PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2021-D18

PROVIDER-
Rolling Plains Memorial Hospital

Provider No.: 45-0055

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –

October 7, 2020

Cost Reporting Period Ended –
09/30/2012

CASE NO. 17-2259

INDEX

ISSUE STATEMENT

Whether Rolling Plains Memorial Hospital ("Rolling Plains" or "Provider") is entitled to a Volume Decrease Adjustment ("VDA") for Fiscal Year End September 30, 2012 ("FY 2012"), greater than the amount determined by the Medicare Contractor.[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated the VDA payment for FY 2012 for Rolling Plains, and that Rolling Plains should receive an additional VDA payment in the amount of $353,588, resulting in a total VDA payment of $774,862 for FY 2012.

INTRODUCTION

Rolling Plains is a 34-bed non-profit acute care hospital located in Sweetwater, Texas.[2] Rolling Plains was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[3] The Medicare contractor[4] assigned to Rolling Plains for this appeal is Novitas Solutions, Inc. ("Medicare Contractor"). Rolling Plains initially requested a VDA payment of $832,388 to compensate it for a decrease in inpatient discharges during FY 2012.[5] Rolling Plains subsequently revised its calculated VDA amount to $1,094,987.[6] The Medicare Contractor calculated the Rolling Plains' FY 2012 VDA payment to be $421,274.[7] Rolling Plains 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 October 7, 2020. Rolling Plains was represented by Richard Morris of Discovery Healthcare Consulting Group, LLC. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

The Medicare program pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-

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[1] Provider Final Position Paper at 1.
[2] *Id.*
[3] Stipulation of Facts at ¶ 1 ("Stipulations").
[4] 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.
[5] *See* Exhibit P-3.
[6] Provider Final Position Paper at 3. *See also* Exhibit P-2. The record also contains a worksheet which reflects a VDA request of $1,093,406. *See* Exhibit P-1. The difference in the actual amount requested by Rolling Plains is immaterial to the Board's decision in this case.
[7] Stipulations at ¶ 5. *See also* Exhibit C-2 at 6.

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 patient discharges of more than 5 percent from one cost reporting year to the next. VDA payments are designed to compensate a hospital for the fixed costs it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.[8] The implementing regulations, located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that Rolling Plains experienced a decrease in discharges greater than 5 percent from FY 2011 to FY 2012 due to circumstances beyond its control, and that, as a result, Rolling Plains was eligible to have a VDA calculation performed for FY 2012.[9] Rolling Plains requested a VDA payment in the amount of $1,094,987 for FY 2012.[10] However, when the Medicare Contractor made the FY 2012 VDA calculation, it determined that Rolling Plains was entitled to a VDA payment in the amount of $421,274.[11]

The regulation at 42 C.F.R. § 412.92(e) (2011) directs how the Medicare Contractor must determine the VDA once an SCH demonstrates it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.92(e)(3) states, in pertinent part:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[12] 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. . . .

The preamble to the final rule published on August 18, 2006[13] references the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 371), which offers further guidance related to VDAs. This manual provision 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

[8] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[9] Stipulations at ¶ 5; Exhibit C-2 at 6. *See also* Provider Final Position Paper at 3.
[10] Provider Final Position Paper at 3. *See also* Exhibit P-2.
[11] Stipulations at ¶ 5. *See also* Exhibit C-2 at 6.
[12] (Emphasis added.)
[13] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).

> 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 chart below depicts how the Medicare Contractor and Rolling Plains 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	$4,580,136	$4,580,136
b) IPPS update factor	1.019	1.019
c) Prior year Updated Operating Costs (a x b)	$4,667,159	$4,667,159
d) FY 2012 Operating Costs	$4,410,266	$4,410,266
e) Lower of c or d	$4,410,266	$4,410,266
f) DRG/SCH payment	$3,193,884	$3,193,884
g) CAP (d-f)	$1,216,382	$1,216,382
h) FY 2012 Inpatient Operating Costs	$4,117,023[17]	$4,410,266
i) Fixed Cost percent	87.81	90.02
j) FY 2012 Fixed Costs (h x i)	$3,615,158	$3,970,121
k) Total DRG/SCH Payments	$3,193,884	$2,875,134
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line d exceeds line f)	$ 421,274	
m) VDA Payment Amount (The Providers VDA is based on the amount by which line d exceeds line f.)		$ 1,094,987

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

[14] (Emphasis added).
[15] Exhibit C-2 at 3.
[16] Exhibit P-2.
[17] Exhibit C-2 at 6.
[18] Stipulations at ¶ 16.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor disagrees with Rolling Plains' assertion that there should be a "reciprocal adjustment removing the variable costs percentage from diagnosis-related group (DRG) payments in the [VDA] calculation[.]"[19] In support of its position, the Medicare Contractor includes the following excerpt from the Administrator's decision in *Fairbanks Memorial Hospital*:

> In addition, contrary to the MAC's methodology, the Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS DRG revenue leaving $10,702,205, in contrast to the DRG revenue used by the MAC of $12,847,839. 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.[20]

Further, the Medicare Contractor performed a core staffing analysis.[21] Rolling Plains contends that the Medicare Contractor used "old" data for the core staffing comparison and that only Adult and Pediatrics and ICU areas should be included in the analysis.[22] The Medicare Contractor verified with CMS that using the 2009 information was proper.[23] Moreover, the Medicare Contractor disagrees with Rolling Plains' contention that Adult and Pediatrics and ICU areas are the only areas to be used in the analysis, citing to PRM 15-1 § 2810.1(C)(6) (Rev. 371), which states:

> The intermediary's analysis of core staff is limited to those cost centers (general service, inpatient, ancillary, etc.) whose costs are components of Medicare inpatient operating cost.

Rolling Plains argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor improperly changed the Medicare rules by calculating Rolling Plains' VDA payment based on a comparison of Rolling Plains' fixed costs to its total DRG payments.[24] Rolling Plains asserts that this approach does not fully compensate the hospital for its fixed and semi- fixed inpatient operating costs.[25] Rolling Plains maintains that the most appropriate methodology to calculate the VDA payment can be found in 42 C.F.R. § 412.92(e) and PRM 15-1 § 2810.1. This methodology results in a total VDA payment to Rolling Plains of $1,094,987.[26]

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[19] Medicare Contractor's Final Position Paper at 6.
[20] *Id.* at 8 (citing *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2007-D11 (June 9, 2015)).
[21] *Id.* at 10-12.
[22] Provider Final Position Paper at 7-8.
[23] Medicare Contractor's Final Position Paper at 12.
[24] Provider Final Position Paper at 5-6.
[25] *Id.*
[26] *Id.* at 3. *See also* Exhibit P-2.

Rolling Plains, in essence, reasons that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. This method, Rolling Plains maintains, would assure an accurate matching of revenue with expenses because the DRG payment is intended to cover both fixed *and* variable costs. Rolling Plains also references the fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[27] Indeed, removing variable costs from both the revenue and cost sides of the VDA equation would result in Rolling Plains receiving a VDA payment for FY 2012 of $1,094,987.

The Board identified three basic differences between the Medicare Contractor's and Rolling Plains' calculation of the VDA payment. First, Rolling Plains contends that the Occupational Mix data used by the Medicare Contractor to calculate the Excess Staffing is outdated and is not contemporaneous with the VDA period under review.[28] Based on this contention, Rolling Plains did not include Excess Staffing in their VDA calculation.

The Board disagrees with Rolling Plains on this point, and finds that the Medicare Contractor's inclusion of the Occupational Mix in the computation of Excess Staffing was in accordance with PRM 15-1 § 2810.1.C.6. Rolling Plains disagrees with the fact that the Medicare Contractor, when computing Excess Staffing, compared prior year to current year nursing staff for all areas of the hospital that utilize nurses.[29] Rolling Plains asserts that PRM 15-1 § 2810.1(C)(6)(a) supports its position that the comparison should only include Adults and Pediatrics and ICU.[30] PRM 15-1 § 2810.1(C)(6)(a) (Rev. 371) states that "The intermediary's analysis of core staff is limited to those cost centers (general service, inpatient, ancillary, etc.) *whose costs are components of Medicare inpatient operating cost*. Core nursing staff is determined by comparing FTE staffing in the Adults and Pediatrics and Intensive Care Unit cost centers."[31] The Board reviewed PRM 15-1 § 2810.1(C)(6)(a) and finds the Medicare Contractor was correct to include cost centers from general service, inpatient and ancillary "whose costs are components of Medicare inpatient operating cost."[32]

The second difference between the VDA calculations is that the Medicare Contractor, in computing the Fixed Cost Percentage, considered all the costs, other than salary, in certain cost centers as variable costs.[33] Rolling Plains states that it submitted a detailed Working Trial Balance to determine whether costs were variable or fixed/semi-fixed for all the accounts grouped to:

- Laboratory;
- Dietary;
- Laundry;
- Medical supplies charged to patients;
- Implantable devices charged to patients; and

[27] Provider Final Paper at 9.
[28] *Id.* at 7-8.
[29] *Id.* at 8. *See also* Medicare Contractor's Final Position Paper at 12; Exhibit C-2.
[30] Provider Final Position Paper at 7.
[31] (Emphasis added.)
[32] PRM 15-1 § 2810.1(C)(6)(a) (Rev. 371).
[33] Provider Final Position Paper at 6; Medicare Contractor's Final Position Paper at 9.

- Drugs charged to patients.[34]

On the Working Trial Balance, Rolling Plains marked which accounts, other than salary, it considered to be variable.[35] The Medicare Contractor, in its final position paper, noted that Rolling Plains' calculation of the fixed cost percentage had not been provided to it previously, and did not include the rationale behind the classification of the costs as variable.[36] Because of this, the Medicare Contractor did not accept Rolling Plains' calculation of the fixed percentage. Rolling Plains, since this time, has stipulated that it is in agreement with the Medicare Contractor's computed Fixed and Semi-Fixed percentage of 87.81 percent.[37]

The third difference is the total DRG payment amount used in the VDA calculation. Rolling Plains used $2,875,134 for its total DRG payment for FY 2012. This amount was adjusted for the fixed costs percentage of 90.02 percent.[38] The Medicare Contractor used $3,193,884 from Worksheet E, Part A, Line 49 (Total payment for inpatient operating costs).[39]

This issue is not new to the Board. In recent decisions, the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because this 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.[40] 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, so there is an apples-to-apples comparison.

The Administrator has overturned these Board decisions, stating:

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . . In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. . . . The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has

[34] Provider Final Position Paper at 4, 6-7.
[35] Exhibit P-1.
[36] Medicare Contractor's Final Position Paper at 10.
[37] Stipulations, Addendum A at ¶ 1.
[38] Exhibit P-2.
[39] Exhibit C-2 at 6.
[40] *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. 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).

> been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[41]

Recently, 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."[42]

At the outset, the Board notes that the CMS 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.[43]

Moreover, the Board notes that Rolling Plains is not located in the Eighth Circuit and, thus, the *Unity HealthCare* 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 the FFY 2018 IPPS Final Rule,[44] 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.[45] 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."[46]

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[41] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[42] 918 F.3d 571, 579 (8th Cir. 2019).
[43] (Bold and italics emphasis added).
[44] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[45] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).
[46] 82 Fed. Reg. at 38180.

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 Rolling Plains' 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 determined Rolling Plains' VDA payment by comparing its FY 2012 fixed costs to its total FY 2012 DRG payments. However, neither the language nor the examples[47] 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[48] and the FFY 2009 IPPS Final Rule[49] 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 lessor 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 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 Rolling Plains' 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 that the Medicare Contractor calculated Rolling Plains' FY 2012 VDA based on an otherwise *new* methodology that the Administrator apparently adopted through adjudication in her decisions, which is best described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[50] 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.[51]

The intent of 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 costs:

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[47] PRM 15-1 § 2810.1(C)-(D).
[48] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[49] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[50] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2007-D16 at 8 (Sept. 4, 2007).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2007-D15 at 8 (Sept. 4, 2007); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm'r Dec. 2017-D1 at 12 (Dec. 15, 2016).
[51] 82 Fed. Reg. at 38179-38183.

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

In the Final Rule published on 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."[52] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments.—. . . .
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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*

[52] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> *entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
>
> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[53]

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."[54]

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."[55] Under 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 rationale necessarily 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) makes it clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines the 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

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[53] (Emphasis added.)
[54] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[55] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

determining the payment amount.[56] 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 hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year as well as its full fixed costs in that year.

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG 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)(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, the Administrator's methodology 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.[57] 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.

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 Rolling Plains' fixed costs (which includes semi-fixed costs) were 87.81 percent[58] of Rolling Plains' Medicare costs for FY 2012. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

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[56] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) (2011) 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.
[57] 48 Fed. Reg. at 39782.
[58] Exhibit C-2 at 6.

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$4,580,136[59]
Multiplied by the 2012 IPPS update factor	1.019[60]
2011 Updated Costs (max allowed)	$4,667,159
2012 Medicare Inpatient Operating Costs	$4,410,266[61]
Lower of 2011 Updated Costs or 2012 Costs	$4,410,266
Less 2012 IPPS payment	$3,193,884[62]
2012 Payment CAP	$1,216,382

Step 2: Calculation of VDA

2012 Medicare Inpatient Fixed Operating Costs	$3,872,655[63]
Less Excess Staffing	293,243[64]
2012 Medicare Inpatient Fixed Operating Costs less Excess Staff	$3,579,412
Less 2012 IPPS payment – fixed portion (87.81[65] percent)	$2,804,550[66]
Payment adjustment amount (subject to CAP)	**$ 774,862**

Since the payment adjustment amount of $774,862 is less than the CAP of $1,216,382, the Board determines that Rolling Plains' total VDA payment for FY 2012 should be $774,862. However, Rolling Plains already received a VDA payment in the amount of $421,274 for FY 2012. Accordingly, Rolling Plains should be paid an additional VDA payment of $353,588.[67]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Rolling Plains' VDA payment for FY 2012, and that Rolling Plains should receive an additional VDA payment in the amount of $353,588 resulting in a total VDA payment of $774,862 for FY 2012.

[59] *Id*. at 3.
[60] *Id*.
[61] *Id*.
[62] *Id*.
[63] The $3,872,655 is calculated by multiplying Medicare Operating costs of $4,410,266 by 87.81 percent (the fixed cost percentage determined by the Medicare Contractor).
[64] *See* Exhibit C-2. Excess staffing is computed by subtracting current operating costs of $4,410,266 from current operating costs after the removal of core staffing adjustment of $4,117,023.
[65] Stipulations, Addendum A at ¶ 1.
[66] The $2,804,550 is calculated by multiplying $3,193,884 (the FY 2012 SCH payments) by 0.8781 (the fixed cost percentage determined by the Medicare Contractor).
[67] The $353,588 is calculated by subtracting the VDA payment already received by Rolling Plains ($421,274) from the total VDA amount due ($774,862),

Board Members Participating:

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

For the Board:

6/10/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A