PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2020-D1

PROVIDER-
Halifax Regional Medical Center

Provider No.: 34-0151

vs.

MEDICARE CONTRACTOR –
Palmetto GBA.

RECORD HEARING DATE –
January 8, 2019

Cost Reporting Period Ended –
September 30, 2013

CASE NO. – 17-1826

INDEX

ISSUE STATEMENT

The sole disputed issue in this appeal is the methodology used to calculate the Volume Decrease Adjustment ("VDA") payment.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated Halifax Regional Medical Center's ("Halifax" or "Provider") VDA payment for Fiscal Year ("FY") 2013, and that Halifax should receive a VDA payment for FY 2013 in the amount of $475,131.

INTRODUCTION

Halifax is a non-profit acute care hospital located in Roanoke Rapids, North Carolina. Halifax was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare administrative contractor[3] assigned to Halifax for this appeal is Palmetto GBA ("Medicare Contractor"). Halifax requested a VDA payment of $475,131 to compensate it for a decrease in inpatient discharges during FY 2013.[4] After the Medicare Contractor determined that Halifax did not qualify for a VDA payment, the Provider appealed and met the jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on January 8, 2019. Halifax was represented by Joseph Glazer, Esq. of The Law Office of Joseph D. Glazer, P.C. The Medicare Contractor was represented by Joseph J. Bauers, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

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

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[1] Stipulations of the Parties at 1 ("Stipulations").
[2] *Id.* at ¶1.
[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.
[4] Provider's Final Position Paper at 12. *See also* Exhibit P-1 at 6.
[5] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

It is undisputed that Halifax experienced a decrease in discharges greater than 5 percent from FY 2012 to FY 2013 due to circumstances beyond Halifax's control and that, as a result, Halifax was eligible to have a VDA calculation performed.[6] Halifax requested a VDA payment in the amount of $475,131.[7] However, when the Medicare Contractor made the FY 2013 VDA calculation, it determined that Halifax was not entitled to a VDA payment, because Halifax's total Medicare inpatient revenue exceeded the calculated fixed operating costs. Therefore, the Medicare Contractor denied the VDA request on February 16, 2017.[8] Halifax timely appealed the Medicare Contractor's denial on July 13, 2017.[9]

42 C.F.R. § 412.92(e) (2012) directs how the Medicare Contractor must adjudicate a VDA request once an SCH demonstrates it suffered a qualifying decrease in total inpatient discharges. In pertinent part, § 412.92(e)(3) states:[10]

> (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 references the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356),[13] which provides further guidance related to VDAs stating, 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 costs 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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[6] Stipulations at ¶ 9.
[7] Provider's Final Position Paper at Exhibit P-1.
[8] Stipulations at ¶¶ 10-11.
[9] *Id.* at ¶ 12.
[10] The terms "volume decrease adjustment" and "low volume adjustment" are used interchangeably in this decision.
[11] (emphasis added).
[12] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[13] Copy at Exhibit P-3.

> 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*[14] with utilization such as food and laundry costs.

The chart below depicts how the Medicare Contractor and the Provider each calculated the VDA payment.[15] The Medicare Contractor compares fixed cost to total Medicare payments, while the Provider's calculation compares fixed cost to fixed Medicare payments.[16]

	Medicare Contractor calculation using fixed costs	Provider calculation using fixed costs
a) Prior Year Medicare Inpatient Operating Costs	$23,229,866	$23,229,866
b) IPPS update factor[17]	1.019	1.018
c) Prior year Updated Operating Costs (a x b)	$23,671,233	$23,648,004
d) FY 2013 Operating Costs	$22,701,088	$22,701,088
e) Lower of c or d	$22,701,088	$22,701,088
f) DRG/SCH payment	$22,127,258	$22,127,258
g) CAP (e-f)	$ 573,830	$ 573,830
h) FY 2013 Inpatient Operating Costs	$22,701,088	
i) Fixed Cost percent (not in dispute)	.8280	.8280
j) FY 2013 Fixed Costs (h x i)	$18,796,958	
k) Total DRG/SCH Payments	$22,127,258	
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds* line k)	$ 0	
m) VDA Payment Amount (The Providers VDA is based on the amount of line g x line i.)		$ 475,131

The parties to this appeal dispute the interpretation of the statute and regulation used to calculate the VDA payment. Specifically, the parties dispute the appropriateness of the methodology as it relates to the use of the fixed cost ratios in calculating the VDA payment.[18]

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[14] (Emphasis added).
[15] MAC Final Position Paper at Exhibit C-5. Provider's Final Position Paper at Exhibit P-1 at 6.
[16] *Id.*
[17] The Medicare Contractor uses a IPPS Update factor is 1.019 while the Provider uses a IPPS update factor of 1.018. This difference is not relevant as the Provider's FY 2013 operating cost are under the calculated Cap. The FY 2013 IPPS final rule reflects a FY 2013 IPPS update factor of 1.018. 77 Fed. Reg. 53257, 53710 (Aug. 31, 2012).
[18] Stipulations at ¶ 14.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that the law is quite clear when it states that the purpose of a VDA payment is "to fully compensate the hospital for the fixed costs it incurs in the period" and, therefore, the removal of variable costs from the VDA calculation is required.[19] In support of its position, the Medicare Contractor points out that the CMS Administrator has discussed the appropriate methodology to calculate a VDA payment in numerous Administrator decisions, including those involving Lakes Regional Healthcare,[20] Unity Healthcare,[21] St. Anthony Regional Medical Center,[22] Trinity Regional Medical Center,[23] and Fairbanks Memorial Hospital.[24] Specifically, these Administrator's decisions all state that:

> 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. . . . Thus, the [p]rovider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.][25]

Halifax argues that the Medicare Contractor was wrong when it calculated Halifax's VDA payment amount because it compared Halifax's total fixed costs to total DRG payments, engaging in an "apples-to-oranges" comparison.[26] Halifax asserts that there is no statutory basis for this lack of symmetry[27] and that the most appropriate methodology to calculate the VDA payment can be found in PRM 15-1 § 2810.1(D)[28]. Under that guidance, the Secretary requires a comparison of costs and payments, with neither adjusted by a fixed cost ratio.[29] Halifax maintains that PRM 15-1 cannot be ignored as the Secretary has *repeatedly* endorsed the PRM in the Federal Register. For example, in the preamble to the Final Rules, published on August 18, 2006 and on August 19, 2008, CMS stated:

> The process for determining the amount of the volume decrease adjustment can be found in section 2810.1 of the Provider Reimbursement Manual. . . . 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

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[19] MAC Final Position Paper at 10.
[20] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. No. 2014-D16 (Sept. 4, 2014).
[21] *Unity Healthcare v. BlueCross BlueShield Ass'n/Wisconsin Physician Servs.*, Adm. Dec. No. 2014-D15 (Sept. 4, 2014).
[22] *St. Anthony Reg'l Hosp. v. Wisconsin Physician Servs.*, Adm. Dec. No. 2016-D16 (Aug. 29, 2016).
[23] *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. No. 2017-D1 (Dec. 15, 2016).
[24] *Fairbanks Mem'l Hosp. v. Wisconsin Physician Servs.*, Adm. Dec. No. 2015-D11 (Aug. 5, 2015).
[25] *See, e.g., St. Anthony Reg. Hosp.* at 11-13; *Trinity Reg'l Med. Ctr.* at 10-12.
[26] Provider's Final Position Paper at 9, 13.
[27] *Id.* at 9.
[28] *Id.* at 11-12 & Exhibit P-3 at 7-9.
[29] *Id.* at 11.

> update factor minus any adjustment for excess staff. The [hospital] receives the difference in a lump-sum payment.[30]

In the alternative, Halifax reasons that, if variable costs are to be excluded from inpatient operating cost when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. This method, Halifax maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. According to Halifax, removing variable costs from both the revenue and cost sides of the VDA equation would result in Halifax receiving a VDA payment for FY 2013 of $475,131.[31]

The issue of how to calculate a VDA payment is not new to the Board. In recent decisions,[32] the Board has disagreed with the methodology used by multiple Medicare contractors to calculate VDA payments because it compares fixed costs to total DRG payments, and 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 DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

The Administrator has overturned the Board's decisions stating:

> [T]he Board attempted to remove the portion of the DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . . In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. . . . The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[33]

Recently, the Eighth Circuit Court of Appeals ("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."[34]

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[30] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006); 73 Fed. Reg. 48433, 48630-48631 (Aug. 19, 2008).
[31] Provider's Final Position Paper at 12.
[32] *St. Anthony Reg'l Hosp. v. Wisconsin Physician Servs.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physician Servs.*, PRRB Dec. No. 2017-D1 (Dec. 15, 2016); *Fairbanks Memorial Hosp. v. Wisconsin Physician Servs.*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[33] *Fairbanks Mem'l Hosp. v. Wisconsin Physician Servs.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[34] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019).

At the outset, it must be recognized that 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.[35]

The Board notes that the Provider is not located in the Eighth Circuit and further notes that, *subsequent to the time period at issue*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to 2018 IPPS Final Rule,[36] CMS prospectively changed the methodology for calculating a VDA. Significantly, the new methodology is very similar to the methodology used by the Board, requiring Medicare contractors to compare the estimated portion of the DRG payment, related to fixed costs to the hospital's fixed costs, when determining the amount of the VDA payment (this amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e)(3)). The preamble to the 2018 IPPS Final Rule makes this change effective for cost reporting periods beginning on or after October 1, 2017, explaining that it will "remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment."[37]

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 Halifax's VDA methodology for FY 2013 was not correct because it was *not* based on CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of that PRM 15-1 policy in the relevant Final Rules.

The Medicare Contractor determined Halifax's VDA payment by comparing its fixed costs to its DRG payments. However, neither the language nor the examples[38] in the PRM 15-1 compare the hospital's fixed costs to its DRG payments when calculating a hospital's VDA payment. Similar to the PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[39] and the FFY

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[35] (Emphasis added).
[36] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[37] *Id.* at 38180.
[38] PRM 15-1 § 2810.1(C), (D).
[39] 71 Fed. Reg. at 48056.

2009 IPPS Final Rule[40] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> The adjustment amount is determined by subtracting the second year's MS-DRG payment from the lessor of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

It is clear from the preambles to these Final Rules that the only permissible adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Halifax's VDA using the methodology laid out by CMS in the PRM 15-1 or by the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Halifax's FY 2013 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[.]"[41] 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 FFY 2009 Final Rules, the PRM, and the statute. Noticeably, in applying this new methodology through adjudication, CMS did not otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[42]

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 cost:

> 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 . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

In the final rule published on September 1, 1983, 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

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[40] 73 Fed. Reg. at 48631.
[41] *Lakes Reg'l Healthcare*, Adm. Dec. No. 2014-D16 at 8; *Unity Healthcare*, Adm. Dec. No. 2014-D15 at 8; *Trinity Reg'l Med. Ctr.*, Adm. Dec. No. 2017-D1 at 12.
[42] 82 Fed. Reg. at 38179-38183.

made for truly variable costs, such as food and laundry services."[43] However, the VDA payment methodology explained in the FFY 2007 and FFY 2009 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.—. . . .
>
> 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*. . . .
>
> D. Determination on Requests.—. . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
>
> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[44]

At first blush, this would appear to conflict with both the statute and the 1983 Final Rule which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this 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

[43] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).
[44] (Emphasis added).

DRG payment . . . subject to the ceiling[.]"[45] It is this new methodology that the Eighth Circuit found reasonably complied with the mandate to provide full compensation.[46]

As Halifax is not located in the Eighth Circuit, the Board is not obligated to follow the Eighth Circuit's decision on this issue. Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[47] Under the Administrator's methodology, 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, 42 U.S.C.§ 1395ww(a)(4) makes it clear that the DRG payment includes payment for both fixed *and* variable cost 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 simply cannot ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments for fixed cost.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an SCH for 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." Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs, but the hospital will always have some variable cost related to its *actual* patient load.

Critical to the proper application of the statute, regulation and Manual provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished services in the current year are not part of the volume decrease, and; (2) the DRG payment made to the SCH for services furnished to the Medicare patients in the current year is payment for both the fixed and variable costs of the services furnished to those patients. Therefore, in order to fully compensate an SCH 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 in the current cost year and impermissibly mischaracterizes 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 is clear that the DRG payment is payment for fixed and variable costs - and deem the full 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, it is not a reasonable interpretation of the statute.

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[45] *See supra* n.41.
[46] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019).
[47] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

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.[48] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that the DRG payment is intended to pay for both variable and fixed costs for Medicare services *actually* furnished. The Board concludes that, in order to ensure the hospital is fully compensated for its fixed costs and consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to the portion of the hospital's DRG payment attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine a 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 Halifax's fixed costs (which include semi-fixed costs) were 82.8 percent[49] of the Provider's Medicare costs for FY 2013. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2012 Medicare Inpatient Operating Costs	$23,229,866[50]
Multiplied by the 2013 IPPS update factor	1.018[51]
2012 Updated Costs (max allowed)	$23,648,004
2013 Medicare Inpatient Operating Costs	$22,701,088[52]
Lower of 2012 Updated Costs or 2013 Costs	$22,701,088
Less 2013 IPPS payment	$22,127,258[53]
2013 Payment CAP	$ 573,830

Step 2: Calculation of VDA

2013 Medicare Inpatient Operating Costs – Fixed	$18,796,501[54]
Less 2013 IPPS payment – fixed portion (82.8 percent)	$18,321,370[55]
Payment adjustment amount (subject to CAP)	$ 475,131

Since the payment adjustment amount of $475,131 is less than the CAP of $573,830, the Board determines that Halifax should receive a VDA for FY 2013 in the amount of $475,131.

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[48] 48 Fed. Reg. at 39782.
[49] Exhibit P-1 at 32.
[50] *Id.* at 6 (listing $23,229,866 as the FY 2012 Program Operating Costs Worksheet D-1, Part II, Line 53).
[51] *Id.* (listing the 2013 IPPS update factor as 10.18 percent).
[52] *Id.* (listing $22,701,088 as the FY 2013 Program Operating Cost Worksheet D-1, Part II, Line 53).
[53] *Id.* (listing $22,127,258 as the FY 2013 SCH Payments Worksheet E, Part A, Line 49).
[54] *See* Provider's Final Position Paper at 12. The $18,796,501 is calculated by multiplying $22,701,088 (Lower of FY 2012 Updated Costs or FY 2013 Costs) by 0.828 (the fixed cost percentage).
[55] The $18,321,370 is calculated by multiplying $22,127,258 (the FY 2013 SCH payments - Worksheet E, Part A, Line 49) by 0.828 (the fixed cost percentage). *See id.*

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated the Provider's VDA payment for FY 2013 and that the Provider should receive a VDA payment for FY 2013 in the amount of $475,131.

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FOR THE BOARD:

1/31/2020

X Clayton J. Nix

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