PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2020-D11

PROVIDER-
Olympic Medical Center

Provider No.: 50-0072

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions, LLC

HEARING DATE –
March 7, 2019

Cost Reporting Period Ended –
December 31, 2012

CASE NO. – 16-2515

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor was correct in calculating the Provider's Sole Community Hospital ("SCH") Volume Decrease Adjustment ("VDA").[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated the VDA payment pertaining to Olympic Medical Center ("Olympic" or "Provider") for Fiscal Year ("FY") 2012 and that Olympic should receive a VDA payment for FY 2012 in the amount of $2,500,062.

INTRODUCTION

Olympic is a non-profit acute care hospital located in Port Angeles, Washington. Olympic was designated as a SCH during the fiscal year at issue. The Medicare administrative contractor assigned to Olympic is Noridian Healthcare Solutions, LLC ("Medicare Contractor"). Olympic requested a VDA payment of $2,929,138 to compensate it for a decrease in inpatient discharges during FY 2012.[2] The Medicare Contractor reviewed the request and determined that a VDA payment was not warranted. Olympic timely appealed and met the jurisdictional requirements for a hearing before the Board.

The Board held a live hearing on March 7, 2019. Olympic was represented by Ronald Rybar, Esq. of The Rybar Group, P.C. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays hospitals a predetermined, standardized amount per discharge, subject to certain payment adjustments. One of these payment adjustments, the VDA, is available to SCHs if they incur a decrease in patient discharges of more than 5 percent from one cost reporting year to the next, due to circumstances beyond its control. These adjustments are designed to compensate the hospital for the fixed costs it incurs in the period for providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.[3] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that Olympic experienced a decrease in discharges greater than 5 percent from FY 2011 to FY 2012 due to circumstances beyond Olympic's control and that Olympic was eligible to have a VDA calculation performed for FY 2012.[4] Olympic requested a VDA payment

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[1] *See* the Medicare Contractor's Final Position Paper at 4 (issue statement); Provider's Revised Final Position Paper at 2; Transcript ("Tr.") at 5. The Transcript issue statement wording at 5 does not contain the exact wording as in the Medicare Contractor's Final Position Paper.
[2] Exhibit P-3 at 251; Exhibit I-1 at 26.
[3] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[4] Medicare Contractor's Final Position Paper at 8.

in the amount of $2,929,138.[5] The Medicare Contractor denied this request on April 12, 2016 because Olympics' DRG revenue exceeded its fixed and semi fixed Medicare costs.[6] Olympic timely requested that the Medicare Contractor reconsider this denial.[7] Olympic states that the Medicare Contractor did not respond to this reconsideration request.[8]

42 C.F.R. § 412.92(e) (2011) directs how the Medicare Contractor must adjudicate the VDA request once an SCH demonstrates it suffered a qualifying decrease in total inpatient discharges. In pertinent part, § 412.92(e)(3) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed* the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs . . . .
>
> (i) In determining the adjustment amount, the intermediary considers—
>
> …….
>
> (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; . . .[9]

As CMS notes in the preamble to the final rule published on August 18, 2006,[10] the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 371) provides further guidance related to VDAs. In particular, § 2810.1(B) (Rev. 371) states, in pertinent part:

> Additional payment is made . . . 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.
>
> 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

[5] Exhibit P-3 at 251; Exhibit I-1 at 26.
[6] Exhibit P-2 (copy of the Medicare Contractor's denial).
[7] Provider's Revised Final Position Paper at 2. *See also* Exhibit P-3 (copy of Olympic's reconsideration request).
[8] Provider's Revised Final Position Paper at 2.
[9] (Emphasis added.)
[10] 71 Fed. Reg. 47869, 48056 (Aug.18, 2006).

> costs for items and services that vary *directly* with utilization such as food and laundry costs.[11]

The chart below depicts the Medicare Contractor's and the Provider's VDA payment calculations for FY 2012.[12] The Medicare Contractor compares fixed costs to total Medicare payments while the Provider's calculation compares total operating costs to total Medicare payments.[13]

	Medicare Contractor calculation using fixed costs	Provider/PRM calculation using total costs
a) Prior Year Medicare Inpatient Operating Costs	$22,820,141	$22,820,141
b) IPPS update factor	1.019	1.026
c) Prior year Updated Operating Costs (a x b)	$23,253,724	$23,413,465
d) FY 2012 Operating Costs	$22,040,907	$22,040,907
e) Lower of c or d	$22,040,907	$22,040,907
f) DRG/SCH payment	$19,125,383	$19,125,383
g) CAP (e-f)	$2,915,524	$2,915,524
h) FY 2012 Inpatient Operating Costs	$22,040,907	$22,040,907
i) Fixed Cost percent	.8575	
j) FY 2012 Fixed Costs (h x i)	$18,900,078	
k) Total DRG/SCH Payments	$19,125,383	$19,125,383
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 0	
m) VDA Payment Amount (The Providers VDA is based on the amount line e exceeds line k.)		$2,915,524

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment. Specifically, the parties dispute the fixed cost percentage and the use of fixed costs in determining Olympic's VDA payment.[14]

[11] (Emphasis added) (available on Wolters Kluwer website (irus.wolterskluwer.com) in the archive CMS program manuals in the healthcare Cheetah product line). *See* PRM 15-1, Transmittal 371 (Aug. 1, 1993) (revising, in part, PRM 15-1 § 2810).

[12] *See* Exhibit P-2 at 238 (the Medicare Contractor's VDA calculation); Provider's Final Position Paper at 9 (the Provider's final VDA calculation). Olympic's original VDA request and its final VDA calculation are different because Olympic's original VDA request was submitted prior to the issuance of its FY 2012 notice of program reimbursement.

[13] Exhibit I-4 at 2; Provider's Revised Final Position Paper at 9, Table 4.

[14] Tr. At 11-12.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor alleges that a VDA payment is intended to reimburse a qualifying hospital for its fixed costs only and, therefore, the removal of variable costs from the VDA calculation is required.[15] The Medicare Contractor points out that the Administrator recently reviewed several recent Board decisions concerning the proper calculation of the VDA, specifically referencing the Administrator's decision in *Fairbanks Mem'l Hosp.* ("*Fairbanks*").[16] The Medicare Contractor asserts its calculation is consistent with the Administrator's decision in *Fairbanks.*[17]

Olympic maintains that the most appropriate methodology to calculate the VDA payment is found in the PRM which the Secretary has repeatedly endorsed in the Federal Register.[18]

> The adjustment amount [VDA] is determined by subtracting the second year's DRG payment from the lesser of: (a) 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 [hospital] receives the difference in a lump-sum payment.[19]

Olympic argues that the Medicare Contractor's calculation of the VDA was wrong because the Medicare Contractor improperly changed the Medicare rules by calculating Olympic's VDA payment based on a comparison of Olympic's fixed costs to its total DRG payments. Olympic asserts that this approach is wrong because "reducing a hospital's total fixed cost by DRG revenue attributable to both fixed and variable costs render[s] an understated VDP.[20] In effect, it is subtracting apples from oranges."[21]

In the alternative, Olympic reasons that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. This method, Olympic maintains, would assure an accurate matching of revenue with expenses because the DRG payment is intended to cover both fixed *and* variable costs. Olympic also references the fact that CMS essentially adopted this approach when it prospectively changed the methodology for calculating VDA payments, starting in FFY 2018.[22]

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[15] Medicare Contractor's Final Position paper at 8-9.
[16] *See* Medicare Contractor's Final Position Paper at 9 (referencing Exhibit I-7 which contains a copy of *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015)).
[17] *Id.* at 10.
[18] Provider's Revised Final Position Paper at 2.
[19] 71 Fed. Reg. at 48056; 73 Fed. Reg. 48433, 48631 (Aug. 19, 2008).
[20] Olympic used the term "VDP" which refers to volume decrease payment. VDP can be used interchangeably with VDA payment.
[21] Provider's Revised Final Position Paper at 5.
[22] *Id.* at 6-7.

However, if the Board were to use this alternate approach, Olympic maintains that its FY 2012 fixed (including semi-fixed) cost percentage needs to be corrected as the Medicare Contractor did not calculate it correctly. Although Olympic does not dispute the amount of variable cost,[23] it maintains that *total cost* should be the amount on Worksheet A, Column 3, Line 200 of the Medicare cost report.[24] Olympic supports its position with statements and examples in the 2018 IPPS Final Rule that it asserts demonstrate that a hospitals fixed cost percentage should be calculated by dividing the hospital's fixed costs by total costs in the cost reporting period.[25] Olympic points out that the Medicare Contractor removed Capital, Rural Health Clinic ("RHC") and Home Health Agency ("HHA") costs from this calculation, reducing fixed and total costs significantly, and lowering its fixed cost percentage.[26]

Both parties provided their proposed calculations of the VDA for the Board's consideration. The Board examined both parties' calculations, and finds that the payment amount is different because of differences in: (1) the use of fixed costs rather than total costs in calculating the VDA; and (2) the fixed cost percentage.

This issue of whether the VDA calculation should be based on fixed costs or total costs is not new to the Board. In recent decisions,[27] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because it compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

The Administrator has overturned these Board decisions, stating:

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . . In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. . . . The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has

[23] Olympic submitted variable cost of 13,693,847 (*see* Exhibit P-5 at 260). The Medicare Contractor made minor adjustments changing the amount to $13,677,963 (*see* Exhibit I-5).
[24] Tr. at 43-47.
[25] 82 Fed. Reg. 37990, 38180-38181 (Aug. 14, 2017).
[26] Provider's Revised Final Position Paper at 3.
[27] *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D1 (Dec. 15, 2016) , *modified by*, Adm'r Dec. (Feb. 9, 2017); *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs*, PRRB Dec. No. 2015-D11 (June 9, 2015), *modified by*, Adm'r Dec. (Aug. 5, 2015).

> been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[28]

Recently, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[29]

At the outset, it must be recognized that Administrator decisions are not binding precedent; as explained by PRM 15-1 § 2927.C.6.e:

> e. Nonprecedential Nature of the Administrator's Review Decision.—Decisions by the Administrator ***are not precedents*** for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy [sic] having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.[30]

Moreover, the Board observes that the Provider is not located in the Eighth Circuit and, thus, the *Unity HealthCare* decision is not binding precedent in this appeal.

Significantly, *subsequent to the time period at issue*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the 2018 IPPS Final Rule,[31] CMS prospectively changed the way the VDA is calculated to a methodology that is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated portion of the DRG payment that is related to fixed costs, to the hospital's fixed costs, when determining the amount of the VDA payment.[32] The 2018 IPPS Final Rule makes this change effective for cost reporting periods beginning on or after October 1, 2017, explaining that it will "remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment."[33]

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[28] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[29] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019).
[30] (Emphasis added.)
[31] 82 Fed. Reg. at 38179-38183.
[32] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).
[33] 82 Fed. Reg. at 38180.

The Medicare Contractor, in their calculation, determined Olympic's VDA payment by comparing its fixed costs to its DRG payments. However, neither the language nor the examples[34] in PRM § 15-1 compare the hospital's fixed costs to its DRG payments when calculating a hospital's VDA payment. Similar to PRM § 15-1, the preambles to both the FFY 2007 IPPS Final Rule[35] and the FFY 2009 IPPS Final Rule,[36] reduce a hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> [T]he adjustment amount is determined by subtracting the second year's MS-DRG payment from the lessor of: (a) The second year's cost 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 or MDH receives the difference in a lump-sum payment.

It is clear from these preambles that the only adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Olympic's VDA using the methodology laid out by CMS in the PRM 15-1 or the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Olympic's FY 2012 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions. The statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) is clear that the VDA payment is to fully compensate a hospital for its fixed cost:

> In the case of a sole community 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.

In the FFY 1984 IPPS Final Rule, the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed cost it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[37] However, the VDA payment methodology explained in the FFY 2007 and FFY 2009 Final Rules and PRM 15-1 § 2810.1 compares a

[34] PRM 15-1 § 2810.1(C), (D).
[35] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[36] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[37] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments, stating, in pertinent part:

> C. Requesting Additional Payments.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
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> 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. . . .
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since the 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 Cost* ***and FY 1987 DRG payments***.
>
> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . 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***.[38]

At first blush, PRM 15-1 § 2810.1 would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limits the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the Administrator decisions stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[39] Notably, in applying this

[38] (Emphasis added.)
[39] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.

new methodology through adjudication, CMS did not otherwise alter its written policy statements in either the PRM or Federal Register.

Based on its review of the statute, regulations, PRM 15-1, and the Eighth Circuit's decision,[40] the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[41] Under the Administrator's methodology, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment ***only*** *for fixed costs* of the services actually furnished to Medicare patients. However, the statute at 42 U.S.C.§ 1395ww(a)(4) makes it clear that the DRG payment includes payment for both fixed *and* variable cost of the services rendered because it defines operating costs of inpatient services as "**all** routine operating costs . . . and include the ***cost*** *of all services* for which payment can be made." The Administrator simply cannot ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments for fixed cost of the Medicare services actually rendered, when the hospital in fact incurred both fixed and variable costs for those services.

Rather, based on the relevant law and regulations, the Board must conclude that the purpose of the VDA payment is to compensate a hospital for its fixed costs associated with the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "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." This approach is also consistent with the directive in 42 C.F.R. § 412.92(e) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[42] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs, but the hospital will always have some variable cost related to its *actual* patient load.

Critical to the proper application of the statute, regulation and manual provisions related to the VDA are the unequivocal facts that: (1) the Medicare patients to which a provider furnished services in the current year are not part of the volume decrease, and (2) the DRG payment made to the hospital for services furnished to Medicare patients in the current year is payment for both the fixed and variable costs of the services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year as well as its full fixed costs in that year.

The Administrator's methodology clearly does not do this as it takes the portion of the DRG payment intended for variable costs and impermissibly mischaracterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(D)(ii) allowing

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[40] *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019).
[41] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[42] The Board recognizes that 42 C.F.R. § 412.92(e) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

the Secretary to ignore U.S.C.§1395ww(a)(4) – which is clear that the DRG payment is payment for both fixed and variable costs - and deem the full DRG payment as payment for fixed costs. The Board concludes that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is clear that the VDA payment is *not* intended to fully compensate a hospital for its variable costs.[43] Additionally, based on 42 U.S.C. §1395ww(a)(4), the Board finds that the DRG payment is intended to pay for both variable and fixed costs for services *actually* furnished. The Board concludes that, in order to ensure a hospital is fully compensated for its fixed costs and consistent with the PRM 15-1 assumption that a "hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare a hospital's fixed costs to that portion of a hospital's DRG payment attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the hospital's fixed/variable cost percentages as a proxy. The Board notes that that Olympic disputes the fixed cost percentage calculated by the Medicare Contractor. While the parties do not disagree with the costs identified as variable, Olympic believes the Medicare Contractor should use the total costs from Worksheet A, Column 3, Line 200 of the Medicare cost report to determine its fixed cost percentage.[44] The Medicare Contractor disagrees as it believes Capital, RHC, and HHA costs should be excluded when calculating Olympic's fixed cost percentage.

The Board disagrees with Olympic that total costs from Worksheet A, Column 3, Line 200 of the Medicare cost report (which include Olympic's Capital, RHC and HHA costs) should be used to determine its fixed cost percentage. First the Board points out that the fixed cost percentage is used to estimate Olympic's fixed operating cost and the fixed portion of Olympics DRG payment. However, Capital, RHC and HHA costs are not part of a hospital's operating cost and are not paid as part of Medicare's DRG payment.[45] Next, the Board finds nothing in CMS regulations or manuals to support Olympic's assertion that total cost must be the amount from Worksheet A, Column 3, Line 200 of the Medicare cost report. Finally the Board disagrees with Olympic's statement that the example in the 2018 Final Rule[46] clarified that the hospital's total cost should include the cost of the entire business entity (including other provider types such as HHAs and RHCs identified by unique CMS Certification Numbers ("CCN")).[47] The Board finds nothing in the Final Rule or regulations that identifies the term total cost as the total cost of the entire business entity including the cost of multiple Medicare billing numbers or CCNs.[48] Based

[43] 48 Fed. Reg. at 39782.
[44] Tr. at 43-47.
[45] *See* U.S.C.§1395ww(a)(4).
[46] 82 Fed. Reg. 38181.
[47] Tr. at 43-44, 97.
[48] *See also* Tr. at 104 (stating there is nothing in the regulation stating that the total cost should be the total cost of the entire hospital complex/business entity).

on the above, the Board concludes that the Medicare Contractor's methodology, which excludes Capital, RHC, and HHA costs from Olympic's fixed cost percentage, results in a reasonable proxy to calculate the fixed portion of Olympic's operating costs and DRG payments.

By excluding Capital, RHC, and HHA costs, the Medicare Contractor determined that Olympic's fixed costs (which includes semi-fixed costs) were 85.75 percent[49] of the Provider's costs for FY 2012. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$22,820,141[50]
Multiplied by the 2012 IPPS update factor	1.019[51]
2011 Updated Costs (max allowed)	$23,253,724
2012 Medicare Inpatient Operating Costs	$22,040,907[52]
Lower of 2011 Updated Costs or 2012 Costs	$22,040,907
Less 2012 DRG payment	$19,125,383[53]
2012 Payment CAP	$2,915,524

Step 2: Calculation of VDA

2012 Medicare Inpatient Fixed Operating Costs	$18,900,078[54]
Less 2012 IPPS payment – fixed portion (85.75 percent)	$16,400,016[55]
Payment adjustment amount (subject to CAP)	$2,500,062

Since the payment adjustment amount of $2,500,062 is less than the CAP of $2,915,524, the Board determines that Olympic should receive a VDA for FY 2012 in the amount of $2,500,062.

DECISION

After considering the Medicare law and regulations, the evidence presented, and the parties' contentions, the Board finds that the Medicare Contractor improperly calculated Olympic's VDA for FY 2012 and that Olympic should receive a VDA payment for FY 2012 in the amount of $2,500,062.

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[49] *See* Exhibit P-5 (identifying variable cost of $13,677,963 and total cost of $96,001,291 for a variable cost percentage of 14.25 percent and a fixed cost percentage of 85.75 percent). *See also* Medicare Contractor's Final Position Paper at 9.
[50] Exhibit I-4 (FY 2011 Program Operating Costs Worksheet D-1, Part II, Line 53).
[51] *Id.* (FY 2012 IPPS update factor). *See also* 76 Fed. Reg. 51476, 51797 (Aug. 18, 2011).
[52] Exhibit I-4 (FY 2012 Program Operating Cost Worksheet D-1, Part II, Line 53).
[53] *Id.* (FY 2012 DRG Payments).
[54] *Id.* (FY 2012 Fixed costs were calculated by multiplying 22,040,907 by 85.75 percent).
[55] The $16,400,016 is calculated by multiplying $19,125,383 (the FY 2012 DRG payments) by 85.75 percent (the fixed cost percentage).

BOARD MEMBERS:

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Charlotte F. Benson, CPA
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FOR THE BOARD:

7/31/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A