PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D21

PROVIDER-
Carlsbad Medical Center

Provider No.: 32-0063

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
August 4, 2021

Cost Reporting Period Ended –
08/31/2014

CASE NO. – 17-1626

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Carlsbad Regional Medical Center ("Carlsbad" or "Provider") for its cost reporting period ending August 31, 2014 ("FY 2014").[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 2014, and that Carlsbad should receive a VDA payment in the amount of $434,314 for FY 2014.

INTRODUCTION

Carlsbad, an acute care hospital located in Carlsbad, New Mexico, was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Carlsbad for this appeal is Novitas Solutions, Inc. ("Medicare Contractor"). Carlsbad requested a VDA payment of $606,924 for FY 2014 to compensate it for a decrease in inpatient discharges during FY 2014.[4] The Medicare Contractor calculated Carlsbad's FY 2014 VDA payment to be $0, concluding that Carlsbad had been fully compensated for its fixed (and semi-fixed) costs and, thus, was not eligible for an additional lump sum adjustment.[5] Carlsbad timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board. A jurisdictional decision was issued by the Board in this case on May 20, 2021.

The Board approved a record hearing on August 4, 2021. Carlsbad 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 total inpatient cases of more than 5 percent from one cost reporting year to the next.[6] VDA payments are designed to

[1] *See* Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's 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] Provider's Final Position Paper ("Provider's FPP") at 3.
[5] Exhibit C-1 at 9.
[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 Carlsbad experienced a decrease in inpatient cases greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond Carlsbad's control and that, as a result, Carlsbad was eligible to have a VDA calculation performed for FY 2014.[8] Carlsbad requested a VDA payment in the amount of $606,924 for FY 2014.[9] However, when the Medicare Contractor calculated the FY 2014 VDA, it determined that Carlsbad was not entitled to a VDA payment because it was fully compensated for its fixed/semi-fixed costs.[10]

The regulation at 42 C.F.R. § 412.92(e) (2016) directs how the Medicare Contractor must resolve a VDA request once an SCH demonstrates it suffered a qualifying decrease in total inpatient discharges. In pertinent part, § 412.92(e)(3) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[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. 371), which provides further guidance related to calculating VDAs stating, 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 ¶ 4.
[9] Provider's FPP at 3.
[10] Exhibit C-1 at 9.
[11] (Emphasis added.)
[12] 71 Fed. Reg. 47870, 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 Carlsbad 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		$8,988,534
b) IPPS update factor		1.025
c) Prior year Updated Operating Costs (a x b)		$9,213,247
d) FY 2014 Operating Costs		$8,431,118
e) Lower of c or d		$8,431,118
f) DRG/SCH payment		$7,824,194
g) CAP (e-f)		$ 606,924
h) FY 2014 Inpatient Operating Costs	$8,421,118[16]	
i) Fixed Cost percent	90.94 percent[17]	
j) FY 2014 Fixed Costs (h x i)	$7,667,259[18]	
k) Total DRG/SCH Payments	$7,953,535[19]	
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 0[20]	
m) VDA Payment Amount (The Provider's VDA is based on the amount line e exceeds line f.)		$ 606,924

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[21]

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[13] (Emphasis added.)
[14] Stipulations at ¶ 9.
[15] *Id.* at ¶ 6.
[16] *Id.* at ¶ 9 (Fixed Operating Costs after variable costs removed via A-8 adjustments on the 2014 Medicare Cost Report).
[17] *Id.* at ¶ 10.
[18] *Id.* at ¶ 9.
[19] *Id.*
[20] Exhibit C-1 at 9 (As the calculated amount would be negative, the Medicare Contractor determines no (or $0) VDA payment is due).
[21] Stipulations at ¶ 11.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor disagrees with Carlsbad assertion that the Federal Register does not specifically state that variable costs should be removed from total costs to compute the VDA. The Medicare Contractor asserts that Carlsbad has misinterpreted the Federal Register.[22] In support of its position, the Medicare Contractor cites to U.S. Court of Appeals for the Eighth Circuit ("Eighth Circuit") decision in *Unity Healthcare v. Azar*.[23]

The Medicare Contractor identified variable costs through an analysis of the working trial balance and Worksheet A of Carlsbad's cost report. Those variable expenses were excluded from the VDA calculation.[24] The Medicare Contractor asserts that "[t]he CMS instructions in PRM 15-1, Section 2810.1(B) similarly support the removal of variable costs in the VDA calculation. . . . Variable costs are defined as `those costs for items and services that vary directly with utilization such as food and laundry costs.'"[25] The Medicare Contractor continues its argument, alleging that PRM 15-1, Section 2810.1 also states that, "generally, semi-fixed costs should be considered fixed but if the volume decrease continues, 'some of the semi-fixed costs may not be included in determining the amount of the payment adjustment.'"[26] According to the Medicare Contractor, this language clearly "shows that not all costs are to be considered in the VDA calculation and that – depending on the duration of the volume decrease - some semi-fixed costs would be considered variable and would therefore be removed from the calculation."[27]

The Medicare Contractor further contends that 42 U.S.C. §1395ww(d)(5)(D)(ii), "clearly specifies that the VDA for qualifying SCHs [must] `fully compensate the hospital for the fixed costs it incurs'" and that, "[i]mplicit in that statement is that variable costs are to be removed from the payment calculation."[28] The Medicare Contractor concludes that the statute would reference "costs," rather than "fixed costs," if all costs were to be included in the VDA calculation.[29] The Administrator agreed with this approach in the *Unity, Lakes Regional*, and *Fairbanks* decisions.[30]

Carlsbad counters that the Medicare Contractor's calculation of the VDA was wrong because the Medicare Contractor "departed from CMS' [Provider Reimbursement] manual instructions and step-by-step guide and added an unauthorized and monumental extra step."[31] Carlsbad states the

[22] Medicare Contractor's FPP at 6-7.
[23] *Id.* at 9 (citing *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir.), *cert. denied*, 140 S. Ct. 523 (2019) ("*Unity*").
[24] Exhibit C-1 at 6-8.
[25] Medicare Contractor's FPP at 7
[26] *Id.*
[27] *Id.*
[28] *Id.* at 6.
[29] *Id.*
[30] *Id.* at 8-10 (citing *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); *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r Dec. at 8 (Aug. 5, 2015)).
[31] Provider's FPP at 7.

Medicare Contractor's methodology for calculating the VDA is flawed, and does not fully compensate them for all of its fixed costs, as required.[32]

Carlsbad claims the Medicare Contractor unlawfully changed the VDA payment calculation without going through notice-and-comment rulemaking, as required by the Medicare Statute and the Administrative Procedure Act.[33] Carlsbad's position is that "the applicable lawful regulations are those that were published in the Federal Register on August 19, 2008."[34]

In recent decisions, the Board has consistently 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.[35] In these cases, the Board 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 then 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 . . . .[36]

Recently, the Eighth Circuit upheld the Administrator's methodology in *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 Administrator decisions are not binding precedent, as explained by PRM 15-1 § 2927(C)(6)(e):

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[32] *Id.* at 8-12.
[33] *Id.*
[34] *Id*. at 12.
[35] *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).
[36] *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).
[37] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir.), *cert. denied*, 140 S. Ct. 523 (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.[38]

Further, the Board notes that Carlsbad 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*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to 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]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As explained in detail below, the Board finds that the Medicare Contractor's calculation of Carlsbad's VDA 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 Carlsbad's VDA payment by comparing its FY 2014 fixed costs to its total FY 2014 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

[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. § 412.108(d)(3).
[41] 82 Fed. Reg. at 38180.
[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).

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 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 Carlsbad's VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preambles to the FFY 2007 and FFY 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Carlsbad's FY 2014 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions. This calculation is best 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 statute and the methodology explained in the PRM, and endorsed in the FFY 2007 and 2009 IPPS Final Rules. 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 statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) is clear that the VDA payment is to fully compensate the hospital for its fixed cost:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

In the final rule published on Septmber 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

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[45] *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 (Feb. 9, 2017).

[46] 82 Fed. Reg. at 38179-38183.

services."[47] 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***.
>
> 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***.[48]

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."[49] Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully

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

disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[50]

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, 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 when 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. 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.[51] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce the variable costs associated with the volume loss, but the hospital will always have some variable costs 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 the 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 payments intended for variable costs, and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(D)(ii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG payment is payment for both fixed and variable costs – and deem the entire DRG payment as payment solely for fixed costs. The Board, therefore, 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.

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[50] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

[51] The Board recognizes that 42 C.F.R. § § 412.92(e)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

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 ***also not*** intended to fully compensate the hospital for its variable costs.[52] 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.

The Board notes a discrepancy in the total DRG payment in the various stipulations agreed to by the parties in this case. Carlsbad identifies the total DRG Payment as $7,824,194, per the cost report Worksheet E, Part A, Line 47.[53] The Medicare Contractor originally contended that the total DRG Payment was $7,953,535, per the cost report Worksheet E, Part A, Line 49, which included the hospital-specific payment.[54] The parties ultimately stipulated that the total DRG Payment was $7,824,194, noting that this amount is "Excluding Hospital Specific Payment."[55] Thus, it appears that the parties initially disagreed as to whether the hospital-specific payment amount should be used when calculating the VDA payment. This issue has been addressed in other Board decisions relating to the VDA.

The Board reviewed the VDA regulations at 42 C.F.R. § 412.92(e). 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 for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 . . . .)"[56] To determine which payments should be included in the hospital's "total DRG revenue for inpatient operating costs," the Board reviewed 42 C.F.R. § 412.92(d), which provides that SCHs are paid for inpatient operating costs based on:

> whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:
>
> i) The Federal payment rate applicable to the hospitals as determined under subpart D of this part.
>
> * * * *

[52] 48 Fed. Reg. at 39782.
[53] Stipulations at ¶ 6.
[54] *Id.* at ¶ 9.
[55] *Id.* at ¶ 10.
[56] 42 C.F.R. § 412.92(e)(3) (emphasis added.)

> v) For cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate as determined under § 412.78.

Further, 42 C.F.R. § 412.78(a) states "If the 2006 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under § 412.4 or the hospital-specific rates for either FY 1982 under § 412.73, FY 1987 under § 412.75 or FY 1996 under § 412.77, this 2006 rate will be used in the payment formula set forth in § 412.92(d)(1)." Thus, it is clear that the hospital-specific rate and related payments "will be used," per § 412.78(a), so that "SCHs are paid for inpatient operating costs," per §412.92(d). Based on these regulations, the Board finds that an SCH's total DRG *revenues* for inpatient operating costs for FY 2014 includes both the amount paid for the DRGs, and any potential additional amount paid based on the hospital-specific rate. Therefore, the Board concludes that the Medicare Contractor was correct in their original calculation (as reflected in Stipulation ¶ 9).[57] The Board will accordingly make the final calculation using Worksheet E, Part A, Line 49 (as reflected in Stipulation ¶ 9).

The Board does not have the IPPS actuarial data to independently determine the split between fixed and variable costs related to each DRG payment. Therefore, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case the Medicare Contractor determined that Carlsbad's fixed costs (which includes semi-fixed costs) were 90.94 percent[58] of Carlsbad'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	$ 8,988,534[59]
Multiplied by the 2014 IPPS update factor	1.025[60]
2013 Updated Costs (max allowed)	$ 9,213,247
2014 Medicare Inpatient Operating Costs	$ 8,431,118[61]
Lower of 2013 Updated Costs or 2014 Costs	$ 8,431,118
Less 2014 IPPS payment	$ 7,953,535[62]
2014 Payment Cap	**$ 477,583**

[57] In making this finding, the Board notes that, in Stipulation ¶ 10, the parties incorrectly characterize the Board's methodology for calculating a VDA payment that involves a hospital specific payment made to an SCH.
[58] Stipulations at ¶ 10.
[59] *Id*.
[60] *Id*. (The parties have stipulated this IPPS update factor, however, this is neither the factor for federal fiscal year (FFY) 2013 (1.018), which would apply to the month of September, 2013, nor is it the factor for FFY 2014 (1.017) which would apply to the remainder of the cost report fiscal year ended August 31, 2014. However, as the 2014 inpatient costs are less than the 2013 costs, this factor does not affect the calculation of the cap, nor the VDA.)
[61] *Id*.
[62] *Id*. at ¶ 9.

Step 2: Calculation of VDA

2014 Medicare Inpatient Fixed Operating Costs	$7,667,259[63]
Less 2014 IPPS payment – fixed portion (90.94 percent)	$7,232,945[64]
Payment adjustment amount (subject to Cap)	**$ 434,314**

Since the payment adjustment amount of $434,314 is less than the Cap of $477,583, the Board determines that Carlsbad's VDA payment for FY 2014 should be $434,314.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Carlsbad's VDA payment for FY 2014, and that Carlsbad should receive a VDA payment in the amount of $434,314 for FY 2014.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
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FOR THE BOARD:

5/31/2022

X Clayton J. Nix

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

[63] *Id.* at ¶ 10.
[64] The $7,232,945 is calculated by multiplying $7,953,535 (the FY 2014 SCH payments) by 0.9094 (the fixed cost percentage determined by the Medicare Contractor).