PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2021-D20

PROVIDER-
Alta Vista Regional Hospital

Provider No.: 32-0003

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –

November 19, 2020

Cost Reporting Period Ended –
08/31/2010

CASE NO. – 15-1617

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ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending August 31, 2010 ("FY 2010").[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 FY 2010 for Alta Vista Regional Hospital ("Alta Vista" or "Provider"), and that Alta Vista should receive a VDA payment in the amount of $644,638.

INTRODUCTION

Alta Vista is a non-profit acute care hospital located in Las Vegas, New Mexico. Alta Vista was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare administrative contractor[3] assigned to Alta Vista for this appeal is WPS Government Health Administrators ("Medicare Contractor"). In order to compensate it for a decrease in inpatient discharges, Alta Vista requested a VDA payment of $1,696,819 for FY 2010.[4] The Medicare Contractor calculated Alta Vista's FY 2010 VDA payment to be $0.[5] Alta Vista timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The parties requested, and the Board approved, a record hearing on November 19, 2020. Alta Vista 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 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. One of these payment adjustments is referred to as a VDA payment and it is available to SCHs 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.[6] VDA payments are designed to

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[1] Medicare Contractor Supplement to its Final Position Paper and Response to Provider's Revised Final Position Paper (hereinafter "Medicare Contractor FPP") at 3.
[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 ¶ 7.
[5] *Id.* at ¶ 9. Since DRG payments exceed the 2008 fixed costs, the VDA payment is $0.
[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

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.[7] The implementing regulations, located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that Alta Vista experienced a decrease in discharges greater than 5 percent from FY 2009 to FY 2010 due to circumstances beyond Alta Vista's control and that, as a result, Alta Vista was eligible to have a VDA calculation performed for FY 2010.[8] Alta Vista requested a VDA payment in the amount of $1,696,819 for FY 2010.[9] However, when the Medicare Contractor made the FY 2010 VDA calculation, it determined that Alta Vista was not entitled to a VDA payment because it had already been fully compensated for its fixed/semi-fixed costs.[10]

42 C.F.R. § 412.92(e) (2010) directs how the Medicare Contractor must determine the VDA once an SCH demonstrates it experienced 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*[11] 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,[12] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356). PRM 15-1 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.

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[7] *Id.*
[8] Stipulations at ¶ 6.
[9] *Id.* at ¶ 7.
[10] *Id.* at ¶ 9.
[11] (Emphasis added.)
[12] 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*[13] with utilization such as food and laundry costs.

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

	Medicare Contractor calculation using fixed costs[14]	Provider/PRM calculation using total costs[15]
a) Prior Year Medicare Inpatient Operating Costs	$6,352,696	$6,352,696
b) IPPS update factor	1.021	1.021
c) Prior year Updated Operating Costs (a x b)	$6,486,103	$6,486,103
d) FY 2010 Operating Costs	$6,555,475[16]	$6,555,475
e) Lower of c or d	$6,486,103	$6,486,103
f) DRG/SCH payment	$ 5,751,478[17]	$4,789,284
g) CAP (d-f)	$734,625	$1,696,819
h) FY 2010 Inpatient Operating Costs	$6,555,475	$6,486,103[18]
i) Fixed Cost percent	80.18[19]	1.00
j) FY 2010 Fixed Costs (h x i)	$5,256,121	$6,486,103
k) Total DRG/SCH Payments	$5,751,478[20]	$4,789,284
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line d exceeds line f)	$ (495,357)[21]	
m) VDA Payment Amount (The Providers VDA is based on the amount by which line d exceeds line f.)		$1,696,819

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[22]

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[13] (Emphasis added).
[14] Stipulations at ¶¶ 9, 11.
[15] *Id.* at ¶ 7.
[16] Medicare Contractor FPP at 26. The amount reported in Stipulations ¶ 9 of $6,352,696 is in error and should be reported as $6,555,475. *See also* Stipulations at ¶ 7.
[17] Stipulations at ¶ 11. The Medicare Contractor stipulated that the DRG payments, and not the hospital specific payments, should be included in the cap calculation.
[18] *Id.* at ¶ 7. The Provider took the lower of the Prior Year Updated Operating Costs or the FY 2010 Operating Costs minus the Total DRG/SCH Payments.
[19] *Id.* The Fixed Cost percentage was calculated by dividing $5,256,121 by $6,555,475.
[20] *Id.* at ¶ 9. This includes the hospital specific amount on line 8 of the CMS-2552-96 cost report.
[21] When the Fixed Costs are less than the total DRG payments, there is no VDA payment.
[22] Stipulations at ¶ 12.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Alta Vista stipulates that the VDA inpatient operating costs should be reduced by the excess staffing which, based on their calculation, does not apply,[23] and then reduced by the DRG payments resulting in a VDA payment in the amount of $1,696,819.[24] This differs from the Medicare Contractor's VDA payment calculation in that variable costs are removed from the inpatient operating costs which resulted in a $0 payment.[25]

The Board finds that there are three basic disagreements between Alta Vista and the Medicare Contractor in the computation of the VDA payment. The first is the computation of the fixed/semi fixed percentage to be used in the calculation of the VDA payment; the second is that Alta Vista uses the DRG payments and the Medicare Contractor uses the Hospital Specific payment in the VDA calculation; and, the third is Alta Vista's assertion that if the fixed/semi fixed cost percentage is to be used in the VDA calculation, it should be used to reduce not only the inpatient operating payments, but also the IPPS inpatient payments.

In the calculation of the fixed/semi fixed percentage, the Medicare Contractor removed variable costs by using Worksheet A-8 adjustments on Alta Vista's cost report.[26] The Medicare Contractor contends that specific instructions to determine the fixed/semi-fixed costs are not included in the statutes, regulations or PRM 15-1.[27] Therefore, the Medicare Contractor used the cost report to calculate fixed/semi-fixed costs. The Medicare Contractor argues that the Administrator agreed with this approach and, further, that this approach was found not to be arbitrary or capricious in the *Unity* decision.[28] Alta Vista agrees with the Medicare Contractor's fixed/semi fixed percentage calculation of 81.04 percent.[29]

The second dispute between the parties is the total IPPS inpatient payments amount used in the VDA calculation. Alta Vista used $4,789,284 for its total DRG payment for FY 2010 based on cost report Worksheet E, Part A, line 6 (Subtotal of inpatient operating costs).[30] This amount includes Alta Vista's DRG payment (based on the federal rate), its outlier payments, and its DSH payment, but does not include its hospital specific rate payment. The Medicare Contractor used $5,751,478 from Worksheet E, Part A, line 8 (Total payment for inpatient operating costs), which includes the $4,789,284 (Alta Vista's total DRG payment for FY 2010) plus Alta Vista's hospital specific rate payment.[31] The parties agree on the amount Alta Vista was paid based on its hospital specific rate, but disagree whether 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. § 412.92(e) (2010). These regulations require the VDA to be calculated using "the hospital's *total DRG revenue for inpatient*

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[23] *See* Provider's Revised Final Position Paper (hereinafter "Provider's Revised FPP") at 30, Table 12.
[24] Stipulations at ¶ 7.
[25] *Id.* at ¶ 9.
[26] Medicare Contractor FPP at 30.
[27] *Id.* at 15-16.
[28] *Id.* at 28-29.
[29] Stipulations at ¶ 11.
[30] *Id.* at ¶ 9.
[31] *Id.* at ¶¶ 7, 9.

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 for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106. . . .)"[32] The Board also reviewed the VDA payment methodology in 42 C.F.R. § 412.92(e) to determine what payments should be included in the hospital's "total DRG revenue for inpatient operating costs." 42 C.F.R. § 412.92(e) provides that SCH's 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. Based on these regulations, the Board finds that an SCH'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 $5,751,478 as Alta Vista's "total DRG revenue for inpatient operating costs" when calculating Alta Vista's FY 2010 VDA payment.

Additionally, Alta Vista argues that the Medicare Contractor's approach of removing variable costs from the operating payments, and not from the DRG payments, does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[33] Removing the variable costs from the DRG payments would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs.[34]

In its recent decisions,[35] the Board has disagreed with the methodology used by various Medicare contractors, including the methodology used by the Medicare Contractor in this appeal, to calculate VDA payments because that methodology 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

[32] 42 C.F.R. § 412.92(e)(3) (emphasis added.)
[33] Provider's Revised FPP at 6.
[34] *Id.* at 6-7.
[35] *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).

> 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 . . . .[36]

Recently, the U.S. 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."[37]

At the outset, the Board notes that the CMS 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.[38]

Moreover, the Board notes that Alta Vista is not located in the Eighth Circuit and, thus, the *Unity* decision is not binding precedent in this appeal.

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to the FFY 2018 IPPS Final Rule,[39] CMS prospectively changed the methodology for calculating the VDA to one 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.[40] 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."[41]

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[36] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[37] 918 F.3d 571, 579 (8th Cir. 2019).
[38] (Bold and italics emphasis added.)
[39] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[40] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).
[41] 82 Fed. Reg. at 38180.

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 Alta Vista's VDA methodology for FY 2010 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 Alta Vista's VDA payment by comparing its FY 2010 fixed costs to its total FY 2010 DRG payments. However, neither the language nor the examples[42] 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[43] and the FFY 2009 IPPS Final Rule[44] 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 permissible adjustment to the hospital's cost for calculating the VDA is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Alta Vista'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 Alta Vista's 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[.]"[45] 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.[46]

The intent of 42 U.S.C. § 1395ww(d)(5)(D)(ii) is to fully compensate the hospital for its fixed costs:

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[42] PRM 15-1 § 2810.1(C)-(D).
[43] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[44] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[45] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm'r Dec. 2017-D1 at 12 (Dec. 15, 2016).
[46] 82 Fed. Reg. at 38179-38183.

> 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.[47]

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."[48] 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*. . . .
>
> 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***.

[47] (Emphasis added.)
[48] 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***.[49]

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."[50] 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."[51]

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 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.[52] 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.

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[49] (Emphasis added.)
[50] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[51] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[52] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) (2010) 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.

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 incurred in the current year 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 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.[53] 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 be 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, and Alta Vista agreed, that fixed costs (which includes semi-fixed costs) were 81.04 percent[54] of Alta Vista's Medicare costs for FY 2010. However, this calculation was based upon the Medicare Contractor's calculated 2010 fixed costs ($5,256,121) as a percentage of the 2009 Inpatient Operating Costs updated by the 2010 IPPS Update Factor ($6,486,103). The proper percentage, used below, is obtained by calculating the Medicare Contractor's calculated 2010 fixed costs ($5,256,121) as a percentage of the actual 2010 Inpatient Operating Costs (stipulated as $6,555,475). This results in a fixed cost percentage of 80.18 percent. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

[53] 48 Fed. Reg. at 39782.
[54] Stipulations at ¶ 11.

Step1: Calculation of the CAP

2009 Medicare Inpatient Operating Costs	$6,352,696[55]
Multiplied by the 2010 IPPS update factor	1.021[56]
2010 Updated Costs (max allowed)	$6,486,103
2010 Medicare Inpatient Operating Costs	$6,555,475[57]
Lower of 2009 Updated Costs or 2010 Costs	$6,486,103
Less 2010 IPPS payment	$5,751,478[58]
2010 Payment CAP	$ 734,625

Step 2: Calculation of VDA

2010 Medicare Inpatient Fixed Operating Costs	$5,256,121[59]
Less 2010 IPPS payment – fixed portion (80.18 percent) including Hospital Specific Payment	$4,611,483[60]
Payment adjustment amount (subject to CAP)	$ 644,638

Since the payment adjustment amount of $644,638 is less than the CAP of 734,625, the Board concludes that Alta Vista's VDA payment for FY 2010 should be $644,638.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Alta Vista's VDA payment for FY 2010, and that Alta Vista should receive a FY 2010 VDA payment in the amount of $644,638.

[55] *Id*.
[56] *Id*.
[57] *Id*.
[58] Alta Vista stipulated that the IPPS DRG payment should be used in the calculation of the cap but the Board finds that the higher of the IPPS DRG payments or the hospital specific payment is to be included in the cap calculation. *See* PRM 15-1 2810.1. The IPPS payments on worksheet E Part A, line 8 is used in the computation of the cap amount.
[59] Stipulations at ¶ 11. Alta Vista and the Medicare Contractor have stipulated to this amount; however, the Board notes that 6,486,103 times 81.04 percent equals 5,312,557. Accordingly, the Board finds that the proper fixed percent is 80.18 percent as discussed above.
[60] The $4,611,483 is calculated by multiplying $ 5,751,478 (the FY 2010 SCH payments; *see* Stipulations at ¶ 11) by 0.8018 (the fixed cost percentage determined by the Board). The immaterial difference between $4,611,483 and the $4,660,806 listed in Stipulations ¶ 11 is due to an error in the stipulated fixed cost percentage which has been corrected in the Board's calculation.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
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FOR THE BOARD:

6/30/2021

X Clayton J. Nix

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