PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 21-1636

LANCASTER HOSPITAL CORPORATION, formerly doing business as Springs Memorial Hospital,

Plaintiff - Appellant,

v.

XAVIER BECERRA, Secretary, U.S. Department of Health and Human Services,

Defendant - Appellee.

Appeal from the United States District Court for the District of South Carolina, at Rock Hill. Mary G. Lewis, District Judge. (0:19-cv-01857-MGL)

Argued: October 27, 2022 Decided: January 18, 2023
Amended: January 18, 2023

Before WILKINSON and HEYTENS, Circuit Judges, and MOTZ, Senior Circuit Judge.

Affirmed by published opinion. Judge Heytens wrote the opinion, in which Judge Wilkinson and Senior Judge Motz joined.

ARGUED: Mark Douglas Polston, KING & SPALDING, LLP, Washington, D.C., for Appellant. Caroline D. Lopez, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellee. **ON BRIEF:** Juliet M. McBride, Houston, Texas, Michael LaBattaglia, KING & SPALDING LLP, Washington, D.C., for Appellant. Brian M. Boynton, Acting Assistant Attorney General, Abby C. Wright, Civil Division, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C.; Daniel Berry, Acting General

Counsel, Dana J. Petti, Chief Counsel, Howard Lewis, Assistant Regional Counsel, Region IV, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Atlanta, Georgia; M. Rhett DeHart, United States Attorney, OFFICE OF THE UNITED STATES ATTORNEY, Charleston, South Carolina, for Appellee.

TOBY HEYTENS, Circuit Judge:

The Department of Health and Human Services denied a Medicare provider's request for reimbursement because the provider failed to submit information in a form that could be audited. Seeing no reversible error, we affirm the district court's grant of summary judgment to HHS.

I.

The Medicare program provides federally funded health insurance for the elderly and people with disabilities. Under the program, healthcare providers enter written agreements with the Secretary of HHS to supply services to Medicare beneficiaries. See 42 U.S.C. § 1395cc.

This case involves how service providers get paid. Although practices have since changed, providers used to be reimbursed under a "reasonable cost" method, see 42 U.S.C. §§ 1395f(b)(1), 1395x(v)(1)(A), and the parties agree all reimbursements at issue were governed by that method.

Under the reasonable cost method, providers may seek reimbursement for "cost[s] actually incurred, excluding . . . any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." § 1395x(v)(1)(A). HHS regulations state this method "is intended to meet [a provider's] actual costs, however widely they may vary from one institution to another." 42 C.F.R. § 413.9(c)(2); accord § 413.9(c)(3) (similar). At the same time, the regulations emphasize providers are not entitled to reimbursement for all expenditures, including those "substantially out of line with [costs of] other [similar]

institutions" and those "not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services." § 413.9(c)(2) & (3).

Congress empowered HHS to get the information it needs to make reimbursement decisions—indeed, federal law states that "no [ ] payments shall be made to any provider unless it has furnished such information as [HHS] may request in order to determine the amounts due such provider." 42 U.S.C. § 1395g(a).

HHS regulations lay out the necessary information. "The principles of cost reimbursement," the regulations instruct, "require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the [Medicare] program." 42 C.F.R. § 413.20(a). "Providers receiving payment on the basis of reimbursable cost must provide adequate cost data." § 413.24(a). And, critically here, the required cost data "must be based on [a provider's] financial and statistical records" and be "capable of being audited." § 413.24(a) & (c).

II.

Plaintiff Lancaster Hospital Corporation (formerly Springs Memorial Hospital) operates an inpatient rehabilitation facility that provides services for Medicare beneficiaries. In 1994, Lancaster hired a full-service subcontractor to manage all aspects of that facility in exchange for a per-patient-per-day rate for any services provided to its patients. Under this arrangement, Lancaster paid the subcontractor and then sought reimbursement from HHS.

This dispute has narrowed since its inception. The controversy began when an initial decisionmaker (currently known as a Medicare Administrative Contractor) disallowed

reimbursement for fiscal years 1997, 1998, 1999, and 2000 because Lancaster submitted inadequate documentation. After Lancaster supplied more information, the Administrative Contractor allowed reimbursement for fiscal year 1999 but continued to deny payment for the remaining years.

Lancaster filed an administrative appeal to the Provider Reimbursement Review Board (see 42 U.S.C. § 1395oo), which upheld the Administrative Contractor's decision in part and overturned it in part. During the appeal process, Lancaster provided additional documentation for fiscal years 1998 and 2000 that was "similar to what was used by the [Administrative] Contractor to audit" the costs for fiscal year 1999. JA 50. The Board remanded those years to the Administrative Contractor "to audit the documentation" for fiscal years 1998 and 2000 and pay Lancaster the expenses for those years "that the Medicare Contractor determines are reasonable." JA 51.

Like the Administrative Contractor, however, the Board found fault with Lancaster's documentation for fiscal year 1997. "Unlike FYs 1998 and 2000," the Board explained, "the record does not contain documentation that supports the reasonableness of [Lancaster's] payments to [the subcontractor] for services . . . for FY 1997." JA 51. "Specifically," the Board noted:

- Lancaster "did not have [its subcontractor's] payroll information . . . for FY 1997, and could only estimate [the subcontractor's] therapy salaries and hours for this year";

- Lancaster "did not submit FY 1997 salary and hours documentation for the management positions related to the [relevant] contract"; and

- Unlike the value quantitative models Lancaster prepared for fiscal years 1998–2000, the model it submitted for fiscal year 1997 "was based on *estimated* costs and hours rather than on documentation capable of being audited."

Id. Because Lancaster "did not provide auditable documentation for" fiscal year 1997, the Board ruled "the Medicare Contractor properly denied" reimbursement for that year. *Id.*

Unhappy with the Board's decision about fiscal year 1997, Lancaster filed suit in federal district court. See 42 U.S.C. § 1395oo(f)(1) (authorizing judicial review). The district court granted summary judgment to HHS.

We review a district court decision granting summary judgment de novo, "applying the same standard as that court." *National Audubon Soc'y v. United States Army Corps of Eng'rs*, 991 F.3d 577, 583 (4th Cir. 2021). Like the district court, we review the Board's decision under the Administrative Procedure Act. See 42 U.S.C. § 1395oo(f)(1). Under the APA, agency action is unlawful if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "unsupported by substantial evidence." 5 U.S.C. § 706(2)(A), (E). "The scope of review under the 'arbitrary [or] capricious' standard is narrow and a court is not to substitute its judgment for that of the agency." *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

III.

Lancaster faces an uphill climb. The Medicare statute contains a sweeping grant of authority to HHS to require providers to submit information to support reimbursement requests, declaring "no such payments shall be made to any provider unless it has furnished *such information as the Secretary may request* in order to determine the amounts due such provider." 42 U.S.C. § 1395g(a) (emphasis added). Exercising that authority, the Secretary

promulgated regulations stating that "[p]roviders receiving payment on the basis of reimbursable cost"—the method at issue—"must provide adequate cost data." 42 C.F.R. § 413.24(a). That cost data, the regulations continue, "must be based on [a provider's] financial and statistical records which must be capable of verification by qualified auditors" and be "capable of being audited." § 413.24(a) & (c). Here, the Board denied reimbursement for fiscal year 1997 because it concluded the information Lancaster submitted for that year was not auditable.

Lancaster does not ask us to overturn the Board's decision on the ground that the information it supplied for 1997 was, in fact, "capable of being audited" within the meaning of the Secretary's regulations. Nor does Lancaster challenge the validity of 42 C.F.R. § 413.24(c), the regulation containing that requirement. Instead, Lancaster argues: (1) this case is governed by a different regulation; and (2) the alternative information it offered to provide "would have more than sufficed to substitute for the payroll records [HHS] sought." Lancaster Reply Br. 2. Like the district court, we are unpersuaded.

The most prominent strand of Lancaster's argument is that 42 C.F.R. § 413.9(c)(2) establishes "the substantive standard for payment," and that "[n]either the Medicare statute nor the regulations . . . permit the Board to deny payment on the basis of a demand for irrelevant documentation." Lancaster Br. 2–3. According to Lancaster, the *only* justification for denying reimbursement is "if a particular institution's costs are found to be substantially out of line with other [similar] institutions in the same area." 42 C.F.R. § 413.9(c)(2). And, Lancaster continues, HHS may not deny reimbursement based on

inadequate documentation if the provider submits *other* documents that could serve the same purpose as those HHS requests.

The problem for Lancaster is that neither the statute nor the regulations say that. The statute itself mandates another basis for denying reimbursement: A provider's failure to "furnish[ ] such information as the Secretary may request in order to determine the amounts due such provider" means "no [ ] payments shall be made." 42 U.S.C. § 1395g(a). Nor does the statutory text support the notion that courts must try to figure out why HHS asked for one type of information or referee competing claims about whether another type would be an adequate substitute.[1]

Lancaster's reading of the regulations fares no better. The provision Lancaster cites establishes no exclusive test for when reimbursement may be denied, nor does it speak to required documentation. Rather, the cited regulation declares what the reasonable cost method "is *intended to*" do—reimburse a provider's "actual costs"—while noting that goal "is subject to a limitation if a particular institution's costs are found to be substantially out of line with other" comparable institutions. 42 C.F.R. § 413.9(c)(2) (emphasis added). Nothing in that provision says it overrides all other requirements for obtaining reimbursement, including the separate requirement that a provider "must provide adequate cost data" that "must be based on . . . financial and statistical records" "capable of being

[1] This case does not require us to consider what would happen if HHS denied payment because a contractor failed to provide records having nothing to do with Medicare reimbursement. Here, the Board denied reimbursement for fiscal year 1997 based on Lancaster's failure to provide a type of documentation (including payroll records) that Lancaster provided for 1998 to 2000 and was plainly helpful for auditing.

audited." § 413.24(a), (c); see also § 413.9(c)(3) (stating that "operating costs" are "not . . . allowable" if they "include amounts not related to patient care, specifically not reimbursable under [Medicare], or flowing from the provision of luxury items or services").

Lancaster also overreaches in claiming the Board acted arbitrarily by departing from the Provider Reimbursement Manual, an HHS publication that "provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services." CMS Pub. No. 15 (Part I) (Provider Reimbursement Manual), foreword. As Lancaster acknowledges, that Manual "is not itself a regulation adopted through notice-and-comment rulemaking," Lancaster Br. 33, and thus cannot override 42 C.F.R. § 413.24. See *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782, 799 (9th Cir. 2003); accord Provider Reimbursement Manual, foreword (Manual "does not have the effect of regulations").

In any event, there is no conflict. The portion of the Provider Reimbursement Manual Lancaster cites states "[r]ecords must be available which will support the cost of purchased management and administrative support services," and then identifies six broad categories of records that "could" do so. Provider Reimbursement Manual § 2135.5. Nothing in that provision says that any—much less all—of the listed types of records are invariably sufficient to justify reimbursement. Quite the contrary. For one thing, the text is loaded with caveats, stating support for reimbursement for purchased management and administrative services "could include some or all of the following, depending upon the scope or type of contract." *Id.* And, here too, there is no suggestion (and certainly no actual

statement) that this list of examples supersedes the capable-of-being-audited requirement imposed by 42 C.F.R. § 413.24.[2]

Lancaster's insistence that the Board acted arbitrarily by denying its claim for 1997 "after allowing [ ] materially identical claims, on the basis of the same record, for other years" rings hollow. Lancaster Br. 4. Indeed, the Board denied reimbursement for 1997 precisely because the records were materially different from what was provided for other years. As the Board explained, the supplemental records Lancaster provided for 1998 and 2000 contained "information and supporting documentation" that were "similar to what was used by the [Administrative] Contractor to audit" the relevant costs for fiscal year 1999. JA 50. In contrast, the Board found Lancaster "did not provide auditable documentation" for fiscal year 1997 and denied reimbursement on that basis. JA 51. That difference in treatment was directly supported by 42 C.F.R. § 413.24 and was not arbitrary or capricious.

* * *

Lancaster asserts that—even if some reduction were warranted—the Board erred by denying its entire 1997 reimbursement request. There appears no doubt Lancaster provided

[2] We similarly are unpersuaded by Lancaster's reliance on a part of the Provider Reimbursement Manual addressing when "purchased management and administrative support service costs are reasonable." Provider Reimbursement Manual § 2135.3. That provision declares that such costs "*[g]enerally* . . . are reasonable if the costs incurred are comparable with marketplace prices for similar services, or provide for a total guaranteed cost equal to or less than the provider's current cost for such department or service." *Id.* (emphasis added). But like the regulation and the other portions of the Provider Reimbursement Manual just discussed, that language does not say it overrides all other requirements for obtaining reimbursement.

services to Medicare beneficiaries in 1997 and denying all reimbursement for that year may seem harsh. But the principle that people "must turn square corners when they deal with the Government" "has its greatest force when a private party seeks to spend the Government's money." *Heckler v. Community Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 63 (1984). "As a participant in the Medicare program," Lancaster "had a duty to familiarize itself with the legal requirements for cost reimbursement," *id.* at 64, including the need to provide cost data in a form "capable of being audited," 42 C.F.R. § 413.24(c).[3] The Board's decision to deny reimbursement for fiscal year 1997 was neither arbitrary nor capricious and was supported by substantial evidence. The district court's judgment is thus

AFFIRMED.

[3] Lancaster insists it cannot provide the requested information for 1997 because any such data would be in the custody of Lancaster's (now-former) subcontractor, which is unable or unwilling to provide it. That is an issue between Lancaster and its subcontractor rather than a matter for HHS or the courts.