PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D16

PROVIDER –
Lakes Regional Healthcare
Spirit Lake, Iowa

Provider No.: 16-0214

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Wisconsin Physicians Service (MAC)

DATE OF HEARING -
February 3, 2012

Cost Reporting Period Ended -
June 30, 2006

CASE NO.: 10-0859

INDEX

ISSUE:

Whether Wisconsin Physician Service, the Medicare Administrative Contractor, properly calculated the Medicare dependent hospital volume decrease adjustment for Lakes Regional Healthcare, the Provider, for fiscal year 2006, by improperly 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 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 "Medicare Dependent Hospitals" ("MDHs").[8] The main statutory provisions governing MDHs are located in 42 U.S.C.

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[1] Transcript("Tr") at 5-6. The transcript for another similar case involving Unity Healthcare (Case No. 10-0386) was incorporated into the record for this case. Tr. at 17. Accordingly, any references to the transcript involving Unity Healthcare will have the parenthetical "(Unity Case No. 10-0386)."
[2] The Medicare contractor in this case is a MAC. Hereinafter, MAC and intermediary are used interchangeably.
[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 § 412.108.

§ 1395ww(d)(5)(G) and they define an MDH as any hospital: "(I) located in a rural area, (II) that has no more than 100 beds, (III) that is not classified as a sole community hospital under subparagraph (D), and (IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A of this subchapter."[9]

42 U.S.C. § 1395ww(d)(5)(G)(iii) authorizes the Secretary of DHHS to adjust the payment to MDHs 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 Medicare dependent, small rural 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 ... 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 regulations implementing this statutory adjustment are located at 42 C.F.R. § 412.108(d). In particular, subsection (d)(2) specifies the following regarding low volume adjustment for MDHs:

> To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement and it must —
>
> (i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and
>
> (ii) Show that the decrease is due to circumstances beyond the hospital's control.

Once an MDH 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 (d)(3) of the controlling regulation specifies the following regarding the determination of the low volume adjustment amount for MDHs:

> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare

[9] 42 U.S.C. § 1395ww(d)(5)(G)(iv).

> 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
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> (C) The length of time the hospital has experienced a decrease in utilization.[10]

When CMS promulgated § 412.108(d), CMS has made it clear that the low volume adjustment rules for MDHs were identical to those that were already in effect for SCHs:

> [T]he Act also provides that a hospital meeting the MDH criteria is entitled to an additional payment adjustment if, due to circumstances beyond is control, its total number of discharges in a cost reporting period has decreased by more than 5 percent compared to the number of discharges in its preceding cover reporting period. Since this adjustment for a 5 percent reduction in discharges is *identical* to the criteria and adjustment currently provided for SCHs, we are incorporating the *same* criteria and adjustments into the regulation for MDHs.[11]

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."[12] While PRM 15-1 does not specifically address MDH low volume adjustments, it does address SCH low volume adjustments at PRM 15-1 § 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.

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[10] 42 C.F.R. § 412.108(d)(3).

[11] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1999) (emphasis added). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006)

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

Specifically, § 2810.1 provides guidance to assist MACs in the calculation of volume decrease adjustments for sole community hospitals ("SCHs"). In this regard, § 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 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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> 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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> 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.
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> 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 § 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:

Lakes Regional Healthcare ("Provider") is a rural, IPPS hospital located in Spirit Lake, Iowa and the Provider's fiscal year ("FY") ends June 30th. At all relevant times, the Provider qualified and was reimbursed as an MDH. The Provider's designated intermediary is Wisconsin Physician Services ("MAC").

From FY 2005 to FY 2006, the Provider suffered a 10.42 percent decline in inpatient discharges. The MAC agrees with the Provider that the decline was due to external circumstances beyond the Provider's control.[13] On February 12, 2008, the Provider received its NPR for FY 2006.[14] Shortly thereafter, the Provider submitted a request to the MAC for an MDH volume decrease adjustment of $1,184,574.[15]

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.[16] On January 28, 2009 and August 6, 2009, the MAC responded to the Provider's request with a final determination that denied the Provider an MDH volume decrease adjustment for FY 2006.[17] On October 2, 2009, the Provider requested a reconsideration of the MAC's denial. On December 14, 2009, the MAC denied the Provider's reconsideration request.[18]

On March 23, 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 $1,184,574.

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[13] MAC Final Position Paper at 3. *See also* Provider Exhibits P-2, P-3, P-4.
[14] Provider Exhibit P-1.
[15] *See* Provider Exhibit P-5
[16] Provider Exhibits P-2 to P-4; Tr. at 10-11.
[17] Provider Exhibits P-2, P-3.
[18] Provider Exhibit P-4.

The Board conducted a hearing on February 3, 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 $1,184,574.[19] 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 the following fixed and semi-fixed 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 laboratory, blood bank, and diagnostic imaging; and
4. Dietary and linen expenses.[20]

The MAC excluded the reclassified variable costs from the volume decrease adjustment calculation which resulted in a determination that the Provider did not qualify for a volume decrease adjustment.[21] The Provider submits that the reclassified costs are not "variable" but rather are "fixed" 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." The Provider contends that the hospital management had no ability to control the particular costs at issue and, as a result, these costs should properly be defined as fixed for the purpose of calculating the Provider's volume decrease adjustment amount.[22] 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.[23]

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):

> 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.

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[19] *See* Provider Exhibit P-5. *See also* PRM 15-1 § 2810.1(D) (setting forth sample calculation).
[20] *See* Provider Post Hearing Brief at 5; Provider Exhibit P-2 at 5-8.
[21] Provider Exhibit P-2 at 1.
[22] Tr. at 44-46.
[23] *See* Provider Post Hearing Brief at 6-9.

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

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[24] 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 PRM 15-1 § 2810.1(B).[25]

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.[26] Any other interpretation of the 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 little impact on the Provider's volume decrease adjustment.[27]

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 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 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.[28] It was not until the appeal was filed that CMS agreed with the

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[24] *See* Tr. at 30-46.
[25] *See* Provider Post Hearing Brief at 9-11.
[26] *See* PRM 15-1, Foreword.
[27] *See* Provider Post Hearing Brief at 13-14; Provider Exhibit P-9.
[28] Tr at 322-323 (Unity Case No. 10-0386).

MAC's decision, and even then, CMS did not describe the types of costs that should be excluded by the MAC as variable.[29] Guidance provided by CMS after the fact may not be applied retroactively to the detriment of the Provider.[30] Further, the MAC recognized that the excluded costs were not controllable by management, a key characteristic of a "fixed" cost.[31] The MAC also recognized that the excluded costs were essential to hospital operations, and so met the definition of a "semi-fixed" cost.[32] 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.

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."[33] 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."[34] Further, the MAC asserted that "[f]ewer patients means less demand for drugs which should mean less cost for drugs. These costs therefore vary directly with utilization."[35] 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.[36] 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.[37] 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 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.[38]

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 MDH 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:

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[29] MAC Exhibits I-7, I-8.
[30] *See Catholic Health Initiatives - Iowa, Corp. v. Sebelius*, 841 F. Supp. 2d 270, 277, 282 (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).
[31] Tr. at 325-327 (Unity Case No. 10-0386).
[32] Tr. at 306-307 and 318 (Unity Case No. 10-0386).
[33] MAC Final Position Paper at 11.
[34] *Id.*
[35] MAC Final Position Paper at 12-13.
[36] Tr. at 309 (Unity Case No. 10-0386).
[37] Tr. at 312-318 (Unity Case No. 10-0386).
[38] *See* Provider Post Hearing Brief at 11-14.

> In the case of a Medicare dependent, small rural 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.[39]

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.[40]

The MAC also challenges the Provider's contention that the language at 42 C.F.R. § 412.108(d)(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 (d)(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
>
> (C) The length of time the hospital has experienced a decrease in utilization.

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*")[41] as evidenced by the following excerpt:

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[39] 42 U.S.C. § 1395ww(d)(5)(G)(iii) (emphasis added).

[40] *See* MAC Final Position Paper at 5-6. *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006) (stating that "[t]hese [volume decrease] 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"; and that "[s]uch costs include the maintenance of necessary core staff and services").

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

> 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 was $1,570,475, the Provider is entitled to an adjustment of $349,679.[42]

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.[43]

The MAC disagrees with the Provider's assertion that comparing a provider's actual costs, exclusive of variable cost, to the actual amounts that were paid to that provider under IPPS is imbalanced as the payment made under IPPS includes reimbursement for variable costs. Rather, the MAC contends that the intent of the regulation is 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 a provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to that 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 IPPS.[44]

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[42] *Id.* at 8-9. *See* MAC Final Position Paper at 6-7.
[43] *Greenwood County* at 8 n.19. *See* MAC Final Position Paper at 7-8.
[44] *See* MAC Final Position Paper at 8.

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."[45] 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.[46]

The MAC also disputes the Provider's assertion that the costs identified and excluded as variable by the 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.
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> 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.[47] 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.[48] 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.[49]

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 properly excluded variable costs from the calculation of the Provider's MDH 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. § 412.108(d)(3) and PRM 15-1 § 2810.1 and, accordingly, is not proper.

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[45] PRM 15-1 § 2810.1(B).
[46] *See* MAC Final Position Paper at 11.
[47] Tr. at 284 (Unity Case No. 10-0386).
[48] *See supra* note 40.
[49] *See* MAC Final Position Paper at 12-14.

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 MDH volume decrease adjustment. The Provider argues that fixed costs are "those costs over which management has no control"[50] 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"[51] and, "[f]or a short period of time, most semi-fixed costs are considered fixed."[52] 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)(G)(iii), the controlling regulation at 42 C.F.R. § 412.108(d)(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, 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 within the calculation of the volume adjustment but not variable costs. The Board believes that the omission is significant and decisive in this case.

As previously noted, the rules governing MDH low volume adjustments is identical to those governing SCHs. Accordingly, the Board reviewed regulatory history for the SCH low volume adjustments. In this regard, 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.[53] As part of this final rule, CMS adopted the regulatory provision governing SCH low volume adjustments 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 costs paid on a reasonable cost

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[50] PRM 15-1 § 2810.1(B).
[51] *Id.*
[52] *Id.*
[53] 48 Fed. Reg. 39752, 39780-39784 (Sept. 1, 1983).

basis under part 413 of this chapter."[54] 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 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.*
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> 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

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[54] Originally, this regulatory provision was located at 42 C.F.R. § 405.476(d)(3)(ii); 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).

March 1990 and reflects almost verbatim the above discussion on distinguishing fixed and semi-fixed costs from variable costs.[55]

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.[56]

The Provider asks the Board to look past traditional cost accounting concepts of fixed and variable costs and 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.[57] 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 cost 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 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 provider experienced

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[55] PRM 15-1, Transmittal 356 (Mar. 1990) (issuing the criteria PRM 15-1 § 2810.1(B)).
[56] *Greenwood County*, PRRB Dec. No. 2006-D43 at 8.
[57] *See* Provider Exhibit P-3 at 2.

the 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 or 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 $3,560,272 for purposes of the determination on the Provider's request for a Medicare dependent hospital volume decrease adjustment.[58]

CALCULATION OF THE VOLUME DECREASE ADJUSTMENT:

In determining the appropriate formula for calculating the volume decrease adjustment, the Board reviewed the history of the low volume adjustment. When CMS promulgated regulations to implement the low-volume adjustment for SCHs, CMS specified that it was responsible for calculating the low-volume adjustment payment amount for qualifying SCHs on a case-by-case basis.[59] 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)."[60] In the preamble to the 1987 rule, CMS provides the following discussion for making the 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

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[58] *See* MAC Exhibit I-2 at 1; Provider Exhibit P-2 at 3.
[59] *See* 52 Fed. Reg. at 33049.
[60] 52 Fed. Reg. 33034, 33057 (Sept. 1, 1987).

> the length of time the hospital has experienced a decrease in utilization.
>
> 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.[61]

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.[62] Shortly thereafter, in March 1990, CMS issued instructions at PRM 15-1 § 2810.[63] 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

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[61] *Id.* at 33049.

[62] *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").

[63] 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)).

> and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.

Thus, the formula for determining the payment adjustment for both SCHs and MDHs 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 statutory provisions for both MDHs and SCHs which are quite clear when they state that the low-volume payment adjustment is ". . . to ***fully compensate*** the hospital *for the fixed costs* it incurs in the period in providing inpatient hospital services, including the reasonable costs of maintaining necessary core staff and services."[64]

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

> 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	-	$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

[64] Quoting both 42 U.S.C. § 1395(d)(5)(D)(ii) and § 1395ww(d)(5)(G)(iii) (emphasis added)

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.

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 for MDHs 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. § 412.108(d)(3).[65]

[65] 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).

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

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-5:

	Line #	
FY 2005 program operating cost	1	$5,317,296
PPS update factor	2	1.037
FY 2005 Maximum allowable costs	3	$5,514,036
FY 2006 program inpatient operating costs	4	$4,923,186
FY 2006 DRG payment	5	$3,738,612
FY 2006 payment adjustment	6	$1,184,574

However, this amount is only the ceiling as reflected in 42 C.F.R. § 412.108(d)(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 $3,563,068[66] for FY 2006 exceeded this ceiling of $1,184,574 and, accordingly, the volume decrease adjustment amount is $1,184,574 once the ceiling is applied.[67]

The MAC presented the following method[68] that it used to calculate the volume decrease adjustment amount:

WS D-1 Line 53 – Total Program Costs Excluding Capital	$4,923,186
Less Variable Costs for FY 2006	$1,360,118
Net Fixed/Semi-Fixed Costs for FY 2006	$3,563,068
Less Excess Salary Adjustment	$ 0
Net Cost	$3,563,068
WS E, Part A, Line 8- Total PPS Costs	$3,738,612
Net Volume Decrease Adjustment	$ -175,544

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 opposed to all inpatient operating

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[66] Provider exhibit P-2 at 4.

[67] The Board notes that the PRM 15-1 § 2810.1 instructions take into account the three factors delineated in 42 C.F.R. § 412.108(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.

[68] Provider Exhibit P-2 at 4. 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.

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 stated in 42 C.F.R. § 412.108(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 $3,563,068 for purposes of the determination on the Provider's request for an MDH 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. § 412.108(d)(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 $1,184,574. Accordingly, the MAC's calculation of the low volume adjustment payment is modified.

BOARD MEMBERS PARTICIPATING

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FOR THE BOARD:

Michael W. Harty
Chairman

DATE: JUL 10 2014