BLESSING
Health System

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blessinghealth.org

March 22, 2021

Courtney Avery
Administrator
Illinois Health Facilities and Service Review Board
525 West Jefferson, Second Floor
Springfield, IL 62761

Re: Quincy Medical Group Hospital, Project #20-044

Dear Ms. Avery,

My name is Patrick Gerveler and I am the Chief Financial Officer for the Blessing Health System. I was part of the health system 28 years ago when Blessing Hospital and St. Mary's Hospital merged to form one hospital entity in Quincy, IL.

Pursuant to that merger, the Center for Medicare and Medicaid Services (CMS) approved Blessing Hospital's designation as a Sole Community Hospital (SCH)). CMS designates rural hospitals that meet certain criteria (one of which is no other like hospital is located within 25 miles) as a Sole Community Hospitals. Blessing Hospital's SCH status is vital to the organization and community.

As discussed by the Rural Hospital Coalition, SCH's localize care, minimize the need for referrals and travel to urban areas, and provide services that normally would be incurred in urban areas. SCH's also commonly establish satellite sites and outreach clinics to provide primary and emergency care services to surrounding underserved communities, a function which is becoming increasingly important as economic factors force many small rural hospitals to close. SCHs are vital to their local economies. These hospitals typically are significant employers, generating considerable cash outflow into the area economy and boosting the area tax base. For these and other reasons, Congress has long appreciated the special role of SCHs in the rural health care community. Congress also has recognized that SCHs have above-average costs for the mix of patients they serve. Congress has sought to buttress SCHs, and ensure their continued viability by establishing special Medicare payment provisions.

If QMG Hospital's application is approved, Blessing Hospital will lose its SCH status. As a result, Blessing Hospital will immediately see its Medicare rates decreased - triggering an annual loss of revenue of $6,320,736 based on 2020 and as much as $7,510,144 based on 2019 cost reports. The nationally recognized accounting and consulting firm BKD was engaged to confirm the actual loss based on the last two years (see attached letter from BKD).

As part of its application, QMG Hospital is required in Section IX (Safety Net Impact Statement) to assess the impact of safety net services to other health care systems as a result of QMG Hospital's approval. Unfortunately in an attempt to

avoid any transparent and open conversations with Blessing Hospital, QMG Hospital's senior leadership and board kept its application a secret from Blessing, but instead involved Memorial Hospital in Carthage and Culbertson Memorial in Rushville in their planning. Had QMG leadership contacted Blessing we would have immediately informed them that this application would be devastating to our Sole Community Hospital designation (amongst other detrimental impacts), and immediately cut our reimbursement by an average of $6,900,000 based on the last two year's cost reports. It is irrefutable that losing SCH status will materially impact the safety net services provided to the community, as Blessing Hospital will lose irreplaceable federal funding to support safety net services. QMG falsely states in Attachment 37 of its application that "The applicant (QMG Hospital) does not believe that the establishment of the hospital will impact another provider or health system's ability to cross-subsidize safety net services". We trust the Health Facilities and Services Review Board and staff to judge for themselves how inconsistent and misleading the applicant's statements are on this issue **and how truly devastating a $6,900,000 loss** would be to a SCH like Blessing.

BKD also assessed the impact to Blessing Hospital's recently approved 340B program. Because of our SCH status, Blessing safely qualifies for 340B. However, if Blessing loses SCH status our ability to qualify annually for 340B becomes more difficult. If Blessing's loses its 340B status **the community will lose over $7,800,000 in pharmacy savings** that will go towards helping lower costs to patients, Medicaid, employers and the payers. The 340B calculation was based on a study performed by the Advis group. Because QMG has not engaged in meaningful health planning with the providers in the area, they are either unaware of this negative impact or they are not concerned with lowering drug costs for this community.

If QMG Hospital would have properly communicated its plans for a Certificate of Need for a second hospital in our small community, Blessing Hospital would have been able to provide them with the very real losses it will suffer if this application is approved. To recap, these losses include a guaranteed loss of $6,320,736 based on 2020 and as much as $7,510,144 based on 2019 cost reports. Also, the loss of Sole Community Hospital has a very real potential to eliminate Blessing's 340B status, and with it $7,800,000 in pharmacy savings that further support safety net services. For example, 340B savings support our comprehensive cancer program and our chronic diabetic program for our Medicaid and indigent patients, where effective management of managing multiple chronic diseases requires multiple medications and extra resources. We know today that the social determinants of health impact patient's success to achieving their health goals greater than 60% of the time, and that Medicaid and indigent patients are often at higher risk. Medications and easy access to health care regardless of one's ability to pay is key.

Section IX (Safety Net Impact Statement) in the Illinois Health Facilities and Services Review Board application is more than enough evidence that QMG Hospital application #20-044 must be denied to save the community's safety net services provided by Blessing Hospital. Our town didn't need two hospitals 28 years ago and **there is not a demonstrated need this new hospital** today, let alone one that is only 3.5 miles away today.

I've outlined the significant financial impact that this ill-conceived project would have on Blessing, but I'd be remiss if I didn't note that those financial losses would inevitably translate into diminishing our ability to provide all of the services our community needs and deserves. The proposed second hospital isn't equipped to serve our most vulnerable patients; they

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wouldn't be filling any gaps in care. If approved, this project would do the opposite, it would harm our entire region, leaving all our patients with less care, and higher healthcare costs.

Sincerely,

Patrick M. Gerveler

Chief Financial Officer

Blessing Health System

BKD
CPAs & Advisors

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January 6, 2021

Mr. Timothy A. Moore
Vice President Finance
& Chief Accounting Officer
Blessing Health System
P.O. Box 7005
Quincy, Illinois 62305-7005

Dear Tim:

As a follow-up to our conversation regarding the impact of Blessing Hospital's Sole Community Hospital (SCH) status due to the construction of an acute care hospital within the city of Quincy, Illinois, or surrounding service area, my concern is that Blessing Hospital could potentially lose the Medicare designation as a SCH once another acute care hospital facility is operational.

Criteria and Duration of SCH Designation

Criteria for SCH designation is outlined in 42 C.F.R. – Public Health, §412.92, Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, Special treatment: Sole community hospitals (see Attachment 1). CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in §412.64) in which the hospital is located between 25 and 35 miles from other like hospitals and no more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area. This is likely the criteria by which Blessing Hospital originally qualified for designation as a SCH.

As to the duration of classification as a SCH, §412.92 states that "an approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. An approved sole community hospital must notify the Medicare Administrative Contractor (MAC) if any change that is specified in paragraph (b)(3)(ii) of this section occurs. If CMS determines that a sole community hospital failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date that the hospital no longer met the criteria for such classification," and goes on to state that "a sole community hospital must report the following to the MAC within 30 days of the event" such as "the opening of a new hospital in its service area."

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Summary of Benefits

The following is a short summary of the benefits by inpatient, outpatient, other, and 340B drug pricing program provided as part of the SCH designation:

- Inpatient – SCH status provides certain payment enhancements and protections to Blessing Hospital. For inpatient services, SCH's receive the higher of payments under (1) the Inpatient Prospective Payment System (IPPS) or (2) an updated hospital-specific rate, which are payments based on their costs in a base year (1982, 1987, 1996, or 2006) updated to the current year and adjusted for changes in their case mix.

- Outpatient – Since 2006, SCHs also receive an additional adjustment set at 7.1 percent above the Outpatient Prospective Payment System (OPPS) rate for outpatient services. Less impactful, there is also an increase in hospital outpatient lab tests (SCH's receive 62 percent fee schedule rather than 60 percent fee schedule).

- Other – Additionally, SCH's can qualify for adjustments due to decreases in inpatient volume.

- 340B Drug Pricing Program – There is a lower qualification threshold to participate in the 340B Drug Pricing Program (340B) as a SCH. As a SCH, Blessing Hospital can qualify for the 340B program with an 8 percent Disproportionate Share Hospital (DSH) add-on percentage, rather than the 11.75 percent DSH add-on needed to qualify. The drawback of the lower qualifying threshold is there are some drugs, such as orphan drugs used heavily in oncology services, that are not covered under 340B if Blessing Hospital only qualifies as an SCH.

Quantification of Benefits

- Inpatient – The inpatient operating payment increase due to SCH designation for Blessing Hospital would have been approximately $5.2 million for the 2019 cost reporting period and is approximately $4.0 million for the 2020 cost reporting period (see Attachment 2).

- Outpatient – The outpatient benefit is the additional adjustment set at 7.1 percent above the OPPS rate for outpatient services. The outpatient operating payment increase would have been approximately $2.3 million for the 2019 cost reporting period and is approximately $2.3 million for the 2020 cost reporting period (see Attachment 2).

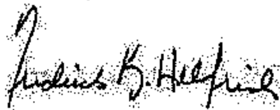
- Outpatient Lab Fee Schedule and Other – Given that it is less material in benefit, I did not look at or try to quantify any benefit derived from an increase in payments for hospital outpatient lab tests. 42 CFR 412.92(e) provides an opportunity for SCH's experiencing significant declines in volume with the opportunity to receive additional reimbursement. A significant decline in volume is defined as greater than a 5 percent decrease in discharges from one cost reporting year to the next. The SCH must also prove that the volume decline is due to circumstances beyond the SCH's control. The additional payment amount that can be requested is the difference between Medicare inpatient operating costs and actual Medicare inpatient payments received for the year that the decrease in volume was experienced. While Blessing Hospital did not experience a decrease in volume greater than 5 percent in either the 2019 or 2020 cost reporting period, should it experience a decrease in volume greater than 5 percent in the future, the opportunity to recoup the difference between Medicare inpatient operating costs and Medicare inpatient payments would be taken away if Blessing Hospital did not retain its SCH designation.

- 340B Drug Pricing Program – Based on Blessing Hospital's 2019 Medicare cost report, it does not appear that Blessing Hospital would qualify for the 340B Drug Pricing Program under the lower qualification threshold for an SCH, as Blessing Hospital only had a 7.7 percent DSH add-on percentage on the 2019 cost report. However, for the 2020 cost reporting period Blessing Hospital's DSH add-on percentage is 12.6 percent, meaning that Blessing Hospital would now qualify for the 340B program regardless of its SCH designation.

Based on the items quantified above, the benefits of Blessing Hospital's SCH designation averaged approximately $6.9 million per year for the 2019 and 2020 cost reporting periods. Clearly, the loss of SCH designation for Blessing Hospital would be significant, both in the decrease of direct payments as well as the other protections and provision this designation provides.

Please let me know if you would like to discuss these matters further at your convenience.

Sincerely,



Frederick K. Helfrich, CPA
Partner

FKH:clr
Attachments
KN/81059

Blessing Hospital
Quantification of Medicare SCH Payment Benefit

	FY 2020	FY 2019
Worksheet E, Part A, line 48	61,996,456	63,179,845
Worksheet E, Part A, line 47	57,971,792	57,958,176
SCH benefit	4,024,664	5,221,669
Worksheet E, Part B, line 3	34,635,115	34,520,524
SCH add-on %	7.1%	7.1%
SCH benefit	2,296,072	2,288,475
	6,320,736	7,510,144

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Oct 1, 2020

412.92 Special treatment; Sole community hospitals.

(a) Criteria for classification as a sole community hospital. CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in §412.64) and meets one of the following conditions:
(1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

(i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;

(ii) The hospital has fewer than 50 beds and the MAC certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or

(iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

(4) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, combined data from the main campus and its remote location(s) are required to demonstrate that the criteria specified in paragraphs (a)(1)(i) and (ii) of this section are met. For the mileage and rural location criteria in paragraph (a) of this section and the mileage, accessibility, and travel time criteria specified in paragraphs (a)(1) through (3) of this section, the hospital must demonstrate that the main campus and its remote location(s) each independently satisfy those requirements.

(b) Classification procedures—
(1) Request for classification as sole community hospital.
(i) The hospital must make its request to its MAC.
(ii) If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:

(A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.

(B) The hospital must provide patient origin data from all other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.

(A) If the hospital is unable to obtain the information required under paragraph (b)(1)(ii)(A) of this section concerning the residences of Medicare beneficiaries who were inpatients in other hospitals located within a 35 mile radius of the hospital or, if larger, within the hospital's service area, the hospital may request that CMS provide this information.

(B) If a hospital obtains the information as requested under paragraph (b)(1)(iii)(A) of this section, that information is used by both the MAC and CMS in making the determination of the residences of Medicare beneficiaries under paragraphs (b)(1)(iii) and (b)(1)(iv) of this section, regardless of any other information concerning the residences of Medicare beneficiaries submitted by the hospital.

(iv) The MAC reviews the request and send the request, with its recommendation, to CMS.

(v) CMS reviews the request and the MAC's recommendation and forward its approval or disapproval to the MAC.

(2) Effective dates of classification.
(i) For applications received on or before September 30, 2018, sole community hospital status is effective 30 days after the date of CMS' written notification of approval, except as provided in paragraph (b)(2)(v) of this section. For applications received on or after October 1, 2018, sole community hospital status is effective as of the date the MAC receives the complete application, except as provided in paragraph (b)(2)(v) of this section.
(ii) When a court order or a determination by the Provider Reimbursement Review Board (PRRB) reverses a CMS denial of sole community hospital status and no further appeal is made, the sole community hospital status is effective as follows:

(A) If the hospital's application was submitted prior to October 1, 1983, its status as a sole community hospital is effective at the start of the cost reporting period for which it sought exemption from the cost limits.

(B) If the hospital's application for sole community hospital status was received on or after October 1, 1983 and on or before September 30, 2018, the effective date is 30 days after the date of CMS' original written notification of denial.

(C) If the hospital's application for sole community hospital status was received on or after October 1, 2018, the effective date is the date the MAC receives the complete application.

(iii) When a hospital is granted retroactive approval of sole community hospital status by a court order or a PRRB decision and the hospital wishes its sole community hospital status terminated before the date of the court order or PRRB determination, it must submit written notice to the CMS regional office within 90 days of the court order or PRRB decision. A written request received after the 90-day period is effective no later than 30 days after the request is submitted.

(iv) For applications received on or before September 30, 2018, a hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS' approval of the classification. For applications received on or after October 1, 2018, a hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after the date the MAC receives the complete application.

(v) If a hospital that is classified as an MDH under § 412.108 applies for classification as a sole community hospital because its status under the MDH program expires with the expiration of the MDH program, and that hospital's sole community hospital status is approved, the effective date of approval of sole community hospital status is the day following the expiration date of the MDH program if the hospital—

(A) Applies for classification as a sole community hospital prior to 30 days before the expiration of the MDH program; and

(B) Requests that sole community hospital status be effective with the expiration of the MDH program.

(3) Duration of classification.

(i) An approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. An approved sole community hospital must notify the MAC if any change that is specified in paragraph (b)(3)(ii) of this section occurs. If CMS determines that a sole community hospital failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date that the hospital no longer met the criteria for such classification, consistent with the provisions of §405.1885 of this chapter.

(ii) A sole community hospital must report the following to the MAC within 30 days of the event:

(A) The opening of a new hospital in its service area.

(B) The opening of a new road between itself and a like provider within 35 miles.

(C) An increase in the number of beds to more than 50 if the hospital qualifies as a sole community hospital under paragraph (a)(1)(ii) of this section.

(D) Its geographic classification changes.

(E) Any changes to the driving conditions that result in a decrease in the amount of travel time between itself and a like provider if the hospital qualifies as a sole community hospital under paragraph (a)(3) of this section.

(iii) A sole community hospital must report to the MAC if it becomes aware of any change that would affect its classification as a sole community hospital beyond the events listed in paragraph (b)(3)(ii) of this section within 30 days of the event. If CMS determines that a sole community hospital has failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date the hospital became aware of the event that resulted in the sole community hospital no longer meeting the criteria for such classification, consistent with the provisions of §405.1885 of this chapter.

(iv) A sole community hospital must report to the MAC any factor or information that could have affected its initial classification as a sole community hospital.

(A) If CMS determines that a sole community hospital has failed to comply with the requirement of paragraph ((b)(3)(iv) of this section, CMS may cancel the hospital's classification as a sole community hospital effective with the date the hospital failed to meet the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter.

(B) Effective on or after October 1, 2012, if a hospital reports to CMS any factor or information that could have affected its initial determination and CMS determines that the hospital should not have qualified for sole community hospital status, CMS will cancel the sole community hospital status effective 30 days from the date of the determination.

(4) Cancellation of classification.

(i) A hospital may at any time request cancellation of its classification as a sole community hospital, and be paid at rates determined under subparts D and E of this part, as appropriate.

(ii) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(iii) If a hospital requests that its sole community hospital classification be cancelled, it may not be reclassified as a sole community hospital unless it meets the following conditions:

(A) At least one full year has passed since the effective date of its cancellation.

(B) The hospital meets the qualifying criteria set forth in paragraph (a) of this section in effect at the time it reapplies.

(5) Automatic classification as a sole community hospital. A hospital that has been granted an exemption from the hospital cost limits before October 1, 1983, or whose request for the exemption was received by the appropriate intermediary before October 1, 1983, and was subsequently approved, is automatically classified as a sole community hospital unless that classification has been cancelled under paragraph (b)(3) of this section, or there is a change in the circumstances under which the classification was approved.

(c) Terminology. As used in this section—

(1) The term *miles* means the shortest distance in miles measured over improved roads. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital.

(2) The term *like hospital* means a hospital furnishing short-term, acute care. Effective with cost reporting periods beginning on or after October 1, 2002, for purposes of a hospital seeking sole community hospital designation, CMS will not consider the nearby hospital to be a like hospital if the total inpatient days attributable to units of the nearby hospital that provides a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system are less than or equal to 8 percent of the similarly calculated total inpatient days of the hospital seeking sole community hospital designation.

(3) The term *service area* means the area from which a hospital draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a sole community hospital. If the most recent cost reporting period ending before the hospital applies for classification as a sole community hospital is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

(d) Determining prospective payment rates for inpatient operating costs for sole community hospitals—
(1) General rule. For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:
(i) The Federal payment rate applicable to the hospitals as determined under subpart D of this part.

(ii) The hospital-specific rate as determined under §412.73.

(iii) The hospital-specific rate as determined under §412.75.

(iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under §412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section).

(v) For cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate as determined under §412.78.

(2) Transition of FY 1996 hospital-specific rate. The MAC calculates the hospital-specific rate determined on the basis of the fiscal year 1996 base period rate as follows:
(i) For Federal fiscal year 2001, the hospital-specific rate is the sum of 75 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 25 percent of the hospital-specific rate as determined under §412.77.

(ii) For Federal fiscal year 2002, the hospital-specific rate is the sum of 50 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 50 percent of the hospital-specific rate as determined under §412.77.

(iii) For Federal fiscal year 2003, the hospital-specific rate is the sum of 25 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 75 percent of the hospital-specific rate as determined under §412.77.

(iv) For Federal fiscal year 2004 and any subsequent fiscal years, the hospital-specific rate is 100 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(3) Adjustment to payments. A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in the number of discharges, as described in paragraph (e) of this section.
(e) Additional payments to sole community hospitals experiencing a significant volume decrease.
(1) For cost reporting periods beginning on or after October 1, 1983, the MAC provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the MAC must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.
(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the MAC's Notice of Amount of Program Reimbursement—

(i) Submit to the MAC 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.

(3) Effective for cost reporting periods beginning before October 1, 2017, the MAC 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). Effective for cost reporting periods beginning on or after October 1, 2017, the MAC determines a lump sum adjustment amount equal to the difference between the hospital's fixed Medicare inpatient operating costs and the hospital's total MS-DRG revenue based on MS-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) multiplied by the ratio of the hospital's fixed inpatient operating costs to its total inpatient operating costs.

(i) In determining the adjustment amount, the MAC 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.

(ii) The MAC makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.

(iii) The MAC determination is subject to review under subpart R of part 405 of this chapter.

50 FR 12741, Mar. 29, 1985, as amended at 51 FR 31496, Sept. 3, 1986; 51 FR 34793, Sept. 30, 1986; 52 FR 30367, Aug. 14, 1987; 52 FR 33057, Sept. 1, 1987; 53 FR 38529, Sept. 30, 1988; 54 FR 36494, Sept. 1, 1989; 55 FR 14283, Apr. 17, 1990; 55 FR 15174, Apr. 20, 1990; 55 FR 36070, Sept. 4, 1990; 56 FR 25487, June 4, 1991; 57 FR 39823, Sept. 1, 1992; 60 FR 45848, Sept. 1, 1995; 65 FR 47107, Aug. 1, 2000; 66 FR 32193, June 13, 2001; 66 FR 39932, Aug. 1, 2001; 66 FR 39933, Aug. 1, 2001; 67 FR 50111, Aug. 1, 2002; 70 FR 47485, Aug. 12, 2005; 71 FR 48138, Aug. 18, 2006; 73 FR 48755, Aug. 19, 2008; 77 FR 53674, Aug. 31, 2012; 82 FR 38511, Aug. 14, 2017; 83 FR 41702, Aug. 17, 2018; 85 FR 59021, Sept. 18, 2020