CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
St. Anthony Regional Hospital	**Reimbursement Determination for Period Ending:**
	June 30, 2009
Provider	
vs.	
Wisconsin Physicians Service	**Review of: PRRB Dec. No. 2016-D16**
Medicare Contractor	**Dated: August 29, 2016**

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.)). The Center for Medicare (CM) submitted comments, requesting that the Administrator reverse the Board's decision. The Medicare Administrative Contractor (MAC)[1] submitted comments, requesting that the Board's decision be partially reversed. The Provider submitted comments, noting that the Board's decision was consistent with the laws and regulations, and requesting that the Administrator affirm the decision of the Board. Accordingly, this case is now before the Administrator for final agency review.

[1] Formerly known as Fiscal Intermediaries (FIs), CMS's payment and audit functions under the Medicare program are now contracted to organizations known as Medicare Administrative Contractors (MACs). However, the term "intermediary" is still used in various statutes and regulations, and is interchangeable with the terms "Medicare Administrative Contractor" or "Medicare Contractor".

ISSUE AND BOARD DECISION

The issue was whether the Medicare Administrative Contractor (MAC), correctly determined the amount of the Sole Community Hospital (SCH) volume decrease adjustment (VDA) in accordance with the regulations and Program instructions per 42 C.F.R. § 412.92(e)(3), and the Provider Reimbursement Manual (PRM), CMS Pub. 15-1 at § 28101.1.

The Board held that the MAC correctly identified and eliminated variable costs from the VDA calculation for the Provider for fiscal year (FY) 2009. The Board noted that the dispute in this case involved the proper classification of costs as fixed, semi-fixed, and variable, and the related issue of the proper method for calculation of the VDA. The Board stated that fixed costs are generally considered costs over which management has no short term control, such as rent, interest, depreciation and capital costs. Variable costs are those costs for items and services that vary directly with utilization, such as food and laundry costs. The Board noted that the PRM 15-1 §§ 2810.1(C) and (D) provide several examples of how to calculate the low volume adjustment. In this case, the Provider disputed the MAC's determination of six categories of costs as variable costs: (1) purchased laundry services; (2) dietary cost of food; (3) central distribution supplies, (4) drugs and IVs; (5) operating room supplies, and (6) implantable devices. While the Provider argued that these costs were essential to maintain its ongoing operations and to provide quality care to its patients, and thus should be considered "semi-fixed", the Board found that the MAC properly classified these costs as variable costs.

The Board stated that notwithstanding the categorization of certain variable costs, the Provider had complained of three errors in the MAC's calculation of the VDA. First, the MAC offset the entire $369,285 cafeteria revenue amount against the fixed costs, without accounting for the fact that cafeteria costs include both a fixed and a variable component. Thus, a portion of the cafeteria revenue should be allocated as a revenue offset against associated variable cafeteria costs (such as food costs), thereby reducing the net variable costs used to compute the variable costs ratio in the MAC's computation of the FDA. The Provider computed the portion of the revenue offset applicable to variable costs to be $111,730.

Similarly, the MAC offset $256,223 of the pharmacy revenue against fixed costs. The Provider received this revenue from employees who chose to fill their outpatient prescriptions at its pharmacy. As employee prescription prices are established based on the direct cost of drugs, they should be considered a recovery of only the purchase cost of the drugs themselves. Thus, the Provider contended that the pharmacy revenue offset should be applied in full to the variable costs,

rather than against fixed costs. The net variable costs after applying the cafeteria and pharmacy revenue offsets total $7,157,729, or 18.48 percent of the total net operating costs.

Finally, the Board stated, the Provider had argued that the MAC incorrectly utilized the as-filed "Total Program Costs Excluding Capital" amount of $8,333,902 instead of the final settled cost report amount when it determined the variable costs to be excluded in the calculation of the VDA. Using the "Total Program Costs Excluding Capital" amount from the final cost report ($8,348,116) and the adjusted variable cost percentage of 18.48 percent results in Medicare program costs net of variable costs of $6,714,309, a difference of $90,775.

The Board found that the MAC improperly calculated the Provider's VDA for FY 2009, thereby erroneously concluding that no adjustment was due to the Provider. The Board noted that in March 1990, CMS issued instructions in Transmittal 356 to Medicare contractors regarding the calculation of the low volume adjustment amount. Additional payment is made to eligible SCHs for the fixed costs incurred 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". The Board pointed out that this was consistent with the statute, which requires that the low volume payment adjustment "fully compensate" for fixed costs incurred in providing inpatient services.

The Board found that neither the MAC nor the Provider's proposed calculation of the low volume adjustment met the requirements of the controlling statute, regulation and interpretive guidance. The Board noted that the MAC's calculation did not take into account that the IPPS/DRG payment is intended to compensate a hospital for both fixed and variable costs, while the Provider's calculation did not recognize any of its costs as variable. Recognizing that it did not have the IPPS actuarial data to determine the IPPS split between the fixed and variable costs, the Board opted to use the MAC's fixed/variable cost percentage split as a proxy. The MAC determined that fixed costs (including semi-fixed costs) were 81.52 percent of its Medicare inpatient operating costs.[2] The Board found that the payment amount should be calculated as follows:

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[2] *See* MAC's Letter to the Board dated July 13, 2015, Appendix I. In this letter, the MAC revised the calculation using the original methodology and correcting the errors noted by the Provider, and determined that the variable costs were 18.4836 percent of total costs. The MAC had previously noted in its "Final Position Paper" that it did not dispute the three errors pointed out by the Provider, but did contest the amount of the error's impact. The MAC also proposed an alternative method to calculate the VDA in its final position paper.

2008 Medicare Inpatient Operating Costs—Fixed	$6,692,689[3]
Multiplied by the 2009 IPPS update factor	1.036[4]
2008 Updated Costs—Fixed (Max Allowed)	$6,933,625
2009 Medicare Inpatient Operating Costs—Fixed	$6,805,084[5]
Lower of Fixed Costs from 2008 Updated or 2009	$6,805,084
Less 2009 DRG payment—fixed portion	$5,114,261[6]
Payment Adjustment Amount	$1,690,823

The Board found that, as the Provider's FY 2009 Medicare fixed/semi-fixed inpatient operating costs were less than that of FY 2008 updated by the 2009 IPPS update factor, the VDA amount is the entire difference between the incurred FY 2009 Medicare fixed/semi-fixed inpatient operating costs and the revenue generated by the fixed/semi-fixed portion of the FY 2009 IPPS payments. Thus, the Board held that the Provider should have received a VDA for FY 2009 in the amount of $1,690,823.[7]

SUMMARY OF COMMENTS

CM submitted comments stating that, while it agreed with the Board that the MAC properly identified and eliminated variable costs, it disagreed with the Board regarding its finding that the MAC improperly calculated the VDA payment for the Provider. As such, CM recommended that the Administrator reverse the Board's decision and uphold the MAC's determination in regard to the VDA payment calculation. CM stated that the Board properly concluded that, pursuant to the statute, regulation, and CMS guidance from the *Federal Register* and PRM, variable costs are to be excluded from the VDA calculation. CM pointed out that the Provider noted three errors in the MAC's calculation of the VDA. First, the

[3] The Board noted that it calculated this figure by multiplying the FY 2008 Program Operating Costs of $8,210,236 by the fixed/semi-fixed cost percentage of 81.52. The Board cited Provider Exhibit P-11, the Provider's FY 2009 workpaper showing the FY 2008 Program Operating Cost of $8,210,236.

[4] The Board cited Provider Exhibit P-11

[5] The Board cited Provider Exhibit P-12.

[6] The Board calculated this figure by multiplying the total IPPS payments of $6,273,905 for FY 2009 by the fixed/semi-fixed cost percentage of 81.52, and cited to the Medicare Contractor's Post-Hearing Brief at Appendix I (showing total IPPS payments for FY 2009); and Provider Exhibit P-12 (showing total IPPS payments for FY 2009).

[7] As the Provider had already received a VDA of $440,400, the Board ordered the MAC to pay an additional payment of $1,250,423 to the Provider.

MAC improperly categorized the entire cafeteria expense amount as a variable cost without considering the adjustment made on the cost report to offset revenue received from meals sold to non-patients. Second, the Provider noted that the MAC improperly categorized the entire pharmacy expense amount as a variable cost without considering the adjustment made on the cost report to offset revenue received from pharmacy sales to hospital employees. CM noted that the MAC agreed that it did not take these cost report adjustments into account when computing the VDA, and that the cafeteria and pharmacy adjustment would result in $7,157,729 in variable costs as opposed to the $7,525,682 in variable costs identified in the MAC's original calculation. Third, CM stated, the Provider noted that the MAC used the as-filed "Total Program Costs Excluding Capital" amount of $8,333,902 as opposed to the final settled "Total Program Costs Excluding Capital" amount of $8,348,116. CM pointed out that the MAC agreed that the "Total Program Costs Excluding Capital" amount should have reflected the final settled amount and not the as-filed amount. CM stated that it agreed with the Provider on these three errors.

However, CM argued that in its finding that the Board improperly calculated the VDA payment, using a fixed cost percentage in its calculation which is not supported by any prior CMS guidance. CM noted that the VDA methodology present by the Board in this case is inconsistent with the methodology affirmed by the Board in *Greenwood*, as it introduces a new factor into the calculation: a fixed cost percentage applied as a proxy to the total DRG payment. CM noted that even if the statute could be interpreted as permitting this alternative methodology, it is not a methodology that CMS has adopted.

CM stated that the correct methodology is as follows:

2008 Medicare Inpatient Operating Costs—Fixed	$6,692,689
Multiplied by the 2009 IPPS update factor	1.036
2008 Updated Costs—Fixed (Max Allowed)	$6,933,625
2009 Medicare Inpatient Operating Costs—Fixed	$6,805,082[8]
Lower of Fixed Costs from 2008 Updated or 2009	$6,805,082
Less 2009 DRG payment	$6,273,905[9]
Payment Adjustment Amount	$531,177

[8] CM noted that this amount differed from the Board's amount of $6,805,084 due to rounding differences.

[9] CM used the total 2009 DRG payment, whereas the Board calculated its figure by multiplying the total DRG payment of $6,273,905 for FY 2009 by the fixed/semi-fixed cost percentage of 81.52.

The MAC submitted comments stating that it disagreed with the Board's finding that it had improperly calculated the VDA payment for the Provider. The MAC noted that for guidance in calculating the VDA and the ceiling, it had relied on the Administrator's decision in *Unity Healthcare*, PRRB Dec. No. 2014-D15. Following the methodology in *Unity*, the VDA and ceiling were calculated as follows:

Calculation of the VDA

Provider's total operating costs	$8,348,116[10]
Net variable costs	$1,543,034[11]
Provider's fixed costs	$6,805,082
Provider's DRG payments	$6,273,905[12]
VDA Payment Amount	$531,177

Calculation of Ceiling

Provider's total operating costs	$8,348,116
Provider's DRG payments	$6,273,905
Ceiling	$2,074,211

Thus, the MAC noted that following the computation method in the Administrator's decision in *Unity*, the VDA payment amount for the Provider should be $531,177, not subject to the ceiling. As it had already paid the Provider $440,400, the net amount due to the Provider should be $90,777.

The Provider submitted comments, arguing that the Board's decision was consistent with the pertinent laws, regulations, and other criteria cited by the Board and the parties as part of the proceeding, and requesting that the Administrator affirm the Board's decision. The Provider noted that all of the parties were in agreement that it was owed an additional $90,773, and that there is no basis in the record for the Administrator to overturn this increase. The Provider argued that the Board's decision regarding the classification of certain categories of costs as variable costs was contrary to its position, and reserved its appeal rights with

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[10] Utilizing the "Total Program Inpatient Operating Cost Excluding Capital Related, Nonphysician Anesthetist, and Medical Education Costs" amount from the final cost report. *See* Provider's Exhibit P-7, "Computation of Inpatient Operating Cost" Line 53.

[11] The net variable costs are 18.4836 percent of the total net operating costs. *See* fn. 2 regarding the MAC's calculation and determination that the variable costs were 18.4836 percent of the total costs.

[12] *See* Provider's Exhibit P-12.

regards to this issue. However, the Provider noted that it recognized that the Board's decision was consistent with the manner in which the relevant federal regulations, Medicare manual guidance, and Administrator review of prior cases have calculated the VDA.

The Provider stated that the Board applied the methodology favored by the MAC and the Administrator in a manner that best accomplishes the VDA's statutory purpose of "fully" compensating a hospital for the fixed costs incurred in the period in providing inpatient hospital services. The Provider noted that if the VDA ceiling is calculated by subtracting from a hospital's fixed costs both the hospital's total DRG fixed cost payment and the total DRG variable cost payment, then the adjustment is not isolating a comparison of the hospital's fixed costs and total fixed DRG payment. Thus, the Provider argued, the calculation would fail to compensate the hospital fully for the fixed costs incurred in providing inpatient services in circumstances when a VDA is merited, as the statute mandates.

The Provider noted that while the Board did not adopt the calculations requested, its methodology is the most sensible way to adhere to the Administrator's prior decisions in this area, while achieving the purpose of the VDA set out in the relevant statute, regulations, and CMS guidance. The Provider pointed out that while CM urged the Administrator to reverse the Board's decision as it was not a methodology that CMS has adopted, the Administrator's review involves determining whether the Board's decision "is in keeping with the pertinent laws, regulations, and other criteria" cited by the Board and the parties. Thus, the Provider argued, the fact that CMS may not have adopted a position previously is not itself grounds for overturning a Board decision if that decision is supported by the pertinent laws, regulations, and other criteria. The Provider stated that the Board's calculation of the VDA is supported by the relevant statute, regulations, CMS manual guidance, and prior Administrator decisions because it adopts the fundamental methodology favored by the MAC and prior Administrator decisions, while at the same time isolating a comparison of the Provider's fixed costs to the Provider's total fixed DRG payment, thereby fulfilling the statutory directive that the VDA fully compensate the Provider for its fixed costs incurred in the relevant period.

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

In this case, the Provider, is a 59-bed acute care hospital located in rural Iowa. The Provider participates in the Medicare program as a Sole Community Hospitals (SCH). 42 U.S.C. § 1395ww(d)(5)(D)(iii) defines a SCH as any hospital:

> (I) that the Secretary determines is located more than 35 road miles from another hospital,
> (II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A of this subchapter, or
> (III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i–4(i)(1) of this title as in effect on September 30, 1997.

On April 2, 2010, the Provider submitted an initial request to the MAC for an additional payment in the form of a low volume adjustment of $1,954,257 due to a decrease in patient discharges of more than 5 percent for FY 2009. On December 7, 2010, the MAC denied this request, stating that the circumstances cited for the decrease did not qualify as being an unusual situation or occurrence externally imposed and beyond the Provider's control, as required by the statute and the regulation. On April 28, 2011, the MAC reconsidered and reversed in part its initial denial determination, and granted a portion of the requested low volume decrease adjustment, in the amount of $440,400.

Section 1886(d)(5)(D)(ii) of the Act authorizes the Secretary of DHHS to adjust the payment of SCHs 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 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, …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 core staff and services.

The regulations implementing this statutory adjustment are located at 42 C.F.R. § 412.92(e). In particular, subsection (e)(1) specifies the following regarding low volume adjustment:

> The intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances [beyond the hospital's control] a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period.

Once an SCH demonstrates that it has suffered a qualifying decrease in total inpatient discharges, the MAC must determine the appropriate amount, if any, due to the provider as an adjustment. The regulation at 42 C.F.R. § 412.92(e)(3) specifies the following regarding the determination of low volume adjustment 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 –
> (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.

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

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[13] *See* CMS Pub. 15-1, Foreword.

> 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. (Emphasis added.)

In the discussion included in the preamble to the August 18, 2006 final rule[14], it was noted:

> The process for determining the amount of the volume decrease adjustment can be found in section 2810.1 of the Provider Reimbursement Manual. Fiscal intermediaries are responsible for establishing whether an SCH or MDH is eligible for a volume decrease adjustment and, if so, the amount of the adjustment. To qualify for this adjustment, the SCH or MDH must demonstrate that: (a) A 5 percent or more decrease of total discharges has occurred; and

[14] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).

> (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal intermediary has established that the SCH or MDH satisfies these two requirements, it will calculate the adjustment. **The adjustment amount is determined by subtracting the second year's DRG payment from the lesser 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 or MDH receives the difference in a lump-sum payment. (Emphasis added.)

The core dispute in this case centers on the application of the statute 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 2009. The MAC's exclusion of the Provider's purchased laundry services, dietary cost of food, central distribution supplies, drugs and IVs, operating rooms supplies, and implantable devices as variable was proper and consistent with the regulation, guidance and intent of the adjustment.

The treatment of variable cost within the calculation of the VDA is well established. 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 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 that takes into account the fact that the IPPS payments include reimbursement for both fixed and variable costs. The Board noted that it did not have IPPS actuarial data to determine the IPPS split between the fixed and variable

costs, but instead, opted to use the MACs fixed/variable cost percentage split (81.52 percent[15]) as a proxy.

Board's Calculation of Payment Adjustment:

2008 Medicare Inpatient Operating Costs—Fixed	$6,692,689[16]
Multiplied by the 2009 IPPS update factor	1.036[17]
2008 Updated Costs—Fixed (Max Allowed)	$6,933,625
2009 Medicare Inpatient Operating Costs—Fixed	$6,805,084[18]
Lower of Fixed Costs from 2008 Updated or 2009	$6,805,084
Less 2009 DRG payment—fixed portion	$5,114,261[19]
Payment Adjustment Amount	$1,690,823

[15] *See* MAC's Letter to Chairman Harty, dated July 13, 2015, Appendix I.

[16] FY 2008 Program Operating Costs of $8,210,236 multiplied by 81.52. The Board cited Provider's Exhibit P-11, the Provider's FY 2009 workpaper showing the FY 2008 Program Operating Cost of $8,210,236.

[17] The Board cited Provider's Exhibit P-11

[18] The Board cited Provider's Exhibit P-12.

[19] The Board noted that it calculated this figure by multiplying the total IPPS payments of $6,273,905 for FY 2009 by the fixed/semi-fixed cost percentage of 81.52, and cited to the Medicare Contractor's Post-Hearing Brief at Appendix I (showing total IPPS payments for FY 2009); and Provider Exhibit P-12 (showing total IPPS payments for FY 2009). Effectively, the Board used the ratio of fixed/semi-fixed to total costs that the MAC found as a proxy for the share of the Provider's IPPS payment that it assumed were attributable to fixed costs. As the MAC had determined that 81.52 percent of the Provider's costs were fixed and semi-fixed costs, the Board assumed that 81.52 percent of the Provider's DRG payments were for fixed costs. The Board's creation of a "fixed portion" of the DRG payment is unsupported by the statute, regulations, manual, and prior case law. Moreover, the statute states that the Secretary is to provide for such an adjustment to the payment amount "as may be necessary to fully compensate the hospital for the fixed costs it incurred." CMS has reasonably concluded that when a SCH experiences a five percent decrease in patient volume due to circumstances beyond its control the total Medicare payments to the SCH which would be made up of the volume adjustment payment and the subsection (d) IPPS payments (e.g., DRG revenue received) which the SCH has received, must be at least equal to the SCH "fixed costs". This is achieved by subtracting the DRG revenue from the fixed costs, thereby assuring "full compensation" for the fixed costs. The Board method assumes that variable costs are also compensated.

The Board's calculation incorrectly concludes that the payment amount for the VDA is $1,690,823. The Administrator finds that the correct payment adjustment, which follows the controlling statute, regulations and is also reflected in *Greenwood* and *Unity*, cited *supra*, is as follows:

Calculation of the VDA	
Provider's total operating costs	$8,348,116[20]
Net variable costs	$1,543,034[21]
Provider's fixed costs	$6,805,082
Provider's DRG payments	$6,273,905[22]
VDA Payment Amount	$531,177

Calculation of Ceiling	
Provider's total operating costs	$8,348,116
Provider's DRG payments	$6,273,905
Ceiling	$2,074,211

Thus, 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 $531,177, subject to the ceiling of $2,074,211. As the MAC has already paid the Provider $440,400, the net amount due to the Provider should be $90,777.

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 2009 for purposes of the determination on the Provider's request for an SCH VDA, and affirms the Board on that portion of the decision. However, as discussed above, the Administrator finds that the Board's calculation of the VDA 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.

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[20] *See* fn. 10 above.
[21] *See* fn. 11 above.
[22] *See* fn. 12 above.

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: 10/03/2016

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