PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2021-D44

PROVIDER-
Columbus Community Hospital

Provider No.: 45-0370

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
May 6, 2021

Cost Reporting Period Ended –
4/30/2014

CASE NO. 18-0031

CONTENTS

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Columbus Community Hospital ("Columbus" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending April 30, 2014 ("FY 2014").[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 Columbus' VDA payment for FY 2014. However, the Board further finds, after revising the calculation to make it consistent with the regulation, that Columbus should not receive a VDA payment for FY 2014 because the fixed portion of the IPPS payments exceeded the fixed portion of inpatient operating costs, after the exclusion of excess staffing costs.

INTRODUCTION

Columbus is a 40-bed hospital located in Columbus, Texas,[2] and was designated as a Medicare Dependent Hospital ("MDH") during FY 2014, the fiscal year at issue.[3] The Medicare contractor[4] assigned to Columbus for this appeal is Novitas Solutions, Inc. ("Medicare Contractor"). Columbus initially requested a VDA in the amount of $65,432 on November 7, 2016.[5] On October 4, 2017, the Contractor issued a denial of the VDA because it concluded that Columbus' fixed costs did not exceed reimbursements and, thus, Columbus was not eligible for a VDA payment.[6] Columbus appealed the denial on October 11, 2017, and revised its VDA request to $352,625.[7] Columbus 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 May 6, 2021. Columbus was represented by Rick Morris of Discovery Healthcare Consulting Group, LLC. 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")

---

[1] Provider Final Position Paper ("Provider's FPP") at 2; Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 3.
[2] Stipulation of Facts ("Stipulations") at ¶ 1.
[3] *Id.*
[4] 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.
[5] Stipulations at ¶ 3; Exhibit P-3.
[6] Stipulations at ¶ 4; Exhibits P-4, P-5.
[7] Provider's FPP at 3; Medicare Contractor's FPP at 2.

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 MDHs if, due to circumstances beyond their control, they incur a decrease in their total number of inpatient discharges of more than 5 percent from one cost reporting year to the next.[8] VDA payments are designed to fully compensate a hospital for the fixed costs 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.[9] The implementing regulations, located at 42 C.F.R. § 412.108(d), reflect these statutory standards. 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").[10]

It is undisputed that Columbus experienced a decrease in discharges greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond its control and that, as a result, Columbus was eligible to have a VDA calculation performed for FY 2014.[11] When the Medicare Contractor made the FY 2014 VDA calculation, it determined that Columbus' fixed costs did not exceed total reimbursements, disqualifying it for additional payment.[12]

42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.108(d)(3) (2014) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed* the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (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;

[8] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[9] *Id.*
[10] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[11] Stipulations at ¶ 2; Provider's FPP at 3-4; Medicare Contractor's FPP at 2.
[12] Medicare Contractor's FPP at 2; Provider's FPP at 4.

> (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. . . .[13]

As CMS noted in the preamble to the final rule published on August 18, 2006,[14] PRM 15-1 § 2810.1 (Rev. 371) provides further guidance related to VDAs. In particular, § 2810.1(B) (Rev. 371) states, in pertinent part:

> Additional payment is made to an eligible [MDH] 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 Columbus 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	$3,931,145	
b) IPPS update factor	1.018[18]	
c) Prior year Updated Operating Costs (a x b)	$3,999,622	
d) FY 2014 Operating Costs	$4,235,851	
e) Lower of c or d	$3,999,622	
f) DRG/MDH payment	$3,822,796	
g) CAP (e-f)	$ 176,826	
h) FY 2014 Inpatient Operating Costs	$3,698,071[19]	$4,235,851
i) Fixed Cost percent	.85[20]	.8910
j) FY 2014 Fixed Costs (h x i)	$3,143,360[21]	$3,774,143

[13] (Emphasis added.)
[14] 71 Fed. Reg. at 48056.
[15] (Emphasis added.)
[16] Exhibit P-5.
[17] Exhibit P-1 (Provider's calculation did not address the calculation of the Cap).
[18] The Medicare Contractor applies two IPPS update factors to encapsulate two federal fiscal years (1.017 and 1.018). *See* Exhibit P-5.
[19] FY 2014 Inpatient Operating Costs of $4,235,851 minus excess staffing of $537,780 equal $3,698,071.
[20] Calculation = 15,925,558/18,736,239 = 0.84998692, rounded to 0.85.
[21] Exhibit P-5.

k) Total DRG/MDH Payments	$3,822,796	$3,406,111
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$ (679,436)	
m) VDA Payment Amount (The Providers VDA is based on the amount by which line j exceeds line k.)		$ 368,032

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

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor states "[t]he Provider does not argue that the intent of the VDA is to compensate for fixed and semi-fixed costs. Rather it argues that since DRG payments compensate providers for fixed, semi-fixed and variable costs these payments should also be reduced by the same 'variable' factor that was determined and used when calculating the Provider's costs."[23]

The Medicare Contractor removed variable costs by analyzing costs on Worksheet A of the Provider's cost report. Certain variable costs were excluded, as were costs related to excluded areas. This resulted in a fixed (and semi-fixed) cost percentage.[24] The Medicare Contractor contends that specific instructions to determine the fixed/semi-fixed costs are not included in the statute, regulations or Provider Reimbursement Manual. Therefore, the Medicare Contractor used the cost report to develop a method of calculating fixed/semi-fixed costs. The Medicare Contractor argues that the Administrator agreed with this approach. The Medicare Contractor also cites to the decision of the U.S. Court of Appeals for the Eighth Circuit ("Eighth Circuit") in *Unity Healthcare v. Azar* ("*Unity*"),[25] which found this approach to be "consistent with the statutory and regulatory language."[26]

Columbus does not agree with the Medicare Contractors assumption that all non-salary laundry, housekeeping, dietary, laboratory, Medical Supplies charged, implantable devices charged, and drugs charged should be entirely classified as variable costs.[27] They state that "[w]hile some non-salary costs in housekeeping, dietary, laundry, etc. correlate with patient volume, other non-salary costs do not."[28] Broadly categorizing all non-salary costs for specific cost centers as variable does not consider whether the hospital has control over the costs based on patient volume."[29]

---

[22] Provider's FPP at 5-6; Medicare Contractor's FPP at 6-7.
[23] Medicare Contractor's FPP at 6-7.
[24] Exhibit P-5 at 2-3.
[25] 918 F.3d 571, 579 (8th Cr. 2019), *cert. denied*, 140 S. Ct. 523, 205 L. Ed. 2d 335 (2019). *See* Medicare Contractor's FPP at 7-9.
[26] Medicare Contractor's FPP at 7-8 (discussing *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D15 (Sept. 4, 2014).
[27] Provider's FPP at 7. *See also* Exhibit C-1 at 2-3 for the variable cost removed by the Medicare Contractor.
[28] Provider's FPP at 7.
[29] *Id.*

The Board notes that Columbus disagrees with the Medicare Contractors methodology of computing the variable cost but did not provide an alternative calculation. Since the methodology used by the Medicare Contactor resembles the calculations that have been found acceptable in the *Unity*, *Lakes Regional* and *Fairbanks* court cases[30] the Board finds that the Medicare Contractor's calculation is acceptable.

With regard to core staffing Columbus notes that "[t]he CMS manual states that peer hospital information is obtained from 'Hospital Administrative Services (HAS) Monitrend' reports, which is currently unavailable. The most current substitute data published on the CMS website is from American Hospital Association (AHA) annual survey for FY 2009 and FY 2009 Occupational Mix (OM) data."[31] Thus it notes that "all available core staffing data published by CMS is based on outdated data that is not contemporaneous with the VDA period under review."[32] It also contends that the Medicare Contractor's methodology includes nursing staff from areas of the hospital outside of Adult and Pediatrics and ICU which is inconsistent with PRM-I § 2810.1.C.6.[33]

The Medicare Contractor states that since the occupational mix data used in the excess staffing analysis was from 2009 it was concerned and forwarded Columbus' inquiry to CMS and was told that since no similar updated data was available the Medicare Contractor was to use the 2009 information.[34] The Medicare Contractor notes that the use of older data would most likely benefit Columbus as it is apparent that staffing levels are declining and people are doing more with less by employing technology and developing other efficiencies.[35] With regard to Columbus' objection of using nursing staff beyond the Adult and Pediatrics and ICU areas, the Medicare Contractor states that Columbus' objections are unsupported and refers to PRM-1 § 2810.1.C.6 which states "[t]he intermediary's analysis of core staff is limited to those cost centers (General Service, Inpatient, Ancillary, etc.) whose costs are components of Medicare inpatient operating cost."[36]

The Board finds that the PRM 15-1 § 2810.1 specifically requires that a provider's staffing levels are to be compared to the occupation mix survey or AHA Annual Survey data. In this regard the Board finds that the FY 2009 Occupation Mix data was the best available data to use in computation of excess staffing. With regard to the inclusion of Nursing areas outside of Adult and Pediatrics and ICU, the Board agrees with the Medicare Contractor that PRM-1 § 2810.1.C.6 mentions that the excess staffing analysis is limited to "general service, inpatient, ancillary, etc." which would include inpatient cost centers outside of Adults and Pediatrics and ICU.

Columbus also argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor adjusted costs to carve out variable costs, but did not carve out payments associated with variable costs, thus not making a "fair comparison and to fully

---

[30] *See* Medicare Contractor's FPP at 9 and n.2.
[31] Provider's FPP at 7.
[32] *Id*.
[33] *Id*.
[34] Medicare Contractor's FPP at 11.
[35] *Id*. at 12.
[36] *Id*.

compensate the hospital for its fixed and semi-fixed costs."[37] Columbus also takes exception to the Medicare Contractor's method for identifying variable costs, contending that "the MAC improperly classified fixed and semi-fixed costs as variable costs . . . ."[38]

Applying the methodology adopted by the Board in previous decisions, Columbus 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.[39] This method, Columbus maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Columbus 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.[40]

The Board identified one basic difference between the Medicare Contractor's and Columbus' calculation of the its VDA payment. There is a difference in the FY 2014 Inpatient Operating Costs used by the parties. The Medicare Contractor adjusted the Inpatient Operating Costs for variable costs and for excess staffing costs before comparing these costs to the total DRG revenue. Columbus argues that the Medicare Contractor's VDA calculation methodology violates the statute, regulations, and Provider Reimbursement Manual instructions.[41]

This issue is not new to the Board. In recent Board decisions addressing VDA payments,[42] the Board has disagreed with the methodology used by various Medicare contractors (including 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

[37] Provider FPP at 6.
[38] *Id.*
[39] *Id.*
[40] *Id.* at 8-9.
[41] *Id.* at 10.
[42] *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 . . . .[43]

Recently, the Eighth Circuit upheld the Administrator's methodology in the *Unity* case, stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[44]

At the outset, the Board notes 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.[45]

Moreover, the Board notes that Columbus is not located in the Eighth Circuit and, thus, the *Unity* decision is not binding precedent in this appeal. The Board further finds that 42 U.S.C. § 1395ww(d)(5)(G)(iii) and 42 C.F.R. § 412.108(d)(3) only provide a framework by which to calculate a VDA payment,[46] and the Board is not bound to apply the *specific* VDA calculation methodology that the Administrator applied in *Unity* and which the Eighth Circuit upheld.[47] In this regard, the Board further notes that 42 C.F.R. § 412.108(d)(3) makes it clear that the VDA

---

[43] *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).

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

[45] (Bold and italics emphasis added.)

[46] With regard to 42 U.S.C. § 1395ww(d)(5)(G)(iii) contains a gap as it directs that "the Secretary shall provide for such . . . payment . . . as may be necessary" and that "'[t]he Secretary has filled that gap in a manner that I find to be reasonable in light of the statutory framework and purposes."), *aff'd, Unity Health Care v. Azar,* 918 F. 3d 571 (8th Cir. 2019) With regard to 42 C.F.R. § 412.108(d)(3), *see, e.g., id.* at 772, 780 (adopting the Magistrate's report which found that "[t]he regulations promulgated by the Secretary in effect during the relevant time period did not provide a specific formula for calculating the VDA payment[,]"' and '"[i]nstead, the regulation directed that the following factors be considered in determining the VDA payment amount . . . ."'). The Board's plain reading of the regulation is confirmed by the Agency's discussion of this regulation in the preamble to rulemakings. *See, e.g.,* 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987) (stating that "[w]e determine *on a case-by-case basis* whether an adjustment will be granted and the amount of that adjustment." (emphasis added)); 48 Fed. Reg. 39752, 39781-82 (Sept. 1, 1983).

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

payment determination is subject to review through the Board appeals process.[48] Thus, the Board finds that the Eighth Circuit's *Unity* decision was simply adjudicating a dispute regarding the reasonableness of the Administrator's interpretation of the statute and regulations governing VDAs that the Administrator applied in rendering her decision in *Unity* and, as such, the Eighth Circuit's decision in *Unity* did not create a binding precedent that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[49] CMS prospectively changed the methodology for calculating the VDA to one that is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated portion of the DRG payment that is related to fixed costs to the hospital's fixed costs, when determining the amount of the VDA payment.[50] 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."[51]

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 Columbus' VDA methodology for FY 2014 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 Columbus' VDA payment by comparing its FY 2014 fixed costs to its total FY 2014 DRG payments. However, neither the language nor the examples[52] 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[53] and the FFY 2009 IPPS Final Rule[54] 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 lesser of: (a) The second

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

[49] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

[50] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).

[51] 82 Fed. Reg. at 38180.

[52] PRM 15-1 § 2810.1(C)-(D).

[53] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).

[54] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

> 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 Columbus' 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 Columbus' FY 2014 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[.]"[55] 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.[56]

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

> 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.[57]

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."[58] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

---

[55] *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 (Feb. 9, 2017).
[56] 82 Fed. Reg. at 38179-38183.
[57] (Emphasis added.)
[58] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> 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***.
>
> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[59]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the Administrator decisions stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[60]

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."[61] Using the Administrator's rationale, a hospital is fully compensated for its fixed costs when the total DRG

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

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.[62] 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 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)(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 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

[62] 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.

hospital for its variable costs.[63] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for Medicare services *actually* furnished. The Board concludes that, in order to both 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 that Columbus's fixed costs (which includes semi-fixed costs) were 85 percent[64] of Columbus's Medicare costs for FY 2014. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2013 Medicare Inpatient Operating Costs	$3,931,145[65]
Multiplied by the 2013 IPPS update factor	1.017[66]
2013 Updated Costs (max allowed)	$3,997,974
2014 Medicare Inpatient Operating Costs	$4,235,851[67]
Lower of 2013 Updated Costs or 2014 Costs	$3,997,974
Less 2014 IPPS payment	$3,822,796[68]
2014 Payment Cap	**$ 175,178**

Step 2: Calculation of VDA

2014 Medicare Inpatient Fixed Operating Costs	$3,600,473[69]
Less Excess Staffing	$ 537,780[70]
2014 Medicare Inpatient Fixed Op. Costs less Excess Staff	$3,062,693
Less 2014 IPPS payment – fixed portion (85 percent[71])	$3,249,327[72]
Payment adjustment amount (subject to CAP)	**$ (186,634)**

[63] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).
[64] Exhibit P-5 at 3 (Calculation = 15,925,558/18,736,239 = 0.84998691, rounded to 0.85).
[65] *Id.*.
[66] *Id.* (Calculation = 153 days at FY 2013 update factor of 1.018 and 212 days at FY 2014 update factor of 1.017, divided by 365 = ((1.018 x 153) + (1.017 x 212)) / 365 = 1.0174191781; rounded to 1.017.)
[67] *Id.*
[68] *Id.*
[69] *Id.* (Total Inpatient Operating Costs from p. 5 (4,235,851) x fixed cost percentage from p. 4 (85.00 percent) = Fixed Operating Costs (3,600,473))
[70] Exhibit P-5. Total Fixed Operating Costs from p. 3 (4,235,851) less Operating Costs net of Excess Staffing from p. 5 (3,698,071) = Excess Staffing (537,780).
[71] *Id.* at 3. (Calculation = 15,925,558/18,736,239 = 0.84998691, rounded to 0.85).
[72] Calculation = 3,822,796 * 0.84998691 = $3,249,326.56, rounded to $3,249,327.

As demonstrated by these calculations, the fixed portion of the IPPS payment exceeds the fixed portion of inpatient operating costs (after excess staffing costs have been removed). Thus, the Board finds that the Medicare Contractor was correct in denying a VDA payment to Columbus, despite its use of an incorrect calculation.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Columbus' VDA payment for FY 2014. However, the Board further finds, after revising the calculation to make it consistent with the regulation, that Columbus should not receive a VDA payment for FY 2014 because the fixed portion of the IPPS payments exceeded the fixed portion of inpatient operating costs, after the exclusion of excess staffing costs.

BOARD MEMBERS

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Susan Turner, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

9/30/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV