PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2016-D16

PROVIDER –
St. Anthony Regional Hospital

Provider No.: 16-0005

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

HEARING DATE –
May 7, 2015

Cost Reporting Period Ended –
June 30, 2009

CASE NO.: 12-0031

INDEX

ISSUE STATEMENT

Whether the Medicare Administrative Contractor (Medicare Contractor) correctly determined the amount of the Sole Community Hospital ("SCH") volume decrease adjustment in accordance with the regulations and Program instructions per 42 C.F.R. § 412.92(e)(3) and the Provider Reimbursement Manual, CMS Pub 15-1 ("PRM 15-1"), § 2810.1.[1]

DECISION

After considering the Medicare law and regulations, the evidence presented, and the parties' contentions, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor correctly identified and eliminated variable costs from the volume decrease adjustment calculation for St. Anthony Regional Hospital ("St. Anthony" or "Provider") for fiscal year ("FY") 2009. However, the Medicare Contractor improperly calculated St. Anthony's volume decrease adjustment for FY 2009 thereby erroneously concluding that no adjustment was due the Provider. St. Anthony's Medicare fixed/semi-fixed inpatient operating costs should be reduced by the fixed/semi-fixed portion of its payments under the inpatient prospective payment system ("IPPS"). Consistent with the application of PRM 15-1 § 2810.1, St. Anthony should receive a volume decrease adjustment for FY 2009 in the amount of $1,690,823. As the Medicare Contractor had previously paid St. Anthony a volume decrease adjustment of $440,400 in a Notice of Correction of Program Reimbursement dated May 18, 2011, St. Anthony is due an additional payment of $1,250,423.

INTRODUCTION

St. Anthony is a 59-bed acute care hospital located in Carroll, Iowa and participates in the Medicare program as a SCH[2]. The Medicare Contractor, Wisconsin Physicians Service, first denied, then partially granted, St. Anthony's request for a volume decrease adjustment for fiscal year 2009.

STATEMENT OF FACTS

On April 2, 2010, St. Anthony submitted an initial request to the Medicare Contractor 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% for FY 2009.[3] On December 7, 2010, the Medicare Contractor denied St. Anthony's request in its entirety while stating that the circumstances cited for the decrease did not qualify as being an unusual situation or occurrence externally imposed and beyond St. Anthony's control as required by the statute and the regulation.[4]

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[1] Transcript ("Tr") at 5-6.

[2] 42 U.S.C. § 1395ww(d)(5)(D)(iii) defines an SCH as a facility that: (1) is located more than 35 road miles from another hospital; (2) by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care, location, weather conditions, travel conditions, or absence of other like hospitals, is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A; or (3) is located in a rural area that has been designated as an essential access community hospital under 42 U.S.C. § 1395i-4(i)(1).

[3] *See* Provider Exhibit P-4.

[4] *See* Provider Exhibit P-8.

On April 28, 2011, the Medicare Contractor 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.[5] St. Anthony met the jurisdictional requirements for a hearing and timely appealed the Medicare Contractor's calculation of its SCH volume decrease adjustment citing 42 C.F.R. § 412.92(e).

The Board conducted a telephonic hearing on May 7, 2015. St. Anthony was represented by Ross D'Emanuele of Dorsey & Whitney LLP. The Medicare Contractor was represented by Arthur E. Peabody, Jr., Esq. of the Blue Cross and Blue Shield Association.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

A. CLASSIFICATION OF COSTS.

Federal statute requires the Secretary to adjust the payment to SCHs that incur a decrease of more than 5 percent in patient discharges due to circumstances beyond their control, and that the adjustment "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.[6]

Implementing regulations[7] require the Medicare contractors to consider 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; 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 the length of time the hospital has experienced a decrease in utilization. This regulation limits the low volume adjustment to its total inpatient operating cost (excluding pass-through costs and increased by the IPPS update factor) minus its DRG revenue.[8]

The heart of the parties' dispute involves the proper classification of costs as fixed, semi – fixed or variable and the related issue of the proper method for calculation of the volume decrease adjustment. CMS policy guidelines further require the Medicare contractors to distinguish fixed costs from variable costs. 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 generally considered those costs for items and services that vary directly with utilization such as food and laundry costs.[9] Notably, the PRM 15-1 §§ 2810.1(C) and (D) provide several examples of how to calculate the low volume adjustment.

St. Anthony disputes the Medicare Contractor's determination of the following six categories of costs as variable costs: (1) purchased laundry services; (2) dietary cost of food; (3) central distribution supplies; (4) drugs and IV's; (5) operating room supplies; and (6) implantable devices. Instead, St. Anthony maintains that during the period covered by the appeal, the costs

[5] *See*: Provider Exhibit P-10 and MAC Position Paper, Exhibit I-5.
[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[7] 42 C.F.R. § 412.92(e). *See:* Provider's Notice of Intent to Appeal and Final Position Paper, Exhibit P-5 at 5 of 6.
[8] *Id.*
[9] PRM 15-1 § 2810.1(B). *See:* Provider's Notice of Intent to Appeal and Final Position Paper, Exhibit P-6 at 7 of 18.

incurred to provide services to its patients were all fixed or semi-fixed costs as defined by Medicare program guidance. This guidance allows that many hospitals costs are neither perfectly fixed nor perfectly variable, but can be properly classified as semi-fixed, i.e., costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume.[10] For purposes of the volume decrease adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.[11]

St. Anthony contends that, while these six categories of costs may vary somewhat based on volume fluctuations, these costs are essential to maintain its ongoing operations and to provide quality care to its patients and, therefore, qualify as "semi-fixed" costs as defined by the Medicare program. The only costs that St. Anthony incurred for such supplies and services were directly related to the care of its actual patients. St. Anthony maintains that it made every effort to reduce its core staffing costs in all patient care areas while maintaining sufficient core staff personnel to provide its customary high standard of patient care. For example, St. Anthony successfully reduced one-time expenses by $247,000 and long-term expenses by $386,000 for a total reduction of $633,000.[12] Therefore, St. Anthony maintains that all remaining costs incurred should properly be considered either fixed or semi-fixed when computing the volume decrease adjustment because the non-reduced, residual incurred costs could not be eliminated notwithstanding any decrease in service volume.[13]

The Board finds that the Medicare Contractor properly classified the disputed costs as variable costs. The Board can find nothing in the federal statute, regulation or the manual guidance that supports St. Anthony's position that, once costs are experienced in an environment of reduced volume, they automatically become fixed or, alternatively semi-fixed, regardless of their nature or characteristics. While the controlling federal statute does allow the Secretary to adjust payment amount …"as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital service," it also recognizes that not all costs are *fixed*. The preambles to the final rules published on September 2, 1983 and April 20, 1990 highlight examples of variable costs and use the same food and laundry services at issue in this case as examples of "truly variable costs."[14]

Significantly, the PRM 15-1, § 2810.1 guidance, initially published in March 1990, reflects almost verbatim this distinction between variable costs and fixed or semi-fixed costs.[15] It is clear that CMS did not intend to construe any and all variable costs as fixed or semi-fixed for the purposes of the low volume adjustment. Certain items, food and laundry, for example, that St. Anthony argues should be considered semi-fixed are clearly identified as variable costs in Manual guidance.[16] The Board concludes that the six categories of cost cited by the Medicare Contractor would generally be expected to vary substantially with patient volume as they are tied directly or indirectly to patient services and that St. Anthony has not provided any evidence (*e.g.*, contracts) to demonstrate to the contrary.

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[10] *Id.*
[11] *Id.*
[12] Provider's Notice of Intent to Appeal and Final Position Paper, at 3.
[13] *Id.* at 4.
[14] 48 Fed. Reg. 3975, 39782 (Sept. 2, 1983); 55 Fed. Reg. 15150, 15156 (Apr. 20, 1990).
[15] PRM 15-1, Transmittal No. 356 (Mar. 1990) (issuing the criteria PRM 15-1 § 2810.1(B)).
[16] *Id.*

B. CALCULATION OF THE VOLUME DECREASE ADJUSTMENT.

Notwithstanding the categorization of certain variable costs, St. Anthony noted three errors in the Medicare Contractor's calculation of the volume decrease adjustment that pertain to the application of the categorization in terms of calculational methodology.[17] The first two errors relate to the manner in which the Medicare Contractor treated Cost Report Worksheet A-8 revenue offsets in its calculation, specifically the cafeteria and pharmacy revenue offsets. The Medicare Contractor offset the *entire* $369,285 cafeteria revenue amount against *fixed* costs without accounting for the fact that cafeteria costs, by their nature, include both a fixed and variable component. St. Anthony contends that the cafeteria revenue therefore, is a recovery of *both* the fixed and variable costs of preparing meals for its employees and guests in the cafeteria. As such, a portion of the cafeteria revenue should be allocated as a revenue offset against associated variable cafeteria costs (such as the food costs) thereby reducing the net variable costs used to compute the variable costs ratio in the Medicare Contractor's computation of the volume decrease adjustment. St. Anthony computed the portion of the revenue offset applicable to variable costs to be $111,730.[18]

Similar to the cafeteria revenue offset, the Medicare Contractor offset $256,223 of pharmacy revenue against fixed costs. St. Anthony explains that it receives this revenue from employees who choose to fill their outpatient prescriptions at its pharmacy. Employee prescription prices are established based on the direct cost of drugs and, therefore, should be considered a recovery of only the purchase cost of the drugs themselves. Since the Medicare Contractor identified the cost of drugs as a variable cost in its computation of the volume decrease adjustment, St. Anthony contends that consistency and fact pattern demand that the pharmacy revenue offset should be applied in full to the variable costs rather than against the 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.[19]

Finally, St. Anthony contends that the Medicare Contractor incorrectly utilized the *as-filed* "Total Program Costs Excluding Capital" amount of $8,333,903, instead of the *final settled cost report amount*, to determine the variable costs to be excluded in the calculation of the volume decrease adjustment. Utilizing the "Total Program Costs Excluding Capital" amount from the *final* cost report of $8,348,116 and the adjusted variable cost percentage of 18.48 percent noted above results in Medicare program costs net of variable costs of $6,805,084 compared to Medicare program costs net of variable costs of $6,714,309 as calculated by the Medicare Contractor based on the as-filed cost report, a difference of $90,775. Accordingly, St. Anthony concludes that, at a minimum, the volume decrease adjustment should be increased by $90,775 to correct for all three aforementioned calculation errors.[20]

Additionally, St. Anthony objects to the Medicare Contractor's revision of its low volume adjustment methodology to conform to the CMS Administrator's methodology in its review of

[17] Provider's Notice of Intent to Appeal and Final Position Paper at 4.
[18] *Id.*
[19] *Id.* at 5.
[20] *Id.*

Unity Healthcare v Blue Cross Blue Shield Ass'n[21] during this appeal and that, as a result of this change of methodology, St. Anthony's volume decrease adjustment is further decreased (rather than increased).[22] St. Anthony maintains that the Medicare Contractor should not be permitted to introduce a new methodology to calculate the volume decrease adjustment.[23]

The Board finds that the Medicare Contractor incorrectly calculated the low volume adjustment. In March 1990, CMS issued instructions to Medicare contractors regarding the calculation of the low volume adjustment amount:

> Additional payment is made to an eligible SCH 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, *not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue*.[24]

Thus, the formula determined the payment adjustment as "fixed costs . . . not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue" is consistent with the controlling statute which quite clearly requires that the low volume payment adjustment ". . . ***fully*** *compensate* the hospital *for fixed costs* it incurs in the period in providing inpatient hospital services, including the reasonable costs of maintaining necessary core staff and services."[25]

In the case at hand, the Board finds that neither party's proposed calculation of the low volume adjustment meets the requirements of the controlling federal statute, regulation and the interpretive guidance. Specifically, the Medicare Contractor's calculation[26] does not take into consideration that the IPPS/DRG payment is intended to compensate a hospital for both fixed and variable costs.[27] While the Provider's calculation, as discussed above, does not recognize any of its costs as variable.

The Board reasons that the volume decrease adjustment payment calculation should take into account the fact that the IPPS payments include reimbursement for both fixed and variable costs.[28] The Board recognizes that it does not have the IPPS actuarial data to determine the IPPS

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[21] *Unity Healthcare v Blue Cross Blue Shield Ass'n* Adm'r Dec. (Sept. 4, 2014), *reversing in part*, PRRB Dec. No. 2014-D15 (Jul. 10, 2014). *See:* Medicare Administrative Contractor's Notice of Supplemental Authority, Exhibit I-12.

[22] *See:* Medicare Administrative Contractor's Post Hearing Memorandum at 3 -4 (June 23, 2015); Response to Medicare Contractor Post Hearing Memorandum at 3 (July 9, 2015).

[23] *See* Response to Medicare Contractor Post Hearing Memorandum at 3 (July 9, 2015).

[24] PRM 15-1, Transmittal 356 (Mar. 1990) (adding § 2810 "instructions [to] specify the criteria that a hospital must meet to be classified as an SCH, the procedures for obtaining this classification, and *the special payment provisions applicable to these hospitals*" (emphasis added)).

[25] PRM 15-1 § 2810.1(B).

[26] *See:* MAC's Letter to Chairman Harty dated July 13, 2015, Appendix 1. The first calculation uses the Medicare Contractor's original methodology and corrects the errors noted by the Hospital. The second calculation uses the Administrator's methodology in *Unity Healthcare* and corrects for the errors noted by the Hospital.

[27] *See* 42 U.S.C. § 1395ww(a)(1), (4).

[28] The Board is aware of the following discussion included in the preamble to the August 18, 2006 final rule:

split between these costs. As a result, the Board opts to use the Medicare Contractor's fixed/variable cost percentage split as a proxy. In this case, the Medicare Contractor determined that fixed costs (which include semi-fixed costs) were 81.52 percent of its Medicare inpatient operating costs.[29]

The Board finds the payment amount in this case should be calculated as follows:

2008 Medicare Inpatient Operating Costs – Fixed	$6,692,689[30]
Multiplied by the 2009 IPPS update factor	1.036[31]
2008 Updated Costs - Fixed (Max Allowed)	$6,933,625
2009 Medicare Inpatient Operating Costs - Fixed	$6,805,084[32]
Lower of Fixed Costs from 2008 Updated or 2009	$6,805,084
Less 2009 DRG payment – fixed portion	$5,114,261[33]
Payment Adjustment Amount	$1,690,823

Since St. Anthony'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 volume decrease adjustment 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. Since the Medicare Contractor has previously paid St. Anthony an adjustment amount of $440,400 on May 18, 2011, St. Anthony is presently due an additional payment of $1,250,423.

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

See 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006) (emphasis added) (excerpt included at Medicare Contractor Exhibit I-3). *See also* 73 Fed. Reg. 48434, 48630-48631 (Aug. 19, 2008) (restating this same discussion). This discussion suggests that the ceiling amount is in fact the payment adjustment amount. However, the Board finds that this discussion must be read in the larger context of PRM 15-1 § 2810.1 to which this discussion cites and not just subsection (D) where the ceiling is calculated. In particular, subsection (B) must be given effect and subsection (D) must be read together with subsection (B).

[29] *See:* MAC's Letter to Chairman Harty dated July 13, 2015, Appendix 1

[30] The Board calculated this figure by multiplying the FY 2008 Program Operating Cost of $8,210,236 by fixed/semi-fixed cost percentage of 81.52 percent. *See* Provider Exhibit P-11 (St. Anthony FY 2009 workpaper showing FY 2008 Program Operating Cost of $8,210,236).

[31] *See* Provider Exhibit P-11.

[32] *See* Provider Exhibit P-12. In Appendix I attached to MAC's Letter to Chairman Harty dated July 13, 2015, the Medicare Contractor conceded the three errors cited by St. Anthony in its arguments regarding the Medicare Contractor's calculation of the volume decrease adjustment.

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

DECISION:

After considering the Medicare law and regulations, the evidence presented, and the parties' contentions, the Board finds that the Medicare Contractor correctly identified and eliminated variable costs from St. Anthony's volume decrease adjustment calculation for FY 2009. However, the Medicare Contractor improperly calculated St. Anthony's volume decrease adjustment for FY 2009. St. Anthony's Medicare fixed/semi-fixed inpatient operating costs should be reduced by the fixed/semi-fixed portion of its IPPS payments. Consistent with the application of PRM 15-1 § 2810.1, St. Anthony should receive a volume decrease adjustment for FY 2009 in the amount of $1,690,823. As the Medicare Contractor had previously paid St. Anthony a volume decrease adjustment of $440,400 in a Notice of Correction of Program Reimbursement dated May 18, 2011, St. Anthony is due an additional payment of $1,250,423.

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FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: August 29, 2016