PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2020-D12

PROVIDER-
Lake Region Healthcare Corporation

Provider No.: 24-0052

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
November 14, 2019

Cost Reporting Period Ended –
September 30, 2013

CASE NO. – 17-1190

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor's final determination of the Provider's Sole Community Hospital ("SCH") Volume Decrease Adjustment ("VDA") was properly calculated.[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 of Lake Region Healthcare Corporation ("Lake Region" or "Provider") for Fiscal Year ("FY") 2013 and that Lake Region should receive a VDA payment for FY 2013 in the amount of $1,947,967 related to Lake Region's operating costs.

INTRODUCTION

Lake Region is a hospital located in Fergus Falls, Minnesota. Lake Region was designated as an SCH during the fiscal year at issue. The Medicare administrative contractor assigned to Lake Region is National Government Services, Inc. ("Medicare Contractor").[2] Lake Region maintains that it should receive a VDA payment of $2,002,950 for FY 2013, comprised of $1,947,967 for operating costs and $54,983 for capital costs.[3] The Medicare Contractor determined that a VDA payment was not warranted.[4] Lake Region timely appealed the Medicare Contractor's determination and met the jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on November 14, 2019. Lake Region was represented by Sven Collins of Squire Patton Boggs, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

42 U.S.C. § 1395ww(d) requires Medicare Part A to pay the operating costs of acute care hospital stays through an inpatient prospective payment system ("IPPS") that is based in part on the diagnostic related group ("DRG") of the patient. Additionally, 42 U.S.C. § 1395ww(g) requires the Secretary to pay for the capital related costs of inpatient hospital services with a prospective payment system ("Capital PPS"). Both IPPS and Capital PPS payments are subject to various payment adjustments. Section 1395ww(d)(5)(D)(ii) allows SCHs to be paid a VDA if, due to circumstances beyond its control, the SCH incurs a decrease in patient discharges of more than 5 percent from one cost reporting year to the next. The VDA payment is designed to

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[1] Medicare Contractor's Final Position Paper at 3.
[2] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare Contractor" refers to both FIs and MACs as appropriate.
[3] Provider's Final Position Paper at 2; Stipulated Facts and Stipulated Alternative Decisions ("Stipulations") at Stipulated Facts ¶¶ 7-9.
[4] Stipulations at Stipulated Facts ¶¶ 10-12.

compensate a hospital for the fixed costs that it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.[5] The implementing regulations for the VDA, located at 42 C.F.R. § 412.92(e), reflect these statutory requirements.

The parties agree that: (1) Lake Region's inpatient discharges decreased by more than five percent from FY 2012 to FY 2013 due to circumstances outside of Lake Region's control; and (2) as a result, Lake Region was eligible to have a VDA calculation performed.[6] On March 16, 2015, Lake Region submitted a request for a VDA payment in the amount of $2,622,255 which included $2,571,404 for operating costs and $50,851 for capital costs.[7] On August 19, 2016, the Medicare Contractor denied this request because Lake Region's DRG revenue exceeded its total fixed and semi-fixed Medicare inpatient operating costs.[8] Shortly thereafter, on August 30, 2016, Lake Region submitted a revised request for a VDA payment in the amount of $1,947,967 for operating costs.[9] On September 7, 2016, the Medicare Contractor responded to the request and reaffirmed the VDA denial.[10] Lake Region appealed the Medicare Contractor's determination claiming it should receive a VDA of $1,947,967 for operating costs,[11] and a VDA of $54,983 for capital costs.[12]

42 C.F.R. § 412.92(e) directs how the Medicare Contractor must determine the VDA once an SCH demonstrates it suffered a qualifying decrease in total inpatient discharges and provides for review of that determination through the Board appeals process. In particular, § 412.92(e)(3) (2012) states, in pertinent part:

> (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 (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs 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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> (i) In determining the adjustment amount, the intermediary *considers* –
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> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and

[5] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[6] Medicare Contractor's Final Position Paper at 7.
[7] Exhibit P-1 at Ex. B; Exhibit C-1 at 8.
[8] Exhibit P-2.
[9] Exhibit P-3 at Ex. B.
[10] Exhibit C-2 at 1.
[11] Stipulations at ⁋ 7.
[12] The Provider's Final Position Paper at 6, 12; Stipulations at ⁋ 8.

> services in view of minimum staffing requirements imposed by State agencies;
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> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
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> (C) The length of time the hospital has experienced a decrease in utilization.
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> (ii) The intermediary makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.
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> (iii) The intermediary determination is subject to review under subpart R of part 405 of this chapter.[13]

As CMS notes in the preamble to the final rule published on August 18, 2006,[14] the Medicare Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2810.1 (Rev. 356)[15] provides further guidance related to VDAs. In particular, PRM 15-1 § 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.
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> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary *directly* with utilization such as food and laundry costs.[16]

The chart below depicts how the Medicare Contractor and the Provider each calculated the VDA payment:

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[13] (Emphasis added.)
[14] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[15] *See* Exhibit C-5.
[16] (Emphasis added.)

	Medicare Contractor calculation using fixed costs[17]	Provider/PRM calculation using total costs[18]
a) Prior Year Medicare Inpatient Operating Costs	$11,370,447	$11,370,447
b) IPPS update factor[19]	1.026	1.02
c) Prior year Updated Operating Costs (a x b)	$11,666,079	$11,592,171
d) FY 2013 Operating Costs	$10,026,809	$10,026,809
e) Lower of c or d	$10,026,809	$10,026,809
f) DRG/SCH payment	$7,323,927	$7,323,927
g) CAP (e-f)[20]	$2,702,882	$2,702,882
h) FY 2013 Inpatient Operating Costs[21]	$10,026,809	$10,026,809
i) Fixed Cost percent (not in dispute)[22]	.7207	.7207
j) FY 2013 Fixed Costs (h x i)	$7,226,018	$7,226,321
k) Total DRG/SCH Payments	$7,323,927	$7,323,927
l) FY 2013 Fixed/semi fixed portion of the DRG/SCH Payments (k x i)		$5,278,354
m) Medicare Contractor's VDA for operating costs (the amount line j exceeds line k)	$ 0	
n) Provider's VDA for operating costs (the amount line j exceeds Line l)		$1,947,967
o) Capital costs[23]		$586,799
p) Capital payments[24]		$531,816
q) Provider's VDA for capital costs (the amount line o exceeds line p)		$54,983
r) Providers Total VDA calculation for operating and capital (line n plus line q.)[25]		$2,002,950

The parties to this appeal dispute the interpretation of the statute and regulation used to calculate the VDA payment.[26] Specifically, the parties dispute how fixed cost are used in the VDA calculation and if a VDA should be paid for capital costs.

[17] Exhibit C-3 at 6.
[18] Exhibit P-3 at Ex. B; Stipulations at Stipulated Facts ¶¶ 7, 8.
[19] The difference in the Provider's and Medicare Contractor's IPPS update factor is irrelevant because there is no dispute that the Provider's prior year undated operating cost is higher than the Provider's 2013 operating costs and, as a result, the prior year's updated operating costs is not used in the VDA calculation.
[20] Stipulations at Stipulated Facts at ¶ 6.
[21] *Id*.
[22] *Id.* at ¶ 7.
[23] Exhibit P-6 (Worksheet D-1, line 52).
[24] *Id.* (Worksheet E, Part A, line 50).
[25] The Provider's Final Position Paper at 5; Stipulations at Stipulated Facts ¶ 9.
[26] Stipulations at 1-2.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor interprets the Statute and regulations govering VDA payments in a manner that allows a VDA payment only when the fixed and semi-fixed operating costs exceed the hospital's total DRG revenue.[27] The Medicare Contractor argues that the "law is quite clear when it states that the [VDA] payment adjustment is '…to fully compensate the hospital for the **fixed costs** it incurs in the period in providing hospital services, including the reasonable costs of maintaining necessary core staff and services.'"[28] In support of this argument, the Medicare Contractor points to PRM 15-1 § 2810.1 and asserts that the VDA payment is to compensate for fixed and semi-fixed costs only, and not variable costs.[29] Additionally, the Medicare Contractor includes the following excerpt from the Administrator's decision in *Fairbanks.*[30]:

> The plain language of the relevant statute and regulation, § 1886(d)(5)(G)(iii) and 42 C.F.R. § 412.108(d), make it clear that the VDA is intended to compensate qualifying hospitals for their fixed costs, not for their variable costs. Therefore, pursuant to the statute, regulation and CMS guidance from the Federal Register and PRM, variable costs are to be excluded from the VDA calculation. This is consistent with the statute, CMS regulations and the Board's previous decision regarding VDAs in the case of *Greenwood County Hospital*, PRRB Decision No. 2006-D43.[31]

Additionally, the Medicare Contractor contends that capital costs are not to be included in the VDA calculation referencing regulations at 42 C.F.R. § 412.92(e)(3) which state that the VDA is "not to exceed the difference between the hospital's Medicare **inpatient operating costs** and the hospital's total DRG revenue for **inpatient operating costs**."[32] Because the statute defines operating costs as routine, ancillary, and special care unit costs, the Medicare Contractor contends that it has properly excluded capital costs from the calculation of Lake Region's VDA.[33]

Lake Region argues that the Medicare Contractor's calculation of the VDA was wrong because the Medicare Contractor improperly changed the Medicare Program's rules by calculating Lake Region's VDA payment based on a comparison of Lake Region's fixed costs to its total DRG payments.[34] Lake Region believes if variable costs are to be excluded from inpatient operating

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[27] Medicare Contractor's Final Position Paper at 10.
[28] *Id.* at 9 (quoting 42 U.S.C. 1395ww(d)(5)(D)(ii)) (emphasis in original).
[29] *Id.* at 10.
[30] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015) ("*Fairbanks*"). Although *Fairbanks* is a Medicare Dependent Hospital ("MDH") the MDH regulations at 42 C.F.R. § 412.108(d) are nearly identical to the SCH regulations at 42 C.F.R. § 412.92(e).
[31] Medicare Contractor's Final Position Paper at 10-11. Although this section references the statute and regulations related to VDAs for Medicare Dependent Hospitals ("MDHs") the SCH VDA statute and regulation are almost identical.
[32] *Id.* at 15 (emphasis in original).
[33] *Id.* (citing 42 U.S.C. § 1395ww(a)(4)).
[34] The Provider's Final Position Paper at 9-10.

costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs.[35] This method, Lake Region maintains, would ensure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Lake Region also references the fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[36]

In addition to a VDA for its operating costs, Lake Region maintains that it should be paid a VDA for its capital costs because, similar to operating costs, capital costs are paid on a prospective basis and, therefore, payment of those costs vary with volume based on the number and type of discharges for Medicare patients.[37] Lake Region points out that prior to cost reporting periods beginning in FFY 2002, capital costs, (such as rent, interest and depreciation,) were paid on a reasonable cost basis, regardless of volume. However, after FFY 2002, the payment of capital costs transitioned to a prospective payment system ("PPS") methodology.[38] Lake Region maintains that the intent of PRM 15-1 § 2810.1(B) was to exclude capital costs because Medicare paid capital based on costs. Given that the Medicare program pays capital costs prospectively based on Medicare discharges, Lake Region asserts it is now proper to include capital costs in the VDA payment, as Medicare payment for these fixed costs necessarily varies with volume.[39]

The Board reviewed the statute and regulations governing VDAs and disagrees with Lake Region that capital costs should be included in the VDA calculation. While the Board understands that capital costs are now paid based on prospective rates pursuant to 42 U.S.C. § 1395ww(g)(1)(A) and that the Medicare Program's payment of thoses fixed costs does, in fact, vary with volume, the Board finds no authority in the statute or regulations governing VDAs that allow for a VDA payment relating to ***capital*** costs. Rather, the governing statute and regulations only allow for a VDA payment relating to ***operating*** costs. In this regard, § 1395ww(d)(5)(D)(ii) which authorizes VDAs to be paid to SCHs states:

> In the case of a sole community hospital that experiences . . . 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.[40]

This statute clearly limits VDA payment to ***operating*** costs because § 1395ww(d) specifically pertains only to the "amount of payment with respect to the ***operating*** *cost* of inpatient hospital

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[35] *Id*. at 9-11.
[36] *Id*. at 9.
[37] Exhibit P-1 at Ex. A unnumbered page 6.
[38] Provider's Final Position Paper at 12.
[39] Exhibt P-1 at Ex. A, unnumbered page 4.
[40] (Emphasis added.)

services (as defined in subsection (a)(4)).”[41] In defining operating costs § 1395ww(a)(4) states, “the term ‘***operating*** cost of inpatient hospital services’ includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient services as such costs are determined on an average per admission or per discharge basis . . . . Such term does ***not*** include costs of approved educational activities, a return on equity capital, [and] other ***capital-related costs***. . . .”[42] Rather, there is a separate subection in § 1395ww that addresses reimbursement of capital costs for in patient hospital services, namely § 1395ww(g).[43] Significantly, Congress did *not* include any language in subsection (g) to permit a VDA payment for capital costs.

Likewise, CMS regulations are clear that a VDA is only for ***operating*** costs by stating that the VDA payment is “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 . . .).”[44] Accordingly, the Board concludes that the Medicare Contractor was correct in excluding Lake Region’s ***capital*** costs and payments from the VDA calculation.

Accordingly, the Board reviewed the methodology used to calculate the VDA as it relates to ***operating*** costs, including how the Medicare Contractor used fixed costs (which includes semi-fixed costs) in calculating Lake Region’s VDA payment. This issue is not new to the Board. In recent decisions,[45] 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

[41] 42 U.S.C. § 1395ww(a)(4) (emphasis added).
[42] (Emphasis added.)
[43] 42 U.S.C. § 1395ww(g)(1)(A).
[44] 42 C.F.R § 412.92(e)(3).
[45] *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).

> costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider. . . .[46]

At the outset, it must be recognized that Administrator decisions are themselves not binding precedent as the Administrator explains in 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.[47]

Recently, U.S. Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's VDA calculation methodology that was applied in *Unity HealthCare v. Azar* ("*Unity*") and, in this regard, stated that the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[48] While Lake Region is in the Eighth Circuit, the Board finds that 42 U.S.C. § 1395ww(d)(5)(D)(ii) and 42 C.F.R. § 412.92(e)(3) only provide a framework by which to calculate a VDA payment[49] and the Board is not bound to apply the *specific* VDA calculation methodology that the Administrator applied in *Unity* and the Eighth Circuit upheld.[50] In this regard, the Board further notes that § 412.92(e)(3) makes it clear that

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[46] *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) (copy at Exhibit C-10).

[47] (Emphasis added.)

[48] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

[49] With regard to 42 U.S.C. § 1395ww(d)(5)(D)(ii), *see, e.g., St. Anthony Reg'l Hosp. v. Azar*, 294 F. Supp. 3d 768, 779 (N.D. Iowa 2018) (stating that § 1395ww(d)(5)(D)(ii) contains a gap as it directs that "the Secretary shall provide for such . . . payment . . . as may be necessary" and that "[t]he Secretary has filled that gap in a manner that I find to be reasonable in light of the statutory framework and purposes."), *aff'd*, *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019). With regard to 42 C.F.R. § 412.92(e)(3), *see, e.g., id.* at 772, 780 (adopting the Magistrate's report which found that "'[t]he regulations promulgated by the Secretrary in effect during the relevant time period did not provide a specific formula for calculating the VDA payment[,]'" and "'[i]nstead, the regulation directed that the following factors be considered in determining the VDA payment amount . . . .'"). The Board's plain reading of the regulation is confirmed by the Agency's discussion of this regulation in the preamble to rulemakings. *See, e.g.*, 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987) (stating that "[w]e determine *on a case-by-case basis* whether an adjustment will be granted and the amount of that adjustment." (emphasis added)); 48 Fed. Reg. 39752, 39781-82 (Sept. 1, 1983).

[50] *See, e.g., Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1107-08 (D.C. Cir. 2014) (discussing regulatory interpretations adopted through adjudication versus through rulemaking).

the VDA payment determination is subject to review through the Board appeals process.[51] Thus, the Board finds that the Eighth Circuit's *Unity* decision was simply adjudicating a dispute regarding the reasonableness of the Administrator's interpretation of the statue and regulations governing VDAs that the Administrator applied in rendering her decision in *Unity* and, as such, the Eighth Circuit's decision in Unity did not create a binding precedent that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue*, CMS essentially adopted the Board's methodology for calculating VDA payments ***through the rulemaking process***. In the preamble to FFY 2018 IPPS Final Rule,[52] CMS prospectively changed the methodology for calculating the VDA which 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.[53] The preamble to the FFY 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."[54]

In its calculation of the VDA payment, the Medicare Contractor determined Lake Region's VDA payment by comparing its FY 2013 fixed costs to its total FY 2013 DRG payments. However, neither the language nor the examples[55] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[56] and the FFY 2009 IPPS Final Rule[57] reduce the 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.

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[51] Moreover, the Board notes that, subsequent to the Eighth Circuit's decision in *Unity*, the U.S. Supreme Court issued its decision in *Azar v. Allina Health Servs*, 587 U.S. __, 139 S.Ct. 1804, 1810, 1817 (2019) ("*Allina II*") where the Supreme Court ruled on the scope of Medicare policy issuances that are subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) by making clear that the "the government's 2014 announcement of the 2012 Medicare fractions [to be used in DSH calculations for FY 2012 where the Agency] 'le[t] the public know [the agency's] current . . . adjudicatory approach' to a crtical question involved in calculating payments for thousands of hospitals nationwide" was a "statement of policy . . . that establishes or changes a substantive legal standard" as that phrase is used in 42 U.S.C. § 1395hh(a)(2) and, thus, was subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2). (Citations omitted.)

[52] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

[53] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e)(3).

[54] 82 Fed. Reg. at 38180.

[55] PRM 15-1 § 2810.1(C), (D).

[56] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

[57] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

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

Rather, the Board finds the Medicare Contractor calculated Lake Region's FY 2013 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 the 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 costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[58] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states 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*

[58] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> *cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
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> 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***.[59]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limit 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."[60] Notably, in applying this 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 governing statutory, regulatory, and PRM 15-1 provisions as well as the Eighth Circuit's decision in *Unity* and the Supreme Court's decision in *Allina*, 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."[61] Using the Administrator's rationale, 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 the* ***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 a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines operating costs of inpatient services as "***all*** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]" The Administrator cannot simply ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments solely for the fixed cost of the Medicare services actually rendered when the hospital in fact incurred both fixed and variable costs for those services.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an SCH for all the fixed costs associated with the qualifying volume decrease (which must be 5 percent

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[59] (Emphasis added.)
[60] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[61] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

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 cost." This approach is also consistent with the directive in 42 C.F.R. § 412.92(e)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[62] Clearly, when a hospital experiences a decrease in volume, it should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

Critical to the proper application of the statute, regulation and PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished *actual* services in the current year are not part of the volume decrease, and (2) the DRG payments 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 *actual* 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 characterizes 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 the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG payment is payment for both fixed and variable operating costs - and deem the entire DRG payment as payment solely 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 the hospital for its variable costs.[63] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed operating costs for Medicare services *actually* furnished. The Board concludes that, in order to ensure the hospital is fully compensated for its fixed costs and consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments 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 Medicare Contractor's fixed/variable cost percentages as a proxy. In this case the Medicare Contractor determined that

[62] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) 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.
[63] 48 Fed. Reg. at 39782.

Lake Region's fixed costs (which includes semi-fixed costs) were 72.07 percent[64] of the Provider's Medicare costs for FY 2013 and the Provider does not dispute this percentage.[65] Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2012 Medicare Inpatient Operating Costs	$11,370,447[66]
Multiplied by the 2013 IPPS update factor[67]	1.018
2012 Updated Costs (max allowed)	$11,575,115
2013 Medicare Inpatient Operating Costs	$10,026,809[68]
Lower of 2012 Updated Costs or 2013 Costs	$10,026,809
Less 2013 IPPS payment	$ 7,323,927[69]
2013 Payment CAP	$ 2,702,882

Step 2: Calculation of VDA

2013 Medicare Inpatient Fixed Operating Costs	$7,226,321[70]
Less 2013 IPPS payment – fixed portion (72.07 percent)	$5,278,354[71]
Payment adjustment amount (subject to CAP)	$1,947,967

Since the payment adjustment amount of $1,947,967 is less than the CAP of $2,702,882, the Board concludes that Lake Regional's total VDA payment for FY 2013 should be $1,947,967. Since Lake Regional did not receive a VDA payment for FY 2013, Lake Regional should be paid $1,947,967.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Lake Region's VDA payment for FY 2013, and that Lake Region should receive a VDA payment in the amount of $1,947,967 related to Lake Region's operating costs.

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[64] Exhibit P-2.
[65] Provider's Final Position Paper at 4.
[66] Exhibit P-5 (FY 2012 Program Operating Costs Worksheet D-1, Part II, Line 53).
[67] 77 Fed. Reg. 53258, 53699 (Aug. 31, 2012). The prior year undated cost is not relevant as this amount is greater than the Provider's current year operating costs.
[68] Exhibit P-6 (FY 2013 Program Operating Cost Worksheet D-1, Part II, Line 53).
[69] *Id.* (FY 2013 Payments Worksheet E, Part A, Line 49).
[70] The $7,226,321 is calculated by multiplying $10,026,809 (the lower of the prior year updated or current year operating costs) by .7207 (the fixed cost percentage determined by the Medicare Contractor).
[71] The $5,278,354 is calculated by multiplying $7,323,927 (the FY 2013 SCH payments - Worksheet E, Part A, Line 49) by 0.7207 (the fixed cost percentage determined by the Medicare Contractor).

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FOR THE BOARD:

8/14/2020

X Clayton J. Nix

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Signed by: Clayton J. Nix -A