CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Lakes Regional Healthcare **Spirit Lake, Iowa**	**Reimbursement Determination for Period Ending:**
	June 30, 2006
Provider	
vs.	**Review of:**
Blue Cross Blue Shield Association/ **Wisconsin Physicians Service (MAC)**	**PRRB Dec. No. 2014-D16**
	Dated: July 10, 2014
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from CMS' Center for Medicare (CM) requesting a partial reversal of the Board's decision. Comments were also received from the Provider requesting a partial reversal of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Medicare Administrative Contractor (MAC), properly calculated the Medicare dependent hospital volume decrease adjustment (VDA) for the Provider, for fiscal year 2006, by excluding certain variable and semi-fixed costs.

The Board affirmed the Intermediary's determination in regard to variable costs and found that the MAC correctly identified and eliminated variable costs in determining that the Provider's fixed costs for FY 2006 was $5,563,068 for

purposes of the determination on the Provider's request for an Medicare Dependent Hospitals (MDH) volume decrease adjustment.

Regarding the volume decrease adjustment amount, the Board found that the MAC improperly calculated the low volume adjustment payment for the Provider. The Provider is subject to the "not to exceed" limitation imposed by the controlling regulation found at 42 CFR 412.108(d)(3) and the application of PRM 15-1 Section 2180.1. The Provider should receive a volume decrease adjustment payment in the amount $1,184,574. Accordingly, the Board modified the MAC's calculation of the low volume adjustment payment.

SUMMARY OF COMMENTS

CM submitted comments stating that it agreed with the Board that the MAC properly identified and eliminated variable costs. CM disagreed with the Board regarding its finding that the MAC improperly calculated the VDA payment for the Provider. CM recommended that the Administrator reverse the Board's decision and uphold the MAC's determination in regard to the VDA payment calculation.

The Provider submitted comments stating that it disagreed with the Board's finding that the MAC properly identified and eliminated variable costs. The Provider recommended that the Administrator reverse the Board's decision and uphold the MAC's determination in regard to the exclusion of VDA payments. The Provider agreed with the Board regarding its finding that the MAC improperly calculated the VDA payment for the Provider.

The Intermediary submitted comments which incorporated CM's comments. The Intermediary also requested that the Administrator reverse the Board's VDA calculation methodology, while affirming the Board's decision to remove variable costs.

BACKGROUND AND DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision and finds that the Board's decision should be modified. The Board's decision on the calculation of the VDA is not supported by the controlling regulations, policies and precedents.

The Provider, Lakes Regional Healthcare is a rural, inpatient prospective payment system (IPPS) hospital located in Spirit Lake, Iowa and the Provider's fiscal year

(FY) ends June 30th. At all relevant times, the Provider qualified and was reimbursed as an Medicare Dependent Hospital (MDH).

From FY 2005 to FY 2006, the Provider experienced a 10.42 percent decline in inpatient discharges. The MAC agrees with the Provider that the decline was due to external circumstances beyond the Provider's control.[1] On February 12, 2008, the Provider received its notice of program reimbursement (NPR) for FY 2006.[2] Shortly thereafter, the Provider submitted a request to the MAC for an MDH volume decrease adjustment of $1,184,574.[3]

In reviewing this low volume adjustment request, the MAC adjusted the Provider's reported expenses by classifying certain costs, specifically, billable medical supplies, billable drugs, IV drugs, third-party goods and services, including physical therapy, lab, blood and radiology, as variable costs and excluded those reclassified costs from the low volume adjustment calculation.[4] On January 28, 2009 and August 6, 2009, the MAC responded to the Provider's request with a final determination that denied the Provider an MDH volume decrease adjustment for FY 2006. On October 2, 2009, the Provider requested a reconsideration of the MAC's denial. On December 14, 2009, the MAC denied the Provider's reconsideration request.[5]

The Administrator finds that the MAC correctly identified and eliminated variable cost in determining that the Provider's fixed costs for FY 2006 for purposes of the Provider's request for an MDH volume decrease adjustment. Furthermore, the MAC properly calculated the low volume adjustment payment for the Provider since the Provider is subject to the "not to exceed" limitation imposed by the controlling regulation and PRM instructions.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the IPPS. The IPPS provides Medicare payment for hospital inpatient operating and capital related costs at predetermined, specific rates for each hospital discharge.

The IPPS also allows special treatment for facilities that qualify as an MDH. The main statutory provisions governing MDHs are located in Section 1886(d)(5)(G) of the Social Security Act (the "Act") and they define an MDH as any hospital: "(I) located in a rural area, (II) that has no more than 100 beds, (III) that is not classified

---

[1] MAC Final Position Paper at 3. *See also* Provider Exhibits P-2, P-3, P-4.
[2] Provider Exhibit P-1.
[3] *See* Provider Exhibit P-5
[4] Provider Exhibits P-2 to P-4; Transcript of Oral Hearing at 10-11.
[5] Provider Exhibit P-4.

as a sole community hospital under subparagraph (D), and (IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A of this subchapter."

Section 1886(d)(5)(G) of the Act authorizes the Secretary of DHHS to adjust the payment to MDHs that incur a decrease in discharges of more than 5 percent from one cost reporting year to the next, stating:

> 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 … as 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.

The regulations implementing this statutory adjustment are located at 42 CFR Section 412.108(d). In particular, subsection (d)(2) specifies the following regarding low volume adjustment for MDHs:

> To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Program Reimbursement and it must –

(i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and
(ii) Show that the decrease is due to circumstances beyond the hospital's control.

Once an MDH demonstrates that it has experienced a qualifying decrease in total inpatient discharges, the intermediary must determine the appropriate amount, if any, due to the provider as an adjustment. In this regard, subsection (d)(3) of the controlling regulation specifies the following regarding the determination of the low volume adjustment amount for MDHs:

> (3) The intermediary determines a lump sum adjustment amount not 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 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;
> (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; and
> (C) The length of time the hospital has experienced a decrease in utilization.[6]

When CMS promulgated Section 412.108(d), CMS has made it clear that the low volume adjustment rules for MDHs were identical to those that were already in effect for SCHs:

> [T]he Act also provides that a hospital meeting the MDH criteria is entitled to an additional payment adjustment if, due to circumstances beyond is control, its total number of discharges in a cost reporting period has decreased by more than 5 percent compared to the number of discharges in its preceding cover reporting period. Since this adjustment for a 5 percent reduction in discharges is identical to the criteria and adjustment currently provided for SCHs, we are incorporating the same criteria and adjustments into the regulation for MDHs.[7]

In addition to the controlling regulation, CMS also provides interpretive guidelines in the Provider Reimbursement Manual, CMS Pub. No. 15-1 (PRM 15-1). PRM 15-1 is intended to ensure that Medicare reimbursement standards "are uniformly applied nationally without regard to where covered services are furnished.[8] While PRM 15-1 does not specifically address MDH low volume adjustments, it does address SCH low volume adjustments at PRM 15-1 Section 2810.1. As the criteria for SCH and MDH low volume adjustments are identical, the PRM 15-1 guidance on SCH low volume adjustment is applicable to MDH low volume adjustments.

---

[6] 42 CFR Section 412.108(d)(3).
[7] 55 Fed. Reg 15150, 15155 (Apr. 20, 1999) (emphasis added). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[8] *See* CMS Pub. 15-1, Foreward.

Specifically, Section 2810.1 provides guidance to assist MACs in the calculation of volume decrease adjustments for sole community hospitals (SCHs). In this regard, Section 2810.1(B) states the following regarding the amount of a low volume adjustment:

> B. Amount of Payment Adjustment. Additional payment is made to an eligible SCH for 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.
>
> 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.
>
> In evaluating semi-fixed costs, the MAC considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semi-fixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semi-fixed costs may not be included in determining the amount of the payment adjustment.

PRM 15-1 Section 2810.1(D) provides the following instruction regarding the processing of an adjustment request:

> D. Determination on Requests. The MAC reviews a hospital's request for additional payment for completeness and accuracy. If any of the required documentation is missing, incomplete, or inaccurate, the MAC requests the needed information. The MAC makes a

> determination on the request and notifies the hospital of the decision within 180 days of the date the MAC receives all required information.
>
> The payment adjustment is calculated under the same assumption used to elevate 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.

The core dispute in this case centers on the application of the statutes to the proper classification and treatment of costs and the proper calculation of the amount for the low volume adjustment. The Administrator's examination of the governing statutes and implementing regulations and guidance clearly recognize three categories of costs, i.e., fixed, semi-fixed and variable. The guidance only considers fixed and semi-fixed costs within the calculation of the volume adjustment but not variable costs.

The Board properly accepted the MAC's determination and elimination of variable costs for FY 2006. The MAC's exclusion of the Provider's billable medical supplies, billable drugs and IV solutions, professional services obtained from third party providers, and dietary and linen expenses as variable was proper and consistent with the regulation and guidance and intent of the adjustment.

The treatment of variable cost within the calculation of the volume decrease adjustment is well established. The plain language of the relevant statute and regulation, Section 1886(d)(5)(G)(iii) and 42 CFR 412.108(d), make it clear that the VDA is intended to compensate qualifying hospitals for their fixed costs, not their variable costs. This position is also supported by past decisions, such as *Greenwood County*, PRRB Dec. No. 2006-D43, where the Board correctly eliminated variable costs from the calculation. Therefore the Administrator affirms the Board's decision regarding the elimination of variable costs from the Provider's VDA payment adjustment request.

Regarding the methodology and proper calculation of the Provider's payment adjustment, the Administrator finds that the Board improperly calculated the Provider's adjustment and reverses that portion of the Board's decision. The VDA calculation methodology used by the Board is in direct contradiction to the statute and CMS' regulations and guidance. The Board's methodology uses a VDA

payment equal to the hospital's fixed costs not to exceed the difference between the hospital's total operating costs and its DRG payment as follows:

Board's Calculation of Payment Adjustment:

Provider's total operating costs:	$4,923,186
Net Variable costs:	$1,360,118
Provider's fixed costs / VDA Payment Amount:	**$3,563,068**

Per the Board's methodology, the Provider's VDA is equal to its fixed costs of $3,563,068 not to exceed the ceiling:

Board's Calculation of the Ceiling:

Provider's total operating costs:	$4,923,186
Provider's DRG payment:	$3,738,612
Ceiling:	**$1,184,574**

The Board's calculation incorrectly concludes that the payment amount for the VDA is $3,563,068 subject to the ceiling of $1,184,574, resulting in a VDA payment of $1,184,574. The Administrator finds that the Board properly calculated the ceiling amount, however, the MAC properly calculated the correct payment adjustment by following the controlling statute, regulations as also reflected in the prior Board decision in *Greenwood*, cited *supra*, as follows:

MAC's Calculation of Payment Adjustment:

Provider's total operating costs:	$4,923,186
Net Variable costs:	$1,360,118
Provider's fixed costs:	$3,563,068
Provider's DRG payment:	$3,738,612
VDA Payment Amount:	**$-175,544**

The MAC applied the proper methodology which represents that the Provider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG payment, which in this case equates to $0 (given the $-175,544 VDA payment amount), subject to the ceiling of $1,184,574.

The payment amount calculated by the Board over-compensates the Provider since the Provider's DRG payments contain partial compensation for its fixed costs.[9] Furthermore, by maintaining that the payment amount is equal to the hospital's fixed costs not to exceed the ceiling (i.e., the difference between the hospital's total costs and its DRG payment), the Board is essentially saying that the VDA payment is equal to the ceiling because the fixed costs ($3,563,068 in this case) will always be greater than the ceiling as calculated by the Board ($1,184,574). This renders the MAC's elimination of variable costs as affirmed by the Board, meaningless because the payment amount will always result in the difference between the hospital's total costs and its DRG payment which does not, fully compensate [a qualifying provider] for the fixed costs it incurs. The Board's methodology does not isolate the difference between the hospital's fixed and semi-fixed costs and its DRG payment in order to properly compensate the provider for its fixed and semi-fixed costs.

In sum, the Administrator finds that the Board properly found that the MAC correctly identified and eliminated variable costs in determining the Provider's fixed costs for FY 2006 for purposes of the determination on the Provider's request for an MDH volume decrease adjustment, and affirms the Board on that portion of the decision. However, as discussed above, the Administrator finds that the Board's calculation of the volume decrease adjustment amount was improper. Therefore the Administrator modifies the Board's decision as it specifically relates to the calculation of the Provider's volume decrease amount adjustment.

---

[9] In the September 1, 1987 final rule, CMS revised 412.92(e)(3) to specify that the VDA would be paid as 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 based on DRG-adjusted prospective payment rates." Hospitals that receive payments that are greater than the hospital's Medicare inpatient operating costs have been "fully compensated" for those costs by the prospective payment system… Therefore, 412.92(e)(3) was revised to make it clear that any adjustment amounts granted to SCHs for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and the total payments made under the inpatient prospective payment system, including outlier payments and indirect medical education costs. (52 Fed. Reg. 33049, September 1, 1987).

DECISION

The decision of the Board is modified in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: Sept. 4, 2014

/s/
Marilynn Tavenner
Administrator
Centers for Medicare & Medicaid Services