PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D26

PROVIDER-
Ridgecrest Regional Hospital

Provider No.: 05-0448

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions, Inc.

RECORD HEARING DATE –
August 10, 2021

Cost Reporting Period Ended –
01/31/2012

CASE NO. – 16-0008

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly determined the sole community hospital ("SCH") volume decrease adjustment ("VDA") granted for the fiscal year ending January 31, 2012 ("FY 2012").[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 did not properly calculate the VDA payment for Ridgecrest Regional Hospital ("Ridgecrest") for FY 2012, and that the revised calculation results in an overpayment in the amount of $626,417 due from Ridgecrest to the Medicare Program.

INTRODUCTION

Ridgecrest is located in Ridgecrest, California, and was designated as an SCH during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Ridgecrest for this appeal is Noridian Healthcare Solutions, Inc. ("Medicare Contractor"). On September 6, 2013, Ridgecrest requested a VDA payment in the amount of $2,576,620 because it experienced a decrease in total discharges of greater than 5 percent.[4] The Medicare Contractor calculated Ridgecrest's FY 2012 VDA payment to be $1,914,802.[5] Ridgecrest timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on August 10, 2021. Ridgecrest 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 their total number of inpatient discharges of more than 5 percent from one cost reporting year to the next.[6] VDA payments are designed to fully compensate a hospital for the fixed costs that it incurs for providing inpatient hospital services during the period covered by the VDA, including the

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[1] Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 3.
[2] Stipulations of the Parties ("Stipulations") at ¶ 1 (July 27, 2021).
[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 Consolidated Final Position Paper ("Provider's FPP") at 3; Exhibit C-2; Stipulations at ¶ 4.
[5] Stipulations at ¶ 5; Exhibit C-3; Exhibit P-1.
[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

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 Ridgecrest experienced a decrease in discharges of greater than 5 percent from FY 2011 to FY 2012 due to circumstances beyond its control and that, as a result, Ridgecrest was eligible to have a VDA calculation performed for FY 2012.[8] Ridgecrest requested a VDA payment in the amount of $2,576,620 for FY 2012.[9] At the request of Ridgecrest, the Medicare Contractor performed the FY 2012 VDA calculation and it determined that Ridgecrest was entitled to a VDA payment of $1,914,802.[10]

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

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[11] the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs . . . .
>
> (i) In determining the adjustment amount, the Intermediary considers— . . .
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter. . . .

In the preamble to the final rule published on August 18, 2006,[12] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), which provides further guidance related to VDAs and states in relevant part:

> B. Additional payment is made . . . for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
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> 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,

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[7] *Id*.
[8] Stipulations at ¶ 4.
[9] Provider's FPP at 3.
[10] *Id.* at 4.
[11] (Emphasis added.)
[12] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).

> 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 Ridgecrest 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	$10,196,403	$10,679,277
b) IPPS update factor	1.019	1.03
c) Prior year Updated Operating Costs (a x b)	$10,390,135	$10,999,655
d) FY 2012 Operating Costs	$ 8,844,010	$ 7,984,611
e) Lower of c or d	$ 8,844,010	$ 7,984,611
f) DRG/SCH payment	$ 6,636,237	$ 5,407,991
g) CAP (e-f)	$ 2,207,773	$ 2,576,620
h) FY 2012 Inpatient Operating Costs	$ 8,844,010[16]	
i) Fixed Cost percent	86.73%	
j) FY 2012 Fixed Costs (h x i)	$ 7,670,410	
k) Total DRG/SCH Payments (fixed portion only)	$ 5,755,608[17]	
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 1,914,802	
m) VDA Payment Amount (The Providers VDA is based on the amount line e exceeds line f.)		$ 2,576,620

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

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[13] (Emphasis added.).
[14] Stipulations at ¶ 9.
[15] *Id.* at ¶ 6.
[16] Fixed Operating Costs per Worksheet D-1, line 53 on the 2012 Medicare Cost Report. *See* Stipulations ¶¶ 6, 9, 10. All stipulations are consistent in the use of this amount.
[17] While Stipulation ¶ 8 indicates the Medicare Contractor "subtracted 100% of the Provider's DRG amount in making its determination," this is incorrect. Per the stipulated Medicare Contractor's FYE 1/31/12 VDA calculation (Stipulation ¶ 9), the Medicare Contractor clearly reduced the total DRG payments of $6,636,237 to $5,755,608 (86.73 percent) using the fixed percentage applied to the inpatient operating costs. The Board notes that the Medicare Contractor argues in the Medicare Contractor's FPP at 11 that the VDA should be calculated using "the full amount of the DRG payments" resulting in a lower VDA of $1,034,173 ($7,670,410 - $6,636,237). The Medicare Contractor's FPP is dated April 13, 2021. However, the Stipulations at ¶ 9 identify the "MAC's methodology for calculating the Provider's VDA payment" as shown in the table above, with a fixed percentage applied to the DRG payments. Further, the Stipulations at ¶12 state that "[t]he MAC's methodology for calculating the VDA in this appeal is the same as the Secretary's." This may be true of the Contractor's argued methodology in the Contractor's FPP, but is not true of the methodology in the original VDA or in the Stipulations, which are dated July 26, 2021.
[18] Stipulations at ¶ 11.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor states that beyond the differences in the VDA calculation discussed by Ridgecrest, that there are other differences to be noted between the two calculations. Specifically, the Medicare Contractor states Ridgecrest used the Prior Year program operating costs of $10,679,277, when the correct figure should be obtained from Worksheet D-1, line 53, FYE January 31, 2011, which was $10,196,403.[19] The Medicare Contractor also states the current year amounts used in Ridgecrest's "Table A do not agree with Worksheets D-1 and E, Part A of the Final . . .[Medicare Cost report]. . . ."[20] The Medicare Contractor asserts the correct current year program operating cost from Worksheet D-1 and the DRG Payment from Worksheet E Part A[21] can be found in Ridgecrest's Table B,[22] which recaps the Medicare Contractor's calculation.

The Medicare Contractor insists it properly calculated and processed Ridgecrest's request for VDA payment, including limiting the VDA payment to fixed costs.[23] The Medicare Contractor states the adjustments were made in accordance with 42 C.F.R. §412.92 .[24] The Medicare Contractor also cites to CMS Pub. 15-1, Section 2810.1(B) (Revision 479) which states:

> Additional payment is made to an eligible SCH 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 payment for inpatient operating costs.[25]

The Medicare Contractor contends "[t]he intent of the VDA is to compensate qualified hospitals for their fixed costs and not their variable costs....[t]his is achieved by subtracting the DRG revenue from the fixed costs, thereby assuring "full compensation" for the fixed costs."[26] The Medicare Contractor has determined Ridgecrest's fixed and semi-fixed cost percentage as 86.73% (13.27% variable), and states this determination was based upon Ridgecrest's summary of its expenses by category.[27]

In support of its position, the Medicare Contractor cites to several CMS Administrator decisions, and also to the United States Court of Appeals for the Eighth Circuit, *Unity Healthcare, St. Anthony Regional Hospital and Lakes Regional Healthcare vs. Alex M Azar, II, Secretary, U.S. Department of Health and Human Services*.[28]

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[19] Medicare Contractor's FPP at 8; Exhibit C-4 at 3.
[20] Medicare Contractor's FPP at 8; Exhibit C-7 at 2-6.
[21] Medicare Contractor's FPP at 8.
[22] Provider's FPP at 4.
[23] Medicare Contractor's FPP at 10.
[24] *Id.* at 7.
[25] *See* Exhibit C-10 at 7.
[26] Medicare Contractor's FPP at 11-12.
[27] *See id.* at 8; Exhibit C-5 (the Medicare Contractor's workpaper summarizing the Provider's fixed and semi-fixed cost percentage).
[28] Medicare Contractor's FPP at 14-16.

Ridgecrest argues that the Medicare Contractor's calculation of the VDA was wrong because the Medicare Contractor "departed from CMS' [Provider Reimbursement M]anual instructions and step-by-step guide and added an unauthorized and monumental extra step."[29] Ridgecrest states the Medicare Contractor's methodology for calculating the VDA was flawed, and did not fully compensate them for all of their fixed costs as required.[30] Ridgecrest also maintains that the Medicare Contractor improperly calculated Ridgecrest's Medicare fixed costs, and included an additional adjustment by removing variable costs in the VDA payment calculation.[31]

Ridgecrest argues that the Medicare Contractor changed the VDA payment calculation without going through notice-and-comment rulemaking, and this unlawfully changed the regulation. Ridgecrest states that the VDA payment "methodology in effect during the four years under appeal was the one described in section 2810.1 of the PRM, as formally adopted and modified in the IPPS rulemakings for FYs 2007 and 2009."[32]

Ridgecrest reasons that in applying the methodology adopted by the Board, the DRG component of the VDA calculation is multiplied by the percentage of program fixed costs to total program costs to calculate fixed DRG payments. The fixed DRG payments are then deducted from the fixed program costs to calculate the VDA payment. Ridgecrest also references the fact that CMS adopted a nearly identical methodology in the IPPS Final Rule for FFY 2018.[33]

The Board identified one basic difference in the Medicare Contractor's and Ridgecrest's calculation of the VDA payment. There is a difference in the FY 2012 Inpatient Operating Costs used by the parties. The Medicare Contractor adjusted the Inpatient Operating Costs for variable costs by identifying variable costs through an analysis of Worksheet A from the cost report. The Medicare Contractor states "[t]his percentage was applied to adjust current year program operating costs calculated on . . . [worksheet] D-1 line 53 creating a current year allowable amount."[34] Ridgecrest argues that the Medicare Contractor's VDA calculation methodology "recalculated its inpatient operating costs as if the Provider did not have to provide any food, any drugs, any medical supplies, or any laundry services to its inpatients....[and] is contrary to the statute and the regulation."[35]

In recent decisions,[36] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because it compared fixed costs to total DRG payments and only resulted in a VDA payment if the fixed costs exceeded the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed

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[29] Provider's FPP at 11.
[30] *Id.* at 12.
[31] *Id.*.
[32] *Id.* at 15.
[33] *Id.* at 13.
[34] Stipulations at ¶ 9.
[35] Provider's FPP at 10.
[36] *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).

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 the 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 . . . .[37]

The Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[38]

At the outset, the Board notes that the 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.[39]

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

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[37] *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).
[38] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019) *cert. denied*, 140 S. Ct. 523 (2019).
[39] (Bold and italics emphasis added.)

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,[40] 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.[41] 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."[42]

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

The Medicare Contractor originally determined Ridgecrest's VDA payment by comparing its FY 2012 fixed costs to its total FY 2012 DRG payments reduced by the fixed cost percentage, and it is this final determination which is being appealed by Ridgecrest. Subsequently, in its final position paper, the Medicare Contractor noted that this handling was in accordance with the updated instructions from the Final 2018 IPPS Rule. However, based on the hospital's fiscal year end, the Medicare Contractor's final position paper states:

> [T]he updated instructions for the calculation of the of the VDA payment amont in CMS Pub. 15-1, Section 2810.1(D)(2)(a) do not instruct . . . [Medicare Contractors] to apply the Fixed/Semi-fixed Percentage to the DRG Payments to determine the VDA payment amount for cost reporting periods beginning prior to October 1, 2017. . . . The Provider's VDA Payment Amount should have been determined by comparing the Adjusted Fixed/Semi-fixed Medicare Inpatient Costs to the full amount of the DRG Payments, which would have resulted in a considerably lower VDA Payment Amount of $1,034,173 ($7,670,410 - $6,636,237).[43]

It appears the Medicare Contractor now argues that its original calculation was incorrect. Similarly, the parties are both incorrect when their agreed-upon stipulations state "The . . . [Medicare Contractor's] methodology removed the costs it had identified as variable from the Provider's program costs ***and subtracted 100% of the Provider's DRG amount in making its determination. The portion of the Provider's DRG payment intended to reimburse the Provider for its variable costs was not identified and removed from the Provider's DRG***

[40] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[41] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92 (e)(3).
[42] 82 Fed. Reg. at 38180.
[43] Medicare Contractor's FPP at 11.

payment."[44] Both parties have stipulated incorrectly as the Medicare Contractor's final determination clearly reduces the DRG payments, using the fixed cost percentage.

The Board notes that neither the language nor the examples[45] 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[46] and the FFY 2009 IPPS Final Rule[47] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> The adjustment amount is determined by subtracting the second year's MS-DRG payment from the 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 Ridgecrest's VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Ridgecrest's FY 2012 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling . . . ."[48] 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.[49]

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

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[44] Stipulations at ¶ 8 (emphasis added).
[45] PRM 15-1 § 2810.1(C)-(D).
[46] 71 Fed. Reg. at 48056.
[47] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[48] *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).
[49] 82 Fed. Reg. at 38179-38183.

> subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

In the FFY 1984 IPPS Final Rule, the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[50] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 (rev. 356) 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.—. . . .
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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*

[50] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

> *difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[51]

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 . . . ."[52]

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 . . . ."[53] Using the Administrator's rationale, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment ***only*** *for the* ***fixed*** *costs* of the services actually furnished to Medicare patients. However, the statute at 42 U.S.C. § 1395ww(a)(4) is clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines operating costs of inpatient services as "**all** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]" The Administrator cannot simply ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments solely for the fixed cost of the Medicare services actually rendered when the hospital in fact incurred both fixed and variable costs for those services.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an SCH for all the fixed costs associated with the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 412.92 (e)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[54] 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

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[51] (Emphasis added.)
[52] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[53] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[54] 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.

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 does not do this, as it takes the portion of the DRG payment intended for variable costs and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(D)(ii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG payment is payment for both fixed and variable costs – and deem the entire DRG payment as payment solely for fixed costs. The Board concludes that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is clear that the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[55] 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 that Ridgecrest's Consolidated Final Position Paper ("CFFP") addresses VDA Case Nos. 16-0008 (for the fiscal year ending ("FYE") January 31, 2012) and 16-1817 (for FYE August 7, 2012). On page 6 of Ridgecrest's CFPP, there is discussion of an anomalous situation. However, per the discussion on that page, and the following supporting schedules (Tables 1 and 2), Ridgcrest is arguing that it "meets the criteria for an anomalous situation" for the FYE August 7, 2012, not for FYE January 31, 2012 which is the period at issue here. As such, the Board will not address any potential anomalous situation in the current decision relating to FYE January 31, 2012 because they have no relevance to the period at issue before the Board.

The Board must also address the issue that both Ridgecrest and the Medicare Contractor have stipulated to $6,636,237 as the FY 2012 IPPS payments.[56] This is supported by cost report Worksheet E Part A which is included in Exhibit C-7, on pages 4-6. The amount of $6,636,237 reconciles to Line 49 of Worksheet E part A. However, this does not include the low volume payments made to Ridgecrest, which appear on Lines 70.96 and 70.97 of Worksheet E, Part A. The VDA statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) entitles an SCH to "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 in incurs. . . ."[57] The VDA provisions are

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[55] 48 Fed. Reg. at 39782.

[56] Stipulations at ¶¶ 9, 10.

[57] The Board recognizes that this statutory provision includes the following exception: "such adjustment to the payment amounts under this subsection (*other than under paragraph (9)*." (Emphasis added.) However, the *sole* exception for Paragraph (9) of subsection (d)is not applicable since paragraph (9) addresses payments to Puerto Rico subsection (d) hospitals.

located in subsection (d) at paragraph 12, and therefore, *must* be considered when calculating the VDA payment. Thus, although not included in the Stipulations, the Board will include the LVA payments as reported on Lines 70.96 ($439,202) and 70.97 ($283,059) of Worksheet E, Part A as part of the IPPS payments in the VDA calculation.

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 Ridgecrest's fixed costs (which includes semi-fixed costs) were 86.73 percent[58] of Ridgecrest's Medicare costs for FY 2012. Applying the rationale described above, and making the necessary corrections for the incorrect Stipulations, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2011 Medicare Inpatient Operating Costs	$ 10,196,403[59]
Multiplied by the 2012 IPPS update factor	1.021984[60]
2011 Updated Costs (max allowed)	$ 10,420,561
2012 Medicare Inpatient Operating Costs	**$ 8,844,010**[61]
Lower of 2011 Updated Costs or 2012 Costs	$ 8,844,010
Less 2012 IPPS payment (includes LVA)	$ 7,358,498[62]
2012 Payment CAP	**$ 1,485,512**

Step 2: Calculation of VDA

2012 Medicare Inpatient Fixed Operating Costs	$ 7,670,410[63]
Less 2012 IPPS payment – fixed portion (86.73 percent)	$ 6,382,025[64]
Payment adjustment amount (subject to Cap)	**$ 1,288,385**

[58] Stipulations at ¶ 9.
[59] *Id*. at ¶ 10.
[60] The Board notes that the parties have stipulated the 2012 IPPS Update Factor as 1.019. The is the correct IPPS Update Factor for the Federal Fiscal Year of 2012 (10/1/2011 to 9/30/2012). However, Ridgecrest has a fiscal year end of 1/31/2012. Thus, the applicable cost report is 242 days (2/1/2011 to 9/30/2011) in federal fiscal year 2011 and 123 days in federal fiscal year 2012 (10/1/2011 to 1/31/2012). The IPPS Update Factor for 2011 is 1.0235. Thus, both rates must be partialized to reflect Ridgecrest's fiscal year as follows. ((242/365 * 1.0235) + (123/365 * 1.019)) = (0.678595 + 0.343389) = 1.021984. The Board will use this calculated IPPS Update Factor in its VDA calculation above. (This has no effect on the final VDA adjustment, as the current year costs are less than the prior year adjusted costs.)
[61] Stipulations at ¶ 10.
[62] Exhibit C-7 at 5-6. (This figure is accumulated from Worksheet E Part A as follows: $6,636,237 (Line 49) + $439,202 (Line 70.96) + $283,059 (line 70.97) = $7,358,498.)
[63] Stipulations at ¶ 10 (This figure is calculated as the fixed cost percentage (86.73 percent) applied to the total current year inpatient operating costs of $8,844,010).
[64] The $6,382,025 is calculated by multiplying $7,358,498 (the total FY 2012 DRG payments, including LVA) by 0.8673 (the fixed cost percentage determined by the Medicare Contractor).

Since the payment adjustment amount of $1,288,385 is less than the Cap of $1,485,512, the Board determines that Ridgecrest's VDA payment for FY 2012 should be $1,288,385. As Ridgecrest received $1,914,802 in the final determination, this results in an overpayment of $626,417, due from Ridgecrest to the Medicare Program.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor did not properly calculate the VDA payment for Ridgecrest for FY 2012, and that the revised calculation result in an overpayment in the amount of $626,417 due from Ridgecrest to the Medicare Program.

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9/12/2022

X Clayton J. Nix

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Signed by: PIV