CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
	Reimbursement Determination **For Period Ending:**
	December 31, 2005
Fairbanks Memorial Hospital	**Review of:** **PRRB Dec. No. 2015-D11**
The Provider	
	Dated: June 09, 2015

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board's (the "Board") decision. The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from CMS' Division of Acute Care (DAC) requesting reversal of the Board's decision. Comments were also received from the Provider requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Medicare Administrative Contractor's (MAC or Medicare Contractor) calculation of the Provider's volume decrease adjustment (VDA) amount was determined correctly.

The Board found that the Medicare Contractor properly excluded variable costs from the calculation of the Provider's Sole Community Hospital (SCH) volume decrease adjustment (VDA) amount. However, the Board also found that the Medicare Contractor's calculation of that payment adjustment amount was incorrect, as it did not conform to the instructions laid out in the Provider Reimbursement Manual (PRM). The Board found that the Provider is subject to the "not to exceed" limitation imposed by the controlling regulation found at 42 C.F.R. § 412.92(e)(3). Consistent with the application of PRM 15-1 § 2180.1 and that limitation to this case, the Board concluded that the Provider should receive a low volume adjustment for FY 2005 in the amount of $4,956,713.

SUMMARY OF COMMENTS

CMS submitted comments to the Board's decision and requested that the Administrator reverse the Board's decision in this case, stating that CMS agrees with the Board that the MAC properly identified and eliminated variable costs. However, CMS disagreed with the Board regarding its finding that the MAC improperly calculated the VDA payment for the Provider.

CMS stated that the MAC properly calculated that the payment amount for the VDA is $2,316,727 subject to the ceiling of $4,956,713, which results in a VDA payment of $2,316,727. According to CMS, the VDA methodology presented by the Board in this case is inconsistent with the methodology affirmed by the Board in *Greenwood County Hospital, PRRB Decision 2006-D43* because the methodology introduces a completely new factor into the calculation: a fixed cost percentage applied as a proxy to the total Diagnosis Related Group (DRG) revenue. CMS stated that, even if the statute could be interpreted as permitting this alternative methodology, it is not a methodology that CMS has adopted.

The Provider submitted comments requesting that the Administrator affirm the Board's decision that the Provider is due a payment of $4,956,713. The Provider states that this conclusion is consistent with the intent of the Medicare regulation implementing the VDA. According to the Provider, both the regulations and the PRM are clear that the payment is to compensate the Provider for its fixed costs. The Board in its decision recognized that DRG payments included *partial* compensation for fixed costs. To subtract total DRG revenue from the Provider's fixed cost would not compensate providers for their fixed costs. Therefore, the Board has recognized that this approach would take DRG revenue intended to compensate for variable costs and apply it to fixed costs.

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. All comments were received timely and are included in the record and have been considered.

Part A of the Medicare program covers "inpatient hospital services." As part of the Social Security Amendments of 1983, Congress changed Medicare reimbursement by establishing the prospective payment system for inpatient hospital services (IPPS). Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. The

Social Security Act contains statutory provisions addressing IPPS and contains a number of provisions that adjust payment based on hospital-specific factors.

Under the Act, the Secretary adjusts payments to certain hospitals that qualify to participate in the Medicare program as SCHs. Under the implementing regulations at 42 C.F.R. § 412.92(e) that reflect the statutory requirements, the Secretary adjusts the payment to SCHs that incur a decrease in patient discharges of more than five percent from one cost reporting year to the next, due to circumstances beyond their control, and 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.

Once an SCH demonstrates that it has suffered a qualifying decrease in total inpatient discharges, the MAC must determine the appropriate adjustment, if any, due to the provider. In this regard, 42 C.F.R. § 412.92(e)(3) specifies the following regarding the determination of the VDA amount:

> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs....
>
> (i) In determining the adjustment amount, the intermediary considers-
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> (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;
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> (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
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> (C) The length of time the hospital has experienced a decrease in utilization.

The regulation at 42 C.F.R. § 412.92(e)(3) limits the VDA 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. CMS issued guidelines in the Provider Reimbursement Manual, CMS Pub. No. 15-1 (PRM 15-1), to assist MACs in the calculation of the VDA amount for an SCH. PRM 15-1 § 2810.1(B) states the following regarding 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 costs for items and services that vary directly with utilization such as food and laundry costs.

Although the PRM 15-1 §§ 2810.l(C) and (D) provides several examples of how to calculate the low volume adjustment, the parties to this case dispute the appropriate application of these examples and differ as to how to properly classify costs and calculate the low volume adjustment amount under the existing statute and regulations.

The Provider in this case, located in Fairbanks, Alaska, is qualified to participate in the Medicare program as an SCH. From fiscal year (FY) 2004 to FY 2005, the Provider suffered a 5.44 percent decline in inpatient discharges. On May 23, 2007, the Medicare Contractor issued an NPR for the Provider's FY 2005. On October 15, 2007, the Provider submitted a request to the Medicare Contractor for a low volume adjustment of $5,948,114.14.

Upon receipt of the Provider's request, the Medicare Contractor identified the following categories of costs as "variable" costs because they either vary directly with utilization or are within the Provider's control:

1. Medical Supplies;
2. Pharmaceuticals;
3. Cost of Goods Sold ("COGS");
4. Food;
5. Dietary Formula;
6. Linen and Bedding;
7. Other Non-Med Supplies;
8. Patient Surveys;
9. Hazardous Material Disposal;
10. Collection Agency Fees;
11. Freight;
12. Advertising;
13. Community Relations; and
14. Charitable Contributions.

These variable costs were subtracted from the Provider's total costs to determine the Provider's total fixed and semi-fixed costs for FYs 2004 and 2005. Through the application of a factoring process, the Medicare Contractor determined that the Provider's Medicare fixed and semi-fixed

costs were $15,728,470 for FY 2005 and $15,143,948 for FY 2004. Using this information, the Medicare Contractor applied an excess salary adjustment of $563,904 and calculated $2,316,727 as the Provider's FY 2005 low volume adjustment payment.

The Administrator finds that the calculation of the Medicare Contractor resulting in an excess salary adjustment of $563,904 and a low volume adjustment of $2,316,727 for FY 2005 was correct. The plain language of the relevant statute and regulation, §1886(d)(5)(G)(iii) and 42 C.F.R § 412.108(d), make it clear that the VDA is intended to compensate qualifying hospitals for their fixed costs, not for their variable costs. Therefore, pursuant to the statute, regulation and CMS guidance from the Federal Register and PRM, variable costs are to be excluded from the VDA calculation. This is consistent with the statute, CMS regulations and the Board's previous decision regarding VDAs in the case of *Greenwood County Hospital*, PRRB Decision No. 2006-D43 *("Greenwood").*

The Board was incorrect in its finding that the MAC improperly calculated the VDA payment. This portion of the Board's decision contradicts its own prior decision in *Greenwood* and the VDA calculation methodology introduced by the Board in the case at bar, is not supported by the controlling regulations, policies and precedents.

In this case, the Board introduced a methodology whereby the VDA payment is calculated by applying a ratio of the Provider's fixed/semi-fixed costs to its total costs and its DRG payment to arrive at a "fixed DRG payment." The Board acknowledged that it did not have IPPS actuarial data to determine the IPPS split between the Provider's fixed/semi-fixed and variable costs and therefore it opted to use the ratio of fixed/semi-fixed to total costs as reported on the cost report as a proxy. The Board laid out the calculation as follows:

Step 1: Calculation of the Cap (adjusted for fixed/variable split)

a)	2004 Medicare Inpatient Operating Costs- Fixed	$15,143,948
	Multiplied by the prorated 2005 IPPS update factor	1.034008
	2004 Updated Costs – Fixed (Max Allowed)	$15,658,963
	2005 Medicare Inpatient Operating Costs- Fixed	$15,728,470
b)	Provider's fixed/variable cost percentage	83.3%
	Multiplied by 2005 total DRG revenue	$12.847.839
	2005 DRG payment -fixed portion	$10,702,250
c)	Lower of Fixed Costs from 2004 Updated or 2005	$15,658,963
	Less 2005 DRG payment - fixed portion	$10.702.250
	2005 Cap - Fixed costs	$4,956,713

Step 2: Calculation of Volume Decrease Payment Amount

a)	2005 Medicare Inpatient Operating Costs - Fixed	$15,728,470
	Less Fixed 2005 IPPS Payments (83.3% of IPPS Payments)	$10.702.250
	Payment Adjustment Amount (Subject to the 2005 Cap)	$5,026,220

The Board incorrectly compared the $4,956,713 cap to the adjustment amount of $5,026,220 to determine the Provider's VDA amount. Since the adjustment amount is above the cap, the Board incorrectly found that the VDA amount is limited to the cap amount of $4,956,713.

The Board's calculation deviates from CMS regulations and precedent on the VDA calculation for the following reasons:

1. The Board's calculation of the cap or ceiling for the VDA payment uses the Provider's fixed costs as opposed to the total costs (*see,* 42 C.P.R.§ 412.92(e)(3) and PRM 15-1 § 2810.1).

2. The Board's methodology in its calculation of the VDA payment introduces the use of a fixed cost percentage that is not supported by any prior CMS guidance on VDAs.

3. In contradiction to the statue and applicable regulations and guidance, the Board's calculation of the Provider's fixed costs do not account for excess staffing (calculated as $563,904 by the MAC) and therefore the fixed costs used by the Board in its calculation are overstated.

In contrast, the MAC's methodology is consistent with the statute, CMS regulations, and the Board's decision in *Greenwood.* The MAC's methodology is as follows:

Step 1: Calculation of the Cap

a)	2004 Medicare Inpatient Operating Costs	$18,177,760
	Multiplied by the 2006 IPPS update factor	1.037
	2004 Updated Costs - Fixed (Max Allowed)	$18,850,337
	2005 Medicare Inpatient Operating Costs - Fixed	$ 18,883,261
	Multiplied by the 2006 IPPS update factor	1.037

	2005 Updated Costs - Fixed (Max Allowed)	$19,581,941
b)	Lower of Fixed Costs from 2004 Updated or 2005 Updated	$18,850,337
	Less 2005 DRG payment	$12,847.839
	2005 Ceiling/Cap	$6,002,498

Step 2: Calculation of Volume Decrease Payment Amount

a)	2005 Medicare Inpatient Operating Costs - Fixed	$15,728,470
	Less excess staffing $563,904	
	Less 2005 DRG Revenue	$12,847,839
	Payment Adjustment Amount (Subject to the 2005 Cap)	$2,316,727

The MAC properly calculated that the payment amount for the VDA as $2,316,727 subject to the ceiling of $4,956,713, which results in a VDA payment of $2,316,727. The Board improperly concluded that the MAC incorrectly calculated the VDA Provider's payment. As noted above, the Board's calculation is not supported by the controlling regulations, policies and precedents as well as its own decision in *Greenwood*[1] and the purpose of the VDA payment.

The plain language of the relevant statute and regulation, support that the VDA is intended to compensate qualifying hospitals for their fixed costs, not their variable costs. Therefore, the Board properly agreed with the MAC that variable costs were to be excluded from its calculation. This is consistent with the statute, CMS regulations and the Board's previous decision regarding VDAs in the case of Greenwood County Hospital, PPRB Decision No. 2006-D43 ("Greenwood"). However the Board went a step further and derived a new method of calculating the adjustment.

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[1]The Board's decision is in direct conflict with its prior PRRB decision addressing the VDA calculation methodology in *Greenwood County Hospital,* PRRB Decision 2006-D43. Since 2006, this decision has been used extensively by MACs and CMS to support the VDA calculation methodology. In *Greenwood*, the Board affirmed the MAC's calculation which reduced the provider's total costs by removing variable costs. The MAC then subtracted the total DRG payment from the fixed and semi-fixed costs to calculate the adjustment.

The VDA methodology presented by the Board in this case is inconsistent with the methodology affirmed by the Board in *Greenwood* because the methodology introduces a completely new factor into the calculation, namely, a fixed cost percentage applied as a proxy to the total DRG revenue. Even if the statute could be interpreted as permitting this alternative methodology, it is not a methodology that CMS has adopted.

The Board arrived at a lower 2005 Cap than the MAC based in part on using the Provider's fixed costs as opposed to the total costs required under 42 CFR 41.92(e)(3) and PRM 15-1 section 2810.1. However, while the MAC and the Board both arrived at the same 2005 Medicare Inpatient operating costs—Fixed- of $15,728,470, the Board did not eliminate the $563.904 in excess staffing. 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.

The SCH VDA payments are intended to compensate SCHs that incur losses or reductions that are recognized under the statute and regulations for their fixed costs due to a decrease in patient discharges of more than five percent from one cost reporting year to the next, due to circumstances beyond their control. 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 by comparing the provider's actual costs exclusive of variable costs to the actual amounts paid to the provider under the IPPS/DRG methodology. The appropriate VDA calculations are critical in order to adequately "cure" providers for their losses for fixed costs while at the same time preventing providers from receiving more than the required amount of compensation for those variable costs over which a prudent and cost conscious provider has control and which are related to inpatient utilization.

The Administrator finds that adjustments to SCH payments are intended to compensate or "make whole" SCHs that incur losses or reductions that are recognized under the statute and regulations, i.e., from a decrease in patient discharges of more than five percent from one cost reporting year to the next, due to circumstances beyond their control, and 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. The SCH adjustments are not intended to be used as a payment or compensation mechanism that allow providers to receive a "net profit" from the Medicare program when circumstances exist that allow providers to receive SCH payment adjustments. Under these circumstances, the appropriate VDA calculations are critical in order to adequately "cure" providers for their losses while at the same time preventing special payment formulas such as the VDA to inadvertently allow providers to receive more than the required amount of compensation.

Accordingly, the Administrator modifies the Board's decision allowing the Provider to receive the VDA amount of $4,956,713. The Administrator finds that the MAC properly calculated the

payment amount for the VDA using the guidelines and requirements under the existing statute, regulations, policy instructions and prior decisions. As such, the proper payment amount for the VDA, as calculated by the MAC, is $2,316,727 subject to the ceiling of $4,956,713, which appropriately results in a final VDA payment to the Provider in the amount of $2,316,727. Accordingly, the aspect of the Board's decision is reversed with respect to VDA adjustment calculation and the MAC's calculation of the VDA payment was appropriate.

DECISION

The decision of the Board regarding the Medicare Administrative Contractor's calculation of the Provider's VDA payment is modified in accordance with the foregoing opinion.

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

Date: 8/5/15

/s/
Patrick Conway, M.D.
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services