

**PROVIDER REIMBURSEMENT REVIEW BOARD  
DECISION  
On the Record**

2021-D02

**PROVIDER-**  
Berwick Hospital Center

**Provider No.:** 39-0072

**vs.**

**MEDICARE CONTRACTOR –**  
WPS Government Health Administrators

**RECORD HEARING DATE –**  
July 21, 2020

**Cost Reporting Period Ended –**  
06/30/2013

**CASE NO. –** 17-0003

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## **ISSUE STATEMENT**

Whether the Medicare Contractor properly calculated the volume decrease adjustment (“VDA”) owed to Berwick Hospital Center (“Berwick” or the “Provider”) for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2013 (“FY 2013”).<sup>1</sup>

## **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 2013 for Berwick, and that Berwick should receive a VDA payment in the amount of \$889,192.

## **INTRODUCTION**

Berwick is a non-profit acute care hospital located in Berwick, Pennsylvania. Berwick was designated as a Medicare Dependent Hospital (“MDH”) during FY 2013, the fiscal year at issue.<sup>2</sup> The Medicare administrative contractor<sup>3</sup> assigned to Berwick for this appeal is WPS Government Health Administrators (“Medicare Contractor”). Berwick requested a VDA payment of \$1,109,373 for FY 2013 to compensate it for a decrease in inpatient discharges during FY 2013.<sup>4</sup> The Medicare Contractor calculated the Berwick’s FY 2013 VDA payment to be \$0.<sup>5</sup> Berwick 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 July 21, 2020. Berwick was represented by Ronald K. Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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<sup>1</sup> Provider’s Revised Final Position Paper (hereinafter “Provider’s Revised FPP”) at 2. Berwick submitted a *consolidated* Revised FPP covering multiple fiscal years. However, this decision only pertains to Case No. 17-0003 (FY 2013). In addition, the Board notes that Berwick’s cover letter to its Revised FPP suggests that the Medicare Contractor may have had objections to this filing. However, the Medicare Contractor never filed an objection with the Board and, accordingly, the Board accepted the Provider’s Revised FPP into the record.

<sup>2</sup> Stipulations at ¶ 1.

<sup>3</sup> 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.

<sup>4</sup> Medicare Contractor’s Final Position Paper at 5; Provider’s Consolidated Final Position Paper at 6; Provider’s Consolidated Optional Response at 2; Provider’s Revised FPP at 8. *See also* Stipulations at ¶ 6.

<sup>5</sup> Provider’s Revised FPP at 9. *See also* Stipulations at ¶ 8.

## **STATEMENT OF FACTS AND RELEVANT LAW**

Medicare 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 MDHs if, due to circumstances beyond their control, they incur a decrease in patient discharges of more than 5 percent from one cost reporting year to the next.<sup>6</sup> VDA 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.<sup>7</sup> The implementing regulations, located at 42 C.F.R. § 412.108(d), reflect these statutory requirements. When promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals (“SCHs”).<sup>8</sup>

It is undisputed that Berwick experienced a decrease in discharges greater than 5 percent from FY 2012 to FY 2013 due to circumstances beyond its control and that, as a result, Berwick was eligible to have a VDA calculation performed for FY 2013.<sup>9</sup> Berwick requested a VDA payment in the amount of \$1,109,373 for FY 2013.<sup>10</sup> However, when the Medicare Contractor made the FY 2013 VDA calculation, it determined that Berwick was not entitled to a VDA payment because it had already been fully compensated for its fixed/semi-fixed costs.<sup>11</sup>

42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates it experienced a qualifying decrease in total inpatient discharges. In particular, § 412.108(d)(3) (2013) states, in pertinent part:

(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 (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).

(i) In determining the adjustment amount, the Intermediary *considers* –

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<sup>6</sup> 42 U.S.C. § 1395ww(d)(5)(G)(iii).

<sup>7</sup> *Id.*

<sup>8</sup> 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

<sup>9</sup> Stipulations at ¶ 4.

<sup>10</sup> *See supra* note 4.

<sup>11</sup> Medicare Contractor’s Final Position Paper at 8.

(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. . . .<sup>12</sup>

As CMS notes in the preamble to the final rule published on August 18, 2006,<sup>13</sup> PRM 15-1 § 2810.1 (Rev. 371) provides further guidance related to VDAs. In particular, § 2810.1(B) (Rev. 371) states, in pertinent part:

Additional payment is made to an eligible [MDH] 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.

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.<sup>14</sup>

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

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<sup>12</sup> (Emphasis added.)

<sup>13</sup> 71 Fed. Reg. at 48056.

<sup>14</sup> (Emphasis added.)

	Medicare Contractor calculation using fixed costs <sup>15</sup>	Provider/PRM calculation using total costs <sup>16</sup>
a) Prior Year Medicare Inpatient Operating Costs	\$6,850,066 <sup>17</sup>	\$6,850,066
b) IPPS update factor	1.0253 <sup>18</sup>	1.0253
c) Prior year Updated Operating Costs (a x b)	\$7,023,373 <sup>19</sup>	\$7,023,373
d) FY 2013 Operating Costs	\$6,608,473 <sup>20</sup>	\$6,608,473
e) Lower of c or d	\$6,608,473	\$6,608,473
f) DRG/MDH payment	\$5,499,100 <sup>21</sup>	\$5,499,100
g) CAP (e-f)	\$1,109,373	\$1,109,373
h) FY 2013 Inpatient Operating Costs	\$6,608,473	\$6,608,473
i) Fixed Cost percent	.8018 <sup>22</sup>	1.0000
j) FY 2013 Fixed Costs (h x i)	\$5,298,370 <sup>23</sup>	\$6,608,473
k) Total DRG/SCH Payments	\$5,499,100	\$5,499,100
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line d exceeds line f)	\$ 0	
m) VDA Payment Amount (The Providers VDA is based on the amount line d exceeds line f.)		\$1,109,373

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.<sup>24</sup>

### **DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW**

Berwick asserts that the Federal Register does not specifically state that variable costs should be removed from total costs to compute the VDA. The Medicare Contractor asserts that Berwick has misinterpreted the Federal Register.<sup>25</sup> In support of its position, the Medicare Contractor cites to the decision of the U.S. Court of Appeals for the Eighth Circuit (“Eighth Circuit”) in *Unity Healthcare, v. Azar (“Unity”)*.<sup>26</sup>

The Medicare Contractor removed variable costs through Worksheet A-8 adjustments on Berwick’s cost report. The Medicare Contractor contends that specific instructions to determine the fixed/semi-fixed costs is not included in the statute, regulations or Provider Reimbursement

<sup>15</sup> Medicare Contractor’s Final Position Paper at 8.

<sup>16</sup> Provider’s Revised FPP at 8; Stipulations ¶ 6.

<sup>17</sup> Stipulations ¶ 6.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> Stipulations at ¶ 9. Fixed percentage calculated by dividing Inpatient Operating Costs \$5,298,370/\$6,608,473.

<sup>23</sup> Exhibit P-2 at pdf page 28; Stipulations at ¶ 8. Fixed Operating Costs after variable costs removed via A-8 adjustments on the FY 2013 Medicare Cost Report.

<sup>24</sup> Stipulations at ¶ 10.

<sup>25</sup> Medicare Contractor’s Final Position Paper at 15.

<sup>26</sup> 918 F.3d 571 (8th Cr. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

Manual. Therefore, the Medicare Contractor used the cost report to develop an allegedly accurate method of calculating fixed/semi-fixed costs and argues that the Administrator agreed with this approach which was found not to be arbitrary or capricious in the *Unity* decision.<sup>27</sup>

Berwick argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor departed from the instructions and step-by-step guidance in the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), and added an unauthorized and monumental extra step.<sup>28</sup> According to Berwick, the Medicare Contractor's removal of all variable costs appears to rest on a misunderstanding of a single line in the preamble to the Federal Register<sup>29</sup> which states, "an adjustment will not be made for truly variable costs." Berwick asserts that "adjustment" refers to "additional payment."<sup>30</sup>

Berwick also argues that CMS changed its methodology for calculating VDA payments without going through notice-and-comment rulemaking and that the new methodology being applied by CMS to its variable costs represents a change in policy. Berwick argues that it was not afforded fair notice of CMS's new methodology.<sup>31</sup>

Berwick contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.<sup>32</sup> Berwick maintains that the most appropriate methodology to calculate the VDA payment can be found in 42 C.F.R. §§ 412.92 and 412.108(d), and PRM 15-1 § 2810.1.C.

Berwick 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, Berwick maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Berwick 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.<sup>33</sup> Indeed, removing variable costs from both the revenue and cost sides of the VDA equation would result in Berwick receiving a VDA payment for FY 2013 of \$889,444.<sup>34</sup>

The Board identified one basic difference in the Medicare Contractor's and Berwick's calculation of the Provider's VDA payment that relates to the FY 2013 Inpatient Operating Costs. The Medicare Contractor adjusted the Inpatient Operating Costs for variable costs via Worksheet A-8 adjustments on the cost report. Berwick argues that the Medicare Contractor's

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<sup>27</sup> Medicare Contractor's Final Position Paper at 24 (discussing *Unity Healthcare v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. 2014-D15 (Sept. 4, 2014)).

<sup>28</sup> Provider's Revised FPP at 13.

<sup>29</sup> 48 Fed. Reg. 39782 (Sept. 1, 1983).

<sup>30</sup> Provider's Revised FPP at 14.

<sup>31</sup> *Id.* at 15-16.

<sup>32</sup> *Id.* at 17-20.

<sup>33</sup> *Id.* at 18.

<sup>34</sup> *Id.*

VDA calculation methodology violates the statute, regulations, and Provider Reimbursement Manual instructions.<sup>35</sup>

In recent Board decisions addressing VDA payments,<sup>36</sup> the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because that methodology 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 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 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 . . . .<sup>37</sup>

Recently, the Eighth Circuit upheld the Administrator's methodology in the *Unity* case, stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."<sup>38</sup>

At the outset, the Board notes 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

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<sup>35</sup> *Id.* at 2.

<sup>36</sup> *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).

<sup>37</sup> *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).

<sup>38</sup> *Unity Healthcare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

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.<sup>39</sup>

Moreover, the Board notes that Berwick is not located in the Eighth Circuit and, thus, the *Unity* 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,<sup>40</sup> 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.<sup>41</sup> 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 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."<sup>42</sup>

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 Berwick's VDA methodology for FY 2013 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 Berwick's VDA payment by comparing its FY 2013 fixed costs to its total FY 2013 DRG payments. However, neither the language nor the examples<sup>43</sup> 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<sup>44</sup> and the FFY 2009 IPPS Final Rule<sup>45</sup> reduce the hospital's cost *only* by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

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<sup>39</sup> (Bold and italics emphasis added).

<sup>40</sup> 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

<sup>41</sup> This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).

<sup>42</sup> 82 Fed. Reg. at 38180.

<sup>43</sup> PRM 15-1 § 2810.1(C)-(D).

<sup>44</sup> 71 Fed. Reg. at 48056.

<sup>45</sup> 73 Fed. Reg. at 48631.

[T]he adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser 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 for calculating the VDA is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Berwick'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 Berwick'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[.]"<sup>46</sup> 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 otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.<sup>47</sup>

The statute at 42 U.S.C. § 1395ww(d)(5)(G)(iii) is clear that the VDA payment is intended to fully compensate the hospital for its fixed costs:

In the case of a medicare dependent, small rural 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.<sup>48</sup>

In the final rule published on September 1, 1983 ("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

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<sup>46</sup> *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D16 at 8 (Sep. 4, 2014); *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Dec. 15, 2016).

<sup>47</sup> 82 Fed. Reg. at 38179-38183.

<sup>48</sup> (Emphasis added.)

services.”<sup>49</sup> 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.— . . .

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.

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.*<sup>50</sup>

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limit 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.”<sup>51</sup>

<sup>49</sup> 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

<sup>50</sup> (Emphasis added).

<sup>51</sup> *St. Anthony Reg’l Hosp.*, Adm’r Dec. at 13; *Trinity Reg’l Med. Ctr.*, Adm’r Dec. at 12.

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."<sup>52</sup> 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 the purpose of the VDA payment is to compensate an MDH 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. § 405.108(d)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.<sup>53</sup> 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)(G)(iii) 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

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<sup>52</sup> 42 U.S.C. § 1395ww(d)(5)(G)(iii).

<sup>53</sup> The Board recognizes that 42 C.F.R. § 405.108(d)(3)(i)(B) 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.

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)(G)(iii) 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.<sup>54</sup> 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 both ensure the hospital is fully compensated for its fixed costs and 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 Berwick's fixed costs (which includes semi-fixed costs) were 80.18 percent<sup>55</sup> of Berwick'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	\$6,850,006 <sup>56</sup>
Multiplied by the 2012 IPPS update factor	<u>1.0253<sup>57</sup></u>
2012 Updated Costs (max allowed)	\$7,023,373
2013 Medicare Inpatient Operating Costs	\$6,608,473 <sup>58</sup>
Lower of 2012 Updated Costs or 2013 Costs	\$6,608,473
Less 2013 IPPS payment	<u>\$5,499,100<sup>59</sup></u>
2013 Payment CAP	<u>\$1,109,373</u>

<sup>54</sup> 48 Fed. Reg. at 39782.

<sup>55</sup> Fixed Inpatient Operating Costs/Total Inpatient Operating Costs (\$5,298,370/\$6,608,473=80.18 percent).

<sup>56</sup> FY 2012 Program Operating Costs Worksheet D-1, Part II, Line 53. Stipulations at ¶¶ 6, 9.

<sup>57</sup> FY 2013 IPPS update factor as 102.53 percent. *Id.* at ¶ 6.

<sup>58</sup> FY 2013 Program Operating Cost Worksheet D-1, Part II, Line 53. *Id.* at ¶¶ 6, 9.

<sup>59</sup> FY 2013 MDH Payments Worksheet E, Part A, Line 49. Exhibit P-1 at pdf page 31; Stipulations at ¶¶ 6, 8.

Step 2: Calculation of VDA

2013 Medicare Inpatient Fixed Operating Costs	\$5,298,370 <sup>60</sup>
Less 2013 IPPS payment – fixed portion (80.18 percent <sup>61</sup> )	\$4,409,178 <sup>62</sup>
Payment adjustment amount (subject to CAP)	<u>\$ 889,192</u>

Since the payment adjustment amount of \$889,192 is less than the CAP of \$1,109,373, the Board determines that Berwick’s VDA payment for FY 2013 should be \$889,192.

**DECISION**

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Berwick’s VDA payment for FY 2013, and that Berwick should receive a FY 2013 VDA payment in the amount of \$889,192.

Board Members Participating:

For the Board:

Clayton J. Nix, Esq.  
Gregory H. Ziegler, CPA  
Robert A. Evarts, Esq.  
Susan A. Turner, Esq.

10/26/2020

**X** Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

<sup>60</sup> FY 2013 Program Operating Cost Worksheet D-1, Part II, Line 53 (FY 2013 Fixed costs after A-8 adjustments for variable costs). Exhibit P-1 at pdf page 28; Stipulations at ¶ 8.

<sup>61</sup> Stipulations at ¶ 9. Calculated by dividing Inpatient Operating Costs \$5,298,370/\$6,608,473.

<sup>62</sup> The \$4,409,178 is calculated by multiplying \$5,499,100 (the FY 2013 MDH payments) by 0.8018 (the fixed cost percentage determined by the Medicare Contractor).