# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2017-D1

**PROVIDER –**
Trinity Regional Medical Center
Fort Dodge, Iowa

Provider No.: 16-0016

**vs.**

**MEDICARE CONTRACTOR –**
Wisconsin Physicians Services

**HEARING DATE –**
June 4, 2015

Cost Reporting Period Ended –
December 31, 2007

**CASE NO.:** 13-1012

**INDEX**

## ISSUE STATEMENT

Whether Trinity Regional Medical Center ("Trinity" or "Provider") was entitled to a Volume Decrease Adjustment ("VDA")? [1]

## DECISION

After considering the Medicare law and regulations, the evidence presented, and the parties' contentions, the Board finds that the Medicare Contractor correctly identified and eliminated variable costs from Trinity's VDA calculation. However, the Medicare Contractor improperly calculated Trinity's VDA for FY 2007. Trinity's Medicare fixed/semi-fixed inpatient operating costs should be reduced by the fixed/semi-fixed portion of its IPPS payment. Consistent with the application of PRM 15-1 § 2810.1, Trinity should receive a low volume adjustment/VDA for FY 2007 in the amount of $581,537.

## INTRODUCTION

Trinity is a 200-bed acute care hospital located in Fort Dodge, Iowa and participates in the Medicare program as a Sole Community Hospital ("SCH"). The Medicare Contractor assigned to Trinity is Wisconsin Physicians Service ("Medicare Contractor"). Trinity requested additional payment of approximately $800,000 to compensate it for a decrease in inpatient discharges during FY 2007. The Medicare Contractor denied this adjustment and Trinity timely appealed and met the jurisdictional requirements for a hearing before the Board.

The Board conducted a live hearing on June 4, 2015. Trinity was represented by Whitney C. West, Esq. and Kirk Blecha, Esq. of Baird Holm LLP. The Medicare Contractor was represented by Robin Sanders, Esq. of the Blue Cross and Blue Shield Association.

## STATEMENT OF FACTS

Medicare pays hospitals a predetermined, standardized amount per discharge, subject to certain payment adjustments.[8] One of these payment adjustments, referred to as a "volume decrease adjustment" is available to sole community hospitals if they incur a decrease in patient discharges of more than 5 percent from one cost reporting year to the next, due to circumstances beyond its control. These adjustments are designed to compensate the hospital for the fixed costs it incurs in the period for providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.[2] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements. The parties agree that Trinity's inpatient discharges decreased by more than five percent from FY 2006 to FY 2007, for reasons outside Trinity's control.[3]

Trinity initially requested a VDA in the amount of $793,826. The Medicare Contractor denied this request on June 5, 2012 because the total Medicare inpatient revenue exceeded the total

[1] Transcript ("Tr") at 5-6.
[2] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[3] *See* Provider Exhibit P-7 at 1 (copy of the Medicare Contractor's workpapers for Trinity's FY 2007).

fixed and semi-fixed Medicare inpatient costs.[4] Trinity timely requested that the Medicare Contractor reconsider this denial.[5] During the reconsideration period, the Medicare Contractor finalized Trinity's FY 2007 cost report and issued a Notice of Program Reimbursement ("NPR").[6] As a result, Trinity incorporated the final figures from Trinity's FY 2007 NPR into the VDA calculation to increase its VDA request to $812,333.[7] The Medicare Contractor ultimately denied the reconsideration on November 16, 2012 for the same reason, namely that total Medicare inpatient revenue exceeded the fixed and semi-fixed Medicare inpatient costs.[8]

42 C.F.R. § 412.92(e) directs how the Medicare Contractor must adjudicate the VDA request once a SCH demonstrates it suffered a qualifying decrease in total inpatient discharges. In particular, § 412.92(e)(3) states in pertinent part:[9]

> (3) The Medicare Contractor 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 . . . .
>
> (i) In determining the adjustment amount, the Medicare Contractor 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; . . .

Significantly, the above regulation limits the low volume adjustment amount for an SCH to its total inpatient operating cost (excluding pass-through costs and increased by the IPPS update factor) minus its DRG revenue.[10]

Central to this case is the classification of costs as either fixed, semi-fixed or variable. The Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1(B) provides further guidance on the classification of costs for SCHs:

> 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

[4] *See* Provider Exhibit P-2 (copy of the Medicare Contractor's denial).
[5] *See* Provider Exhibit P-3 (copy of Trinity's reconsideration request).
[6] *See* Provider Exhibit P-4 (copy of Trinity's NPR for FY 2007).
[7] *See* Provider Exhibit P-5 (copy of Trinity's revised VDA calculation based on the NPR).
[8] *See* Provider Exhibit P-6 (copy of the Medicare Contractor's reconsideration decision).
[9] The terms volume decrease adjustment and low volume adjustment are used interchangeably in this decision.
[10] *See also* 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987).

> costs for items and services that vary *directly*[11] with utilization such as food and laundry costs.

PRM 15-1 §§ 2810.1(C) and (D) also provide several examples of how to calculate the low volume adjustment. The parties dispute the application of the statute and regulation used to properly classify costs and calculate the VDA.

A. VARIABLE VERSUS FIXED OR SEMI-FIXED COSTS

Trinity argues that the Medicare Contractor miscalculated the VDA by improperly classifying Trinity's fixed and semi-fixed costs as variable costs, or improperly excluding variable costs. Trinity disagrees with the Medicare Contractor's determination that some of its costs were variable and contends that *all* patient care costs were either fixed or semi-fixed costs as defined by the Medicare program. Trinity relies on the following language of PRM 15-1 § 2810.1(B):

> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.[12]

Trinity states that the key to identifying "fixed costs" is whether hospital administrators have control over the expenses. Under this approach, if the administrators cannot reduce a particular cost, it is fixed. In addition, Trinity argues that some variable costs should be considered "semi-fixed" because they are necessary for the hospital's continued operation during a period of decreased utilization.[13] For this reason, CMS specifically permits Medicare Contractors to consider "many semi-fixed costs ... as fixed" when evaluating VDA requests.

As an example, Trinity maintains that the Medicare Contractor improperly reclassified the Trinity's costs for billable medical supplies, billable drugs, housekeeping, dietary, and laundry expenses as "variable" in order to exclude these expenses from qualifying as VDA reimbursable fixed costs.[14] Trinity believes that some of these costs, such as medical supplies, drugs, and food, should be considered as semi-fixed because they do not decrease in response to reductions in patient volume, but rather vary solely with changes in patient acuity, patient need, and physician orders. Trinity's witness testified that *all* patient care costs are, at minimum, semi-fixed costs since they are entirely dependent on physician orders and patient acuity over which the hospital management has no control.[15] Other costs, like housekeeping expenses, may be generally correlated with inpatient volume but cannot be wholly variable because regulatory

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[11] (Emphasis added.)
[12] Provider's Post Hearing Brief at 4-5.
[13] *Id.*
[14] *Id.* at 8.
[15] *Id.* at 9. *See also* Tr. at 32–33.

standards such as the Medicare Conditions of Participation and state health regulations require the maintenance of a baseline level of service.[16]

Finally, Trinity explains that CMS instructs Medicare Contractors to consider qualifying semi-fixed costs *as fixed costs over the short term* because such costs are beyond the SCH's immediate, short-term control.[17] Here, Trinity contracts with third parties for medical supplies, drugs, housekeeping, dietary, and linen services and cannot terminate the contracts in the short term unless a party has breached its obligations. These contract costs may vary somewhat with patient utilization but at least some portion of these costs is an unavoidable expense and should be considered "fixed" costs over the short term.[18] Trinity identifies contracts for food, environmental, pest control, medical waste and document shredding services[19] that should be considered semi-fixed costs and excluded from variable costs for the purposes of the VDA calculation.[20]

Trinity contends that it calculated its VDA request in accordance with the controlling regulation and PRM instructions regarding which costs were validly considered fixed or semi-fixed however, the Medicare Contractor improperly re-classified certain FY 2007 costs as "variable" costs. The effect of this reclassification was to exclude certain fixed and semi-fixed costs from that portion of the VDA calculation and negates the requested VDA of $812,333 in its entirety[21].

B. CALCULATION OF THE VDA

Trinity maintains that Medicare Contractor skipped the first step in the prescribed analysis which requires the Medicare Contractor to determine the maximum allowable amount that the VDA cannot "exceed." This maximum amount or ceiling is the difference between Trinity's total Medicare inpatient operating costs in FY 2007 and the operating portion of the FY 2007 DRG reimbursement received for these expenses. Trinity asserts that the proper application of a ceiling calculated per 42 C.F.R. § 412.92(e)(3) is to compare the *ceiling* amount against Trinity's total *fixed* inpatient operating costs—that is, operating costs less net variable costs for the fiscal year.[22]

Trinity argues that, even accepting the Medicare Contractor's reclassification, a proper VDA calculation should have set the VDA at the lessor of either the $812,333 ceiling[23] based on fixed and semi-fixed costs or the net total inpatient operating costs after removal of costs classified as "variable". The determination of fixed or semi-fixed costs would yield a result of $22,035,582,

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[16] *See, e.g.*, 42 C.F.R. §§ 482.41(c)(2), 482.42.
[17] *See* PRM § 2810.1[B].
[18] As explained by the Provider's Director of Finance at the hearing.
[19] Tr. at 77–82; *see also* Provider Exhibit P-16.
[20] As set out in Provider Exhibit P-15, these were covered by a contract with a third party, Aramark Management Services. *See* Tr. at 74–75. As described by Mr. Mason: *See* Tr. at 75–77.
[21] The Medicare Contractor arrived at $22,035,582 of revised inpatient cost after removing variable cost then compared these total fixed and semi-fixed costs to the Trinity's DRG payment of $28,939,219, which equated to a negative number of <$6,903,637> which provided the basis for a determination that the Trinity could not receive a VDA payment. *See* Medicare Contractor Post Hearing Brief at 6.
[22] Provider's Final Position paper at 8.
[23] *Id.*

the difference between $27,549,808 (total operating cost) and $5,514,226 (Medicare Contractor's assessment of variable cost) which far exceeds the $812,333 ceiling. As such, regardless of the validity of the Medicare Contractor's cost reclassification, in order to be consistent with applicable regulations, the VDA should have been granted as requested, limited only by the ceiling amount of $812,333.[24]

Trinity further criticizes the Medicare Contractor's VDA calculation by saying that it removed variable costs from the cost side of the VDA equation without removing these same costs from the revenue side of the calculation. This methodology ignores basic tenets of IPPS reimbursement which, based on DRGs, is intended to reimburse a hospital's fixed, semi-fixed, and variable costs of providing inpatient services to its Medicare patients. If variable costs are to be excluded from the cost input, then in order to assure accurate matching of revenue with expenses, total DRG reimbursement should also correspondingly be decreased by the DRG component that is intended to reimburse variable costs. Indeed, removing variable costs from both the revenue/reimbursement and cost sides of the VDA equation would lead to a net neutral result, yielding the same $812,333 adjustment that Trinity requested. Trinity contends that this is why it is appropriate to compare the ceiling adjustment amount with its fixed costs, as this appropriately takes into account both its Medicare payments and all of its costs.[25]

Trinity submits that, in accordance with the controlling VDA regulation, 42 C.F.R. § 412.92(e)(3)(i), the Medicare Contractor was required to consider the Trinity's fixed and semi-fixed expenses in determining the Trinity's total Medicare inpatient operating costs, against which the VDA ceiling amount is to be compared.[26]

## DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

### A. CLASSIFICATION OF COSTS

The Board's examination of the governing statutes and implementing regulations and guidance does not support the Trinity's argument that *all* of the costs excluded by the Medicare Contractor are either fixed or semi-fixed costs. The Board can find nothing in the language of the controlling federal statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii), the controlling regulation at 42 C.F.R. § 412.92(e)(1)-(3), or the manual guidance at PRM 15-1 § 2810.1(B) that supports Trinity's position that, once costs are experienced in an environment of reduced volume, they automatically become fixed or, alternatively semi-fixed, regardless of their nature or characteristics. While the controlling federal statute provides that the Secretary "shall provide for such adjustment to the payment amounts under this subsection… as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital service," it recognizes that not *all* costs are *fixed*. In this regard, the preambles to the final rules published on September 2, 1983 and April 20, 1990 explicitly recognize that fact and provide examples of variable costs, explicitly stating: "An adjustment will not be made for truly variable costs, such as food and laundry services."[27]

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[24] Provider's Post Hearing Brief at 6.
[25] Provider's Final Position Paper at 10-11.
[26] *Id*.at 5-8.
[27] 48 Fed. Reg. 39752, 39782 (Sept. 2, 1983); 55 Fed. Reg. 15150, 15156 (Apr. 20, 1990).

Significantly, the PRM 15-1, § 2810.1 guidance was initially published in March 1990 and reflects almost verbatim the above discussion on distinguishing fixed and semi-fixed costs from variable costs.[28] It is clear from the language of these provisions that CMS distinguished fixed and semi-fixed costs from variable costs and did not intend to construe any and all variable costs as fixed or semi-fixed for the purposes of the low volume adjustment. Certain items, food and laundry, for example, that Trinity argues should be considered semi-fixed, are clearly identified as variable costs in the PRM 15-1 guidance.[29] In this regard, the Board notes that the types of costs associated with all of the categories of cost cited by the Medicare Contractor would generally be expected to be inherently correlated to some degree with patient volume as they are tied directly or indirectly to patient services.[30] Accordingly, the Board rejects Trinity's general arguments that any of the cost categories identified by the Medicare Contractor as variable should, more correctly, be designated as either fixed or semi-fixed. The Board further notes that with respect to the assessment of the nature of the actual costs claimed, Trinity has provided incomplete source documentation, which does not tie back to the summary documents and does not provide proper evidence (*e.g.*, contracts) to establish that all (or some portion) of the costs in each category are properly deemed fixed or semi-fixed. As such, the evidence provided, was at best, inconclusive.

### B. CALCULATION OF THE VDA

In the case at hand, both of the parties provided their proposed calculation of the VDA for the Board's consideration. The Board examined both and found that neither party's calculations met the requirements of the controlling federal statute, regulation and interpretive guidance. Specifically, the Medicare Contractor's calculation does not take into consideration that the IPPS payment is intended to compensate a hospital for *both* fixed and variable costs.[31] In contrast, Trinity's calculation does not recognize *any* of its costs as variable.

Based upon the rationale laid out in the preamble accompanying promulgation of the final rule, the Board reasons that the VDA payment calculation should take into account the fact that the IPPS payments include reimbursement for *both* fixed and variable costs.[32] The Board recognizes

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[28] PRM 15-1, Transmittal No. 356 (Mar. 1990) (issuing the criteria PRM 15-1 § 2810.1(B)).
[29] *Id.*
[30] *See* Medicare Contractor Exhibit I-5 (the Medicare Contractor's workpaper lists the following cost centers as having variable costs: laundry & linen, housekeeping, dietary, medical supplies charged to patients, and drugs charged to patients).
[31] *See* 42 U.S.C. § 1395ww(a)(1), (4).
[32] The Board is aware of the following discussion included in the preamble to the August 18, 2006 final rule:

> To qualify for this adjustment, the SCH . . . must demonstrate that: (a) a 5 percent or more decrease of total discharges has occurred; and (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal MAC has established that the SCH . . . satisfies these two requirements, it will calculate the adjustment. *The adjustment amount is determined by subtracting the second year's DRG payment from the lessor of: (a) the second year's costs 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 . . . receives the difference in a lump-sum payment.*

that it does not have the IPPS primary source actuarial data required to determine the split of the DRG payment between fixed and variable costs. However by using the Hospital's revised NPR and an *ad hoc* cost report generated specifically for VDA analysis, the Board finds that a fixed/semi-fixed cost percentage can be developed to approximate the portion of the DRG payment that relates to the payment of fixed/semi-fixed costs. In this case, the proxy ratio developed of fixed costs (which include semi-fixed costs) to total was 0.71582 or 71.582 percent of Medicare inpatient operating costs.[33]

Applying the rationale described above, the Board finds the payment amount in this case should be calculated as follows:

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|---|---|
| Step 1: | |
| 2006 Medicare Inpatient Operating Costs | $29,475,624[34] |
| Multiplied by the 2007 IPPS update factor | 1.034[35] |
| Updated Costs (Max Allowed) | $30,477,795 |
| 2007 Medicare Inpatient Operating Costs | $27,549,808[36] |
| Lower of Updated Costs or 2007 Medicare Inpatient Operating Costs | $27,549,808 |
| Less 2007 DRG payments | $26,737,475[37] |
| 2007 Payment CAP | $812,333 |

71 Fed. Reg. 47870, 48056 (Aug. 18, 2006). *See also* 73 Fed. Reg. 48434, 48630-48631 (Aug. 19, 2008) (restating this same discussion). This discussion suggests that the ceiling amount is in fact the payment adjustment amount. However, the Board finds that this discussion must be read in the larger context of PRM 15-1 § 2810.1 to which this discussion cites and not just subsection (D) where the ceiling is calculated. In particular, subsection (B) must be given effect and subsection (D) must be read together with subsection (B).

[33] *See* Medicare Contractor Exhibit I-5 (listing $19,720,756 as the Total Fixed/Semi-fixed Operating Cost (D-1 Part II, Line 53)); Provider Exhibit P-5 (listing $27,549,808 as the Total Program Operating costs (Adjusted FY 6/30/07 Final Reopened NPR Dated 7/27/12, D-1, Part II, Line 53)).

[34] *See* Exhibit P-5 (listing $29,475,624 as the FY 2006 Program Operating Costs Worksheet D-1, Part II, Line 53).

[35] *See* Provider Exhibit P-5 (listing the 2007 IPPS update factor as 103.40 percent as published in 71 Fed. Reg. 47870, 48154 (Aug. 18, 2006)).

[36] *See* Provider Exhibit P-5 (listing $27,549,808 as the FY 2007 Program Operating Cost Worksheet D-1, Part II, Line 53 of Adjusted FY 6/30/07 Final Reopened NPR Dated 7/27/12 (as referenced by the Provider as cost report schedule is not part of the administrative record)).

[37] *See* Exhibit P-5 (listing $26,737,475 as the FY 2007 DRG Operating Payments Worksheet E, Part A, Line 8 of Adjusted FY 6/30/07 Final Reopened NPR Dated 7/27/12 (as referenced by Provider as cost report schedule is not part of the administrative record)).

| | |
|---|---|
| Step 2: | |
| 2007 Audited Medicare Inpatient **Fixed** Operating Costs (excluding pass through costs) | $19,720,756[38] |
| Less 2007 DRG payments – **Fixed** Portion | $19,139,219[39] |
| Payment Adjustment Amount. | $581,537 |

To determine Trinity's low volume adjustment amount, the Board compared the payment adjustment amount of $581,537 to the cap of $812,333. Since the payment adjustment amount is less than the CAP amount, the Board determined that Trinity should receive a VDA for FY 2007 in the amount of $581,537.

## DECISION

After considering the Medicare law and regulations, the evidence presented, and the parties' contentions, the Board finds that the Medicare Contractor correctly identified and eliminated variable costs from Trinity's VDA calculation. However, the Medicare Contractor improperly calculated Trinity's VDA for FY 2007. Trinity's Medicare fixed/semi-fixed inpatient operating costs should be reduced by the fixed/semi-fixed portion of its IPPS payment. Consistent with the application of PRM 15-1 § 2810.1, Trinity should receive a low volume adjustment/VDA for FY 2007 in the amount of $581,537.

## BOARD MEMBERS PARTICIPATING

Michael W. Harty
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## FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: December 15, 2016

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[38] *See* Medicare Contractor Exhibit I-5 at 7 (listing $19,720,756 as Trinity's FY 2007 Audited net Medicare fixed/semi-fixed costs as reflected on D-1 Part II, Line 53).

[39] The $19,139,219 is calculated by multiplying $26,737,475 (the FY 2007 DRG Operating Payments - Worksheet E, Part A, Line 8 from the Adjusted FY 6/30/07 Final Reopened NPR Dated 7/27/12 (*see* Provider Exhibit P-5)) by 0.71582 (the fixed cost percentage (which was determined by Board using as a proxy the ratio of Fixed/Semi-fixed Program Inpatient Operating Cost to Total Program Inpatient Operating Cost from the Adjusted FY 6/30/07 Final Reopened NPR Dated 7/27/12).