PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2020-D23

PROVIDER-
Three Rivers Community Hospital

Provider No.: 38-0002

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions

HEARING DATE –
October 16, 2019

Cost Reporting Period Ended –
09/30/2011

CASE NO. – 16-1155

INDEX

ISSUE STATEMENT

Whether the contractor was correct in calculating the Provider's Sole Community Hospital Volume Decrease Adjustment.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated the Volume Decrease Adjustment ("VDA") payment to Three Rivers Medical Center ("Three Rivers" or "Provider") for Fiscal Year ("FY") 2011, and that Three Rivers should receive a VDA payment for FY 2011 in the amount of $2,221,578.

INTRODUCTION

Three Rivers is a non-profit acute care hospital located in Grants Pass, Oregon. Three Rivers was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare administrative contractor[3] assigned to Three Rivers for this appeal is Noridian Healthcare Solutions ("Medicare Contractor"). Three Rivers requested a VDA payment of $4,084,462 to compensate it for a decrease in inpatient discharges during FY 2011.[4] After the Medicare Contractor determined that Three Rivers was not entitled to a VDA payment, Three Rivers appealed and met the jurisdictional requirements for a hearing before the Board.

The Board held a live hearing on October 16, 2019. Three Rivers was represented by Ronald K. Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

Medicare pays hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to each patient. These DRG payments are also subject to certain payment adjustments. One of these payment adjustments is referred to as a VDA payment, and it is available to SCHs if they experience a decrease in patient discharges, due to circumstances beyond their control, of more than 5 percent from one cost reporting year to the next. VDA payments are designed to compensate the hospital for the fixed costs it incurs in the relevant cost reporting period for providing inpatient hospital services, including the reasonable cost of maintaining necessary core

[1] Transcript of Proceedings ("Tr.") at 9.
[2] *Id.* at 13.
[3] 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.
[4] Exhibit C-1 at 25-26.

staff and services.[5] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

Three Rivers requested a VDA payment in the amount of $4,084,462.[6] However, the Medicare Contractor denied Three Rivers' VDA request on September 9, 2015, because it determined that Three Rivers was not entitled to a VDA payment based on its finding that the total DRG payments made to Three Rivers for FY 2011 were greater than Three Rivers' fixed and semi-fixed costs.[7] Three Rivers timely appealed the Medicare Contractor's denial of the VDA request, on February 29, 2016.

There is no dispute that Three Rivers experienced a decrease in discharges greater than 5 percent from FY 2010 to FY 2011 due to circumstances beyond Three Rivers' control and that, as a result, Three Rivers was eligible to have a VDA calculation performed.[8]

42 C.F.R. § 412.92(e) (2011) directs how the Medicare Contractor must adjudicate a 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*[9] 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. . . .

In the preamble to the final rule published on August 18, 2006,[10] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), which provides further guidance related to VDAs and states in relevant part:

> B. 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.

---

[5] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[6] Exhibit P-1.
[7] Medicare Contractor's Final Position Paper at 5. *See also* Exhibit C-3.
[8] Medicare Contractor's Final Position Paper at 7.
[9] (Emphasis added).
[10] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).

> 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*[11] with utilization such as food and laundry costs.

The chart below depicts how the Medicare Contractor and Three Rivers calculated the VDA payment.[12]

	Medicare Contractor's calculation	Three Rivers' calculation[13]
a) Prior Year Medicare Inpatient Operating Costs	$22,046,671	$23,808,628[14]
b) IPPS update factor	1.0235[15]	1.026
c) Prior year Updated Operating Costs (a x b)	$22,564,768	$24,427,652
d) FY 2011 Operating Costs	$24,628,816	$24,628,816
e) Lower of c or d	$22,564,768	$24,427,652
f) DRG/SCH payment	$20,343,190	$20,343,190
g) CAP (e-f)		$
h) FY 2011 Inpatient Operating Costs	$24,628,816	
i) Fixed Cost percentage	86.99[16]	
j) FY 2011 Fixed Costs	$19,628,858	
k) Total DRG/SCH Payments	$20,343,190	
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds* line k)	0	
m) VDA Payment Amount (Three Rivers' VDA is line e – line f)		$ 4,084,462

The parties to this appeal dispute the interpretation of the statute and regulation used to calculate the VDA payment. Specifically, the parties dispute the appropriateness of the methodology used by the Medicare Contractor as it relates to the use of the fixed cost ratios in calculating the VDA payment. Additionally, Three Rivers maintains that the Medicare Contractor should have taken into consideration the fact that Three Rivers' overall discharges decreased by 7.8 percent, while its Medicare discharges increased by 1.3 percent, and then should have restated its 2010 Medicare operating costs.[17] This type of situation Three Rivers asserts is described in PRM 15-1

[11] (Emphasis added).
[12] Exhibit C-3 at 5; Provider Final Position Paper at 7, 10.
[13] Provider Final Position Paper at 10.
[14] 2010 Inpatient cost was updated by Three Rivers for Anomalous Situation. *See* Provider Final Position Paper at 10.
[15] Three Rivers agreed that this IPPS update factor is appropriate. Tr. at 51.
[16] Three Rivers agreed that the fixed cost percentage is 86.99 percent. *Id.* at 42-43.
[17] Provider Final Position Paper at 3.

§ 2810.1(D) as producing an "anomalous result" where the Medicare Contractor may request a review by CMS.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that Three Rivers is not entitled to a VDA payment because its total DRG payments for the cost year exceed Three Rivers' fixed and semi-fixed costs for that year.[18] Furthermore, the Medicare Contractor asserts that PRM 15-1 § 2810.1 does not give Three Rivers a right to an additional VDA payment if it believes there is an anomalous result, nor does it require the Medicare Contractor to determine if there is an anomalous result and seek review from CMS.[19] The Medicare Contractor points out that the difference between Three Rivers' prior year cost plus the IPPS update factor was less than Three Rivers' FY 2011 operating costs and, therefore, Three Rivers is not entitled to the VDA amount requested.[20]

The Medicare Contractor points out that the CMS Administrator has discussed the appropriate methodology to calculate a VDA payment in numerous Administrator decisions, including those involving *Lakes Regional Healthcare*,[21] *Unity Healthcare*,[22] *St. Anthony Regional Medical Center*,[23] and *Fairbanks Memorial Hospital*.[24] The Medicare Contractor believes its VDA calculation for Three Rivers is consistent with these Administrator decisions.[25]

Three Rivers argues that the Medicare Contractor was wrong when it calculated Three Rivers' VDA payment amount because it compared Three Rivers' total fixed costs to total DRG payments. Three Rivers asserts that this is like "subtracting apples from oranges" and understates the VDA payment because DRG revenue compensates a hospital for both fixed and variable costs.[26] Three Rivers asserts that the most appropriate methodology to calculate the VDA payment can be found in PRM 15-1 § 2810.1.[27] Three Rivers maintains that PRM 15-1 cannot be ignored as the Secretary has *repeatedly* endorsed PRM 15-1 in the Federal Register. For example, in the preamble to two Final Rules, published on August 18, 2006 ("FFY 2007 IPPS Final Rule") and on August 19, 2008 ("FFY 2009 IPPS Final Rule"), CMS stated:

> The process for determining the amount of the volume decrease adjustment can be found in section 2810.1 of the Provider Reimbursement Manual. . . . The adjustment amount 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

[18] Medicare Contractor's Final Position Paper at 7.
[19] *Id.* at 8.
[20] *Id.* at 8-9.
[21] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. No. 2014-D16 (Sept. 4, 2014).
[22] *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. No. 2014-D15 (Sept. 4, 2014).
[23] *St. Anthony Reg'l Hosp. v. Wisconsin Physician Servs.*, Adm'r Dec. No. 2016-D16 (Oct. 3, 2016).
[24] *Fairbanks Mem'l Hosp. v. Blue Cross Blue Shield Ass'n* , Adm'r Dec. No. 2015-D11 (Aug. 5, 2015).
[25] Medicare Contractor's Final Position Paper at 10.
[26] Provider Final Position Paper at 7.
[27] *Id.* at 5.

> update factor minus any adjustment for excess staff. The [hospital] receives the difference in a lump-sum payment.[28]

In the alternative, Three Rivers reasons that, if variable costs are to be excluded from inpatient operating cost when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. This method, Three Rivers maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. According to Three Rivers, removing variable costs from both the revenue and cost sides of the VDA equation would result in Three Rivers receiving a VDA payment for FY 2011 of $3,617,396.[29]

Additionally Three Rivers maintains that it "meets the criteria for an anomalous situation as described in [PRM §] 2810" since its Medicare discharges increased, while overall discharges decreased.[30] Therefore, it recalculated its 2010 Medicare inpatient operating costs using its 2011 Medicare utilization rates resulting in a restated 2010 total operating costs of $23,808,628.[31] Three Rivers contends that this restated 2010 total operating cost should be multiplied by the IPPS update factor and used in its VDA calculation.[32]

The issue of how to calculate a VDA payment is not new to the Board. In recent decisions,[33] the Board has disagreed with the methodology used by multiple 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 compared this fixed DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

The Administrator has overturned the Board's decisions using the above-described methodology, 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 mechanism that allow providers to be made whole from variable

---

[28] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006); 73 Fed. Reg. 48433, 48630-48631 (Aug. 19, 2008).
[29] *See* Provider Final Position Paper at 7, 10.
[30] Exhibit P-1 at 37.
[31] Provider Final Position Paper at 3-4.
[32] *Id.* at 4-5. The recalculated 2010 cost of $23,808,628 is multiplied by the IPPS update factor of 1.026 percent for a revised 2010 Total operating cost of $24,427,652. Using the IPPS update factor of 1.0235 (*see supra* note15 and accompanying text), the revised figure is $24,052,309.
[33] *St. Anthony Reg'l Hosp. v. Wisconsin Physician Servs.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physician Servs.*, PRRB Dec. No. 2017-D1 (Dec. 15, 2016); *Fairbanks Mem'l Hosp. v. Wisconsin Physician Servs.*, PRRB Dec. No. 2015-D11 (June 9, 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 . . . .[34]

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.[35]

Notably, subsequent to the time period at issue, *CMS essentially adopted the Board's methodology for calculating VDA payments.* In the preamble to 2018 IPPS Final Rule,[36] CMS prospectively changed the methodology for calculating a VDA. Significantly, the new methodology promulgated by CMS is very similar to the methodology used by the Board, and requires Medicare contractors to compare the estimated fixed costs portion of the DRG payment to the hospital's fixed costs, when determining the amount of the VDA payment.[37] The preamble to 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."[38]

Last year, the U.S. Court of Appeal for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation as applied in *Unity* was not arbitrary or capricious and was consistent with the regulation" that was in place at that time.[39] However, as Three Rivers is not located in the Eighth Circuit, the Board is not obligated to follow the Eighth Circuit's decision on this issue.

---

[34] *Fairbanks Mem'l Hosp. v. Wisconsin Physician Servs.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[35] (Italics and bold emphasis added).
[36] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[37] This amount continues to be subject to the Cap specified in 42 C.F.R. § 412.92(e)(3).
[38] 82 Fed. Reg. at 38180.
[39] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As set forth below, the Board finds that the Medicare Contractor's calculation of Three Rivers' VDA methodology for FY 2010 was not correct because it was *not* based on CMS' stated policy, as delineated in PRM 15-1 § 2810.1, nor the Secretary's endorsement of that PRM 15-1 policy in the relevant Final Rules.

The Medicare Contractor determined Three Rivers' VDA payment by comparing its fixed costs to its total DRG payments. However, neither the language nor the examples[40] in the PRM 15-1 compare the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[41] and the FFY 2009 IPPS Final Rule[42] 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.

It is clear from the preambles to these Final Rules that the only deduction to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Three Rivers' VDA using the methodology laid out by CMS in the 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 Three Rivers' FY 2010 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions, described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[43] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the methodology explained in the FFY 2007 and FFY 2009 Final Rules, the PRM, and the statute. When creating and applying this new methodology through adjudication, CMS conspicuously did not otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[44]

The statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) is clear that the VDA payment is intended to fully compensate the hospital for its fixed costs:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a

[40] PRM 15-1 § 2810.1(C), (D).
[41] 71 Fed. Reg. at 48056.
[42] 73 Fed. Reg. at 48631.
[43] *Lakes Reg'l Healthcare*, Adm. Dec. No. 2014-D16 at 8; *Unity Healthcare*, Adm. Dec. No. 2014-D15 at 8; *Trinity Reg'l Med. Ctr.*, Adm. Dec. No. 2017-D1 at 12.
[44] 82 Fed. Reg. at 38179-38183.

> 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 . . . 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 final rule published on September 1, 1983 ("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."[45] However, the VDA payment methodology explained in the FFY 2007 and FFY 2009 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.—
>
> * * * *
>
> 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*. . . .
>
> 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 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.
>
> 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***.

[45] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> 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***.[46]

At first blush, this would appear to conflict with both 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 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[.]"[47] It is this new methodology that the Eighth Circuit found reasonably complied with the mandate to provide full compensation.[48]

Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, 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."[49] 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 the* ***fixed*** *costs* of the services actually furnished to Medicare patients. However, 42 U.S.C.§ 1395ww(a)(4) makes it clear that the DRG payment includes payment for both fixed *and* variable cost 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 simply cannot ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments for fixed costs.

Indeed, the Board must conclude, consistent with the statutory language, that the purpose of the VDA payment is to compensate an SCH for the 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 cost." Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs, but the hospital will always have some variable costs 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 SCH for services furnished to the 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 follow the statutory directive and fully compensate an SCH for its fixed costs in the current year,

---

[46] (Emphasis added).
[47] *See supra* note 43.
[48] *Unity HealthCare v. Azar*, 918 F.3d 571, 577 (8th Cir. 2019).
[49] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

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 (subject to the ceiling).[50]

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs in the current cost year 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 the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which is clear that the DRG payment is payment for fixed and variable costs - and deem the full DRG payment as payment solely for fixed costs. The Board concludes that the Administrator's methodology does not ensure that a hospital that has been found to be eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, it 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.[51] 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 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 the portion of the 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 fixed/variable cost percentages as a proxy. In this case, Three Rivers' fixed costs (which include semi-fixed costs) were 86.99 percent of Three Rivers' Medicare costs for FY 2011 and the Board will apply this percent to identify the fixed portion of Three Rivers' DRG payments.

While the Board agrees with Three Rivers that only the fixed portion of the DRG payment should be used in the VDA calculation, the Board declines to accept Three Rivers' argument that its VDA calculation produced an anomalous result and that, therefore, the Medicare Contractor should have used an alternate calculation when determining Three Rivers' VDA payment. Specifically, Three Rivers maintains that the Medicare Contractor should have restated Three Rivers' FY 2010 inpatient operating costs based on FY 2011 utilization when calculating its VDA Payment, because Three Rivers' Medicare discharges increased 1.3 percent while its total discharges decreased by 7.8 percent.[52]

---

[50] For cost reporting periods beginning prior to October 1, 2017, CMS utilized a ceiling when determining the VDA payment. This ceiling is determined by subtracting the total payment for inpatient operating costs for the cost reporting period of the VDA request, from the lesser of: 1) the prior cost reporting period program inpatient operating costs updated by the IPPS factor; *or* 2) the actual program inpatient operating costs for the cost reporting period of the VDA request. *See* PRM 15-1 § 2810.1(D)(2)(a) (Rev. 479).

[51] 48 Fed. Reg. at 39782.

[52] Provider Final Position Paper at 3; *see also* Exhibit P-1 at 37-38.

First, the Board points out that the facts in Three Rivers' case do not meet the sole example in PRM § 2810.1(D)(2) of a situation that may produce an anomalous result. In the PRM, CMS granted the discretion to the Medicare contractor to request a review by CMS in those circumstances where "the procedures in this section, when applied to a specific adjustment request, generate an anomalous result." The PRM gives a single example of what might produce an anomalous result stating: "when the decrease in Medicare discharges is significantly *less* than the decrease in total discharges."[53] Here, Three Rivers' FY 2011 Medicare discharges actually *increased* when compared to FY 2010, such that Three Rivers does not meet the plain language of the only example, that may produce an anomalous result, that the Board can find in any controlling authority (*i.e.*, guidance in case law, in regulations, in Federal Register pronouncements, or PRM 15-1 provisions).

Second, the Board recognizes that Three Rivers has submitted information that allegedly supports a finding that an anomalous result was produced. However, the Board finds that this information is insufficient and too limited for the Board to make such a finding and to overturn the Medicare Contractor's valid exercise of discretion to not request a review by CMS.[54] The Board declines to substitute its view of whether the calculation produced an anomalous result for the Medicare Contractor's discretion, especially in light of the lack of published guidance from CMS on how the Agency anticipated that discretion to be exercised.

As such the Board has recalculates Three Rivers' VDA as follows:

Step 1: Calculation of the CAP

2010 Medicare Inpatient Operating Costs	$22,046,671[55]
Multiplied by the 2011 IPPS update factor	1.0235[56]
2010 Updated Costs (max allowed)	$22,564,768
2011 Medicare Inpatient Operating Costs	$24,628,816[57]
Lower of 2010 Updated Costs or 2011 Costs	$22,564,768
Less 2011 IPPS payment	$20,343,190[58]
2011 Payment CAP	$ 2,221,578

[53] (Emphasis added.)
[54] While the Board understands that a change in utilization could result in a different allocation of costs to the Medicare Program, the Board declines to overturn the Medicare Contractor's judgment related to an anomalous result, in part, because of the limited information in the record (*e.g.*, limited information on the reason for the 6.7 percent increase in Medicare days (*see* Exhibit P-1 at 19); the reason for the increase in cost from the parent company (*see id.* at 27); and reasons for other cost increases). Similarly, the Board notes that the record does not include copies of the cost report worksheets and that the limited record raises concerns about the basis for the unusual 5.1 percent increase in Three Rivers' total costs (*see id.* at 26) even though its total volume decreased by 7.8 percent (*see id.* at 19).
[55] Exhibit C-6 at 2.
[56] *Id. See also* Tr. at 51 (stating "[w]e have accepted the MAC's IPPS update factor as the one that we should use").
[57] Provider Final Position Paper at 6 (Worksheet D-1, Part II, Line 53).
[58] *Id.* (Worksheet E, Part A).

Step 2: Calculation of VDA

2011 Medicare Inpatient Operating Costs – Fixed	$21,424,607[59]
Less 2011 IPPS payment – fixed portion (86.99 percent)	$17,696,541[60]
Payment adjustment amount (subject to CAP)	$ 3,728,066
VDA payment (CAP is less than payment calculation)	$2,221,578

Since the payment adjustment amount of $ 3,728,066 is more than the CAP of $2,221,578, the Board finds that Three Rivers' VDA is limited by the CAP and therefore is entitled to receive a VDA payment for FY 2011 in the amount of $2,221,578.

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 to Three Rivers for FY 2011, and that Three Rivers should receive a VDA payment for FY 2011 in the amount of $2,221,578.

BOARD MEMBERS:
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

9/9/2020

X Clayton J. Nix

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

[59] 2011 Medicare Inpatient Operating Costs of $24,628,816 x Fixed cost percentage (0.8699) equals $21,424,607.
[60] The $17,696,541 is calculated by multiplying $20,343,190 (the FY 2011 DRG payments by 0.8699 (the fixed cost percentage).