PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2021-D15

PROVIDER-
Lamb Healthcare Center

Provider No.: 45-0698

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
October 7, 2020

Cost Reporting Period Ended –
09/30/2012

CASE NO. – 17-1947

INDEX

ISSUE STATEMENT

Whether the 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 Lamb Healthcare Center ("Lamb" or the "Provider"), and that Lamb should receive an additional VDA payment in the amount of $104,861, resulting in a total VDA payment of $161,069 for FY 2012.

INTRODUCTION

Lamb is a non-profit acute care hospital located in Littlefield, Texas. Lamb was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare administrative contractor[3] assigned to Lamb for this appeal is Novitas Solutions, Inc. ("Medicare Contractor"). Lamb initially requested a VDA payment of $200,074 to compensate it for a decrease in inpatient discharges during FY 2012.[4] Lamb subsequently revised its calculated VDA amount to $166,685.[5] The Medicare Contractor calculated the Provider's FY 2012 VDA payment to be $56,208.[6] Lamb 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. Lamb 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-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 five (5) percent from one cost reporting year to the next. VDA

[1] Provider Final Position Paper at 1.
[2] Stipulation of Facts at ¶ 1 ("Stipulations").
[3] 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 and relevant.
[4] Provider Final Position Paper at 3.
[5] *Id.* at 10.
[6] Exhibit P-7 at 10.

payments are designed to compensate a hospital for the fixed costs that 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.[7] The implementing regulations, located at 42 C.F.R. § 412.92(e), reflect these statutory requirements.

It is undisputed that Lamb experienced a decrease in discharges greater than 5 percent from FY 2011 to FY 2012 due to circumstances beyond Lamb's control and that, as a result, Lamb was eligible to have a VDA calculation performed for FY 2012.[8] Lamb requested a VDA payment of $200,074 for FY 2012.[9] However, when the Medicare Contractor made the FY 2012 VDA calculation, it determined that Lamb was entitled to a $56,208 VDA payment.[10]

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

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[11] 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. . . .

In the preamble to the final rule published on August 18, 2006,[12] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), which provides further guidance related to VDAs and 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 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.

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[7] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[8] Stipulations at ¶ 2; Provider Final Position Paper at 3; Medicare Administrative Contractor's Final Position Paper at 2.
[9] Provider Final Position Paper at 3.
[10] Exhibit P-7 at 10.
[11] (Emphasis added.)
[12] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).

> 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.[13]

The chart below depicts how the Medicare Contractor and Lamb each calculated the VDA payment.

	Medicare Contractor calculation using fixed costs[14]	Provider/PRM calculation using total costs[15]
a) Prior Year Medicare Inpatient Operating Costs	$1,671,432[16]	$1,729,268[17]
b) IPPS update factor	1.019[18]	1.019
c) Prior year Updated Operating Costs (a x b)	$1,703,189	$1,762,124
d) FY 2012 Operating Costs	$1,055,729[19]	$1,055,729
e) Lower of c or d	$1,055,729	$1,055,729
f) DRG/MDH payment	$ 855,655[20]	$ 855,655
g) CAP (e-f)	$ 200,074	$ 200,074
h) FY 2012 Inpatient Operating Costs	$1,055,729	$1,055,729
i) Excess Staffing	$ 14,076[21]	$ 14,076[22]
j) Inpatient Operating Costs, Less Excess Staffing	$1,041,653[23]	$1,041,653
k) Fixed Cost percent	87.54[24]	89.62[25]
l) FY 2012 Fixed Costs (j x k)	$ 911,863	$ 933,492
m) Total DRG/SCH Payments	$ 855,655[26]	$ 766,807[27]
n) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line l exceeds line m.)	$ 56,208	
o) VDA Payment Amount (The Providers VDA is based on the amount line l exceeds line m.)		$ 166,685[28]

[13] (Emphasis added.)
[14] Exhibit C-2.
[15] Exhibit P-1.
[16] Exhibit C-2 at 6.
[17] Exhibit P-3.
[18] Exhibit C-2 at 6.
[19] *Id.*
[20] *Id.*
[21] Final excess staffing reduction is not shown on Exhibit C-2 but is the difference between $1,055,729 and the final number the Medicare Contractor uses of $1,041,653. *See also* Exhibit P-1 at 1.
[22] *Id.*
[23] Exhibit C-2 at 10.
[24] *Id.*
[25] Exhibit P-1 at 1.
[26] Exhibit C-2 at 6.
[27] Exhibit P-1 at 1.
[28] *Id.*

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[29]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor disagrees with Lamb's assertion that there should be a "reciprocal adjustment removing the variable costs percentage from diagnosis-related group (DRG) payments in the [VDA] calculation."[30] 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.[31]

Further, the Medicare Contractor performed a core staffing analysis.[32] Lamb 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.[33] The Medicare Contractor verified with CMS that using the 2009 information was proper.[34] As for Lamb's contention that adult and pediatrics and ICU areas are the only areas to be used in the analysis, the Medicare Contractor states that this is misplaced. The Medicare Contractor cites to PRM 15-1 § 2810.1(C)(6) (Rev. 356),[35] 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.

Lamb argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor improperly changed the Medicare rules by calculating Lamb's VDA payment based on a comparison of Lamb's fixed costs to its total DRG payments.[36] Lamb asserts that this approach does not fully compensate the hospital for its fixed and semi-fixed inpatient

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[29] Stipulations at ¶ 6.
[30] Medicare Contractor's Final Position Paper at 6.
[31] *Id.* at 8 (quoting *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. at 8 (Aug. 5, 2007), *modifying*, PRRB Dec. No. 2007-D11 (June 9, 2007)).
[32] *Id.* at 10-12.
[33] Provider Final Position Paper at 7-8.
[34] Medicare Contractor's Final Position Paper at 12.
[35] *Id.*
[36] Provider Final Position Paper 5-6.

operating costs.[37] Lamb 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 Lamb of $166,685.[38]

Lamb, 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, Lamb maintains, would assure an accurate matching of revenue with expenses, because DRG payments are intended to cover both fixed *and* variable costs. Lamb 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.[39]

The Board identified three basic differences between the Medicare Contractor and Lamb's calculation of Lamb's VDA payment. First, Lamb 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.[40] Based on this contention, Lamb did not include Excess Staffing in their VDA calculation.

The Board disagrees with Lamb's Excess Staffing argument, 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. Lamb 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.[41] Lamb asserts that PRM 15-1 § 2810.1(C)(6)(a) supports its position that the comparison should only include Adults and Pediatrics and ICU.[42] PRM 15-1 § 2810.1(C)(6)(a) (Rev. 356) states that "The contractor's analysis of core staff is limited to those cost centers (general service, inpatient, ancillary, etc.) *where 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 . . ."[43] 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 "where costs are components of Medicare inpatient operating cost."

The second difference in the two VDA calculations is that the Medicare Contractor, in computing the Fixed Cost Percentage, considered all the costs, other than salary, in certain costs centers as variable costs.[44] Lamb states that it submitted a detailed Working Trial Balance to determine whether costs are variable or fixed/semi-fixed for all the accounts grouped to:

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[37] *Id.*
[38] Exhibit P-1 at 1.
[39] Provider Final Position Paper at 9.
[40] *Id.* at 8.
[41] *Id.* at 7-8. *See also* Exhibit C-2.
[42] Provider Final Position Paper at 7.
[43] (Emphasis added.)
[44] Provider Final Position Paper at 6; Medicare Contractor's Final Position Paper at 9.

1. Laboratory;
2. Medical supplies charged to patients; and
3. Drugs charged to patients.[45]

On the Working Trial Balance, Lamb marked which accounts, other than salary, it considered to be variable costs.[46] The Medicare Contractor, in its Final Position Paper, notes that Lamb's analysis did not explain why the accounts were considered variable. In addition, the Medicare Contractor notes that the Working Trial Balance total amounts do not tie to the cost centers reported on the cost report. The Medicare Contractor also states that this analysis was first submitted with Lamb's Final Position Paper, some three years after its VDA request and nearly two years after the Medicare Contractor's notification of the VDA payment amount.[47] The Provider, since this time, has stipulated that it is in agreement with the Medicare Contractor's computed Fixed and Semi-Fixed percentage of 87.54 percent.[48]

The third difference is the total DRG payment amount used in the two VDA calculations. Lamb used $766,807 for its total DRG payment for FY 2012. This amount was derived by adjusting the DRG payment of 855,655, on Worksheet E, Part A, Line 49, for the fixed costs percentage of 89.62 percent.[49] The Medicare Contractor used $855,655 from Worksheet E, Part A, Line 49 (Total payment for inpatient operating costs).[50] This issue is not new to the Board.

In recent decisions,[51] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because it compares fixed costs to total DRG payments which only results in a VDA payment if the fixed costs exceed the total DRG payment amount. 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

[45] Provider Final Position Paper at 6-7. *See also* Exhibit P-1.
[46] Exhibit P-1.
[47] Medicare Contractor's Final Position Paper at 9-10.
[48] Stipulation of Facts, Addendum A.
[49] Exhibit P-1 at 1.
[50] Exhibit C-2 at 6.
[51] *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).

> 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 . . . .[52]

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."[53]

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.[54]

Moreover, the Board notes that Lamb 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 FFY 2018 IPPS Final Rule,[55] CMS prospectively changed the methodology for calculating the VDA to one that 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.[56] 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

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[52] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. at 8 (Aug. 5, 2007), *modifying*, PRRB Dec. No. 2007-D11 (June 9, 2007).
[53] 918 F.3d 571, 579 (8th Cir. 2019).
[54] (Bold and italics emphasis added).
[55] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[56] This amount continues to be subject to the cap specified in 412.92(e).

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."[57]

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 Lamb's 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 Lamb's VDA payment by comparing its FY 2012 fixed costs to its total FY 2012 DRG payments. However, neither the language nor the examples[58] 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[59] and the FFY 2009 IPPS Final Rule[60] 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 these Final Rule preambles that the only permissible adjustment to a hospital's cost for calculating the VDA is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Lamb's 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 the Medicare Contractor calculated Lamb's FY 2012 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions 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[.]"[61] 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

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[57] 82 Fed. Reg. at 38180.
[58] PRM 15-1 § 2810.1(C)-(D).
[59] 71 Fed. Reg. at 48056.
[60] 73 Fed. Reg. at 48631.
[61] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2007-D16 at 8 (Sep. 4, 2007); *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2007-D15 at 8 (Sept. 4, 2007); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Dec. 15, 2016).

otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[62]

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:

> 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.[63]

In the final rule published on September 1, 2918 ("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."[64] 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.

[62] 82 Fed. Reg. at 38179-38183.
[63] (Emphasis added).
[64] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> 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 entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
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> 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***.[65]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule, which limits 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."[66] 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[s] the hospital for the fixed costs it incurs."[67]

Using 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 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 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, consistent with 42 U.S.C. § 1395ww(d)(5)(D)(ii), 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) (2011) that the Medicare contractor "considers . . .

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[65] (Emphasis added).
[66] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[67] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

[t]he individual hospital's needs and circumstances" when determining the payment amount.[68] 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, 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.[69] 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 to be 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 Lamb's fixed costs (which includes semi-fixed costs) were 87.54 percent[70] of the Provider's

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[68] 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.

[69] 48 Fed. Reg. at 39782.

[70] Exhibit C-2. *See also* Stipulation of Facts, Addendum A at ¶ 1.

Medicare costs for FY 2012. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$1,671,432[71]
Multiplied by the 2012 IPPS update factor	1.019[72]
2011 Updated Costs (max allowed)	$1,703,189
2012 Medicare Inpatient Operating Costs	$1,055,729[73]
Lower of 2011 Updated Costs or 2012 Costs	$1,055,729
Less 2012 IPPS payment	$ 855,655[74]
2012 Payment CAP	$ 200,074

Step 2: Calculation of VDA

2012 Fixed Medicare Inpatient Operating Costs	$924,185[75]
Less Excess Staffing	$ 14,076[76]
Total Medicare Inpatient Operating Costs less Excess Staffing	$910,109
Less 2012 IPPS payment – fixed portion (87.54[77] percent)	$749,040[78]
Payment adjustment amount (subject to CAP)	$161,069

Since the payment adjustment amount of $161,069 is less than the CAP of $200,074, the Board determines that Lamb's total VDA payment for FY 2012 should be $161,069. Since Lamb already received a VDA payment in the amount of $56,208[79] for FY 2012, Lamb should be paid an additional VDA payment of $104,861.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Lamb's VDA payment for FY 2012, and that Lamb should receive an additional VDA payment in the amount of $104,861 resulting in a total VDA payment of $161,069 for FY 2012.

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[71] Exhibit C-2 at 6.
[72] *Id*.
[73] *Id*.
[74] *Id*.
[75] Calculated by multiplying 2012 Medicare Operating Costs by 87.54 percentage (fixed payment percentage).
[76] Exhibit P-1 at 1. *See also supra* note 21.
[77] *See* Stipulation of Facts Addendum A.
[78] The $749,040 is calculated by multiplying $ 855,655 (the FY 2012 SCH payments) by 0.8754 (the fixed cost percentage determined by the Medicare Contractor).
[79] Provider's Final Position Paper at 3.

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3/30/2021

X Clayton J. Nix

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