CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Washington County Memorial Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/ TriSpan Health Services** **Intermediary**	**Provider Reimbursement for Cost Reporting Period Ending 08/31/00** **Review of: PRRB Dec. No. 2006-D9 Dated: Dec. 22, 2005**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the CMS' Centers for Medicare and Medicaid Services (CMM). Accordingly, the Board decision is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue is whether the Intermediary's computation of the Medicare dependent, small rural hospital (MDH) adjustment, due the Provider for its fiscal year (FY) 2000 cost report decrease in discharges, was correct

The Board held that the Provider's computation of the additional payment amount for its FY 2000 cost report significant volume decrease, based upon its status as a Medicare-dependent hospital (MDH), was proper. The Provider's total discharges decreased more than five percent between 1999 and 2000. Thus, the Board found

that the Provider qualified for the additional payment set forth at 42 CFR 412.108 and as computed under 42 CFR 412.108(d)(3), which is governing in this case.

The Board further found that the Intermediary's reliance on section 2810.1 of the Provider Reimbursement Manual was misplaced, as the Board has previously ruled that section 2810.1 applies only to sole community hospitals (SCHs) and not to MDHs.[1]

The Board observed that the controlling regulation does not specify which cost report is required to be the source for the figures used in the computation at issue in this case. The Board found that the Provider's use of the FY 2000 cost figures was reasonable because the decrease in discharges occurred in FY 2000. Moreover, the Intermediary's reliance on section 2810.1 of the Manual, which applies only to SCHs and which dictates the use of the 1999 cost report, was baseless. Finally, the Board stated that the Provider clearly demonstrated the reasonableness of its computation of the additional payment by using the Intermediary's methodology to compute its figure while giving effect to the variances in Medicare discharges and average length of stay. Thus, the Board reversed the Intermediary's determination in this case, and held that the Provider's computation of the additional amount due to a significant volume decrease in its FY 2000 discharges was correct.

SUMMARY OF COMMENTS

CMM requested reversal of the Board's decision in this case for the following reasons. CMM stated that the law and regulations implementing the significant volume decrease adjustment for both MDHs and SCHs are identical under section 1886(d)(5)(D)(ii) of the Social Security Act, and materially identical in the governing regulations. CMM contended that the only discrepancy between the guidance for implementing the significant volume decrease adjustment for MDHs and SCHs is the existence of section 2810 of the Manual, which discusses payment only for SCHs.

When MDH status was created by the Omnibus Budget Reconciliation Act (OBRA) of 1989, the significant volume decrease adjustment benefit had already been applicable to SCHs under section 2810.1 of the PRM for seven years. CMM maintained that Congress intended for the Secretary to implement the adjustment for MDHs in the same way that it had been implemented for SCHs, based on the

[1] *Boone County Hospital*, PRRB Dec. No. 2002-D29 (Aug. 2, 2002), and *Standish Community Hospital*, PRRB Dec. No. 2003-D29 (May 14, 2003).

identical legislative language. In the April 20, 1990 *Federal Register*, CMS confirmed that the adjustment would be calculated in the same way for MDHs and SCHs.[2] Specifically, CMS explained that, " '[s]ince 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.'"[3] Accordingly, the legislative and regulatory history support the identical treatment of the significant volume decrease for SCHs and MDHs. Since the Board calculated the MDH adjustment differently from the calculation used for SCHs, its decision was incorrect.

CMM also pointed out that, in the absence of a specific manual provision instructing the Intermediary how to apply the significant volume decrease adjustment to MDHs, the Board incorrectly substituted the Provider's view of the regulations at §412.108(d) for the Intermediary's view without finding that the Intermediary's view of the regulations was unreasonable. There is no specific Manual provision instructing intermediaries how to apply the adjustment to MDHs. Thus, CMM argued, an intermediary must use its own judgment as to how to apply the adjustment consistent with the regulations. For the Board to substitute its own or the Provider's method of effectuating the adjustment in place of the Intermediary's method, the Board must have first found that the Intermediary's method was unreasonable. But the Board failed to take that preliminary step. Rather, it found that the Provider had a "reasonable interpretation" of the regulation, and substituted that view of the regulation for that of the Intermediary.

CMM maintained that the Intermediary's implementation of the significant volume decrease adjustment at 42 CFR 412.108 was not only reasonable, but also the better application of the rule, given the identical provisions of the statute and regulations that apply to SCHs and MDHs. Thus, CMM requested reversal of the Board's decision in this case.

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[2] 55 Fed. Reg. 15150, 15155-6.
[3] *Id.* at 15155.

DISCUSSION

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

Section 1886(d)(5)(D) of the Social Security Act provides for an additional payment for sole community hospitals. Prior to 1990, Section 1886(d)(5)(D) of the Act provided that:

> In the case of a sole community hospital that experiences, in a cost reporting period (beginning on or after October 1, 1983, and before October 1, 1990) compared to the previous cost reporting period, a decrease of more that 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospitals for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable costs of maintaining necessary staff and services.

Pursuant to the section 6003(e)(1)(A) of the Omnibus Budget Reconciliation Act (OBRA) of 1989,[4] a new subsection 1886(d)(5)(D) of the Act deleted the sunset date on the 5 percent volume decline adjustment for SCHs set forth in new clause (ii) which had limited the cost reporting periods to those beginning before October 1, 1990. This change allowed SCHs to receive the adjustment indefinitely.

The criteria for SCH classification is set forth at 42 CFR 412.92(a), while the SCH significant volume decrease adjustment criteria is set forth at 412.92(e). Finally the SCH significant volume decrease calculation is set forth at 42 CFR 412.92(e)(3). It states that:

> The intermediary determines a lump sum adjustment amount <u>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</u> (including outlier payments for inpatient operating costs determined under subpart F of this part and additional

[4] Pub. Law 101-239.

> 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).
> (i) In determining the adjustment amount, the intermediary considers-
> (A) The individual hospital's needs and circumstances, including the reasonable costs 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 reasonable cost basis under part 413 of this chapter; and
> (C) The length of time the hospital has experienced a decrease in utilization. (Emphasis added.)

In addition, Section 6003(f) of OBRA 1989 also established a new category of hospitals eligible for a special payment adjustments under IPPS pursuant to Section 1886(d)(5)(G) of the Act.[5] The adjustment is limited to subsection (d) ("IPPS") hospitals which are Medicare-dependent, small rural hospitals also referred to as "MDHs".[6] Section 1886(d)(5)(G)(iii), similar to the SCH provision, states:

> 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 to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

Notably, the Conference Report states that:

> The new payment provisions established for SCHs that are more than 35 miles from another hospital are extended to apply to all SCHs…. The agreement also applies the new payment provisions to rural hospitals that are not SCHs, but have 100 or fewer beds and depend on Medicare for at least 60 percent of their patient days or discharges…. These

[5] For cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994 or discharges occurring on or after October 1, 1997, and before October 1, 2006.
[6] Section 6003(f)(1) of the OBRA of 1989 (Pub. Law 101-239) added subparagraph (d)(5)(G).

> hospitals will also be eligible for the volume adjustment provided for SCHs…[7] (Emphasis added.)

The criteria for classification as an MDH is set forth at 42 CFR 412.108(a).[8] The criteria for the significant volume adjustment is set forth at §412.108(d)(2).[9] The implementing regulations, at 42 CFR 412.108(d)(3) (1999) establishes the methodology for computing the adjustment, as follows:

> 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 (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).
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> (ii) In determining the adjustment amount, the intermediary considers-
> (A) The individual hospital's needs and circumstances, including the reasonable costs 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 reasonable cost basis under part 413 of this chapter; and
> (C) The length of time the hospital has experienced a decrease in utilization. (Emphasis added.)

The Secretary stated in promulgating the final rule that:

> We note that there would be no advantage to a hospital approved as an SCH to give up that status to qualify for the MDH adjustment since the payment provisions for both are identical and MDHs are also entitled to the same volume adjustment protection (described below) that is

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[7] H.R Conf. Rep. No. 101-386 at 727-728 (1989).

[8] The Intermediary agreed that the Provider has met the criteria to be classified as an MDH.

[9] The Intermediary agreed that the Provider has met the criteria for the significant volume decrease adjustment.

> afforded to SCHs. However a hospital might wish to qualify for SCH status to take advantage of the higher rate for capital payments afforded to these hospitals. If a hospital that qualifies as an MDH also meets the criteria to qualify for SCH status, it can switch to SCH status by submitting a request to its fiscal intermediary and demonstrating that it meets the qualifying criteria for SCH status under 412.92.[10]

In addition, the Secretary noted that:

> Section 1886(d)(5)(G)(iii) of the Act also provides that a hospital meeting the MDH criteria is entitled to an additional adjustment if, due to circumstances beyond its 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 cost 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 regulations for MDHs.[11]

Finally, the Secretary stated that:

> We recognize that some rural hospitals experiencing a volume decline may be having financial difficulties despite the fact that they have recovered their full Medicare inpatient operating costs under the prospective payments system, While it may be true that some hospitals are suffering financial hardship for any number of reasons, it is clearly inappropriate for Medicare to share in the costs attributable to non-Medicare beneficiaries. Therefore we wish to clarify that any adjustment amounts granted to Medicare-dependent small rural hospital may not exceed the difference between the hospitals Medicare inpatient operating costs and total payments made under the prospective payment system, including outlier payments, disproportionate share adjustment amounts and indirect medical education payment amounts.[12]

CMS promulgated an interpretative guideline at section 2810.1 of the Provider Reimbursement Manual to address the significant volume decrease adjustment for SCHs. This Manual provision was issued March 1990 (Trans. No. 356) In doing so, the Transmittal noted that: "These instructions reflect changes in the regulations on the SCH provisions that were effective October 1, 1989. Instructions to implement

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[10] 55 Fed. Reg. 15150 at 15155 (April 20,1990).
[11] 55 Fed. Reg. 15150 at 15155 (April 20, 1990).
[12] Id.

changes in the SCH criteria and payment methodology that were made by section 6003(e) of the [OBRA 1989] … which enacted a new section 1886(d)(5)(D)(ii) of the Social Security Act and are effective for cost reporting periods beginning on or after April 1, 1990 will be issued under a separate cover." However, as the provisions of the OBRA 1989 were not subsequently promulgated in the manual, the significant volume decrease adjustment for MDHs and the elimination of the sunset provision for the SCH, both enacted by OBRA 1989, were not specifically set forth in the Manual. Consequently, the guidance offered by section 2810.1 of the Manual was not updated to reflect the changes enacted by OBRA 1989 with respect to SCHS or MDHs.[13]

The Provider argues that the Intermediary incorrectly applied section 2810.1 of the Manual to compute the adjustment in this case. In the alternative, the Provider argues that if the Intermediary is permitted to apply section 2810.1, the Intermediary should be required to apply the provision that states: "[i]f an intermediary determines that the procedures in this section, when applied to a specific adjustment request, generates an anomalous result, the intermediary may request a review by [CMS]. This may occur, for example, when the decrease in Medicare discharges is significantly less than the decrease in total discharges."[14]

After a review of the record and applicable law and policy guidance, the Administrator finds that the Intermediary properly applied the methodology of Section 2810.1 to determine the amount of the Provider's payment for the volume decrease adjustment. The statutory language of the SCH and MDH volume decrease adjustment is identical. A canon of statutory construction is that "the same language used repeatedly in the same connection is presumed to bear the same meaning throughout the statute."[15] Thus, the language set forth at section 1886(d)(5)(G)(iii) of

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[13] CCH Medicare and Medicaid Guide Para 4298 p. 1509-4, Provider Reimbursement Manual I-Chapter 28 History (The following annotations described changes that were made to chapter 28 through the end of 2002. Many sections have not been updated for years, so that the *Provider Reimbursement Manual* text may not describe current CMS policy.)

[14] The Provider makes two separate calculations, one based on a per diem method, and the other based on its FY 2000 inpatient Program operating costs and not the use of the FY 1999 costs multiplied by the IPPS update factors. Pursuant to its Position Paper and Exhibit 10, the Provider appears to have adopted the latter methodology to defend before the Board.

[15] See 4 Sutherland, *Statutes and Statutory Construction* 138 (4th Ed. C. Sands 1975) Karl N. Llewellyn, *Remarks on the Theory of Appellate Decision and the Rules of Canons About How Statutes are to be Construed*, 3 Vand. L. Rev. 395, 404 (1950) n. 21 Gregg v. Manno, 667 F 2d 1116 (4th Cir. 1981).

the Act for the MDH is presumed to have the same meaning as the language of section 1886(d)(5)(D)(ii) of the Act for the SCH. Indeed, Congress was well aware of the language for both provisions as the sunset language for the SCH volume decrease adjustment was actually eliminated and the MDH provision and its volume decrease adjustment was established pursuant to the same act of congress. Finally, the legislative history of the MDH provisions shows that Congress specifically intended that the significant volume decrease adjustment payment for MDHs be identical to the volume adjustment payment for SCHs.[16]

Consistent with the statutory language, the regulatory language for both the SCHs and MDH volume decrease adjustment were set forth using identical language at 42 CFR 412.92(e) and 412.108(d)(3). The methodology set forth at section 2810.1 of the Manual is certainly intended to implement the methodology set forth in the regulation for SCH and thus correspondingly to the MDHs.[17] Consequently, the Intermediary properly applied the same methodology as set forth at section 2810.1 of the Manual in computing the volume decrease adjustment for this particular MDH.[18]

The Provider also objects to the use of the IPPS update factor applied to its FY 1999 inpatient program operating costs to determine its inpatient program operating costs for FY 2000. The Manual explains at section 2810.1.B that the 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 costs of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue. Fixed costs are those costs over which management has no control. Most truly fixed costs such as rent, interest and deprecation are capital related 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 the utilization, such as food and laundry costs.

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[16] The Secretary emphasized that there would not be an advantage for a SCH to be redesignated as an MDH for purposes of the significant volume decrease payment, as this payment is identical for SCHs and MDHs.

[17] A strict reading of Section 2810.1 of the Manual would limit its application for SCHs to only those periods allowed under the sunset provision.

[18] The facts in *Boone County Hospital*, PRRB Dec. No. 2002-D29 (Aug. 2, 2002) and *Standish Community Hospital*, PRRB Dec. No. 2003-D29 (May 14, 2003) did not exclude the respective provider from qualifying for MDH status under section 2810.1 of the Manual. Both cases involved decreases in discharges alleged to be due to physician recruitment problems which is cited as a bases for the adjustment in Section 2810.1 of the Manual.

Section 2810.1.D of the Manual explains that 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 costs up to the prior years total program inpatient operating costs (excluding pass-through costs) increased by the PPS inpatient factor. The Intermediary properly limited the recognizable FY 2000 inpatient program operating costs to those reflected by application of the IPPS updated factor to the Provider's FY 1999 inpatient Program operating costs. The payment is intended to recognize the Provider's decrease in DRG payments due to the decrease in discharges and the inability of the provider to reduce certain fixed costs. The statutory language authorizes the significant volume adjustment to compensate the Provider for its fixed costs. The methodology ensures that the provider is not paid for higher costs due to other difficulties unrelated to the decrease in discharges.

The Provider also relies on the language in the Manual which gives the Intermediary the discretion to request review by CMS if it determines that the procedures produce an anomalous result.[19] The Provider showed that the decrease in non-Medicare discharges was much higher than Medicare discharges and that should result in a higher volume adjustment payment. However, the Provider has not shown that the result determined by the Intermediary is in fact anomalous and that the higher decrease in non-Medicare beneficiary discharges should justify a higher Medicare payment. Nor did the Provider show its method better accounts for variances in Medicare discharges and length of stay. Accordingly, the Administrator finds that the Provider's methodology would result in a payment that exceeds the volume decrease adjustment payment allowed under the regulation at 42 CFR 412.108.

[19] The Intermediary in fact did refer the calculation to CMS. Intermediary Exhibit I-5.

DECISION

The Administrator reverses the decision of the Provider Reimbursement Review Board.

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

Date: 2/24/06

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services