No. 18-1316

Unity HealthCare

Plaintiff - Appellant

v.

Alex M. Azar, II, Secretary,
U.S. Department of Health and Human Services

Defendant - Appellee

No. 18-1703

St. Anthony Regional Hospital

Plaintiff - Appellant

v.

Alex M. Azar, II, Secretary,
U.S. Department of Health and Human Services

Defendant - Appellee

No. 18-1704

Lakes Regional Healthcare

Plaintiff - Appellant

v.

App. 2

Alex M. Azar, II, Secretary of the
Department of Health and Human Services

Defendant - Appellee

Appeals from United States District Court
for the Northern District of Iowa - Sioux City

Submitted: November 13, 2018
Filed: March 12, 2019

Before BENTON, BEAM, and ERICKSON, Circuit Judges.

ERICKSON, Circuit Judge.

The Medicare statute directs the Secretary of Health and Human Services to adjust payment amounts to qualifying sole community and rural hospitals through a "volume-decrease adjustment" ("VDA") when a hospital experiences a significant decrease in the number of its inpatients because of circumstances beyond its control. 42 U.S.C. § 1395ww(d)(5)(D)(ii). Appellants Unity HealthCare, Lakes Regional Healthcare, and St. Anthony Regional Hospital are three qualifying rural hospitals. The hospitals challenge the method the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, used to calculate the VDA for certain fiscal years during the mid-2000s. They also challenge the Administrator's classification of certain costs as variable costs when

calculating the adjustment. On January 30, 2018, the district court upheld the actions of the Secretary in Unity HealthCare's and Lake Regional's cases.[1] On February 6, 2018, the district court upheld the actions of the Secretary in St. Anthony's case.[2] We consolidated the cases for argument, and affirm.

I. Background

Before 1983, when a participating provider hospital incurred Medicare-eligible costs the hospital's actual costs incurred were fully reimbursed on a dollar-for-dollar basis so long as the claimed costs were found by the Secretary to be reasonable. Baptist Health v. Thompson, 458 F.3d 768, 771 (8th Cir. 2006). In 1983, Congress responded to concerns that hospitals had "little incentive . . . to keep costs down," and implemented an inpatient prospective payment system. Cty. of Los Angeles v. Shalala, 192 F.3d 1005, 1008 (D.C. Cir. 1999) (quoting Tucson Med. Ctr. v. Sullivan, 947 F.2d 971, 974 (D.C. Cir. 1991)). Under the prospective payment system, a treating hospital receives a predetermined fixed payment based on a given patient's "diagnosis-related group," or DRG. See 42 U.S.C. § 1395ww(d)(1)(A)(iii),

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[1] The Honorable Helen C. Adams, Chief United States Magistrate Judge for the Southern District of Iowa.

[2] The Honorable Leonard T. Strand, Chief Judge, United States District Court for the Northern District of Iowa, adopting the report and recommendations of the Honorable Kelly K.E. Mahoney, United States Magistrate Judge for the Northern District of Iowa.

(d)(4). The DRG-adjusted amount "is theoretically equal to the 'average' cost per patient" for a cost-effective hospital in a given location, but does not represent the actual costs of treatment. Cmty. Hosp. of Chandler, Inc. v. Sullivan, 963 F.2d 1206, 1207–08 (9th Cir. 1992), as amended (July 10, 1992). Hospitals are incentivized to minimize actual costs because they may pocket any excess balance between their costs and the DRG-adjusted amount. See id.

Certain sole community hospitals and Medicare-dependent, small rural hospitals fall under a modified reimbursement scheme. Those hospitals are paid either based off of the standard DRG "or a hospital-specific rate derived from its actual costs of treatment in one of the base years specified in the statute, whichever is higher." Adirondack Med. Ctr. v. Burwell, 782 F.3d 707, 709 (D.C. Cir. 2015) (citing 42 U.S.C. § 1395ww(d)(5)(D, G); 42 C.F.R. §§ 412.92, 412.108). Such hospital is also able to request a VDA if it experiences "a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control." 42 U.S.C. § 1395ww(d)(5)(D)(ii), (d)(5)(G)(iii). The VDA is offered as "necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services." 42 U.S.C. § 1395ww(d)(5)(D)(ii). Eligible fixed costs, such as "rent, interest, and depreciation," were "those over which management has no control." 48 Fed. Reg. 39,752, 39,781 (Sept. 1, 1983). "Variable costs," such as "food and laundry services,"

would not be reimbursed because they "vary directly with utilization." Id. at 39,781–82. The Secretary recognized that certain costs were "essential for the hospital to maintain operation but [would] vary with volume." Id. at 39,781. Those "semi-fixed" costs would be "considered as fixed on a case by case basis." Id. at 39,782. This advice was repeated in § 2810.1(B) of the Provider Reimbursement Manual (the "Manual").

In 1987, the agency amended its regulations after observing hospitals claiming eligibility for VDAs after experiencing a downturn in patients even though their DRG payments actually exceeded their inpatient operating costs. Recognizing that granting a VDA in those circumstances would conflict with the general purpose behind adopting the prospective payment system, the agency made clear "that any adjustment amounts granted to [sole community hospitals] for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and total payments made under the prospective payment system." 52 Fed. Reg. 33,034, 33,049 (Sept. 1, 1987).

To receive a VDA, qualifying hospitals must submit an annual cost report to fiscal intermediaries or Medicare Administrative Contractors. The Centers for Medicare and Medicaid Services contract with those entities to determine payment amounts due providers. 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20(b) and .24(a-b). The contractor then audits the report and notifies the hospital of its total Medicare reimbursement for that fiscal year. 42 C.F.R. § 405.1803. If a hospital disputes

the amount of reimbursement, it may appeal the determination "to the Provider Reimbursement Review Board and, under certain circumstances, may obtain a hearing from the Board." Bethesda Hosp. Ass'n v. Bowen, 485 U.S. 399, 401 (1988). Decisions by the Board are subject to review by the Administrator or the Centers for Medicare and Medicaid Services. 42 C.F.R. § 405.1834. A final decision by the Board or by the Administrator is subject to judicial review. 42 U.S.C. § 1395oo(f); 42 C.F.R. § 405.1877.

During the time period in question, no regulation provided for a specific method of calculating a VDA payment. Instead, the contractors were directed to consider: "(A) [t]he individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies; (B) [t]he hospital's fixed (and semi-fixed) costs, other than those costs paid . . . under [other provisions]; and (C) [t]he length of time the hospital has experienced a decrease in utilization." 42 C.F.R. § 412.92(e)(3). The amount of the adjustment was capped at the "ceiling" of "the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs." Id.

This consolidated appeal arises from contested decisions by the Administrator concerning the VDA amounts due to each hospital. Unity requested $741,308 for fiscal year 2006, the difference between its Medicare inpatient operating costs ($5,698,829) and its DRG payments ($4,957,521) in that year. The contractor

reclassified $664,994 in costs as "variable" for: (i) billable medical supplies; (ii) billable drugs and intravenous solutions; (iii) professional services and supplies obtained from outside providers for physical therapy, reference laboratory, blood bank, and radiology; and (iv) dietary and linen services and supplies. The contractor calculated the net VDA payment as $76,314. Unity appealed the decision to the Board.

Lakes Regional requested $1,184,574 for fiscal year 2006, the difference between its Medicare inpatient costs ($4,923,186) and its DRG payments ($3,738,612) for that year. The contractor reclassified $1,360,118 in costs as "variable" for: (i) billable medical supplies associated with anesthesia, laboratory, oncology and emergency departments and respiratory therapy services; (ii) billable drugs and intravenous solutions; (iii) professional services and supplies obtained from outside providers for physical therapy, speech therapy, blood bank, and radiology; and (iv) dietary and linen services and supplies. Because Lakes Regional's decreased total costs were now lower than the DRG payments Lakes Regional had received for that year, the contractor denied a VDA. Lakes Regional appealed that decision to the Board.

St. Anthony requested $1,954,257 for fiscal year 2009, the difference between its total inpatient operating costs ($8,333,903) and its total Pay Per Service payments for that year. The contractor excluded $1,619,594 attributed to services and supplies similar to those excluded for Unity and Lakes Regional, corrected the subtracted payment total to equal total DRG

payments ($6,273,905) and calculated the VDA payment as $440,404. St. Anthony appealed that decision to the Board.

The Board upheld the contractor's classification of certain costs as variable in all three cases. However, the Board disagreed with the contractor's method for calculating the VDA. In its decisions in the Unity and Lakes Regional cases, the Board proposed a formula under which a contractor would first ask if the precondition was satisfied that a VDA was warranted. If so, then the VDA amount would be the hospital's total fixed costs, but capped at the regulatory "ceiling" that the payment would not exceed the difference between the hospital's total Medicare inpatient operating costs (including variable costs) and its DRG payments. Since Unity's and Lakes Regional's total fixed costs were far in excess of that ceiling, the Board ruled that each was entitled to a payment equal to the difference its total Medicare inpatient operating costs and its DRG payments, which was the amount the hospitals originally requested.

The Board used a different formula to calculate St. Anthony's VDA. The Board used a proportional method in which it used the ratio of the hospital's fixed costs to total costs to apportion some of the DRG payments to the hospital's fixed costs. The Board then subtracted the "fixed portion" of the DRG payments from the hospital's fixed costs to determine the VDA (concluding it would equal $1,690,823).

The Administrator reversed the Board's VDA calculation methodology in all three cases, holding that the contractor's initial methodology was correct. The Administrator affirmed, however, the Board's rulings that the contractors had properly classified certain costs as variable.

Each hospital sought judicial review, claiming that the Secretary's decision was arbitrary, capricious, and contrary to the statute. In support of their calculation methodology, the hospitals relied heavily on sample calculations contained within § 2810.1(B) of the Manual that subtracted total DRG payments from "Program Inpatient Operating Costs." The hospitals also focused on evidence suggesting that more generous formulas had occasionally been used to calculate the VDA before 2006. The hospitals asserted that in the absence of any formal rule change, the Secretary could not adopt the different formula.

While the hospitals' cases were pending, the agency issued a notice of proposed rulemaking to modify the method used to calculate the VDA. See 82 Fed. Reg. 19,796, 19,933–35 (Apr. 28, 2017). The substance of the new proposed rule largely tracked the proportional method the Board had used in the St. Anthony case. Under the new rule, contractors would estimate the "fixed portion" of a hospital's DRG payments by using the ratio of the hospital's fixed costs to total costs. They would then calculate the VDA as the difference between the hospital's fixed costs and the "fixed portion" of its DRG payments. The proposed rulemaking made clear, however, that the agency "continue[d] to

believe that [its] current approach in calculating volume decrease adjustments is reasonable and consistent with the statute." Id. at 19,934. When the agency adopted the new rule, it did not apply it retroactively. See 82 Fed. Reg. 37,990, 38,179–83 (Aug. 14, 2017).

The district court upheld the Secretary's actions in the Unity and Lakes Regional cases in a single opinion. The district court referred St. Anthony's case to a magistrate judge, who recommended ruling in favor of the agency. The district court issued an opinion overruling St. Anthony's objections to the recommendation and accepted the recommendation. The hospitals timely appealed, and we consolidated for argument.

II. Discussion

Medicare reimbursement decisions are given deference under the Administrative Procedure Act. See 42 U.S.C. § 1395oo(f)(1). "Under the APA, the Secretary's decision is 'set aside [only] if it is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, or contrary to law.'" Baptist Health, 458 F.3d at 773 (quoting St. Luke's Methodist Hosp. v. Thompson, 315 F.3d 984, 987 (8th Cir. 2003)). "We afford substantial deference to an agency's interpretation of its own regulations." Kindred Hosps. E., LLC v. Sebelius, 694 F.3d 924, 928 (8th Cir. 2012) (citing Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512 (1994)). This is particularly true when the case involves "a complex and highly technical regulatory

program" such as Medicare, which demands "the exercise of judgment grounded in policy concerns." Thomas Jefferson Univ., 512 U.S. at 512 (quoting Pauley v. BethEnergy Mines, Inc., 501 U.S. 680, 697 (1991)). Whether the district court erred in affirming the Administrator's decision is a question of law we review *de novo*. See, e.g., Baptist Health, 458 F.3d at 773 (quoting Shalala v. St. Paul-Ramsey Med. Ctr., 50 F.3d 522, 527 (8th Cir. 1995)).

A. The Secretary's Interpretation of the Statute

The statute's command that a hospital should be "fully compensated" for its "fixed costs" does not give the Secretary a formula or method for determining what amounts to full compensation. This is an instance where "the Secretary was left with little or no statutory guidance." St. Mary's Hosp. of Rochester, Minn. v. Leavitt, 416 F.3d 906, 914 (8th Cir. 2005). When such a statutory gap "is filled by . . . formal agency adjudication, we will hold such a construction impermissible only if the agency acted unreasonably." Id. (citing Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 843–44 ("Chevron") (1984)).

The Secretary's interpretation is a reasonable interpretation of the plain language of the statute. The precise language at issue says that the VDA should be given "as may be necessary to fully compensate" a qualified hospital "for the fixed costs it incurs . . . in providing inpatient hospital services." 42 U.S.C. § 1395ww(d)(5)(D)(ii). The Secretary's interpretation

ensures that the total amount of a hospital's fixed costs in a given cost year are paid out through a combination of DRG payments and the VDA. As the Secretary points out, the prospective nature of DRG payments makes it difficult to determine how best to allocate those payments against the actual fixed costs a hospital incurs. Given the lack of guidance in the statute and the substantial deference we afford to the agency in this case, the Secretary's decision reasonably complied with the mandate to provide full compensation.

That the Secretary has prospectively adopted a new interpretation (the proportional approach) is not a sufficient reason to find the Secretary's prior interpretation arbitrary or capricious. "An initial agency interpretation is not instantly carved in stone. On the contrary, the agency . . . must consider varying interpretations and the wisdom of its policy on a continuing basis." Nat'l Cable & Telecommunications Ass'n v. Brand X Internet Servs., 545 U.S. 967, 981 (2005) (quoting Chevron, 467 U.S. at 863–64); see also La-Rouche v. FEC, 28 F.3d 137, 141 (D.C. Cir. 1994) ("The mere fact that regulations were modified, without more, is simply not enough to demonstrate that the prior regulations were invalid."). The agency received substantial feedback from hospitals that separating total DRG payments into "fixed" and "variable" estimates before calculating the VDA would better fulfill the statutory command to ensure "full" compensation. On the basis of that feedback, the agency re-evaluated the "wisdom of its policy" through a formal rulemaking. But that re-evaluation does not require us to conclude

that the prior interpretation was unreasonable. A statute can have more than one reasonable interpretation, as in this case. See Smiley v. Citibank (S.D.), N.A., 517 U.S. 735, 744–45 (1996) (stating that "the question before us is not whether [an agency interpretation] represents the best interpretation of the statute, but whether it represents a reasonable one").

B. The Secretary's Interpretation of VDA-Related Regulations

"Where a regulation's plain language does not control the issue, we must uphold an agency's interpretation of its own regulation unless that interpretation is plainly erroneous or inconsistent with the regulation." St. Luke's Methodist Hosp., 315 F.3d at 987 (citations omitted) (internal quotation marks omitted). At first glance, the Secretary's interpretation of the relevant regulations in these cases is clearly consistent with their text. See 42 C.F.R. § 412.92(e)(3). The formula adopted by the Secretary ensures that any given VDA will not exceed "the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs." Id. And in all three cases, the Secretary considered individual characteristics of each hospital alongside the fixed or non-fixed nature of their costs. See id.

The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the

Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that § 2810.1(B) of the Manual, where the examples are located, contains "the process for determining the amount of the volume decrease adjustment." See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006). However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, the Board found "that the examples are intended to demonstrate how to calculate the adjustment limit as opposed to determining which costs should be included in the adjustment." See Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than "equal to," when describing the formula.[3]We conclude that the

[3] The hospitals' argument that some fiscal intermediaries may have used a more generous formula in previous years does not alter our conclusion that the Secretary's interpretation in these cases was not arbitrary or capricious. "While a fiscal intermediary is the Secretary's agent for purposes of reviewing cost reports and making final determinations with respect to the total reimbursement due to a provider absent an appeal to the [Board], intermediary interpretations are not binding on the Secretary,

Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation.[4]

C. The Secretary's Classification of Certain Costs as Variable

The costs at issue in this case are reasonably classified as variable costs. The agency emphasizes that its overriding principle for classifying costs as variable is whether costs vary with patient volume. Each of the identified costs varies with patient volume. The hospitals are correct that some costs that the agency classified as semi-fixed may also, over time, vary with volume. However, that only serves to demonstrate the sound judgment behind considering some "semi-fixed costs, such as personnel-related costs . . . as fixed on a case-by-case basis." Manual § 2810.1(B); see also 42 C.F.R. § 412.92(e)(3)(i) (requiring intermediaries to "consider" semi-fixed costs in determining the VDA,

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who alone makes policy." Cty. of Los Angeles v. Leavitt, 521 F.3d 1073, 1079 (9th Cir. 2008) (citation omitted). To the extent that the Secretary may have discovered that certain intermediaries were incorrectly using a more generous formula, it was not foreclosed from correcting the formula to better comply with its understanding of the statute and regulations.

[4] We note that the Manual contains interpretative rules. See In Home Health, Inc. v. Shalala, 188 F.3d 1043, 1047 (8th Cir. 1999) (citing St. Paul-Ramsey Med. Ctr., 50 F.3d at 527–28 n.4). An agency may change its interpretation of a regulation "if the revised interpretation is consistent with the underlying regulations," as in this case. Perez v. Mortg. Bankers Ass'n, 135 S. Ct. 1199, 1209 (2015) (citation omitted).

without specifying a particular method of incorporating them into the VDA).

The agency's decision to classify certain costs that are directly tied to patient volume as variable was neither arbitrary nor capricious. To the extent any of the hospitals now claims that some portion of its variable costs were in fact semi-fixed, each has failed to meet its burden of demonstrating entitlement to a payment adjustment. See 42 U.S.C. § 1395g(a).

III. Conclusion

We affirm.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA

UNITY HEALTHCARE, Plaintiff(s), vs. ERIC D. HARGAN, Acting Secretary of Health and Human Services,[1] Defendant(s).	3:14-cv-00121-HCA (Davenport Division)
LAKES REGIONAL HEALTHCARE, Plaintiff(s), vs. ERIC D. HARGAN, Acting Secretary of the Department of Health and Human Services, Defendant(s).	5:14-cv-04097-HCA (Northern District of Iowa, Western Division) MEMORANDUM OPINION AND ORDER FOR JUDGMENT (Filed Jan. 30, 2018)

Plaintiffs Unity Healthcare and Lakes Regional Healthcare, both Iowa hospitals, challenge decisions of the Secretary of the Department of Health and Human Services (the "Secretary") denying them payment of a specific Medicare payment known as the

[1] Secretary Hargan is substituted for his predecessor in accordance with Federal Rule of Civil Procedure 25(d).

volume-decrease adjustment or "VDA."[2] The facts are undisputed and the plaintiffs do not challenge the statutes, regulations or interpretive guides under which the Secretary made the decision. At issue is whether the Secretary's decision was arbitrary and capricious or not supported by substantial evidence. Although these cases remain separate, because the PRRB and the Secretary dealt with them jointly, the factual background is similar and legal issues the same, the Court will issue one ruling which will be filed in each case.

I. STATUTORY AND REGULATORY BACKGROUND

The Medicare Program (the "Program") was established to provide health insurance to the aged and disabled. 42 U.S.C. § 1395 *et seq*. The Secretary has delegated authority to administer the Program to the Centers for Medicare and Medicaid Services ("CMS").[3] Under the Program qualifying health care providers are reimbursed for the costs of treating Medicare patients. 42 U.S.C. § 1395g. The payment and audit functions of CMS have been contracted to organizations known as fiscal intermediaries (FIs) and Medicare Administrative Contractors (MACs), both of which determine payment amounts due providers under the applicable law and interpretive guidelines CMS has

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[2] As discussed further *infra* at 8-9, Unity's requested VDA was substantially reduced and Lakes' request denied.

[3] Formerly the Health Care Financing Administration (HCFA). (Def. Brief [25] at 1).

published. 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20(b) and .24(b).

Under the Social Security Amendments of 1983, Pub. L. No. 98-21 tit. VI, 97 Stat. 65, 149-72, hospitals are reimbursed for inpatient operating costs and capital-related costs on the basis of predetermined rates for each patient discharge, the Inpatient Prospective Payment System (IPPS). 42 U.S.C. § 1395ww(d). IPPS payments are based on a diagnosis-related group ("DRG") assigned to each patient. *Id.* § 1395ww(d)(2). DRG amounts "approximate the average cost of caring for a patient with a given diagnosis in a cost-effective hospital" with adjustments for geography and other factors, and not the actual cost of caring for a patient. (Pl. Brief [19-1]).

Providers (hospitals) submit annual cost reports to the MAC at the close of their accounting year, showing costs incurred for the fiscal year and the proportion of the costs allocable to the Program. 42 C.F.R. §§ 413.20, 413.24(f). The MAC audits the cost report and issues a Notice of Program Reimbursement (NPR), the total Medicare reimbursement due the hospital for that fiscal year. 42 C.F.R. § 405.1803. A hospital may appeal the MAC's reimbursement determination to the Provider Reimbursement Review Board ("PRRB"). 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835. The PRRB is an administrative review entity appointed by the Secretary to adjudicate disputes between hospitals and the MACs, 42 U.S.C. § 1395oo(a), conduct hearings and issue written decisions. 42 C.F.R. § 405.1871. A decision by the PRRB is final unless reversed, affirmed

or modified by the Secretary. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1875(b). The Secretary has delegated PRRB review authority to the Administrator of CMS ("Administrator"). 42 C.F.R. § 405.1834. A final decision by PRRB or by the Administrator is subject to judicial review. 42 U.S.C. § 1395oo(f); 42 C.F.R. § 405.1877.

Both plaintiff hospitals qualify as "Sole Community Hospitals" (SCHs) as defined in 42 C.F.R. § 412.92. SCHs may be entitled to an adjustment of their Medicare reimbursement payments if they incur a decrease in inpatient discharges of more than five percent from one cost reporting year to the next, the VDA.

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

42 U.S.C. § 1395ww(d)(5)(D)(ii). To qualify for the VDA, a hospital must timely submit its request for payment with information which "[d]emonstrate[es] the size of the decrease in discharges and the resulting effect on

per discharge costs" and "show[ing] that the decrease is due to circumstances beyond the hospital's control." 42 C.F.R. § 412.92(e)(2). It is undisputed that both plaintiff hospitals experienced qualifying decreases.

The FI or MAC then determines the appropriate adjustment amount, if any, which is due the hospital:

> The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs. . . .
>
> (i) In determining the adjustment amount, the intermediary considers –
>
> > (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
> >
> > (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
> >
> > (C) The length of time the hospital has experienced a decrease in utilization.

42 C.F.R. § 412.92(e)(3). CMS has provided interpretive guidance in the Provider Reimbursement Manual,

CMS Pub. No. 15-1 (PRM 15-1). The applicable guidance instructs the MACs in calculating VDAs:

> B. Amount of Payment Adjustment. – Additional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
>
> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.
>
> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semifixed costs, such as personnel- related costs, may be considered as fixed on a case-by-case basis.
>
> In evaluating semifixed costs, the intermediary considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs are considered fixed. As the period of decreased

> utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment.
>
> The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The intermediary reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

PRM 15-1 § 2810.1(B). In processing an adjustment request the following further directions are provided:

> D. Determination on Requests. – The intermediary reviews a hospital's request for additional payment for completeness and accuracy. If any of the required documentation is missing, incomplete, or inaccurate, the intermediary requests the needed information. The intermediary makes a determination on the request and notifies the hospital of the decision within 180 days of the date the intermediary receives all required information.
>
> The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e., the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost. Therefore, the adjustment allows an increase in cost up to

> the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.

Id. § 2810.1(D). The manual then gives examples of how to make the adjustment request:

> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. The adjustment is calculated as follows:
>
> Hospital C
> PPS Payment Adjustment
> Fiscal Year Ended 09/30/87
>
[1]FY 1986 Program Operating Cost		$2,900,000
PPS Update Factor	x	1.0115
FY 1987 Maximum Allowable Cost		$2,933,350
Hospital C FY 1987 Program Inpatient Operating Cost		$2,800,000
[2]FY 1987 DRG Payment	-	$2,500,000
FY 1987 Payment Adjustment		$ 300,000
>
> [1]From Worksheet D-1, Part II, Line 54
> [2]From Worksheet E, Part A, Lines 1A and 1B
>
> Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost and FY 1987 DRG payments.

EXAMPLE B: hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. The adjustment is calculated as follows:

Hospital D
PPS Payment Adjustment
Fiscal Year Ended 12/31/88

FY 1987 Program Operating Cost		$1,400,000
PPS Update Factor	x	1.0247
FY 1988 Maximum Allowable Cost		$1,434,580
Hospital D FY 1988 Program Inpatient Operating Cost		$1,500,000
FY 1988 DRG Payment	-	$1,020,000
FY 1988 Payment Adjustment		$ 414,580

Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so the adjustment is the difference between FY 1987 cost adjusted by the update factor and FY 1988 DRG payments.

Id.

II. FACTUAL AND PROCEDURAL BACKGROUND

A. Unity Healthcare

Unity Healthcare ("Unity") operates a 48-bed general acute-care facility in Muscatine, Iowa. Unity is certified to provide inpatient hospital services under

the Program and has qualified for and been reimbursed by CMS as an SCH. Its designated intermediary (MAC) is Wisconsin Physician Services. (Tr. [10] at 48).[4]

Between fiscal year (FY) 2005 and FY 2006 Unity experienced a 16.89% decline in inpatient discharges. (Tr. [10] at 48). The MAC has stipulated the decline was due to circumstances beyond Unity's control. (*Id.*) Unity received its NPR for FY 2006 on December 7, 2007 and submitted a request for VDA of $741,308. (*Id.*) Unity calculated its request as follows:

FY 2005 Program Operating Cost	1	$6,714,575
PPS Update Factor	2	x 1.037
FY 2005[5] Maximum Allowable Cost	3	$6,963,014
FY 2006 Program Inpatient Operating Cost	4	$5,698,829
FY 2006 DRG Payment	5	- 4,957,521
FY 2006 Payment Adjustment	6	$ 741,308

(Tr. [10-2] at 722).

The MAC adjusted the reported costs by reclassifying certain costs as "variable," specifically, Unity's costs for (i) billable medical supplies, (ii) billable drugs

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[4] All transcript citations are from the Southern District docket in 3:14-cv-00121-HCA. For ease of reference the Court has referred to the transcripts as "Tr." and the docket number.

[5] The Court, based on the examples given in the PRM, believes that this reference should actually be FY 2006 Maximum Allowable Cost (*see* p.5-6 *supra*), but that issue does not impact the analysis or conclusion in this opinion.

and intravenous solutions, (iii) professional services and supplies obtained from outside providers for physical therapy, reference laboratory, blood bank, and radiology; and (iv) dietary and linen services and supplies. (Tr. at [10-1] at 394, 719). The total variable costs were subtracted from the FY 2006 Program Inpatient Operating Cost as follows:

FY 2006 Program Inpatient Operating Cost	$5,698,829
Less Variable Costs for FY 2006	-664,994
Net FY 2006 Fixed/Semifixed Costs	$5,033,835

The MAC then took the net costs and substituted it into the line 4 amount from Unity's calculations as follows:

Net FY 2006 Fixed/Semifixed Costs	$5,033,835
Less FY 2006 DRG Payment	-4,957,521
Net VDA Payment	$ 76,314

(Tr. [10-2] at 716). Unity disagreed with the MAC's calculations resulting in a lesser VDA and appealed the MAC's decision to the PRRB.

B. Lakes Regional Healthcare

Lakes Regional Healthcare ("Lakes") operates a 49-bed general acute-care facility in Spirit Lake, Iowa. Lakes is also certified to provide inpatient hospital services under the Program and has qualified for and been reimbursed by CMS as an SCH. It has the same

designated intermediary (MAC) as Unity – Wisconsin Physician Services. (Tr. [13-1] at 49).

Between fiscal year (FY) 2005 and FY 2006 Lakes experienced a 10.42% decline in inpatient discharges. (Tr. [13-1] at 49). The MAC has stipulated the decline was due to circumstances beyond Lakes' control. (*Id.*) Lakes received its NPR for FY 2006 on February 12, 2008 and submitted a request for VDA of $1,184,574. (*Id.*) Lakes calculated its request as follows:

FY 2005 Program Operating Cost	1	$5,317,296
PPS Update Factor	2	x 1.037
FY 2005[6] Maximum Allowable Cost	3	$5,514,036
FY 2006 Program Inpatient Operating Cost	4	$4,923,186
FY 2006 DRG Payment	5	- 3,738,612
FY 2006 Payment Adjustment	6	$1,184,574

(Tr. [13-2] at 530).

The MAC adjusted the reported costs by reclassifying certain costs as "variable," specifically, Unity's costs for (i) billable medical supplies associated with anesthesia, laboratory, oncology and emergency departments and respiratory therapy services, (ii) billable drugs and intravenous solutions, (iii) professional services and supplies obtained from outside providers for physical therapy, speech therapy, blood bank, and radiology; and (iv) dietary and linen services and

[6] The Court, based on the examples given in the PRM, believes that this reference should actually be FY 2006 Maximum Allowable Cost (*see* p.5-6 *supra*), but that issue does not impact the analysis or conclusion in this opinion.

supplies. (Tr. at [13-1] at 232). The total variable costs was subtracted from the FY 2006 Program Inpatient Operating Cost as follows:

FY 2006 Program Inpatient Operating Cost	$4,923,186
Less Variable Costs for FY 2006	- 1,360,118
Net FY 2006 Fixed/ Semifixed Costs	$3,563,068

The MAC then took the net costs and substituted it into the line 4 amount from Lake's calculations as follows:

Net FY 2006 Fixed/Semifixed Costs	$ 3,563,068
Less FY 2006 DRG Payment	- 3,738,612
Net VDA Payment	$ - 175,544

(Tr. [13-2] at 374). On this basis, the MAC denied Lakes a VDA. (*Id.* at 371-73). Lakes appealed the MAC's decision to the PRRB.

C. PRRB Proceedings

The PRRB held hearings on these cases on February 2 and 3, 2012, and incorporated the transcript from the Lakes case into the Unity case. Both hospitals argued that the MAC's exclusion of "variable costs" was contrary to statute and regulation and, if the exclusion was permissible, the costs eliminated were fixed or semifixed and should not have been excluded. (Tr. [10-1] at 345-362; [13-2] at 681-698).

During the Unity hearing on February 2, 2012, Dean Steiner, a Medicare auditor at the MAC, testified that in late 2008 his manager gave him the task of looking at VDAs because "we were seeing some very high dollar amounts in reviewing that process." (Tr. [10] at 261). Steiner understood that in the past the MAC had not previously removed variable costs in processing VDA requests. (*Id.* at 273). There had been no change in the regulations nor any change in the manual. (*Id.*) Mr. Steiner understood the purpose of the statute and regulation was "to ensure that the Provider is fully compensated for their fixed and semi-fixed costs so that they could continue operating as a hospital . . . no matter how many patients walk through the door." (*Id.* at 262). After looking at the statute and regulations, Mr. Steiner testified that he had determined the MAC had not been handling variable costs properly and that the only costs the MAC was to consider were fixed and semi-fixed costs. (*Id.* at 263, 274). He testified the MAC asked CMS for guidance but they never received a response. (*Id.*)

Because neither Unity nor Lakes had identified variable costs in their submissions, Mr. Steiner and the MAC reviewed the trial balances submitted with the hospitals' cost reports and "identified those accounts or sub-accounts that in our judgment would vary with utilization." (Tr. [10] at 264). To the extent an account may have included rental equipment or salaries, Steiner did not include those accounts, taking what he testified was a "very conservative approach in identifying what [he] thought were variable costs." (*Id.* at 265).

After coming up with total variable costs, they used a factoring schedule and grouped the adjustments by cost center, then reran the cost report to compute a revised Medicare operating cost. (*Id.*) Mr. Steiner testified some providers may submit variable costs with their requests; some would submit variable costs when the MAC requested; and some would not provide any variable cost estimates. (*Id.* at 266). The PRM manual defined variable costs as "those that vary based on utilization." (*Id.* at 271). He testified that physical therapy services were considered variable since they were usually paid on a per service or percentage of charge basis; medical supplies and drugs because they were charged to particular patients. (*Id.*) His assumption that drugs varied with patient volume was only a "commonsense assumption" and not based on any studies or any reference book. (*Id.* at 270). He agreed that hospital management had no control over physician orders of various things as blood or drugs. (*Id.* at 275).

On July 10, 2014, the PRRB issued its decision in both cases. (Tr. [10] at 44-63; [13-1] at 44-64). It found the MAC was authorized to eliminate variable costs to determine total fixed operating costs, but that the MAC had improperly calculated the adjustment amount and the hospitals were entitled to the VDA amounts they had requested. (*Id.* [10] at 63; [13-1] at 64). Specifically, the PRRB found that the net payment adjustment requested by the hospitals was the ceiling for payment and that since the fixed costs of each (after exclusion of the variable costs) exceeded that "ceiling,"

both hospitals were entitled to the ceiling amount. (*Id.* [10] at 62; [13-1] at 63).

The Administrator notified the parties the PRRB decisions would be reviewed. (Tr. at [10] at 28; [13-1] at 28). The parties and the Director of the CMS Division of Acute Care submitted comments to the Administrator, who after review modified the PRRB decisions, affirming in part and reversing in part. (Tr. [10] at 2-11; [13-1] at 2-11). In the September 4, 2014, decisions the Administrator affirmed the PRRB finding that the MAC correctly identified and removed variable costs, but reversed the PRRB's finding on the methodology for calculating the VDA amount, stating the MAC's methodology was proper. (*Id.* [10] at 8-9; [13-1] at 8-9). The hospitals' complaints seeking judicial review were filed October 30, 2014.

III. STANDARD OF REVIEW

This Court's review of Medicare reimbursement decisions is limited to reviewing the administrative record under the Administrative Procedures Act. 42 U.S.C. § 1395oo(f)(1); 5 U.S.C. 706. The Court only may "hold unlawful and set aside agency action, findings and conclusions" which it finds to be "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law" or "unsupported by substantial evidence." 5 U.S.C. § 706(2)(A), (E). The agency's interpretation of statutes and regulations is entitled to "substantial deference." *Siebrasse v. USDA*, 418 F.3d 847, 851 (8th Cir. 2005). "However, an interpretation

which is 'plainly erroneous or inconsistent with the regulation' must be reversed." *Columbus Cmty. Hosp., Inc. v. Califano*, 614 F.2d 181, 185 (8th Cir. 1980) (quoting *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414, (1945); *Appelwick v. Hoffman*, 540 F.2d 404, 406 (8th Cir. 1976)).

> [T]he APA requires an agency to provide more substantial justification when "its new policy rests upon factual findings that contradict those which underlay its prior policy; or when its prior policy has engendered serious reliance interests that must be taken into account. It would be arbitrary and capricious to ignore such matters."

Perez v. Mortgage Bankers Ass'n, ___ U.S. ___, 135 S. Ct. 1199, 1209 (2015) (quoting *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (citation omitted)).

IV. LEGAL ANALYSIS

A. Arbitrary/Capricious/Contrary to Applicable Law

The hospitals' challenge to the Secretary/Administrator's decision is three-fold: (1) the Secretary ignored the plain language of the VDA statute and regulation; (2) the decision directly contradicts the Secretary's own interpretive guidelines on the VDA regulation; and (3) the Secretary's decision is illogical. The Secretary responds that exclusion of variable costs is supported by the plain language of the statute, regulation and guidelines, and the methodology applied

accomplishes the purposes of the statute. Interestingly, both sides argue the language of the statute, regulation and PRM is plain, plaintiff arguing the Secretary did not follow them, the Secretary arguing he did.

The issue raised is a matter of first impression in this district. The parties have brought to the Court's attention only one other federal court case dealing with the issues at hand: Magistrate Judge Mahoney's Report and Recommendation in *St. Anthony Regional Hospital v. Hargan*, No. 5:16-cv-3117-LTS (N.D. Iowa Dec. 29, 2017).

The statute states the VDA is intended to compensate "medicare dependent, small rural hospital(s)" for fixed costs they incur when they have a qualifying decrease in inpatient cases. The statute does not reference "semi-fixed" or "variable" costs. 42 U.S.C. § 1395ww(d)(5)(G)(iii). The implementing regulation expands reimbursable costs to include "semi-fixed" costs. 42 C.F.R. § 412.92(e)(3). "Variable costs" are not referenced in either. Both the statute and regulation, however, reference "necessary core staff and services" as being included in "fixed costs."

> (i) In determining the adjustment amount, the intermediary considers –
>
> > (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and . . .

42 C.F.R. § 412.92(e)(3). "Variable costs" are separately discussed in the history accompanying publication of the original interim rule:

> Variable costs, on the other hand, are those costs for items and services that vary directly with utilization. However, in a hospital setting many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but will also vary with volume. For the purposes of this adjustment, many semifixed costs, such as personnel related costs, may be considered as fixed on a case by case basis. An adjustment will not be made for truly variable costs, such as food and laundry services.

48 FR 39752, 39781 (Sept. 1, 1983). PRM 15-1 § 2810.1(B) tracks the language from the Federal Register, with the addition of "food and laundry costs" as examples of costs which vary with utilization.

When Congress made the switch to the IPPS system, the Health Care Financing Administration (HCFA)[7] promulgated new rules to implement the switch "from a cost-based, retrospective reimbursement system to a

[7] Now CMS.

diagnosis specific prospective payment system." 48 FR 39752, 39752. HCFA noted as reasons for the change:

> Numerous studies have highlighted the dynamic growth in health care spending in the United States, particularly the rapid increase in Medicare program hospital costs. These cost issues have been, for many years, a focal point of discussion and action on the part of all levels of government and various sections of the health care industry. Of concern to us is that these increasing Medicare expenditures constrain the ability of the Federal government to fund other needed programs.
>
> . . .
>
> A third factor is Medicare's current cost reimbursement system, which by its very nature tends to aggravate this cost problem. The economic incentives of this system contribute to cost increases by rewarding hospitals and physicians who increase utilization and thus their allowable reimbursable costs. There is little incentive for hospitals and physicians to operate more efficiently as all allowable costs are fully reimbursed.
>
> . . .
>
> As a means of restraining hospital expenditure growth, prospective payment places hospitals at risk in terms of the management of their operations and the use of their resources. Thus, we believe that this system will begin to address some of the serious problems inherent in the present cost reimbursement

> payment methodology and, therefore, will allow us to better manage the Medicare program and preserve the integrity of the trust funds.

48 FR 39752, 39804-05. Given the above expressed legislative goal of restraining the growth of hospital expenditures and passing some of the burden (and risk) of cost management on to the hospitals, the Secretary's interpretation of the statute and the regulation as requiring qualifying hospitals be compensated only for fixed (or semifixed) costs is not inconsistent with the plain language of the statute or with the legislative intent.

The hospitals next argue the Secretary's decision contradicts the PRM and he has failed to give a "reasoned basis for failing to comply with [his] own express, longstanding interpretive rules governing calculation of the VDA payment." (Pl. Brief [19-1] at 18). They argue the MAC's explanation "that it was handling more requests and requests for larger amounts" coupled with a 2004 letter from CMS instructing the MAC to include variable costs in the VDA calculation (with respect to the request of another provider) and the instructions in the PRM itself demonstrates the arbitrary and capricious nature of the Secretary's decision to exclude variable costs in the 2006 calculations. (*Id.* at 19-20).

Taking the last argument first, the instructions in the PRM are ambiguous. The PRM examples do not explain what makes up the amount in line 4 of the

examples – FY Program Inpatient Operating Cost – the hospitals assume it is the total cost for the fiscal year. Line 4 could just as readily be, as the Secretary has now determined, the net costs for the fiscal year after variable costs are subtracted. The hospitals do not cite the Court to anything in the PRM which suggests the Line 4 amounts can only be or must be a hospital's total FY inpatient costs, both fixed and variable. In any event, the PRM is not a "notice-and-comment" rule covered by the APA, instead, it falls into the category of "interpretative rules, general statements of policy or rules of agency organization, procedure or practice." *Perez*, ___ U.S. at ___, 135 S. Ct. at 1203-04; 5 U.S.C. § 553(b)(A). As such, it "'do[es] not have the force and effect of law and [is] not accorded that weight in the adjudicatory process.'" *Perez*, ___ U.S. at ___, 135 S. Ct. at 1204 (quoting *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995)). An agency may change its interpretation "if the revised interpretation is consistent with the underlying regulations." *Perez*, ___ U.S. at ___, 135 S. Ct. at 1209 (quoting Petitioner's Brief in 13-1052 at 44). The Secretary's determination is consistent with language accompanying the 1987 amendments to the regulations:

> We believe that this language makes it clear that a hospital that has continued to receive payments under the prospective payment system that are greater than its inpatient operating costs, even though there has been a decline in occupancy, is not entitled to receive a payment adjustment. Hospitals that receive payments that are greater than the hospitals'

> Medicare inpatient operating costs have been "fully compensated" for those costs by the prospective payment system. Consequently, we believe that no further adjustment should be granted to these hospitals.

52 Fed. Reg. 33034, 33049, Section D. *Payments to Sole Community Hospitals* (September 1, 1987).

As for the 2004 letter from CMS instructing the MAC to include variable costs in a VDA for another provider, such a direction is entirely consistent with the directive in 42 C.F.R. § 412.108(d)(3)(i) that "[i]n determining the adjustment amount, the [MAC] consider[ ] . . . [t]he *individual* hospital's needs and circumstances. . . ." *See* 52 Fed. Reg. 33034, 33049 ("We determine on a case-by-case basis whether an adjustment will be granted and the amount of that adjustment."). Clearly, the VDA determinations are made on an individualized basis and in the 2004 case, the provider itself "excluded costs relating to food, drugs and supplies" when it submitted its SCH payment adjustment application. (Tr. [10-2] at 724). It is not determinable from the 2004 determination letter what variable costs CMS determined would be appropriate to include with respect to the provider involved.

The MAC's explanation for exclusion of variable costs came via the testimony of Mr. Steiner, who testified that in late 2008 his manager directed him to look at the VDAs "because "we were seeing some very high dollar amounts in reviewing that process." (Tr. [10] at 261). Mr. Steiner understood that in the past the MAC had not removed variable costs in processing VDA

requests. (*Id.* at 273). After looking at the statute and regulations, Mr. Steiner testified that he had determined the MAC had not been handling variable costs properly and that the only costs the MAC was to consider were fixed and semi-fixed costs. (*Id.* at 263, 274).

At hearing, counsel for the hospitals argued that because hospitals cannot control what tests and medications physicians might order which the hospitals must then provide, those "uncontrollable" costs qualify as "fixed" costs, in line with guidance in the PRM that "Fixed costs are those costs over which management has no control." Again, the PRM does not have the force and effect of law and the Court finds the language in the PRM defining "fixed costs" to be overly simplistic, given the complicated cost accounting involved. Counsel also pointed to provisions in the Iowa Administrative Code requiring hospitals to provide proper dietary services and to Medicare's formulary requirements as supporting a finding medications and food should be considered fixed costs. Mr. Steiner testified that when he reviewed the hospitals' trial balances submitted with their cost reports, he went through and identified accounts or sub-accounts that would vary with utilization, such as medications and supplies charged to patients, outside laboratory tests, radiology and therapy services, but excluded sub-accounts for professional fees and equipment rentals as fixed costs. (Tr. [10] at 264-265). This is consistent with the statute which "also requires that the adjustment amount include the reasonable cost of maintaining necessary core staff and services. HCFA will review the determination of

core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies." 48 FR 39752-01, 39781-82.

The hospitals argued fewer patients does not necessarily translate into less patient utilization if the patients are sicker. As the Secretary pointed out, however, there is nothing in the record to suggest the hospitals had "sicker" patients during the relevant time period.

The Court finds the following: The regulations did not change nor did the facts underlying their promulgation – the Secretary discovered the Department had made a mistake in how it had been calculating VDA payments under the existing regulations. The government was paying out increasing sums to hospitals, payments which covered the hospitals' fixed and variable inpatient costs, a scenario not contemplated by the statute or the intent of the IPPS system: "[to] restrain[] hospital expenditure growth, prospective payment places hospitals at risk in terms of the management of their operations and the use of their resources." 48 FR 39752, 39804-05. The IPPS was not intended to make qualifying hospitals whole, only to "full compensate the hospital for the *fixed costs* it incurs . . . including the reasonable cost of maintaining necessary core staff and services." 42 U.S.C. § 1395ww(d)(5)(D)(ii), (d)(5)(G)(iii). The Secretary took steps to correct the Department's error but did not change the regulations, only the interpretation of the existing regulations. *See* 42 U.S.C. § 1395ww(d)(5)(I) (Secretary authorized "to

provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate"). The steps taken, to exclude variable costs from VDA calculations, are consistent with the statutory and regulatory language and the purpose of the IPPS system. *Cf. Guernsey*, 514 U.S. at 94-95 (Secretary's decision that regulation did not require reimbursement according to GAAP was a "reasonable regulatory interpretation" to which deference was owed); *Bob Jones University v. United States*, 461 U.S. 574, 596 (1983) ("In an area as complex as the tax system, the agency Congress vests with administrative responsibility must be able to exercise its authority to meet changing conditions and new problems."). The Secretary's decision was not arbitrary, capricious or contrary to applicable law.

B. Substantial Evidence

Alternatively, plaintiffs argue the Secretary's decision was not supported by substantial evidence and that the record demonstrated the disputed costs were "at a minimum, semifixed" or "were necessary and essential to maintain core services." (Pl. Brief [19-1] at 19, 26). Defendant responds that both the PRRB and the Secretary agreed with the MAC the costs were variable in accordance with traditional accounting principles. (Def. Brief [25] at 10).

In support of their argument, plaintiffs point to testimony by Mr. Steiner that his statement "[i]f you have fewer patients, it's most likely you're going to

have fewer drugs" was a "commonsense assumption" and not based on empirical studies. (Tr. [10] at 270). Mr. Steiner testified that the PRM defined "variable costs as those that vary based on utilization" and in response to a query whether drugs could be considered "semi-fixed costs" testified that drugs chargeable to a particular patient was utilization and that "[a]s there are fewer drugs prescribed by physicians, fewer drugs provided by the hospital, the cost would go down. There's less utilization of chargeable drugs." (*Id.* at 271). Plaintiffs did not, however, present any evidence regarding the costs excluded by Mr. Steiner, only argument and inferences from cross-examination of witnesses on general cost topics. Plaintiffs did not present any empirical studies to contradict Mr. Steiner's "commonsense" assumptions. Plaintiffs did not bring in any witnesses to explain why the costs excluded were in fact necessary and essential to the hospitals' core services. In fact, outside of the various cost statements included in the record, the Court cannot make any determination about the validity or invalidity of Mr. Steiner's assumptions.

On the record before the Court, plaintiffs have not carried their burden of proof on their claim the Secretary's decision is not supported by substantial evidence.

C. Newly Discovered Authority

While this matter has been pending, CMS posted notice of a proposed rule change on April 28, 2017,

which plaintiff Lakes Regional has brought to the Court's attention.[8] The proposed rule change directly addresses the VDA calculation methodology discussed above, albeit prospectively only for cost reporting periods beginning on or after October 1, 2017. Federal Register, Vol. 82, No. 081, Part II, 82 FR 19796, 19935. Acknowledging the prospective nature of the rule change, Lakes Regional argues it "clearly demonstrate[s] that the Secretary's decision in the instant case was arbitrary, capricious, and contrary to the intent of the VDA statute and the purpose of the VDA payments. . . ." (Pl. Supp. Brief [33-1] at 4). Defendant argues the proposed rule does not apply and if it does, explains why it does not help plaintiffs. Defendant has provided the Final Rule dated August 14, 2017 for the Court's consideration. 82 Fed. Reg. 37990, 2017 WL 3453563 (Aug. 14, 2017). (Def. Resp. [37-1], Ex. A) ("Ex. A").

The Court does not reach the issue how the Proposed Rule or Final Rule apply to plaintiffs' VDA calculations as it agrees neither have any effect in the present case. With respect to the Proposed Rule, under Eighth Circuit law, "proposed regulations . . . have no legal effect." *United States v. Springer*, 354 F.3d 772, 776 (8th Cir. 2004) (quoting *Sweet v. Sheahan*, 235 F.3d 80, 87, 2d Cir. 2000)). As for the Final Rule, by its terms it applies to "cost reporting periods beginning on or after October 1, 2017." (Ex. A at 14) ("We also do not agree that we should apply our proposed methodology

[8] Plaintiff Unity HealthCare has also supplemented their briefing with reference to the amended regulation. (Pl. Supp. Brief [33-1]).

retroactively." (*Id.* at 13)). Plaintiff does not specifically seek retroactive application of the Final Rule but argues it is evidence the Secretary's application of the VDA methodology in the present case was arbitrary, capricious, and an abuse of discretion. (Pl. Brief [33-1] at 4). "The mere fact that regulations were modified, without more, is simply not enough to demonstrate that the prior regulations were invalid." *LaRouche v. Fed. Election Comm'n*, 28 F.3d 137, 141 (D.C. Cir. 1994). *See also Nat'l Cable & Telcomms. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 981-82 (2005) ("An initial agency interpretation is not instantly carved in stone. On the contrary, the agency . . . must consider varying interpretations and the wisdom of its policy on a continuing basis . . . ," quoting *Chevron, USA v. Nat'l Resources Defense Council, Inc.*, 467 U.S. 837, 863-64 (2008)); *Smiley v. Citibank*, 517 U.S. 735, 741-42 (1996) ("change is not invalidating"). The fact that the Secretary has made modifications to VDA methodology to be applied to future cases has no effect on the Court's findings in the present case.

The Court also has reviewed Magistrate Judge Mahoney's Report and Recommendation in *St. Anthony Regional Hospital v. Hargan*, No. 5:16-cv-3117-LTS (N.D. Iowa Dec. 29, 2017). The arguments considered in that Report and Recommendation correspond with those made in this case. The Court agrees with Judge Mahoney's analysis.

V. CONCLUSIONS OF LAW AND ORDER FOR JUDGMENT

The Court finds the Secretary's decision regarding VDA payments to plaintiff hospitals was not arbitrary, capricious or contrary to law and was supported by substantial evidence. The Secretary's decision is **affirmed** and plaintiffs' Complaint is dismissed.

IT IS SO ORDERED.

Dated this 30th day of January, 2018.

/s/ Helen C. Adams
Helen C. Adams
Chief U.S. Magistrate Judge

CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Unity Healthcare Muscatine, Iowa	**Reimbursement Determination for Period Ending**
Provider	**June 30, 2016**
vs.	**Review of: PRRB Dec. No. 2014-D15**
Blue Cross Blue Shield Association/Wisconsin Physicians Service (MAC)	**Dated: July 10, 2014**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from CMS' Center for Medicare (CM) requesting a partial reversal of the Board's decision. Comments were also received from the Provider requesting a partial reversal of the Boards decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Medicare Administrative Contractor (MAC), properly calculated the Medicare dependent hospital volume decrease adjustment (VDA) for the Provider, for fiscal year 2006, by excluding certain variable and semi-fixed costs.

The Board affirmed the Intermediary's determination in regard to variable costs and found that the Medicare Administrative Contractor (MAC) correctly identified and eliminated variable costs in determining that the Provider's fixed costs for FY 2006 was $5,033,835 for purposes of the determination on the Provider's request for an Sole Community Hospitals (SCH) volume decrease adjustment.

Regarding the volume decrease adjustment amount, the Board found that the MAC improperly calculated the low volume adjustment payment for the Provider. The Provider is subject to the "not to exceed" limitation imposed by the controlling regulation found at 42 CFR 412.108(d)(3) and the application of PRM 15-1 Section 2180.1. The Provider should receive a volume decrease adjustment payment in the amount $741,308. Accordingly, the Board modified the MAC's calculation of the low volume adjustment payment.

SUMMARY OF COMMENTS

CM submitted comments stating that it agreed with the Board that the MAC properly identified and eliminated variable costs. CM disagreed with the Board regarding

its finding that the MAC improperly calculated the VDA payment for the Provider. CM recommended that the Administrator reverse the Board's decision and uphold the MAC's determination in regard to the VDA payment calculation.

The Provider submitted comments stating that it disagreed with the Board's finding that the MAC properly identified and eliminated variable costs. The Provider recommended that the Administrator reverse the Board's decision and uphold the MAC's determination in regard to the exclusion of VDA payments. The Provider agreed with the Board regarding its finding that the MAC improperly calculated the VDA payment for the Provider.

The Intermediary submitted comments which incorporated CM's comments. The Intermediary also requested that the Administrator reverse the Board's VDA calculation methodology, while affirming the Board's decision to remove variable costs.

BACKGROUND AND DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision and finds that the Board's decision should be modified. The Board's decision on the calculation of the VDA is not supported by the controlling regulations, policies and precedents.

The Provider, Unity Healthcare is a rural, inpatient prospective payment system (IPPS) hospital located in Muscatine, Iowa and the Provider's fiscal year (FY) ends June 30th. At all relevant times, the Provider qualified and was reimbursed as an Sole Community Hospitals (SCH).

From FY 2005 to FY 2006, the Provider experienced a 16.89 percent decline in inpatient discharges. The MAC agrees with the Provider that the decline was due to external circumstances beyond the Provider's control.[1] On December 7, 2007, the Provider received its notice of program reimbursement (NPR) for FY 2006.[2] Shortly thereafter, the Provider submitted a request to the MAC for an SCH volume decrease adjustment of $741,308.

In reviewing this low volume adjustment request, the MAC adjusted the Provider's reported expenses by classifying certain costs, specifically, billable medical supplies, billable drugs, IV drugs, third-party goods and services, including physical therapy, lab, blood and radiology, as variable costs and excluded those reclassified costs from the low volume adjustment calculation.[3] On July 22, 2009, the MAC responded to the Provider's request with a final determination that granted the Provider an SCH volume decrease adjustment of $76,314 for FY 2006.

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[1] MAC Final Position Paper at 3.

[2] Provider Exhibit P-1.

[3] Provider Exhibits P-2 to P-6; Transcription of Oral Hearing at 13.

The Administrator finds that the MAC correctly identified and eliminated variable cost in determining that the Provider's fixed costs for FY 2006 for purposes of the Provider's request for an SCH volume decrease adjustment. Furthermore, the MAC properly calculated the low volume adjustment payment for the Provider since the Provider is subject to the "not to exceed" limitation imposed by the controlling regulation and PRM instructions.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the IPPS. The IPPS provides Medicare payment for hospital inpatient operating and capital related costs at predetermined, specific rates for each hospital discharge.

The IPPS also allows special treatment for facilities that qualify as "Sole Community Hospitals or SCHs." The main statutory provisions governing SCHs are located at Section 1886(d)(5)(D) of the Social Security Act (the "Act") and they define an SCH as a facility that: (1) is located more than 35 road miles from another hospital; (2) by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care, location, weather conditions, travel conditions, or absence of other like hospitals, is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A; or (3) is located in a rural area that has been designated as an essential access community hospital.

Section 1886(d)(5)(D)(ii) of the Act authorizes the Secretary of DHHS to adjust the payment of SCHs that incur a decrease in discharges of more than 5 percent from one cost reporting year to the next, stating:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining core staff and services.

The regulations implementing this statutory adjustment are located at 42 CFR 412.92(e). In particular, subsection (e)(1) specifies the following regarding low volume adjustment:

> The intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances [beyond the hospital's control] a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period.

Once an SCH demonstrates that it has suffered a qualifying decrease in total inpatient discharges, the intermediary must determine the appropriate amount, if any, due to the provider as an adjustment. In this

regard42 CFR 412.92(e)(3) of the controlling regulation specifies the following regarding the determination of low volume adjustment amount:

> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs. . . .
>
> (i) In determining the adjustment amount, the intermediary considers –
>
> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
>
> (C) The length of time the hospital has experienced a decrease in utilization.

In addition to the controlling regulation, CMS also provides interpretive guidelines in the Provider Reimbursement Manual, CMS Pub. No. 15-1 (PRM 15-1). PRM 15-1 is intended to ensure that Medicare reimbursement standards "are uniformly applied nationally without

regard to where covered services are furnished.[4] While PRM 15-1 does not specifically address MDH low volume adjustments, it does address SCH low volume adjustments at PRM 15-1 Section 2810.1. As the criteria for SCH and MDH low volume adjustments are identical, the PRM 15-1 guidance on SCH low volume adjustment is applicable to MDH low volume adjustments.

Specifically, Section 2810.1 provides guidance to assist MACs in the calculation of volume decrease adjustments for sole community hospitals (SCHs). In this regard, Section 2810.1(B) states the following regarding the amount of a low volume adjustment:

> B. Amount of Payment Adjustment. Additional payment is made to an eligible SCH for fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
>
> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.

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[4] *See* CMS Pub. 15-1, Foreward.

> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.
>
> In evaluating semi-fixed costs, the MAC considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semi-fixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semi-fixed costs may not be included in determining the amount of the payment adjustment.

PRM 15-1 Section 2810.1(D) provides the following instruction regarding the processing of an adjustment request:

> D. Determination on Requests. The MAC reviews a hospital's request for additional payment for completeness and accuracy. If any of the required documentation is missing, incomplete, or inaccurate, the MAC requests the needed information. The MAC makes a determination on the request and notifies the hospital of the decision within 180 days of the date the MAC receives all required information.

> The payment adjustment is calculated under the same assumption used to elevate core staff, i.e. the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.

The core dispute in this case centers on the application of the statute to the proper classification and treatment of costs and the proper calculation of the amount for the low volume adjustment. The Administrator's examination of the governing statutes and implementing regulations and guidance clearly recognize three categories of costs, i.e., fixed, semi-fixed and variable. The guidance only considers fixed and semi-fixed costs within the calculation of the volume adjustment but not variable costs.

The Board properly accepted the MAC's determination and elimination of variable costs for FY 2006. The MAC's exclusion of the Provider's billable medical supplies, billable drugs and IV solutions, professional services obtained from third party providers, and dietary and linen expenses as variable was proper and consistent with the regulation, guidance and intent of the adjustment.

The treatment of variable cost within the calculation of the volume decrease adjustment is well established.

The plain language of the relevant statute and regulation, Section 1886(d)(5)(G)(iii) and 42 CFR 412.108(d), make it clear that the VDA is intended to compensate qualifying hospitals for their fixed costs, not their variable costs. This position is also supported by past decisions, such as *Greenwood County*, PRRB Dec. No. 2006-D43, where the Board correctly eliminated variable costs from the calculation. Therefore the Administrator affirms the Board's decision regarding the elimination of variable costs from the Provider's VDA payment adjustment request.

Regarding the methodology and proper calculation of the Provider's payment adjustment, the Administrator finds that the Board improperly calculated the Provider's adjustment and reverses that portion of the Board's decision. The VDA calculation methodology used by the Board is in direct contradiction to the statute and CMS' regulations and guidance. The Board's methodology uses a VDA payment equal to the hospital's fixed costs not to exceed the difference between the hospital's total operating costs and its DRG payment as follows:

Board's Calculation of Payment Adjustment:	
Provider's total operating costs:	$5,698,829
Net Variable costs:	$ 664,994
Provider's fixed costs/ VDA Payment Amount:	**$5,033,835**

Per the Board's methodology, the Provider's VDA is equal to its fixed costs of $5,033,835 not to exceed the ceiling:

Board's Calculation of the Ceiling:	
Provider's total operating costs:	$5,698,829
Provider's DRG payment:	$4,957,521
Ceiling:	**$ 741,308**

The Board's calculation incorrectly concludes that the payment amount for the VDA is $5,033,835 subject to the ceiling of $741,308, resulting in a VDA payment of $741,308. The Administrator finds that the Board properly calculated the ceiling amount, however, the MAC properly calculated the correct payment adjustment by following the controlling statute, regulations as also reflected in the prior Board decision in *Greenwood*, cited *supra*, as follows:

MAC's Calculation of Payment Adjustment:	
Provider's total operating costs:	$5,698,829
Net Variable costs:	$ 664,994
Provider's fixed costs:	$5,033,835
Provider's DRG payment:	$4,957,521
VDA Payment Amount:	**$ 76,314**

The MAC applied the proper methodology which represents that the Provider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG payment, which in this case equates to $76,314, subject to the ceiling of $741,308.

The payment amount calculated by the Board overcompensates the Provider since the Provider's DRG payments contain partial compensation for its fixed costs.[5] Furthermore, by maintaining that the payment amount is equal to the hospital's fixed costs not to exceed the ceiling (i.e., the difference between the hospital's total costs and its DRG payment), the Board is essentially saying that the VDA payment is equal to the ceiling because the fixed costs ($5,033,835 in this case) will always be greater than the ceiling as calculated by the Board ($741,308). This renders the MAC's elimination of variable costs as affirmed by the Board, meaningless because the payment amount will always result in the difference between the hospital's total costs and its DRG payment which does not, fully compensate [a qualifying provider] for the fixed costs it incurs. The Board's methodology does not isolate the difference between the hospital's fixed and semi-fixed

[5] In the September 1, 1987 final rule, CMS revised 412.92(e)(3) to specify that the VDA would be paid as a "lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue based on DRG-adjusted prospective payment rates." Hospitals that receive payments that are greater than the hospital's Medicare inpatient operating costs have been "fully compensated" for those costs by the prospective payment system . . . Therefore, 412.92(e)(3) was revised to make it clear that any adjustment amounts granted to SCHs for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and the total payments made under the inpatient prospective payment system, including outlier payments and indirect medical education costs. (52 Fed. Reg. 33049, September 1, 1987).

costs and its DRG payment in order to properly compensate the provider for its fixed and semi-fixed costs.

In sum, the Administrator finds that the Board properly found that the MAC correctly identified and eliminated variable costs in determining the Provider's fixed costs for FY 2006 for purposes of the determination on the Provider's request for an SCH volume decrease adjustment, and affirms the Board on that portion of the decision. However, as discussed above, the Administrator finds that the Board's calculation of the volume decrease adjustment amount was improper. Therefore the Administrator modifies the Board's decision as it specifically relates to the calculation of the Provider's volume decrease amount adjustment.

DECISION

The decision of the Board is modified in accordance with the foregoing opinion.

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

Date: Sept. 4, 2014

/s/
Marilyn Tavenner
Administrator
Centers for Medicare
& Medicaid Services

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION
2014-D15

PROVIDER –
UNITY HEALTHCARE
MUSCATINE, IA

Provider No.: 16-0013

vs.

INTERMEDIARY –
BlueCross BlueShield Association/Wisconsin Physician Services

DATE OF HEARING -
February 2, 2012

Cost Reporting Period Ended -
June 30, 2006

CASE NO.: 10-0386

INDEX

Page No.

[2] ISSUES:

Whether the Medicare Administrative Contractor improperly calculated the provider's sole community hospital volume decrease adjustment by excluding certain variable and semi-fixed costs?[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. The Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare and Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare Administrative Contractors ("MACs").[2] FIs and MACs determine payment amounts due the providers under

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[1] Transcript("Tr") at 5-6.

[2] The Medicare contractor in this case is a MAC. Hereinafter, MAC and intermediary are used interchangeably.

Medicare law and under interpretive guidelines published by CMS.[3]

At the close of its accounting year, a provider must submit a cost report to the MAC showing the costs it incurred during the relevant fiscal year and the proportion of those costs to be allocated to the Medicare program.[4] The MAC reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement ("NPR").[5] A provider dissatisfied with the MAC's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the issuance of the NPR.[6] Other relevant laws, regulations and related documents are presented as follows.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Inpatient Prospective Payment System ("IPPS").[7] IPPS provides Medicare payment for hospital inpatient operating and capital related costs at predetermined, specific rates for each hospital discharge.

IPPS also allows special treatment for facilities that qualify as "Sole Community Hospitals" "SCHs").[8] The

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[3] *See* 42 U.S.C. § 1395h; 42 C.F.R. §§ 413.20(b), 413.24(b).

[4] 42 C.F.R. § 413.20.

[5] 42 C.F.R. § 405.1803.

[6] 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

[7] *See* 42 U.S.C. § 1395ww(d).

[8] 42 CFR § 412.92.

main statutory provisions governing SCHs are located in 42 U.S.C. § 1395(d)(5)(D) and they define an SCH as a facility that: (1) is located more than 35 road miles from another hospital; (2) by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care, location, weather conditions, [3] travel conditions, or absence of other like hospitals, is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A; or (3) is located in a rural area that has been designated as an essential access community hospital under 42 U.S.C. § 1395i-4(i)(1).[9]

42 U.S.C. § 1395ww(d)(5)(D)(ii) authorizes the Secretary of DHHS to adjust the payment to SCHs that incur a decrease in discharges of more than 5 percent from one cost reporting year to the next, stating:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

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[9] 42 U.S.C. § 1395ww(d)(5)(D)(iii).

The regulations implement this statutory adjustment are located at 42 C.F.R. § 412.92(e). In particular, subsection (e)(1) specifies the following regarding low volume adjustment:

> The intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances [beyond the hospital's control] a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period.

Once an SCH demonstrates that it has suffered a qualifying decrease in total inpatient discharges, the intermediary must determine the appropriate amount, if any, due to the provider as an adjustment. In this regard, subsection (e)(3) of the controlling regulation specifies the following regarding the determination of the low volume adjustment amount:

> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG- adjusted prospective payment rates for inpatient operating costs. . . .
>
> (i) In determining the adjustment amount, the intermediary considers—
>
> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and [4] services

> in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
>
> (C) The length of time the hospital has experienced a decrease in utilization.[10]

In addition to the controlling regulation, CMS also provides interpretive guidelines in the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2810.1(B). PRM 15-1 is intended to ensure that Medicare reimbursement standards "are uniformly applied nationally without regard to where covered services are furnished."[11] To this end, § 2810.1(B) provides guidance to assist MACs in the calculation of volume decrease adjustments for SCHs. In particular, § 2810.1(B) states the following regarding the amount of a low volume adjustment for SCHs:

> B. Amount of Payment Adjustment. – Additional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.

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[10] 42 C.F.R. § 412.92(e)(3).

[11] *See* CMS Pub. 15-1, Foreword.

> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.
>
> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.
>
> In evaluating semi-fixed costs, the MAC considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semi-fixed costs are considered fixed. As the period of decreased utilization continues, we expect that a [5] cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semi-fixed costs may not be included in determining the amount of the payment adjustment.

The PRM 15-1 § 2810.1(D) provides the following instruction regarding the processing of an adjustment request:

> D. Determination on Requests. – The MAC reviews a hospital's request for additional payment for completeness and accuracy. If any of the required documentation is missing, incomplete, or inaccurate, the MAC requests the needed information. The MAC makes a determination on the request and notifies the hospital of the decision within 180 days of the date the MAC receives all required information.
>
> The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.

The dispute in this case centers on the application of the statutes to the proper classification and treatment of costs and the proper calculation of the amount for the low volume adjustment.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Unity Healthcare ("Provider") is a rural, IPPS hospital located in Muscatine, Iowa and the Provider's fiscal year (FY) ends June 30th. At all relevant times, the Provider qualified and was reimbursed as an SCH. The

Provider's designated intermediary is Wisconsin Physician Services ("MAC").

From FY 2005 to FY 2006, the Provider suffered a 16.89 percent decline in inpatient discharges. The MAC has stipulated that the decline was due to external circumstances beyond the Provider's control.[12] On December 7, 2007, the Provider received its NPR for FY 2006.[13] Shortly thereafter, the Provider submitted a request to the MAC for an SCH volume decrease adjustment of $741,308.

In reviewing this low volume adjustment request, the MAC adjusted the Provider's reported expenses by classifying certain costs, specifically, billable medical supplies, billable drugs, IV drugs, third-party goods and services, including physical therapy, lab, blood and radiology, as [6] variable costs and excluded those reclassified costs from the low volume adjustment calculation.[14] On July 22, 2009, the MAC responded to the Provider's request with a final determination that granted the Provider an SCH volume decrease adjustment of $76,314 for FY 2006.[15]

On January 14, 2010, the Provider timely filed an appeal with the Board and met the jurisdictional requirements of 42 C.F.R §§ 405.1835 - 405.1841. The Medicare reimbursement amount in controversy is the

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[12] MAC Final Position Paper at 3.

[13] Provider Exhibit P-1.

[14] Provider Exhibits P-2 thru P-6; Tr. at 13.

[15] Provider Exhibit P-2.

difference between the $741,308 claimed by the Provider and the $76,314 paid by the MAC: $664,994.

The Board conducted a hearing on February 2, 2012. The Provider was represented by Kirk S. Blecha, Esq., and Andrew D. Kloeckner, Esq., of Baird Holm, LLP. The MAC was represented by James R. Grimes, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that, based upon the decline in its inpatient discharges from FY 2005 to FY 2006, it is eligible to receive a volume decrease adjustment in the amount of $741,308.[16] The Provider argues that it calculated its volume decrease adjustment in accordance with the law and the instructions in the PRM 15-1 § 2810.1 and that the MAC unilaterally and without legal authority reclassified certain fixed and semi-fixed costs as variable.[17] The MAC excluded the reclassified variable costs from the volume decrease adjustment calculation which resulted in a revised adjustment amount of $76,314.[18] The Provider submits that the reclassified costs are not "variable" but rather are "fixed"

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[16] Provider Exhibit P-3; *see also* PRM 15-1 § 2810.1(D) (setting forth sample calculation).

[17] The reclassified categories of costs at issue are: (i) billable medical supplies; (ii) billable drugs and IV solutions; (iii) professional services obtained from third party providers such as physical therapy, reference laboratory, blood bank, and diagnostic imaging; and (iv) dietary and linen expenses. *See* Provider Exhibit P-2 at 6.

[18] Exhibit Provider P-2 at 1.

costs and that these costs should be treated accordingly in the calculation of the adjustment amount. The Provider cites to the PRM 15-1 § 2810.1(B), which defines "fixed costs" as "those costs over which management has no control."[19] The Provider contends that the hospital management had no ability to control the particular costs at issue and that, as a result, these costs should properly be defined as fixed for the purpose of calculating the Provider's volume decrease adjustment amount.[20] The Provider contends that the Board should look past traditional cost accounting concepts of fixed and variable costs and instead rely upon the costing definitions provided in the PRM 15-1.

In the alternative, the Provider contends that, even if the costs excluded by the MAC are not "fixed," they nonetheless should be included in the volume decrease adjustment as "semi-fixed" costs. In support of this argument, the Provider cites the following language from PRM 15-1 § 2810.1(B):

> [7] In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume.

This section further states: "For a short period of time, most semi-fixed costs are considered fixed."

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[19] PRM 15-1 § 2810.1(B).

[20] Tr. at 43-44.

The Provider argues that, based on § 2810.1(B), a semi-fixed cost is a cost that may be considered variable in a cost accounting sense, but is nevertheless a cost that is essential to hospital operations, *i.e.*, the hospital could not operate without the availability of the particular item or service. The Provider contends that the cost categories excluded by the MAC were essential for the Provider to maintain its operations as a hospital,[21] that the MAC's own witness agreed that the excluded costs were "core costs" necessary for the Provider to maintain the operation of the hospital[22] and should, at the very least, be classified as "semi-fixed." The Provider argues further that, because the decreases in discharges occurred over a short period of time, the MAC should have considered these semi-fixed costs as fixed, as directed by the PRM 15-1.[23]

The Provider also asserts that the term "variable" should be limited to those specific examples of "variable" costs provided in the PRM 15-1 § 2810.1(B). The Provider further notes that § 2810.1(B) only uses the term "variable" twice but offers substantive details for other elements of the volume decrease adjustment. The Provider submits that this is consistent with the overarching intent of the PRM 15-1, which is to ensure that reimbursement rules are uniformly applied on a nationwide basis.[24] Any other interpretation of the

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[21] Tr. at 44, 56, 58, 61, 64, 69-70.

[22] Tr. at 306-307, 318.

[23] PRM 15-1 § 2810.1(B).

[24] *See* PRM 15-1, Foreword.

word "variable" would allow MACs to use their own definitions of "variable" and subject the calculation to manipulation, contrary to the express intent of the PRM 15-1. The Provider contends that, even when truly "variable" costs are excluded from the calculation, there is no impact on the Provider's volume decrease adjustment.[25]

The Provider also contends that, when the MAC made its exclusion adjustments, it failed to recognize that the DRG payments received by the Provider throughout the year contain components that are intended to compensate the Provider for its fixed, semi-fixed, and variable costs. Ideally, DRG reimbursement equals the total cost of providing care to a particular patient. The Provider recognizes that a hospital makes or loses money on a Medicare beneficiary depending on whether its actual costs in providing care to the beneficiary (fixed, semi-fixed, and variable) exceed or fall below the DRG payment received from the MAC. The Provider argues that the intent behind the volume decrease adjustment is to make an eligible provider whole if it experiences an unexpected decrease in discharges over a short period of time. The Provider contends that the MAC's cost exclusion violated the intent and spirit of the volume decrease [8] adjustment. It created an imbalance between the Provider's DRG payments and the costs used in the adjustment calculations. If those costs are properly excludable, the Provider contends that the total DRG payment figure

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[25] Provider Exhibit P-7.

utilized to calculate the volume decrease adjustment should also be decreased by the component of the DRG that reimburses the hospital for those same costs.

The Provider also argues that the MAC's cost exclusion was arbitrary, capricious, and made without any basis in law or in fact. The MAC sought guidance from CMS on the calculations but received no response.[26] It was not until the appeal was filed that CMS agreed with the MAC's decision, and even then, CMS did not describe the types of costs that should be excluded by the MAC as variable.[27] Guidance provided by CMS after the fact may not be applied retroactively to the detriment of the Provider.[28] Further, the MAC recognized that the excluded costs were not controllable by management, a key characteristic of a "fixed" cost.[29] The MAC also recognized that the excluded costs were essential to hospital operations, and so met the definition of a "semi-fixed" cost.[30] The Provider contends that the MAC ignored these definitions when it excluded costs as variable costs, and so acted in an arbitrary and capricious manner.

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[26] Tr. at 322-323.

[27] MAC Exhibits I-6 and I-7.

[28] *See Catholic Health Initiatives - Iowa, Corp. v. Sebelius*, 841 F. Supp. 2d (D.D.C. 2012) (holding that the Secretary may not retroactively apply a substantive change in policy or practice when the change attaches new legal consequences to a provider), *rev'd*, 718 F.3d 914 (D.C. Cir. 2013).

[29] Tr. at 325-327.

[30] Tr. at 306-307 and 318.

The Provider also asserts that the MAC's cost exclusions were based on broad statements and assumptions that have no basis in law or in fact. The MAC stated that it "identified those costs that obviously vary with patient volume, i.e., billable drugs and supplies and outside patient services."[31] The MAC further stated that the cost categories eliminated "would obviously vary in direct correlation to the number of patients and are therefore deemed variable."[32] Further, the MAC asserted that "[f]ewer patients mean less demand for drugs, which should mean less cost for drugs. These costs therefore vary directly with utilization."[33] At the hearing, however, the MAC testified that it did not consult any empirical studies or legal documents that would lead to a conclusion that fewer patients mean less drugs.[34] The MAC agreed with the Provider's contention that fewer patients does not necessarily mean that fewer drugs or fewer outside services would be needed but, rather, there could be numerous plausible scenarios where a provider could have fewer but sicker patients who needed significantly more drugs or outside services.[35] The Provider also contends, these costs do not vary directly with utilization, which is a key characteristic of a "variable" cost. Although there may be some correlation between discharges and these costs, such an indirect correlation means these costs

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[31] MAC Final Position Paper at 11.

[32] *Id.*

[33] MAC Final Position Paper at 12-13.

[34] Tr. at 309.

[35] Tr. at 312-318.

only vary somewhat with discharges and that these costs are best classified as semi-fixed. By failing to rely on any sort of studies or other guidance to determine those costs to exclude as variable, the MAC's cost exclusion was arbitrary and capricious and without any basis in law or in fact.

[9] MAC'S CONTENTIONS:

The MAC argues that the collective body of governing statutes, regulations, and CMS guidance make clear that the intention of the volume decrease adjustment is to ensure that a qualifying SCH is compensated for *fixed* costs, which by definition requires that variable costs be excluded from the payment calculation. The controlling federal statute specifies this clearly:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital *for the fixed costs* it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.[36]

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[36] 42 U.S.C. § 1395ww(d)(5)(D)(ii) (emphasis added).

The MAC argues that this language makes clear that the adjustment to the patient amounts is to fully compensate hospitals for only the fixed costs that they incur in providing hospital services as well as core staff and service and that variable cost be removed from the payment calculation.[37]

The MAC also challenges the Provider's contention that the language at 42 C.F.R. § 412.108(e)(3) controls the volume decrease adjustment payment. The MAC argues that the section simply describes the limitation in the lump sum payment, not the calculation of the payment itself. In support, the MAC asserts that this regulation in subsection (e)(3)(i) requires that when "[t]he Intermediary determines a lump sum adjustment amount" it must consider the following factors:

> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

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[37] *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006) (stating that "these adjustments were designed to compensate an SCH or MDH for the fixed costs it incurs in the year following the reduction in discharges (that is, the second year), which it may be unable to reduce. Such costs include the maintenance of necessary core staff and services").

> (C) The length of time the hospital has experienced a decrease in utilization.

[10] The MAC contends that the language in clause (B) requires that the MAC consider the hospital's fixed and semi-fixed costs in determining the payment amount and, by exclusion, not consider variable costs in the payment. The MAC argues that the Board adopted this interpretation in its 2006 decision in *Greenwood County Hospital v. BlueCross BlueShield Association* ("*Greenwood County*")[38]as evidenced by the following excerpt:

> The Board, however, finds that the Intermediary correctly chose not to consider within its calculation those costs which the provider, by its own election, labeled as variable. The Board finds that 42 C.F.R. § 412.96(e) and PRM § 2810.1 explicitly dictate that the adjustment is limited to fixed and semi-fixed costs. While the Provider contends the reference to "operating costs within the regulation allows some variable costs to be included in the adjustment, such reference applies to the methodology for calculating the limit of an adjustment. Accordingly, the $1,003,599 of variable costs identified by the Provider should be excluded from the low volume adjustment. Since the total program cost is now reduced to $1,920,154 and the DRG payment amount

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[38] PRRB Dec. No. 2006-D43 at 9 (Aug. 29, 2006), *declined review*, Administrator (Oct. 13, 2006),

> was $1,570,475, the Provider is entitled to an adjustment of $349,679.[39]

The MAC also challenges the Provider's interpretation of PRM 15-1 § 2810.1 which assumes that, because the limitation is based upon total Medicare operating costs (including variable costs), the payment should be based upon total Medicare inpatient operating costs. The MAC contends that PRM 15-1 § 2810.1 provides a formula for determining a limit on the payment that is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue" and that this calculation of limitation is independent of the calculation of the actual payment. In support of this position, the MAC again cites to the language in the Board's decision in *Greenwood County*:

> The Board notes that while consistent with the regulation, the text at PRM § 2810.B . . . explicitly dictates that fixed (and semi-fixed) costs may comprise the adjustment, the use of the term "operating costs" in the subsequent examples . . . may suggest that variable costs could be included. However, the Board finds that the examples are intended to demonstrate how to calculate the adjustment limit as opposed to determining which costs should be included in the adjustment.[40]

The MAC disagrees with the Provider's assertion that comparing the provider's actual costs, exclusive of

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[39] *Id.* at 8-9.

[40] *Id.* at 8 n.19.

variable cost, to the actual amounts that were paid to the provider under the IPPS payment system is unbalanced as the payment made under the IPPS system includes reimbursement for variable costs. Rather, the MAC contends that the intent of the regulation is [11] to ensure only that the provider has been fully compensated for the *fixed* costs incurred during the fiscal period. To this end, the MAC contends that the only way to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider. This is achieved by comparing the provider's actual costs, exclusive of variables cost, to the actual amounts that were paid to the provider under the IPPS payment system.

In determining variable costs, the MAC followed the written guidance which states: "Variable costs, on the other hand, are those costs for items and service that vary directly with utilization such as food and laundry costs."[41] This definition makes clear that services charged directly to patients, *i.e.*, billable drugs and supplies as well as outside services such as therapy, would vary in direct correlation to the number of patients and should be classified as variable costs. As such they are properly excluded from the volume decrease payment adjustment in accordance with the regulations.

The MAC also disputes the Provider's assertion that the costs identified and excluded as variable by the

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[41] PRM 15-1 § 2810.1(B).

MAC should be classified as semi-fixed. Again, PRM § 2810.1(B) specifies:

> Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.
>
> In evaluating semi-fixed costs, the intermediary considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semi-fixed costs are considered fixed.

The MAC argues that the excluded costs are variable because they vary directly with patient usage.[42] As patient volume decreases, the demand for such services declines, directly reducing the level of the costs generated. Further, the MAC argues that the intent of CMS in considering some semi-fixed costs as fixed was primarily to protect providers' personnel related costs.[43] CMS recognizes that, while a decrease in patient days may indicate a need for less nursing staff, layoffs may disrupt the provider's operations and infringe on minimum staffing requirements. For this reason, the MAC contends that it did not exclude personnel costs from the payment amount and that only those costs with variable characteristics were properly excluded.

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[42] Tr. at 284.

[43] *See supra* note 37.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, evidence presented in the record and the parties' contentions and stipulations, the Board finds and concludes that the MAC [12] properly excluded variable costs from the calculation of the Provider's sole community hospital volume decrease adjustment amount. However, the Board also finds that the MAC's calculation of that payment adjustment amount was not consistent with 42 C.F.R. § 412.92(e)(3) and PRM 15-1 § 2810.1 and, accordingly, is not proper.

VARIABLE COSTS:

A primary dispute between the parties centers on the proper treatment of variable and semi-fixed costs within the calculation of the Provider's sole community hospital volume decrease adjustment. The Provider argues that fixed costs are "those costs over which management has no control"[44] and, accordingly, such costs are properly classified as fixed in the context of a volume decrease. The Provider also contends that, even if the costs excluded by the MAC are not "fixed," they nonetheless should be included in the volume decrease adjustment as "semi-fixed" costs. The Provider argues that "[s]emi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume"[45] and,

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[44] PRM 15-1 § 2810.1(B).

[45] *Id.*

"[f]or a short period of time, most semi-fixed costs are considered fixed."[46] The Provider contends that all of the costs excluded by the MAC were essential for the hospital to maintain its operations and are properly classified as semi-fixed costs. The Provider argues that PRM 15-1 § 2810.1(B) requires that the MAC consider semi-fixed costs to be fixed and include them in the calculation of the volume decrease adjustment amount.

The Board's examination of the governing statutes and implementing regulations and guidance does not support the Provider's argument. The Board can find nothing in the language of the controlling federal statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii), the controlling regulation at 42 C.F.R. § 412.92(e)(1)-(3), or the manual guidance at PRM 15-1 § 2810.1(B) that supports the Provider's position that, once costs are experienced in an environment of reduced volume, they becomes fixed or, alternatively semi-fixed, costs regardless of their nature or characteristics. While the controlling federal statute provides that the Secretary "shall provide for such adjustment to the payment amounts under this subsection . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital service," it recognizes that not all costs are *fixed*. Consistent with the controlling federal statute, both the implementing regulation and manual guidance clearly recognize three categories of costs, *i.e.*, fixed, semi-fixed and variable. Further, the guidance considers only fixed and semi-fixed costs

[46] *Id.*

within the calculation of the volume adjustment but not variable costs. The Board believes that the omission is significant and decisive in this case.

The Board's finding is further supported by the discussion included in the interim final rule published on September 1, 1983 that implemented the special payment provisions for SCHs, including the SCH payment adjustment for SCHs experiencing a 5 percent decrease in patient volume.[47] As part of this final rule, CMS adopted the regulatory provision currently located at 42 C.F.R. § 412.92(e)(3)(B) that specifies that the volume decrease payment adjustment should consider, among other things, "[t]he hospital's fixed (and semi-fixed) costs, other than those [13] costs paid on a reasonable cost basis under part 413 of this chapter."[48] In this regard, CMS included the following discussion in the preamble on fixed and semi-fixed costs:

> The statute requires that the payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services including the

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[47] 48 Fed. Reg. 39752, 39780-39784 (Sept. 1, 1983).

[48] Originally, this regulatory provision was located at 42 C.F.R. § 405.476(d)(3)(H); redesignated in 1985 as 42 C.F.R. § 412.92(e)(3)(ii) without substantive change; and again redesignated in 1988 as 42 C.F.R. § 412.92(e)(3)(i)(B) without substantive change. *See* 48 Fed. Reg. at 38828; 50 Fed. Reg. 12740, 12741, 12756 (Mar. 29, 1985); 53 Fed. Reg. 38476, 38530 (Sept. 1, 1988); 55 Fed. Reg. 15150, 15174 (Apr. 20, 1990) (correcting an editorial error made in the September 1, 1988 redesignation). *Compare* 42 C.F.R. § 405.476(d)(3)(ii) (1984) with 42 C.F.R. § 412.92(e)(3)(i)(B) (2005).

reasonable cost of maintaining necessary core staff and services.

Fixed costs are defined as those over which management has no control. Most true fixed costs such as rent, interest, and depreciation are capital-related costs and would be paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization. However, in a hospital setting many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but will also vary with volume. For purposes of this adjustment, many semifixed costs, such as personnel related costs, may be considered as fixed on a case by case basis. *An adjustment will not be made for truly variable costs, such as food and laundry services*.

In evaluating semifixed costs, such as personnel, HCFA will consider the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs would be considered fixed. As the period of decreased utilization continues, we would expect that a cost-effective hospital would take some action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, we would not include such costs in determining the amount of the adjustment.

> The statute also requires that the adjustment amount include the reasonable cost of maintaining necessary core staff and services. HCFA will review the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

Thus, at the outset, CMS distinguished fixed and semi-fixed costs from variable costs. Significantly, the PRM 15-1 guidance at issue located in § 2810.1 was initially published in [14] March 1990 and reflects almost verbatim the above discussion on distinguishing fixed and semi-fixed costs from variable costs.[49]

The treatment of variable cost within the calculation of the volume decrease adjustment is not new to the Board. In *Greenwood County*, the Board considered the elimination of variable costs from the calculation and concluded:

> The Board, however, finds that the Intermediary correctly chose not to consider within its calculation those costs. . . . labeled as variable. The Board finds that 42 C.F.R. § 412.96(e) and PRM § 2810.1 explicitly dictate that the adjustment is limited to fixed and semi-fixed costs.[50]

The Provider asks the Board to look past traditional cost accounting concepts of fixed and variable costs and

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[49] PRM 15-1, Transmittal 356 (Mar. 1990) (issuing the criteria PRM 15-1 § 2810.1(B)).

[50] Greenwood County, PRRB Dec. No. 2006-D43 at 8.

instead rely upon the costing definitions provided in PRM 15-1. However, the Board can find nothing in PRM 15-1 that varies with traditional cost accounting concepts. Accordingly, the Board concludes that the MAC correctly eliminated variable costs from the calculation.

Finally, the Board accepts the MAC's determination and elimination of variable costs for FY 2006. Specifically, the Board affirms the MAC's exclusion of the following costs as variable: (1) billable medical supplies; (2) billable drugs and IV solutions; (3) professional services obtained from third party providers such as physical therapy, reference lab, blood bank, and diagnostic imaging; and (4) dietary and linen expenses.[51] These four categories of costs are for services and items that are tied to patient demand (*i.e.*, utilization) and thus, by their nature, are expected to vary directly based on patient volume. Indeed, as noted above, CMS listed dietary and linen costs as examples of "truly variable costs" which are analogous to the other categories of costs at issue. A key phrase that gives context to whether a cost is a fixed cost versus a variable cost is the description of fixed costs as including "the reasonable cost of maintaining necessary core staff and services."

The Provider focuses on the statement in PRM 15-1 § 2810.1(B) that fixed costs are "those costs over which management has no control" and asserts that, because the services/items underlying these four categories of

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[51] *See* Provider Exhibit P-2 at 6.

costs are necessary for the care of the patient (*e.g.*, physician prescription), the costs for such services/items are beyond management control and, thereby, are fixed costs. Under the Provider's reading, essentially all costs would qualify as fixed or semi-fixed because they are necessary for patient care. Thus, the Provider is really asserting that it is due its full reasonable costs.

However, the Provider misconstrues and takes out of context the statement in PRM 15-1 § 2810.1(B). Consistent with the purpose of the adjustment (*i.e.*, to compensate the hospital for fixed costs during a period the hospital experiences a volume decrease of 5 percent or more), this sentence is stated from a macro perspective of the time period in which the SCH experienced the [15] volume decline (*e.g.*, fiscal year) as demonstrated by the following examples of fixed costs given in ensuing sentence: "Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume."

The Board's conclusion is further supported by the statement in § 2810.1(B) that fixed costs include "the reasonable cost for maintaining core staff and services." The operative words to restrict the scope of the fixed costs are "maintaining" and "core."

The Provider failed to provide sufficient evidence that any of the categories of costs that the MAC excluded contained any fixed/semi-fixed costs. The Provider has failed to meet its burden of proof in this regard.

Based on the above, the Board finds that the MAC correctly identified and eliminated variable cost in determining that the Provider's fixed costs for FY 2006 was $5,033,835 for purposes of the determination on the Provider's request for a sole community hospital volume decrease adjustment.[52]

CALCULATION OF THE VOLUME DECREASE ADJUSTMENT:

When CMS promulgated regulations to implement the low-volume adjustment, CMS specified that it was responsible for calculating the low-volume adjustment payment amount for qualifying SCHs on a case-by-case basis.[53] CMS also stated that it determined such payments as "a per discharge payment adjustment" which is consistent with requirement in 42 C.F.R. § 412.92(e)(2) that an applying SCH "must submit documentation demonstrating . . . the resulting effect [of the volume decrease] on per discharge costs."

In the final rule published on September 1, 1987, CMS revised § 412.92(e)(3) to specify that the low-volume adjustment payment would be paid as "a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue based on DRG-adjusted prospective payment rates (including outlier payments)."[54] In the preamble to the 1987 rule, CMS provides the following discussion for making the

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[52] *See* MAC Exhibit I-2 at 1; Provider Exhibit P-2 at 3.

[53] *See* 52 Fed. Reg. at 33049.

[54] 52 Fed. Reg. 33034, 33057 (Sept. 1, 1987).

payment adjustment as a "lump sum" establishing a ceiling to that "lump sum":

> We determine on a case-by-case basis whether an adjustment will be granted and the amount of that adjustment. As specified in Sec. 412.92(e)(3), a per discharge payment adjustment, including at least an amount reflecting the reasonable cost of maintaining the hospital's necessary core staff and services, is determined based on the individual hospital's needs and circumstances, the hospital's fixed and semi-fixed costs not paid on a reasonable cost basis, and the length of time the hospital has experienced a decrease in utilization.
>
> [16] Based on our experience with this provision and the applications we have received from SCHs for a volume adjustment, we believe it is appropriate at this time to clarify the regulations at 412.92(e). Section 1886(d)(5)(C)(ii) of the Act provides that if an SCH experiences a decrease of more than five percent in its total number of inpatient cases due to circumstances beyond its control, " . . . the Secretary shall provide for such adjustment to the payment amount under this subsection . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services." *We believe that this language makes it clear that a hospital that has continued to receive payments under the prospective payment system that are greater than its inpatient*

> *operating costs, even though there has been a decline in occupancy, is not entitled to receive a payment adjustment*. Hospitals that receive payments that are greater than the hospitals' Medicare inpatient operating costs have been "fully compensated" for those costs by the prospective payment system. Consequently, we believe that no further adjustment should be granted to these hospitals. Therefore, we proposed to revise Sec. 412.92(e)(3) to make it clear that any adjustment amounts granted to SCHs for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and the total payments made under the prospective payment system, including outlier payments and indirect medical education payments.[55]

In 1989, CMS stated that it was transferring the responsibility for calculating the low-volume adjustment determinations (including the calculation of the actual low-volume adjustment payment) to its intermediaries and would be issuing "instructions" to its intermediaries for this purpose.[56] Shortly thereafter, in March 1990, CMS issued instructions at PRM 15-1 § 2810.[57]

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[55] *Id.* at 33049.

[56] *See* 54 Fed. Reg. 36452, 36483 (Sept. 1, 1989) (stating that the low-volume adjustment determination could be "decentralized and handled entirely by intermediaries" and that "[w]e are preparing manual instructions for the intermediaries concerning the determination of volume adjustments").

[57] PRM 15-1, Transmittal 356 (Mar. 1990) (adding § 2810 "instructions [to] specify the criteria that a hospital must meet to be classified as an SCH, the procedures for obtaining this

In particular, in § 2810.1(B), CMS provided the following instructions to its intermediaries on the calculation of the low volume payment adjustment amount:

> Additional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.

[17] Thus, the formula for determining the payment adjustment is "fixed costs . . . not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." This formula is consistent with the controlling statute which is quite clear when it states that the low-volume payment adjustment is " . . . to ***fully*** *compensate* the hospital *for fixed costs* it incurs in the period in providing inpatient hospital services, including the reasonable costs of maintaining necessary core staff and services."[58]

In PRM 15-1 § 2810.1(D), CMS sets for the method for determining the ceiling amount. Specifically, CMS states:

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classification, and *the special payment provisions applicable to these hospitals*" (emphasis added)).

[58] (Emphasis added.)

D. Determination on Requests.—. . . .

The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e., the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in costs. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.

EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. The adjustment is calculated as follows:

Hospital C
PPS Payment Adjustment
Fiscal Year Ended 09/30/87

[1]FY 1986 Program Operating Cost		$2,900,000
PPS Update Factor	x	1.0115
FY 1987 Maximum Allowable Cost		$2,933,350
Hospital C FY 1987 Program Inpatient Operating Cost		$2,800,000
[2]FY 1987 DRG Payment		
FY 1987 Payment Adjustment	-	$2.500,000
		$ 300,000

[1]From Worksheet D-1, Part II, Line 54
[2]From Worksheet E, Part A, Lines 1A and 1B

Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, its adjustment is the entire difference between FY 1987 Program Inpatient Operating Costs and FY 1987 DRG payments.

[18] EXAMPLE B: Hospital B has justified an adjustment to its DRG payment for its FYE December 31, 1988. The adjustment is calculated as follows:

Hospital D
PPS Payment Adjustment
Fiscal Year Ended 12/31/88

FY 1987 Program Operating Cost		$1,400,000
PPS Update Factor	x	1.0247
FY 1988 Maximum Allowable Cost		$1,434,580
Hospital D FY 1988 Program Inpatient Operating Cost		$1,500,000
FY 1988 DRG Payment	-	$1,020,000
FY 1988 Payment Adjustment		$ 414,580

Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so the adjustment is the difference between FY 1987 cost adjusted by the update factor and FY 1988 DRG payments.

Based on the above, the Board concludes that the formula for determining the low volume adjustment payment in situations where there are no excess labor

costs is simply the provider's fixed costs not to exceed the ceiling specified in 42 C.F.R. § 412.92(e)(3).[59]

In the case at hand, both of the parties provided their proposed calculation of the volume decrease adjustment for the Board's consideration. The Board examined both and found that the neither party calculation

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[59] The Board is aware of the following discussion included in the preamble to the August 18, 2006 final rule:

> The process for determining the amount of the volume decrease adjustment can be found *in section 2810.1* of the Provider Reimbursement Manual. Fiscal intermediaries are responsible for establishing whether an SCH . . . is eligible for a volume decrease adjustment and, if so, the amount of the adjustment. To qualify for this adjustment, the SCH . . . must demonstrate that: (a) a 5 percent or more decrease of total discharges has occurred; and (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal intermediary has established that the SCH . . . satisfies these two requirements, it will calculate the adjustment. *The adjustment amount is determined by subtracting the second year's costs minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH . . . receives the difference in a lump-sum payment*.

71 Fed. Reg. 47870, 48056 (Aug. 18, 2006) (emphasis added). *See also* 73 Fed. Reg. 48434, 48630-48631 (Aug. 19, 2008) (restating this same discussion). This discussion suggests that the ceiling amount is in fact the payment adjustment amount. However, the Board finds that this discussion must be read in the larger context of PRM 15-1 § 2810.1 to which this discussion cites and not just subsection (D) where the ceiling is calculated. In particular, subsection (B) must be given effect and subsection (D) must be read together with subsection (B).

met the requirements of the controlling federal statute and regulation and the interpretive guidance.

[19] The Provider utilized the instructions at PRM 15-1§ 2810.1(D) as applied in the examples A and B to calculate its payment adjustment amount. The Provider's calculations are consistent with these examples and identify the differential between the Provider's FY 2005 program operating costs and its FY 2006 DRG payments. Specifically, the Provider made the following calculations as shown in Provider Exhibit P-3:

	Line #	
FY 2005 program operating cost	1	$6,714,575
PPS update factor	2	1.037
FY 2005 Maximum allowable costs	3	$6,963,014
FY 2006 program inpatient operating costs	4	$5,698,829
FY 2006 DRG payment	5	$4,957,521
FY 2006 payment adjustment	6	$ 741,308

However, this amount is only the ceiling as reflected in 42 C.F.R. § 412.92(e)(3). Pursuant to the formula in PRM 15-1 § 2810.1(B) the adjustment amount is fixed costs not to exceed this ceiling. The Board finds that the Provider's fixed costs of $5,033,835 for FY 2006 exceeded this ceiling of $741,308 and, accordingly, the volume decrease adjustment amount is $741,308 once the ceiling is applied.[60]

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[60] The Board notes that the PRM 15-1 § 2810.1 instructions take into account the three factors delineated in 42 C.F.R.

The MAC presented the following method[61] that it used to calculate the volume decrease adjustment amount:

1	FY 2005 Operating Costs	$6,719,371
2	PPS Update Factor	1.037
3	FY Adjusted 2005 Operating Costs	$6,964,876
	FY 2006 Operating Costs	$5,698,829
5	Net Variable Costs for FY 2006	$ 664,994
6	FY 2006 Operating Costs Less Variable Costs	$5,033,835
7	Lesser of adjusted FY 2005 or FY 2006 Operating Costs	$5,033,825
8	FY 2006 DRG Payments	$4,957,521
9	Net Volume Adjustment (Line 7 – Line 8)	$ 76,314

The Board's examination of this method shows that the MAC in essence made a modified ceiling calculation by considering only fixed and semi-fixed costs (as

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§ 412.92(e)(3)(i). First, the formula takes into account the first two factors (*i.e.*, the Provider's needs and circumstances and the Provider's fixed and semi-fixed costs) because the formula uses the budgeted operating costs, the actual operating costs, and the actual fixed/semi-fixed costs. Second, it takes into the length of time that the Provider experienced the volume decrease which in this case was the full fiscal year.

[61] Provider Exhibit P-2 at 3. The MAC has asserted that, at the time that the MAC developed its calculations, complete guidance from CMS on the calculation of the volume decrease allowance was not available. *See* Tr. at 322-330. The MAC developed its estimate based upon its interpretation of the instructions and the limited guidance provided by CMS that was available at that time.

opposed to all inpatient operating costs) in relation to the DRG payments. The MAC should have applied the formula in PRM 15-1 § 2810.1(B) that the low volume adjustment payment is fixed costs not to exceed the ceiling [20] stated in 42 C.F.R. § 412.92(e)(3), *i.e.*, "the difference between the hospital's inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs."

DECISION AND ORDER:

VARIABLE COSTS:

The MAC correctly identified and eliminated variable cost in determining that the Provider's fixed costs for FY 2006 was $5,033,835 for purposes of the determination on the Provider's request for a sole community hospital volume decrease adjustment. Accordingly, the adjustment of these costs is affirmed.

VOLUME DECREASE ADJUSTMENT AMOUNT:

The MAC improperly calculated the low volume adjustment payment for the Provider. The Provider is subject to the "not to exceed" limitation imposed by the controlling regulation found at 42 C.F.R. § 412.92(e)(3) and, consistent with the application of PRM 15-1 § 2180.1 and that limitation to this case, the Provider should receive a volume decrease adjustment payment in the amount of $741,308. Accordingly, the MAC's calculation of the low volume adjustment payment is modified.

BOARD MEMBERS PARTICIPATING

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

/s/ Michael W. Harty

Michael W. Harty
Chairman

DATE: JUL 10 2014

42 U.S.C.A. § 1395ww

§ 1395ww. Payments to hospitals for inpatient hospital services, provides in pertinent part:

(a) Determination of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services" defined

* * *

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, . . . and includes the costs of all services for which payment may be made under this subchapter that are provided by the hospital

* * *

(d) Inpatient hospital service payments on basis of prospective rates;

* * *

(1)(A) . . . the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

* * *

(iii) beginning on or after April 1, 1988, is equal to—

(I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges

* * *

[**(5)(D)**]**(ii)** In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

* * *

42 C.F.R. § 412.92(e) (2004, 2005)

42 C.F.R. § 412.92(e) (2004, 2005), Additional payments to sole community hospitals experiencing a significant volume decrease, provides in pertinent part:

* * *

(e) Additional payments to sole community hospitals experiencing a significant volume decrease.

(1) For cost reporting periods beginning on or after October 1, 1983, the intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period.

* * *

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs.

* * *

(i) In determining the adjustment amount, the intermediary considers—

(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of

minimum staffing requirements imposed by State agencies;

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and. . . .

CMS Pub. 15-1 § 2810.1

Centers for Medicare & Medicaid Services, Provider Reimbursement Manual, CMS Pub. 15-1 § 2810.1, Additional Payments To SCHs That Experience A Decrease In Discharges, provides in pertinent part:

* * *

Additional Payments To SCHs That Experience A Decrease In Discharges.—If a hospital that is classified as an SCH experiences, due to circumstances beyond its control, a decrease of more than 5 percent in its total number of discharges compared to the immediately preceding cost reporting period, the hospital may receive a payment adjustment.

* * *

B. Amount of Payment Adjustment.—Additional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.

Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.

In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semifixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.

In evaluating semifixed costs, the intermediary considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment.

The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The intermediary reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

* * *

C. Requesting Additional Payments.—. . . . The request must include the following documentation.

* * *

4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding pass-through costs, exceeds DRG payments, including outlier payments. No adjustment is allowed if DRG payments exceeded program inpatient operating cost.

* * *

D. Determination on Requests.—

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The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.

EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. The adjustment is calculated as follows:

Hospital C
PPS Payment Adjustment
Fiscal Year Ended 09/30/87

[1]FY 1986 Program Operating Cost		$2,900,000
PPS Update Factor	x	1.0115
FY 1987 Maximum Allowable Cost		$2,933,350
Hospital C FY 1987 Program Inpatient Operating Cost		$2,800,000
[2]FY 1987 DRG Payment	–	$2,500,000
FY 1987 Payment Adjustment		$ 300,000

[1] From Worksheet D-1, Part II, Line 54
[2] From Worksheet E, Part A, Lines 1A and 1B

Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost and FY 1987 DRG payments.

EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. The adjustment is calculated as follows:

Hospital D
PPS Payment Adjustment
Fiscal Year Ended 12/31/88

FY 1987 Program Operating Cost		$1,400,000
PPS Update Factor	x	1.0247
FY 1988 Maximum Allowable Cost		$1,434,580
Hospital D FY 1988 Program Inpatient Operating Cost		$1,500,000
FY 1988 DRG Payment	–	$1,020,000
FY 1988 Payment Adjustment		$ 414,580

Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so the adjustment is the difference between FY 1987 cost adjusted by the update factor and FY 1988 DRG payments.

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