PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2020-D9

PROVIDER-
Baptist Memorial Hospital Booneville

Provider No.: 25-0044

vs.

MEDICARE CONTRACTOR –
Palmetto GBA

RECORD HEARING DATE –
August 22, 2019

Cost Reporting Period Ended –
September 30, 2012

CASE NO. – 17-0187

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ISSUE STATEMENT

Whether the Medicare Administrative Contractor's ("MAC") determination of the Provider's Medicare Dependent Hospital ("MDH") Volume Decrease Adjustment ("VDA") was calculated in accordance with the regulations at 42 C.F.R. § 412.108(d) and Program Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2810.1 calculation.[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated the VDA payment for Fiscal Year ("FY") 2012 for Baptist Memorial Hospital Booneville ("Baptist" or "Provider"), and that Baptist should receive an additional VDA payment in the amount of $230,478 resulting in a total FY 2012 VDA payment of $1,008,899.

INTRODUCTION

Baptist is a non-profit acute care hospital located in Booneville, Mississippi. Baptist was designated as a Medicare Dependent Hospital ("MDH") during the fiscal year at issue.[2] The Medicare administrative contractor[3] assigned to Baptist for this appeal is Palmetto GBA ("Medicare Contractor"). Baptist requested a VDA payment of $1,572,435 for FY 2012 to compensate it for a decrease in inpatient discharges during FY 2012.[4] The Medicare Contractor calculated the Provider's FY 2012 VDA payment to be $778,421.[5] Baptist timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on August 22, 2019. Baptist was represented by Ronald Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments.

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[1] Medicare Contractor's Final Position Paper at 4. The Board notes that the Medicare Contractor's Issue Statement included the bracketed term "('DSH')" which has no application in this appeal. The Board also notes that the manual referenced should be the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1, not the "*Program* Reimbursement Manual." (Empahsis added.)

[2] Stipulations at ¶ 1.

[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 and relevant.

[4] Stipulations at ¶ 4.

[5] *Id.* at ¶ 5.

One of these payment adjustments is referred to as a VDA payment and it is available to MDHs if, due to circumstances beyond their control, they incur a decrease in patient discharges of more than 5 percent from one cost reporting year to the next. VDA payments are designed to compensate a hospital for the fixed costs that it incurs for providing inpatient hospital services in the period coverd by the VDA, including the reasonable cost of maintaining necessary core staff and services.[6] The implementing regulations, located at 42 C.F.R. § 412.108(d), reflect these statutory requirements. When promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals ("SCHs").[7]

It is undisputed that Baptist experienced a decrease in discharges greater than 5 percent from FY 2011 to FY 2012 due to circumstances beyond Baptist's control and that, as a result, Baptist was eligible to have a VDA calculation performed for FY 2012.[8] Baptist requested a VDA payment in the amount of $1,572,435 for FY 2012.[9] However, when the Medicare Contractor made the FY 2012 VDA calculation, it determined that Baptist was entitled to a VDA payment in the amount of $778,421.[10] Baptist timely requested that the Medicare Contractor reconsider this determination.[11]

42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates it suffered a qualifying decrease in total inpatient discharges. In particular, § 412.108(d)(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).
>
> (i) In determining the adjustment amount, the Intermediary *considers* –
>
> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; . . .[12]

[6] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[7] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[8] Stipulations at ¶ 4.
[9] *Id.*
[10] *Id.* at ¶ 5. *See also* Exhibit P-2 at 278 (copy of the Medicare Contractor's determination).
[11] Stipulations at ¶ 6. *See also* Exhibit P-3.
[12] (Emphasis added.)

As CMS notes in the preamble to the final rule published on August 18, 2006[13] that PRM 15-1 § 2810.1 (Rev. 371)[14] 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 costs for items and services that vary *directly* with utilization such as food and laundry costs.[15]

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

	Medicare Contractor calculation using fixed costs[16]	Provider/PRM calculation using total costs[17]
a) Prior Year Medicare Inpatient Operating Costs	$4,750,923	$4,750,923
b) IPPS update factor	1.019	1.03
c) Prior year Updated Operating Costs (a x b)	$4,841,191	$4,893,451
d) FY 2012 Operating Costs	$4,883,331	$4,883,331
e) Lower of c or d	$4,841,191	$4,883,331
f) DRG/MDH payment	$3,809,549	$3,310,896
g) CAP (e-f)	$1,031,642	$1,572,435
h) FY 2012 Inpatient Operating Costs	$4,883,331	$4,883,331
i) Fixed Cost percent (not in dispute)	.9395	
j) FY 2012 Fixed Costs (h x i)	$4,587,970	
k) Total DRG/MDH Payments	$3,809,549	$3,310,896
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 778,421	
m) VDA Payment Amount (The Providers VDA is based on the amount line e exceeds line k.)		$1,572,435

[13] 71 Fed. Reg. at 48056.
[14] *See* Exhibit C-5 at 5-12.
[15] (Emphasis added).
[16] Exhibit P-2
[17] Provider's Final Position Paper at 4, Table 1.

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[18]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that it has an obligation to review "the calculation to determine if there are any costs that should not be included in determining the amount of the [VDA] payment."[19] The Medicare Contractor further alleges that a VDA payment is intended to only reimburse a qualifying hospital for its fixed costs and, therefore, the removal of variable costs from the VDA calculation is required.[20] In support of its position, the Medicare Contractor includes the following excerpt from the Administrator's decision in *Fairbanks Memorial Hospital*:

> 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 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 in the case of Greenwood County Hospital, PRRB Decision No. 2006-D43.[21]

Further, the Medicare Contractor points out that, for this cost reporting period, Baptist was paid a hospital specific payment determined under 42 C.F. R. § 412.79 and that this amount should be used in calculating the VDA.[22]

Baptist argues that the Medicare Contractor's calculation of the VDA was wrong because the Medicare Contractor improperly changed the Medicare rules by calculating Baptist's VDA payment based on a comparison of Baptist's fixed costs to its total DRG payments.[23] Baptist asserts that this approach guarantees that an MDH "will never receive the full compensation mandated by Congress because its fixed costs will always be reduced by reimbursement attributable to both fixed and variable costs."[24] Baptist maintains that the most appropriate methodology to calculate the VDA payment can be found in 42 C.F.R. § 412.92, the FFY 2009 IPPS Final Rule, and PRM 15-1 § 2810.1B. This methodology results in a VDA payment to Baptist of $1,572,435.[25]

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[18] Stipulations at ¶ 9.
[19] Medicare Contractor's Position Paper at 10.
[20] *Id.*
[21] Medicare Contractor's Position Paper at 10 (quoting *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r Dec. at 5 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[22] Medicare Contractor's Position Paper at 12. *See also* Exhibit C-10 at 4.
[23] Provider's Final Position Paper at 3.
[24] *Id.*
[25] *Id.* at 8.

In the alternative, Baptist in essense 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, Baptist maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Baptist 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.[26] Indeed, removing variable costs from both the revenue and cost sides of the VDA equation would result in Baptist receiving a VDA payment for FY 2012 of $1,008,836.[27]

The Board identified three basic differences in the Medicare Contractor's and Baptist's calculation of the Provider's VDA payment. First, there is a difference in the IPPS update factor used by the parties. PRM 15-1 § 2810.1D states that "the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Costs (excluding pass-through costs), increased by the PPS update factor."[28] Based on the FFY 2012 IPPS Final Rule, the inpatient IPPS update factor is 1.019. Therefore, the Board finds the Medicare Contractor was correct to update Baptist's FY 2011 operating costs by 1.019.[29]

The second difference is the total DRG payment amount used in the VDA calculation. Baptist used $3,310,896 for its total DRG payment for FY 2012 based on cost report Worksheet E, Part A, Line 47 (Subtotal of inpatient operating costs). This amount includes Baptist's DRG payment (based on the federal rate), its outlier payment, and its DSH payment, but does not include its hospital specific rate payment. The Medicare contractor used $3,809,549 from Worksheet E, Part A, Line 49 (Total payment for inpatient operating costs), which includes the $3,310,896 Baptist calculated plus Baptist's hospital specific rate payment.[30] The parties agree on the amount Baptist was paid based on its hospital specific rate, but disagree if the hospital specific payment amount should be used in the calculation of the VDA.

The Board reviewed the VDA regulations at 42 C.F.R. § 412.108(d) (2012). These regulations require the VDA to be calculated using "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 . . .)."[31] The Board also reviewed the MDH payment methodology in 42 C.F.R. § 412.108(c) (2012) to determine what payments should be included in the hospital's "total DRG revenue for inpatient operating costs." 42 C.F.R. § 412.108(c) (2012) provides that MDHs are paid for inpatient operating costs based on the ***sum*** of the federal rate plus the amount, if any, that is determined based on the hospital specific rate.[32]

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[26] *Id.* at 5.
[27] *Id.* at 6.
[28] Exhibit C-5 at 10. *See also* 73 Fed. Reg. at 48631.
[29] 76 Fed. Reg. 51476, 51797 (Aug. 18, 2011).
[30] *See* Provider's Final Position Paper at 4, Table 1; Exhibit P-2.
[31] 42 C.F.R. § 412.108(d)(3) (2012) (emphasis added.).
[32] *See* 42 C.F.R. § 412.108(c) (2012). This regulation references varous other regulations including 42 C.F.R. § 412.79, the one that the Medicare Contractor used to calculated Baptist hospital specific rate payment. *See* Medicare Contractor's Position Paper at 12. 42 C.F.R. § 412.79 provides for the determination of the hospital specific rate stating in section (e): "[t]he applicable hospital-specific cost per discharge is multiplied by the

Based on these regulations the Board finds that an MDH's total DRG revenue for inpatient operating costs includes both the amount paid based on the federal rate and the amount paid based on the hospital specific rate. Therefore, the Board concludes the Medicare Contractor was correct to use $3,809,549 as Baptist's "total DRG revenue for inpatient operating costs" when calculating Baptist's FY 2012 VDA payment.

The third issue is the use of fixed costs (which includes semi-fixed costs) in calculating Baptist's VDA payment. This issue is not new to the Board. In recent decisions,[33] 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 been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[34]

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."[35]

At the outset, the Board notes that the Administrator decisions are not binding precedent, as explained by PRM 15-1 § 2927.C.6.e:

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appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge."

[33] *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Serv.*, 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).

[34] *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).

[35] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019).

> 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.[36]

Moreover, the Board notes 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 preamble to FFY 2018 IPPS Final Rule,[37] 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.[38] 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."[39]

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 Baptist's VDA methodology for FY 2012 was incorrect because it was *not* based on CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preambles to the relevant Final Rules.

The Medicare Contractor determined Baptist's VDA payment by comparing its FY 2012 fixed costs to its total FY 2012 DRG payments. However, neither the language nor the examples[40] 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[41] and the FFY 2009 IPPS Final Rule[42] reduce the hospital's cost only

[36] (Bold and italics emphasis added).
[37] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[38] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).
[39] 82 Fed. Reg. at 38180.
[40] PRM 15-1 § 2810.1(C)-(D).
[41] 71 Fed. Reg. at 48056.
[42] 73 Fed. Reg. at 48631.

by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> The 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 adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Baptist's VDA using the methodology laid out by CMS in 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 Baptist's FY 2012 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 2009 IPPS Final Rules/PRM and the statute. Notably, in applying this new methodology through adjudication, CMS 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)(G)(iii) is clear that the VDA payment is to fully compensate the hospital for its fixed cost:

> In the case of a medicare dependent, small rural 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

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[43] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D16 at 8 (Sep. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Dec. 15, 2016).

[44] 82 Fed. Reg. at 38179-38183.

variable costs, such as food and laundry services."[45] 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.—. . . .
>
> 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 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***.
>
> 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 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."[47] Based on its review of the

[45] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).
[46] (Emphasis added).
[47] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.

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."[48] 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 MDH for all 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." This approach is also consistent with the directive in 42 C.F.R. § 405.108(d)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[49] Clearly, when a hospital experiences a decrease in volume, the hospital 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)(G)(iii) 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 costs - and deem the entire DRG payment as payment solely for fixed costs. The Board concludes that the Administrator's methodology does

[48] 42 U.S.C. § 1395ww(d)(5)(G)(iii).

[49] The Board recognizes that 42 C.F.R. § 405.108(d)(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.

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)(G)(iii) 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.[50] 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 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 Baptist's fixed costs (which includes semi-fixed costs) were 93.95 percent[51] of the Provider's Medicare 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	$4,750,923[52]
Multiplied by the 2012 IPPS update factor	1.019[53]
2011 Updated Costs (max allowed)	$4,841,191
2012 Medicare Inpatient Operating Costs	$4,883,331[54]
Lower of 2011 Updated Costs or 2012 Costs	$4,841,191
Less 2012 IPPS payment	$3,809,549[55]
2012 Payment CAP	$1,031,642

Step 2: Calculation of VDA

2012 Medicare Inpatient Fixed Operating Costs	$4,587,970[56]
Less 2012 IPPS payment – fixed portion (93.95 percent)	$3,579,071[57]
Payment adjustment amount (subject to CAP)	$1,008,899

[50] 48 Fed. Reg. at 39782.
[51] Exhibit P-2.
[52] *Id.* (FY 2011 Program Operating Costs Worksheet D-1, Part II, Line 53).
[53] *Id.* (FY 2012 IPPS update factor as 101.9 percent).
[54] *Id.* (FY 2012 Program Operating Cost Worksheet D-1, Part II, Line 53).
[55] *Id.* (FY 2012 MDH Payments Worksheet E, Part A, Line 49).
[56] *Id.* (FY 2012 Fixed costs).
[57] The $3,579,071 is calculated by multiplying $ 3,809,549 (the FY 2012 MDH payments - Worksheet E, Part A, Line 49) by 0.9395 (the fixed cost percentage determined by the Medicare Contractor). *See* Exhibit P-2.

Since the payment adjustment amount of $1,008,899 is less than the CAP of $1,031,642, the Board determines that Baptist's total VDA payment for FY 2012 should be $1,008,899. Since Baptist already received a VDA payment in the amount of $778,421 for FY 2012, Baptist should be paid an additional VDA payment of $230,478.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Baptist's VDA payment for FY 2012, and that Baptist should receive an additional VDA payment in the amount of $230,478 resulting in a total FY 2012 VDA payment of $1,008,899.

BOARD MEMBERS:

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FOR THE BOARD:

7/31/2020

X Clayton J. Nix

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