# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2015-D11

**PROVIDER -**
Fairbanks Memorial Hospital
Fairbanks, Alaska

Provider No.: 02-0012

**vs.**

**INTERMEDIARY –**
Wisconsin Physicians Service/
BlueCross BlueShield Association

**DATE OF HEARING -**
December 9, 2013

Cost Reporting Period Ended -
December 31, 2005

**CASE NO:** 09-1704

**INDEX**

ISSUE:

Whether the Medicare Contractor's calculation of the Provider's low volume adjustment amount was determined correctly.[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, codified at 42 U.S.C. Chapter 7, Subchapter XVIII ("Act"), to provide health insurance to eligible individuals. The Centers for Medicare and Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is part of the U.S. Department of Health and Human Services ("HHS") 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"). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the cost incurred during the relevant accounting period and the portion of those costs allocated to the Medicare program.[4] Each MAC reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues 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]

Part A of the Medicare program covers "inpatient hospital services." As part of the Social Security Amendments of 1983[7], Congress changed Medicare reimbursement by establishing the prospective payment system for inpatient hospital services ("IPPS"). Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8] The statutory provisions addressing the IPPS are located in 42 U.S.C. § 1395ww(d) and they contain a number of provisions that adjust payment based on hospital-specific factors.[9]

The statute requires the Secretary to adjust payment to certain hospitals that qualify to participate in the Medicare program as sole community hospitals ("SCHs").[10] Specifically, 42 U.S.C.

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[1] Transcript ("Tr.") at 7.
[2] FIs and MACs are hereinafter referred to as MACs.
[3] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.-405.1837.
[7] Social Security Amendments of 1983 § 601, Pub.L.No.98-21, 97 Stat. 65, 149-163 (1983).
[8] *See id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] 42 U.S.C. § 1395ww(d)(5)(D)(iii) defines 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

§ 1395ww(d)(5)(D)(ii) requires the HHS Secretary to adjust the payment to SCHs that incur a decrease in patient discharges of more than 5 percent from one cost reporting year to the next, due to circumstances beyond its control, and "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. The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

Once an SCH demonstrates that it has suffered a qualifying decrease in total inpatient discharges, the MAC must determine the appropriate adjustment, if any, due to the provider. In this regard, 42 C.F.R. § 412.92(e)(3) 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 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.

Significantly, this regulation limits the low volume adjustment amount for an SCH to its total inpatient operating cost (excluding pass-through costs and increased by the IPPS update factor) minus its DRG revenue.[11]

CMS issued guidelines in the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), to assist MACs in the calculating the low volume adjustment amount for an SCH. In particular, PRM 15-1 § 2810.1(B) states the following regarding the classification of costs for SCHs:

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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 under 42 U.S.C. § 1395i-4(i)(1).

[11] *See* 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987).

> 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.

PRM 15-1 §§ 2810.1(C) and (D) also provide several examples of how to calculate the low volume adjustment.

The parties dispute the application of the statute and regulation to properly classify costs and calculate the low volume adjustment amount.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Fairbanks Memorial Hospital ("Provider") is located in Fairbanks, Alaska and is qualified to participate in the Medicare program as a SCH. The Provider's designated MAC is Wisconsin Physicians Service ("Medicare Contractor").

From fiscal year ("FY") 2004 to FY 2005, the Provider suffered a 5.44 percent decline in inpatient discharges.[12] On May 23, 2007, the Medicare Contractor issued an NPR for the Provider's FY 2005.[13] On October 15, 2007, the Provider submitted a request to the Medicare Contractor for a low volume adjustment of $5,948,114.[14]

Upon receipt of the Provider's request, the Medicare Contractor identified the following categories of costs as "variable" costs because they either vary directly with utilization or are within the Provider's control:

1. Medical Supplies;
2. Pharmaceuticals;
3. Cost of Goods Sold ("COGS");
4. Food;
5. Dietary Formula;
6. Linen and Bedding;
7. Other Non-Med Supplies;
8. Patient Surveys;
9. Hazardous Material Disposal;
10. Collection Agency Fees;
11. Freight;
12. Advertising;
13. Community Relations; and

[12] Provider Exhibit P-6 at 3 (copy of Provider's Original Request for Payment Adjustment that is located at Provider's Post-Hearing Brief at Tab 3).
[13] *Id.* at Attachment B.
[14] *Id.* at 1.

14. Charitable Contributions.[15]

These variable costs were subtracted from the Provider's total costs to determine the Provider's total fixed and semi-fixed costs for FYs 2004 and 2005. Through the application of a factoring process, the Medicare Contractor determined that the Provider's Medicare fixed and semi-fixed costs were $15,728,470 for FY 2005 and $15,143,948 for FY 2004.[16] Using this information, the Medicare Contractor applied an excess salary adjustment of $563,904 and calculated $2,316,727 as the Provider's FY 2005 low volume adjustment payment.[17]

On May 20, 2009, 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 was $5,537,723 - the difference between the Provider's calculated claim of $7,854,450[18] and the $2,316,727[19] calculated and paid by the Medicare Contractor. The Stipulation of the Parties resolves the Medicare Contractor's adjustment of $563,904 for excess salary in the Provider's favor.[20]

The Board conducted a hearing on December 9, 2013. The Provider was represented by Ronald K. Rybar of the Rybar Group, Inc. The Medicare Contractor was represented by Robin Sanders, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS

In the initial appeal, the Provider disputed three elements of the Medicare Contractor's low volume adjustment calculation: (1) the excess staffing adjustment; (2) the classification of fixed versus variable costs used in the calculation; and (3) the amount used by the Medicare Contractor to represent the Provider's total DRG revenue for inpatient operating costs. As noted in the Stipulation of the Parties, the parties agreed to resolve excess staffing adjustment dispute in the Provider's favor prior to the hearing.

The Provider contends that the Medicare Contractor's calculation of the low volume adjustment payment was performed incorrectly. The Provider contends that the Medicare Contractor removed all costs that it deemed variable without considering the Provider's facts and circumstances as required under the language of the Medicare regulation at 42 C.F.R. § 412.92 and PRM 15-1 § 2810.1.[21]

I. CLASSIFICATION OF COSTS

[15] *See* Provider Exhibit P-1 at 10 (Medicare Contractor workpaper for FY 2005 showing break out of variable costs).
[16] *See id.* at 11, 13.
[17] *See id.* at 11.
[18] Provider's Post Hearing Brief at 23.
[19] *See id* ; Stipulation of the Parties at ¶ 2 (copy included as Provider Exhibit P-5 which is included behind Tab 2 of the Provider's Post Hearing Brief).
[20] The Parties initially disputed the amount of the excess salary adjustment applicable in this case, however, the Parties have agreed to resolve this issue in the Provider's favor. *See* Stipulation of the Parties at ¶¶ 3-6.

[21] *See* Provider's Final Position Paper at 3.

The Provider explains that it determined the amount of the low volume adjustment within the guidelines of 42 C.F.R. § 412.92, and with appropriate consideration to its needs and circumstances. The Provider notes that, for purposes of the payment adjustment calculation, the guidance in PRM 15-1 requires that semi-fixed costs should be considered as fixed and included in the payment adjustment. The Provider advocates that, consistent with the regulations and manual guidance, all of its costs are either fixed or semi-fixed and should be included in the low volume adjustment calculation.[22]

In testimony presented at the hearing, the Provider contends that all of the alleged "variable" costs in dispute in this appeal, "in one form or another, or mostly in all forms, meet the definition of semi-fixed to be treated as fixed for the payment adjustment. If they are necessary for providing the services of the hospital they are considered semi-fixed. And, if they vary somewhat with volume they can be considered semi-fixed."[23]

The Provider contends that expenses associated with treating patients at the hospital (*e.g.*, Medical Supplies and Pharmaceuticals) are fixed according to the definitions in PRM 15-1 § 2810.1(B), "Fixed costs are those over which management has no control." The Provider explains that the Provider must follow the physicians' directives regarding medical supplies/equipment and pharmaceuticals because the Provider's rules and state law mandate that physicians are responsible for treating the patients. Accordingly, management has no control over these costs and they should be considered fixed for purposes of calculating the low volume adjustment payment.[24] Costs that are necessary to maintain core staff and services that are maintained by a hospital qualify for treatment as fixed costs.

The Provider has similar arguments relating to the other categories of costs. The Provider contends that food/dietary and linens should be considered fixed costs because it maintains that it has little or no control over these costs. With regard to the "Patient Survey" costs, the Provider points out that a base number of patient surveys is required for statistical validity and, therefore, these costs are only somewhat related to volume. Similarly, the Provider asserts that "Collection Agency Fees" represent an expense that is due based on prior year obligations and should be considered fixed in the fiscal year at issue. With regard to the "Freight" costs, the Provider claims it is subject to very high fixed cost due primarily to its isolated geographic location in Alaska. Lastly, the Provider explains that expenditures for "Advertising," "Community Relations," and "Charitable Contributions" support core staff and services to the community and there is little relationship to volume in the short run and, as a result, these expenditures should be considered fixed costs.[25]

The Provider states that the Provider is part of a larger health system, Banner Health, and is limited in its ability to reduce or control the cost of medical supplies and pharmaceuticals when a volume decrease occurs because of various management practices within the corporate structure of the health system. Banner Health uses a product standardization committee and group purchasing arrangement to aggregate and standardize the purchase of products across all

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[22] *See id*.
[23] *See* Tr. at 39.
[24] *See* Provider Exhibit P-4 at 32-33 (explaining Provider's interpretation of PRM 15-1 § 2810).
[25] *See* Provider Exhibits P-4b, P-4c.

facilities within the health system.[26] With respect to pharmaceuticals, the Provider utilizes a mostly closed formulary, which ensures that only cost effective pharmaceuticals are purchased but also limits its ability to reduce pharmacy costs. Similarly, the Hospital Pharmacy and Therapeutics Committee constantly evaluates drug efficiency and effectiveness and employs a Therapeutic Substitution Process and Policy.[27] These corporate policies reduce the Provider's ability to reduce costs based on lower utilization. As a result, the cost of medical supplies and pharmaceuticals should be considered semi-fixed and fixed for purposes of calculating the payment adjustment.

To demonstrate that its costs only vary somewhat with volume, the Provider used the correlation coefficient to measure the relationship (*i.e.*, linear correlation) between the following two variables: expense and inpatient days. The Provider asserts that its model revealed that, for the majority of the "variable" costs at issue in this case, there was no relationship between the expense and inpatient days. The possible exception involved "Pharmaceuticals", "COGS [cost of goods sold], and "Linen and Bedding" where only a moderate relationship existed.[28]

Finally, the Provider argues that it did what it could to reduce its costs to address the reduction in patient discharges. The Provider converted the facility's boiler system to natural gas or fuel oil, depending on costs, and renegotiated a three year natural gas rate agreement to save on heating costs. It applied to become a 340B provider of drugs in September of 2005 to reduce drug costs. The "Provider implemented PACS [*i.e.*, picture archiving and communications systems] in June of 2005, which resulted in an annual savings of $290,000 due to the elimination of film, chemicals, and supplies and a reduction in equipment maintenance costs".[29] The Provider also collaborated with the University of Alaska to create local schools for nursing and radiology intended to reduce contract labor expense by increasing the pool of potential candidates for these positions.[30]

## II. Calculation of the Low Volume Adjustment

With respect to the dispute over the amount that the Medicare Contractor used to represent the Provider's total DRG revenue for inpatient operating costs in the volume decrease adjustment calculation, the Provider contends that the regulatory language at 42 C.F.R. § 412.92(e)(3) supports using the DRG payment, outlier payment, and DSH payment lines from the Provider's FY 2005 cost report. These cost report lines are located at Worksheet E, Part A, Lines 1, 1.01, 1.02, 2, 2.01, and 4.04 respectively and the net amount of these lines is reflected in Worksheet E, Part A, Line 6. Accordingly, the total DRG revenue to be used in the calculation should be $10,923,176 as listed in the FY 2005 cost report at Worksheet E, Part A, Line 6.[31]

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[26] *See* Provider Exhibit P-4b at 64; Tr. at 45-46.
[27] *See* Provider Exhibit P-4b at 64; Tr. at 41-42.
[28] *See* Provider Exhibit P-4 at 33.
[29] Provider Exhibit 4 at 35.
[30] *Id.*
[31] Provider's Final Position Paper at 4-5. *See also* Provider's Post Hearing Brief at 8-9.

MEDICARE CONTRACTOR'S CONTENTIONS:

The Medicare Contractor contends that, contrary to the Provider's assertions, CMS' methodology for calculating low volume adjustments "fully compensates" SCHs for their fixed costs as required under 42 U.S.C. § 1395ww(d)(5)(D)(ii).[32] The Medicare Contractor further argues that the Provider did not meet its burden of proof to show that the Medicare Contractor improperly applied the regulations and guidance regarding the volume decrease adjustment. In support of its position, the Medicare Contractor cites to the Board's decision in *LAC & USC Med. Center Los Angeles, CA v. Blue Cross Blue Shield Ass'n*[33] and references 5 U.S.C. § 556(d) to support its burden of proof argument.[34]

I. CLASSIFICATION OF COSTS

The Medicare Contractor explains that an analysis of the costs that the Provider seeks to classify as semi-fixed reveals that they are truly variable costs. First, there can be no dispute that the Provider's food, dietary formula, and linen and bedding costs are variable; particularly since these costs are specifically identified as such throughout the regulatory guidance. Second, by the Provider's own admission, pharmaceuticals, other non-med supplies, and COGS costs are also variable since they become expenses on the cost report only after they are utilized and billed to patients.[35] As such, they vary directly with utilization. Third, the Provider's remaining variable costs – Patient Surveys, Haz Mat Disposal, Collection Agency Fees, Freight, Advertising, Community Relations, and Charitable Contributions – were properly excluded from the volume decrease adjustment calculation because, based on a reasonable exercise of the Medicare Contractor's judgment, the expenditure of these costs are well within the Provider's control. When volumes were decreasing and expenses were being trimmed to compensate for lower revenues, the Provider should have been able to control and limit these costs. [36]

The Medicare Contractor argues that the Provider seeks to expand the scope of the term "semi-fixed costs" to include all variable costs, including those that vary directly with utilization.[37] The Medicare Contractor contends that the plain language of the statute, regulation, and guidance make clear that the volume decrease adjustment payment is meant to compensate providers for their fixed costs and that a volume adjustment payment will not be made for truly variable costs. The Medicare Contractor explains that the incorporation of semi-fixed costs into the volume decrease adjustment determination is the exception, rather than the rule, and the burden of proof is on the provider to demonstrate that each cost claimed is a semi-fixed cost. By making a wholesale argument that each and every non-fixed cost is a semi-fixed cost, the Provider fails to meet its burden of proof.[38]

The Medicare Contractor rejects the Provider's correlation coefficient study as irrelevant for purposes of this case. First, the study is an after the fact creation that was developed for the

[32] Medicare Contractor's Post-Hearing Brief at 7-8.
[33] PRRB Dec. 2003-D26 at 7 (Feb. 13, 2003 ), *decl'd review*, CMS Adm'r (Jun. 21, 2003).
[34] *See* Medicare Contractor's Post-Hearing Brief at 6-7.
[35] Tr. at 190.
[36] Medicare Contractor's Post-Hearing Brief at 10.
[37] *Id.* at 8.
[38] *Id*. at 8-9.

purpose of this appeal; rather than developed as part of the volume decrease adjustment request. Second, the study looks at how costs were expended by the Provider over patient days; rather than actual utilization by individual patients. This individual utilization is what makes these costs variable for purposes of the volume decrease adjustment calculation. [39]

II. CALCULATION OF THE LOW VOLUME ADJUSTMENT

Further, the Medicare Contractor defends its use of the Provider's specific IPPS payment rather than the DRG payment when setting the low volume adjustment cap amount. The Medicare Contractor explains that 42 C.F.R. § 412.92(e)(3) sets a cap on the amount of a qualifying provider's low volume adjustment payment:

> 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* (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105). (emphasis added)

The Medicare Contractor contends that the Provider's argument that the federal DRG payment rate should have been used rather than the hospital-specific DRG payment rate ignores the language of the regulation,[40] which explicitly states that the cap is set by reference to the "hospital's *total* DRG revenue."[41] Further, the Provider's argument ignores the intent of the statute and the implementing regulation, both of which seek to compensate individual providers based on the individual facts and circumstances stemming from their decreases in volume.[42] As determinations regarding the qualification for and amount of a volume decrease adjustment payment are inherently intended to compensate hospitals for their specific fixed costs, relying on an individual hospital's specific payment revenue is not only reasonable, but appropriate.[43] The Provider's hospital-specific payment is the amount from cost report Worksheet E, Part A, Line 8 - $12,847,839.[44]

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 that the Medicare Contractor properly excluded variable costs from the calculation of the Provider's SCH volume decrease

[39] *Id.* at 9.
[40] Medicare Contractor's Post Hearing Brief at 11-12.
[41] 42 C.F.R. § 412.92(e)(3) (emphasis added).
[42] *See* 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987).
[43] Medicare Contractor's Post-Hearing Brief at 11-12.
[44] Medicare Contractor Exhibit I-2 at 6.

adjustment amount. However, the Board also finds that the Medicare Contractor's calculation of that payment adjustment amount was incorrect, as it did not conform with the instructions as laid out in PRM 15-1.

I. CLASSIFICATION OF COSTS:

The Board's examination of the governing statutes and implementing regulations and guidance does not support the Provider's argument that all of the costs excluded by the Medicare Contractor are fixed or semi-fixed costs. 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 become fixed or, alternatively semi-fixed, 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*. In this regard, the preambles to the final rules published on September 2, 1983 and April 20, 1990 recognize that fact and provides examples of variable costs by stating: "An adjustment will not be made for truly variable costs, such as food and laundry services."[45]

Significantly, the PRM 15-1, § 2810.1 guidance was initially published in March 1990 and reflects almost verbatim the above discussion on distinguishing fixed and semi-fixed costs from variable costs.[46] It is clear from the language of these provisions that CMS distinguished fixed and semi-fixed costs from variable costs and did not intend to construe any and all variable costs as fixed or semi-fixed for the purposes of the low volume adjustment. Certain items, food and laundry, for example, that the Provider argues should be considered semi-fixed are clearly identified as variable costs in Manual guidance.[47] To argue that these items are fixed because the physician controls all aspects of patient care is, frankly, absurd. In this regard, the Board notes that the types of costs associated with all of the fourteen categories of cost with the exception of Advertising, Community Relations, and Charitable Contributions would generally be expected to vary with patient volume as they are tied directly or indirectly to patient services.[48] With regard to Advertising, Community Relations, and Charitable Contributions, the Board finds that these costs were not fixed as the Provider generally has control over these services as these are generally discretionary expenditures. Accordingly, the Board rejects the Provider's general arguments that any of the fourteen costs categories identified by the Medicare Contractor as variable are either fixed or semi-fixed and further notes that the Provider has not provided any evidence (*e.g.*, contracts) to demonstrate that all (or some portion) of the costs in each category are fixed or semi-fixed.

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[45] 48 Fed. Reg. 3975, 39782 (Sept. 2, 1983); 55 Fed. Reg. 15150, 15156 (Apr. 20, 1990).
[46] PRM 15-1, Transmittal No. 356 (Mar. 1990) (issuing the criteria PRM 15-1 § 2810.1(B)).
[47] *Id.*
[48] The Board recognizes that the Provider presented a report analyzing the variability of its costs based on patient days rather than by patient. *See* Tr. at 74. As fixed costs are costs that do not vary based on patient volume (*i.e.*, by patient), the Board finds that the Provider's information used the wrong metric to analyze variability and, accordingly, has no evidentiary value for the issue before the Board.

The treatment of variable cost within the calculation of the volume decrease adjustment is not new to the Board. In *Greenwood Cnty. Hosp. v. Blue Cross Blue Shield Ass'n*,[49] 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]

While it is aware of the difficulties Alaskan Providers face in obtaining supplies (either medical or non-medical) because of climate and distance, the Board is unconvinced that the Medicare Contractor erred in classifying Freight as variable costs rather than semi-fixed or fixed costs. The Board finds that generally these types of costs would vary with patient volume (*i.e.*, there would be the general expectation that, with higher patient volume, there is a greater demand for supplies and a greater need for freight to bring in such supplies).

II. CALCULATION OF THE LOW VOLUME ADJUSTMENT

The Board finds that, in calculating the low volume adjustment, the Medicare Contractor correctly determined that the total IPPS payments should be taken from Line 8 of Worksheet E, Part A. Federal regulations are clear that, in determining "prospective payment rates for inpatient operating costs," SCHs receive the greater of: (i) the Federal payment rate applicable to the hospitals as determined under § 412.63; (ii) the hospital-specific rate based on the a 1982 base period as determined under § 412.73; or (iii) the hospital-specific rate based on a 1987 base period as determined under § 412.75.[51] In this case, the hospital-specific rate as determined under § 412.73 was greater than the Federal payment rate and was the amount actually paid to the Provider.

The Board notes that the Medicare Contractor correctly followed the cost report instructions which state:

> Line 7: Sole community hospitals are paid the highest rate of the Federal payment rate, the hospital-specific rate (HSR) determined based on a Federal fiscal year 1982 base period . . . or the hospital-specific rate determined based on a Federal fiscal year 1987 base period . . . . For SCHS and Medicare dependent /small rural hospitals enter the applicable hospital-specific payments. . . .
> Line 8—For SCHs, enter the greater of line 6 or 7. . . .[52]

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[49] PRRB Dec. No. 2006-D43 (Aug. 29, 2006) (copy included at Medicare Contractor Exhibit I-4), *decl'd review*, CMS Adm'r (Oct. 13, 2006).
[50] *Id.* at 8.
[51] 42 C.F.R. § 412.92(d).
[52] PRM 15-2 § 3630.1 (as revised by PRM 15-2, Ch. 36, Transmittal 14 (Apr. 2005)) (providing instructions for Worksheet E, Part A, addressing settlement for inpatient hospital services under IPPS).

In the present case, the hospital-specific rate entered on Line 7 of the FY 2005 cost report, $12,847,839, was greater than the "Subtotal" of Inpatient Hospital Services under IPPS from Line 6, $10,923,176, of that cost report. As a result, the hospital-specific rate of $12,847,839 is the amount listed on Line 8 and it is the correct amount to use in the calculation of the volume decrease adjustment based on the regulation and the program instructions.

> The logic of the regulation is reflected in the preamble to the 1987 rule in which CMS states the following rationale: [T]he 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.[53]

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.[54] Shortly thereafter, in March 1990, CMS issued instructions at PRM 15-1 § 2810.[55] 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

[53] 52 Fed. Reg. at 33049 (emphasis added).
[54] *See* 54 Fed. Reg. 36452, 36480 (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").
[55] 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 classification, and *the special payment provisions applicable to these hospitals*" (emphasis added)).

> Medicare inpatient operating cost and the hospital's total DRG revenue.

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 quite clearly 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."[56]

In the case at hand, both of the parties provided their proposed calculation of the low volume adjustment for the Board's consideration. The Board examined both and found that neither party's calculations met the requirements of the controlling federal statute and regulation and the interpretive guidance. Specifically, the Medicare Contractor's calculation does not take into consideration that the IPPS payment is intended to compensate a hospital for both fixed and variable costs.[57] In contrast, the Provider's calculation does not recognize any of its costs as variable and does not use the correct IPPS payment amount.

The Board reasons that the low volume adjustment payment calculation should take into account the fact that the IPPS payments include reimbursement for both fixed and variable costs.[58] The Board recognizes that it does not have the IPPS actuarial data to determine the IPPS split between these costs. As a result, the Board opted to use the Provider's fixed/variable cost percentage split as a proxy. In this case, the Medicare Contractor determined that fixed costs (which include semi-fixed costs) were 83.3 percent of the Provider's Medicare costs for both FYs 2004 and 2005.[59]

The Board finds the payment amount in this case should be calculated as follows:

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[56] PRM 15-1 § 2810.1(B).

[57] See 42 U.S.C. § 1395ww(a)(1) and (4).

[58] The Board is aware of the following discussion included in the preamble to the August 18, 2006 final rule. *See* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006):

> 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 MAC 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 DRG payment from the lessor of: (a) the second years 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.*

*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).

[59] *See* Provider Exhibit P-1at 11 (Medicare Contractor workpaper for FY 2005 showing net Medicare fixed/semi-fixed costs ($15.73 million) represent 83.3 percent of total Medicare costs ($18.88 million)); Provider Exhibit P-1 at 13 (Medicare Contractor workpaper for FY 2004 showing net Medicare fixed/semi-fixed costs ($15.14 million) represents 83.3 percent of total Medicare costs ($18.18 million)).

Step 1: Calculation of the Cap (adjusted for fixed/variable split)

| | |
|---|---|
| 2004 Medicare Inpatient Operating Costs – Fixed | $15,143,948[60] |
| Multiplied by the prorated 2005 IPPS update factor | 1.034008[61] |
| 2004 Updated Costs - Fixed (Max Allowed) | $15,658,963 |
| 2005 Medicare Inpatient Operating Costs - Fixed | $15,728,470[62] |
| | |
| Lower of Fixed Costs from 2004 Updated or 2005 | $15,658,963 |
| Less 2005 DRG payment – fixed portion | $10,702,250[63] |
| 2005 Cap - Fixed costs | $4,956,713 |

Step 2: Calculation of Volume Decrease Payment Amount

| | |
|---|---|
| 2005 Medicare Inpatient Operating Costs - Fixed | $15,728,470[64] |
| Less Fixed 2005 IPPS Payments (83.3% of IPPS Payments) | $10,702,250[65] |
| Payment Adjustment Amount (Subject to the 2005 Cap) | $5,026,220 |

To determine the Provider's low volume adjustment amount, the Board compared the $4,956,713 cap, to the adjustment amount of $5,026,220. Since the adjustment amount is above the cap, the low volume adjustment amount is limited to the cap amount of $4,956,713.

DECISION AND ORDER:

The Medicare Contractor correctly identified and eliminated variable costs from the Provider's low volume adjustment calculation. However, the Medicare Contractor improperly calculated the Provider's low volume adjustment amount for FY 2005. 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). Consistent with the application of PRM 15-1 § 2180.1 and that limitation to this case, the Provider should receive a low volume adjustment for FY 2005 in the amount of $4,956,713.

[60] *See* Provider Exhibit P-1 at 13 (Medicare Contractor FY 2004 workpaper showing net Medicare fixed/semi-fixed costs of $15,143,948 which is 83.3 percent of total Medicare costs of $18,177,760 as reported on cost report Worksheet D-1, Part II, line 53).
[61] *See* Provider Post-Hearing Brief Exhibit P-6 (Provider Original Request for Payment Adjustment) Exhibit 1 – PPS Update Factor Prorated.
[62] *See* Medicare Contractor Exhibit I-2 at 6 (Medicare Contractor workpaper for FY 2005 showing net Medicare fixed/semi-fixed costs of $15,728,470).
[63] From FY 2005 cost report Worksheet E, Part A, line 8. ($12,847,839 x 0.833).
[64] *See* Medicare Contractor Exhibit I-2 at 6. (Medicare Contractor workpaper for FY 2005 showing net Medicare fixed/semi-fixed costs of $15,728,470).
[65] The Board used the fixed/variable cost percentage split determined by the Medicare Contractor as a proxy (*i.e.*, 83.3 percent of $12,847,839).

BOARD MEMBERS PARTICIPATING

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FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: June 9, 2015