PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D22

PROVIDER-
Henry County Memorial Hospital

Provider No.: 15-0030

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

RECORD HEARING DATE –
August 26, 2021

Cost Reporting Period Ended –
12/31/2010

CASE NO. 15-3430

CONTENTS

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Henry County Memorial Hospital ("Henry County" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2010 ("FY 2010").[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 Henry County's VDA payment for FY 2010, and that Henry County should receive an additional VDA payment of $1,485,075, resulting in a total VDA payment of $2,536,162 for FY 2010.

INTRODUCTION

Henry County is a Medicare Dependent Hospital ("MDH") located in New Castle, Indiana.[2] The Medicare contractor[3] assigned to Henry County for this appeal is WPS Government Health Administrators. ("Medicare Contractor"). Henry County initially requested a VDA adjustment on September 23, 2014.[4] On March 19, 2015, the Medicare Contractor approved Henry County's VDA request for an amount of $1,051,087.[5] Henry County disagreed with the Medicare Contractor's VDA calculation and, on May 15, 2015, the Provider submitted a request for reconsideration. On July 9, 2015 the Medicare Contractor denied the reconsideration request and, on September 10, 2015, Henry County filed a timely appeal, meeting all jurisdictional requirements for a hearing before the Board.[6]

The Board approved a record hearing on August 26, 2021. Henry County was represented by Kyle Smith, CPA of Blue & Co., 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") 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

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[1] Provider Final Position Paper at 2 (May 4, 2021) (hereinafter "Provider's FPP"); Medicare Contractor's Final Position Paper at 3 (May 21, 2021) (hereinafter "Contractor's FPP").
[2] Stipulation of Facts at ¶ 1 (Jul. 2, 2021) (hereinafter "Stipulations").
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Stipulations at ¶ 4; Exhibit P-1.
[5] *Id*. at ¶ 5.
[6] *Id*.

inpatient discharges of more than 5 percent from one cost reporting year to the next.[7] VDA payments are designed 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."[8] 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").[9]

It is undisputed that Henry County experienced a decrease in discharges greater than 5 percent from FY 2009 to FY 2010 due to circumstances beyond its control and that, as a result, Henry County was eligible to have a VDA calculation performed for FY 2010.[10] When the Medicare Contractor calculated the FY 2010 VDA payment amount, it determined that Henry County was entitled to a VDA payment of $1,051,087.[11]

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) 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;

[7] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[8] *Id.*
[9] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[10] Stipulations at ¶ 4; Provider's FPP at 3; Medicare Contractor's FPP at 2.
[11] Stipulations at ¶¶ 5, 8; Medicare Contractor's FPP at 2, 10. In the Medicare Contractor's calculation of the VDA payment of $1,051,807 they included capital. In their revised VDA calculation on Stipulation ¶ 9 the Medicare Contractor correctly removed capital cost from the VDA calculation. The Board also notes capital costs were removed from the VDA calculation in stipulation ¶ 10.

> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter. . . .[12]

As CMS noted in the preamble to the final rule published on August 18, 2006,[13] the Provider Reimbursement Manual ("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.[14]

The following chart depicts how the Medicare Contractor and Henry County each calculated the VDA payment.

	Medicare Contractor calculation using fixed costs[15]	Provider/PRM calculation using total costs[16]
a) Prior Year Medicare Inpatient Operating Costs	$15,995,177	$15,995,177
b) IPPS update factor	1.021	1.021
c) Prior year Updated Operating Costs (a x b)	$16,331,076	$16,331,076
d) FY 2010 Current Year Operating Costs	$14,639,551[17]	$14,639,551[18]
e) Lower of c or d	$14,639,551	$14,639,551
f) DRG/MDH payment	$11,594,491[19]	$11,594,491[20]
g) CAP (e-f)	$3,045,060	$3,045,060
h) FY 2010 Inpatient Operating Costs	$14,639,551	$14,639,551
i) Fixed Cost percent	0.8328[21]	1.000[22]

[12] (Emphasis added.)
[13] 71 Fed. Reg. at 48056.
[14] (Emphasis added.)
[15] Stipulations at ¶ 9.
[16] Stipulations at ¶ 6.
[17] Exhibit F-8, Schedule D-1, Part II, Line 53.
[18] *Id.*
[19] Exhibit C-2 at 7; Exhibit F-8, Schedule E Part A, Line 8.
[20] *Id.*
[21] Medicare Contractor's FPP at 11 (reported as 0.832816, rounded to 0.8328).
[22] Provider's FPP at 2. Henry County disagrees with the Medicare Contractor's adjustment to remove variable costs form the VDA calculation, Therefore, it is using current year Inpatient Operating Costs in total.

j) FY 2010 Fixed Costs (h x i)	$12,192,054[23]	$14,639,551
k) Total DRG/MDH Payments	$11,594,491	$11,594,491
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$597,563	
m) VDA Payment Amount (The Provider's VDA is based on the amount by which line j exceeds line k.)		$3,045,060

The parties to this appeal dispute the application of the statute and regulations used to calculate the VDA payment.[24]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor states:

> The provider believes any potential volume decrease adjustment should ensure it is fully reimbursed for all costs, including variable costs. The [Medicare Contractor] disagrees, and believes the regulation is clear that the volume decrease adjustment is meant to ensure a provider is fully reimbursed for the fixed costs it incurred during a cost reporting period where the hospital experienced a greater that [*sic*] five percent decrease in patient discharges due to circumstances beyond its control, and nothing more.[25]

The Medicare Contractor removed variable costs through Worksheet A-8 adjustments on Henry County's cost report.[26] This resulted in the Medicare inpatient operating costs, on Worksheet D-1, Part II, Line 53, reported in the VDA calculation as $12,192,054.[27] Henry County, in its Preliminary Position Paper, proposed that the Medicare inpatient operating cost should be revised to $13,206,140.[28] Instead of removing the variable costs through the cost report, Henry County proposed to calculate the fixed/semi fixed percentage by dividing the total variable costs from the Medicare Contractor's Worksheet A-8 ("A-8") offsets by the total cost reported on Worksheet A, net of reclasses and adjustment.[29] This would have resulted in the fixed/semi fixed cost being changed from 83.2816%[30] to 90.2086 percent.[31] The Medicare Contractor has not accepted Henry County's proposal, noting that:

> The Provider's preferred method is a much less accurate approach, which does not consider Medicare utilization in any way, but uses

[23] Stipulations at ¶ 9; Medicare Contractor's FPP at 11, Exhibit C-2 at 6.
[24] Provider's FPP at 2-3; Medicare Contractor's FPP at 7.
[25] Medicare Contractor's FPP at 9.
[26] Exhibit C-2 at 3-5; Medicare Contractor's FPP at 10-11. After removing variable cost, the adjusted amount on D-1, part II, line 53 is $12,192,054.
[27] Medicare Contractor's FPP at 11; Exhibit C-2 at 6.
[28] Exhibit F-3.
[29] Exhibit F-3.
[30] Medicare Contractor's FPP at 11.
[31] *Id.* at 10; Exhibit F-3.

> a factoring method comparing an unidentified total cost figure to a variable cost figure and applying the resulting factor to Medicare inpatient costs, resulting in a loose representation of Medicare fixed and semi-fixed costs.[32]

The Medicare Contractor acknowledges that there are no specific instructions to determine the fixed/semi-fixed costs included in the statute, regulations or the PRM.[33] However, the Medicare Contractor asserts that removing variable costs through A-8 and using the Medicare cost report to calculate the Medicare inpatient operating costs is "the most accurate count possible of the Provider's fixed and semi-fixed Medicare inpatient operating costs."[34] The Medicare Contractor further asserts that the Administrator agreed with this approach which was found to not be arbitrary or capricious in the *Unity* decision.[35]

Henry County argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor "departed from the Provider Reimbursement Manual instructions and added unauthorized extra steps.[36] According to Henry County, "the methodology used to calculate the [VDA] should include a variable cost adjustment to *both* the inpatient operating costs *and* the DRG payment amount."[37] The Provider refers to *Brownwood Regional Medical Center v. WPS Government Health Administrators* (PRRB Case Number 20-0536), and states that "the Hospital believes the methodology used by the [Medicare Contractor] to calculate the original VDA unfairly removes a variable portion from the inpatient operating costs while not including a variable adjustment related to DRG payments."[38]

Henry County contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[39] Henry County reasons that the calculation does not include an adjustment to the DRG payments for the variable portion of the payments. They note that the Board has previously supported the assertion that 42 U.S.C § 1395ww(a)(4) "supports the fact that DRG payments include a payment for *both* the fixed and variable costs."[40] The Board identified one basic difference in the Medicare Contractor's and Henry County's calculation of the VDA payment which relates to the FY 2010 Inpatient Operating Costs. The Medicare Contractor adjusted the Inpatient Operating Costs for variable costs via Worksheet A-8 adjustments on the cost report without similarly taking into account the portion of the DRG payments attributable to variable costs.

In recent Board decisions addressing VDA payments,[41] the Board has disagreed with the methodology used by various Medicare contractors (including the one involved in the instant

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[32] Medicare Contractor's FPP at 22.
[33] *Id.* at 14.
[34] *Id.* at 15.
[35] *Id.* at 8-9 (discussing *Unity Healthcare v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. 2014-D15 (Sept. 4, 2014).
[36] Provider's FPP at 2.
[37] *Id.* (emphasis added).
[38] *Id.*
[39] *Id*.
[40] *Id*.
[41] *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.

case) 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. This calculation results in an apples-to-apples comparison. The Board notes that Henry County disagrees with the Medicare Contractor's methodology of computing the variable cost and provided an alternative calculation using its alternate fixed portion of cost and following the Board's methodology for the remainder of the VDA calculation.

Applying the methodology adopted by the Board in previous decisions, Henry County reasons that the "methodology used to calculate the volume decrease adjustment should include a variable cost adjustment to *both* the inpatient operating costs and the DRG payment amount."[42] This method, Henry County maintains, would ensure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs.

The Administrator has previously 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 . . . .[43]

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

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).

[42] Provider's FPP at 2 (emphasis added).

[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).

> 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.[44]

Recently, in the *Unity* case, the Eighth Circuit ruled that the Administrator's methodology "was not arbitrary or capricious and was consistent with the regulation."[45] However, the Board notes that Henry County 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 FFY 2018 IPPS Final Rule,[46] 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.[47] 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."[48]

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 Henry County'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 Henry County's VDA payment by comparing its FY 2010 fixed costs to its total FY 2010 DRG payments. However, neither the language nor the examples[49] 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[50] and the FFY 2009 IPPS Final Rule[51] 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 year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor

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[44] (Bold and italics emphasis added).
[45] *Unity Healthcare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).
[46] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[47] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).
[48] 82 Fed. Reg. at 38180.
[49] PRM 15-1 § 2810.1(C)-(D).
[50] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[51] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

> 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 Henry County'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 Henry County's FY 2010 VDA based on an otherwise *new* methodology that the Administrator apparently 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[.]"[52] 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.[53]

The statute at 42 U.S.C. § 1395ww(d)(5)(G)(iii) is clear that the VDA payment is intended to fully compensate a 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.[54]

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."[55] 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:

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[52] *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).
[53] 82 Fed. Reg. at 38179-38183 (June 13, 2016).
[54] (Emphasis added.)
[55] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> C. Requesting Additional Payments.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
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> D. Determination on Requests.— . . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
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> 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***.[56]

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."[57]

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."[58] 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

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[56] (Emphasis added).
[57] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[58] 42 U.S.C. § 1395ww(d)(5)(G)(iii).

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 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 costs 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. 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.[59] 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 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 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 year of a qualifying decrease, the hospital must receive payment for the variable costs related to its *actual* Medicare patient load, *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 explain 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.[60] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board

[59] 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.
[60] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).

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* to 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 Henry County's fixed costs (which includes semi-fixed costs) were 83.28 percent[61] of Henry County's Medicare costs for FY 2010. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2009 Medicare Inpatient Operating Costs	$15,995,177[62]
Multiplied by the 2010 IPPS update factor	1.021[63]
2009 Updated Costs (max allowed)	$16,331,076
2010 Medicare Inpatient Operating Costs	$14,639,551[64]
Lower of 2009 Updated Costs or 2010 Costs	$14,639,551
Less 2010 IPPS payment	$11,594,491[65]
2010 Payment Cap	**$3,045,060**

[61] Stipulations at ¶ 9; Medicare Contractor's FPP 10-11. There are conflicting stipulations related to the fixed and semi fixed percentage. In Stipulation ¶ 9, Henry County stipulates to 83.28 percent as being the fixed and semi-fixed percentage and in Stipulation ¶ 10, Henry County and the Medicare Contractor stipulate to 90.2086 percent as being the fixed and semi fixed percentage. It is clear based on a review of the Medicare Contractor's final position paper that the Medicare Contractor never accepted Henry County's proposed fixed and semi fixed cost percentage of 90,2086 percent.

[62] Stipulations at ¶ 10.

[63] *Id*. (The Board notes that this is the appropriate IPPS update factor for discharges from October 1, 2009 to March 31, 2010. The update factor was revised to 1.0185 for discharges from April 1, 2010 to September 30, 2010. Further, as Henry County's fiscal year end is December 31, 2010, a portion of the year is in Federal fiscal year 2011, (October 1, 2010 to December 31, 2010), which had an update factor of 1.0235. The properly averaged update factor would be ((1.021 x 90 days) + (1.0185 x 183 days) + (1.0235 x 92 days)) / 365 days = 1.02037. As the current year (2010) costs are less than the prior year costs, without update, this has no effect on the final VDA payment.

[64] *Id*.

[65] *Id.*

Step 2: Calculation of VDA

2010 Medicare Inpatient Fixed Operating Costs	$12,192,054[66]
Less Excess Staffing	$ 0[67]
2010 Medicare Inpatient Fixed Op. Costs less Excess Staff	$12,192,054
Less 2010 IPPS payment – fixed portion (83.28 percent[68])	$9,655,892[69]
Payment adjustment amount (subject to CAP)	**$2,536,162**

Since the payment adjustment amount of $2,536,162 is less than the Cap of $3,045,060, the Board determines that Henry County's VDA payment for FY 2010 should be $2,536,162. As Henry County was already awarded a VDA payment of $1,051,087, Henry County is due an additional VDA payment for FY 2010 in the amount of $1,485,075.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Henry County's VDA payment for FY 2010, and that Henry County should receive an additional VDA payment of $1,485,075, resulting in a total VDA payment of $2,536,162 for FY 2010.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

9/6/2022

X Clayton J. Nix

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

[66] Medicare Contractor's FPP at 11; Exhibit C-2 at 6.
[67] Medicare Contractor's FPP at 16.
[68] Medicare Contractor's FPP at 10-11.
[69] Calculation = 11,594,491 * 0.8328 = $9,655,892.