

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

2020-D10

PROVIDER-
Baptist Memorial Hospital

Provider No.: 25-0044

vs.

MEDICARE CONTRACTOR –
Palmetto GBA

RECORD HEARING DATE –
August 22, 2019

Cost Reporting Period Ended –
September 30, 2011

CASE NO. – 17-0184

INDEX

	Page No.
Issue Statement.....	2
Decision.....	2
Introduction.....	2
Statement of Facts and Relevant Law.....	2
Discussion, Findings of Facts, and Conclusions of Law.....	5
Decision.....	14

ISSUE STATEMENT

Whether the Medicare Administrative Contractor (“MAC”) determination of the Provider’s Medicare Dependent Hospital (“MDH”) Volume Decrease Adjustment (“VDA”) was calculated in accordance with the regulations at 42 C.F.R. § 412.108(d) and Program Reimbursement Manual, CMS Pub. 15-1 (“PRM 15-1”), § 2810.1.¹

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 the VDA for Baptist Memorial Hospital Booneville (“Baptist” or “Provider”) for Fiscal Year (“FY”) 2011, and that Baptist should receive an additional VDA payment in the amount of \$300,146 resulting in a total FY 2011 VDA of \$314,691.

INTRODUCTION

Baptist is a non-profit acute care hospital located in Booneville, Mississippi. Baptist was designated as a Medicare Dependent Hospital (“MDH”) during the fiscal year at issue.² The Medicare contractor³ assigned to Baptist for this appeal is Palmetto GBA (“Medicare Contractor”). Baptist requested a VDA payment of \$693,993⁴ for FY 2011 to compensate it for a decrease in inpatient discharges during FY 2011.⁵ The Medicare Contractor found that Baptist was eligible for a VDA for FY 2011 and calculated the Provider’s VDA payment as \$14,545.⁶ Baptist 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 August 22, 2019. Baptist was represented by Ronald Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

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”)

¹ Medicare Contractor’s Final Position Paper at 4. The issue statement inadvertently included the words “(DSH) calculation” and the Board deleted it.

² Stipulations 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 Baptist initially requested a VDA in the amount of \$693,993 (*see* Exhibit P-1 at 34). However, Baptist is now requesting a VDA payment of \$741,954 as Baptist reduced its Excess Staffing from \$135,419 to \$87,458, thereby increasing the VDA request by \$47,961. Provider’s Final Position Paper at 4.

⁵ *See* Stipulations at ¶ 4.

⁶ *See id.* at ¶ 5.

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. 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.⁷ 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”).⁸

It is undisputed that Baptist experienced a decrease in discharges greater than 5 percent from FY 2010 to FY 2011 due to circumstances beyond Baptist’s control and that, as a result, Baptist was eligible to have a VDA calculation performed for FY 2011.⁹ Baptist requested a VDA payment in the amount of \$693,993 for FY 2011.¹⁰ Subsequently, Baptist revised its VDA calculation by reducing its excess staffing amount and, as a result, increased its VDA claim to \$741,954.¹¹ This is \$727,409 more than the \$14,545 VDA payment Baptist received from the Medicare Contractor for FY 2011.¹²

42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates it suffered a qualifying decrease in total inpatient discharges. In particular, § 412.108(d)(3) (2011) 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* –

* * * *

⁷ 42 U.S.C. § 1395ww(d)(5)(G)(iii).

⁸ 55 Fed. Reg. 15150, 15155 (Apr. 20, 1999). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

⁹ Stipulations at ¶ 4.

¹⁰ Exhibit P-1.

¹¹ Provider’s Final Position Paper at 8.

¹² Stipulations at ¶ 5. *See also* Exhibit C-1 (copy of the Medicare Contractor’s determination); Provider’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. . . .¹³

As CMS notes in the preamble to the final rule published on August 18, 2006¹⁴ that PRM 15-1 § 2810.1 (Rev. 356)¹⁵ provides further guidance related to VDAs. In particular, §2810.1(B) (Rev. 356) states, in pertinent part:

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.

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.¹⁶

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

¹³ (Emphasis added.)

¹⁴ 71 Fed. Reg. at 48056.

¹⁵ See Exhibit C-5 at 5-12.

¹⁶ (Emphasis added.)

	Medicare Contractor calculation using fixed costs ¹⁷	Provider/PRM calculation using total costs ¹⁸
a) Prior Year Medicare Inpatient Operating Costs	\$4,834,090	\$4,834,090
b) IPPS update factor	1.0235	1.026
c) Prior year Updated Operating Costs (a x b)	\$4,947,691	\$4,959,776
d) FY 2011 Operating Costs	\$4,750,923	\$4,750,923
e) Lower of c or d	\$4,750,923	\$4,750,923
f) DRG/MDH payment	\$4,318,650	\$3,921,511
g) CAP (e-f)	\$ 432,273	\$829,412
h) FY 2011 Inpatient Operating Costs	\$4,750,923	\$4,750,923
i) Fixed Cost percent (not in dispute)	.9305	
j) FY 2011 Fixed Costs (h x i)	\$4,420,653	
k) Less Excess Staffing ¹⁹	\$ 87,458	\$ 87,458
l) Total DRG/MDH Payments	\$4,318,650	\$3,921,511
m) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount lines j minus k exceeds line l)	\$ 14,545	
n) VDA Payment Amount (The Providers VDA is based on the amount line h minus k exceeds line l)		\$ 741,954

The parties in this appeal dispute the application of the statute and regulation used to calculate the VDA payment.²⁰ Specifically, the parties dispute the use of fixed cost and the amount of the DRG payment used in the VDA calculation.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that it has “an obligation [to] review . . . the calculation to determine if there are any costs that should not be included in determining the amount of the [VDA] payment.”²¹ The Medicare Contractor further alleges that a VDA payment is intended to only reimburse a qualifying hospital for its fixed costs and, therefore, the removal of variable costs from the VDA calculation is required.²² In support of its position, the Medicare Contractor

¹⁷ Exhibit C-1 at 2 to 3.

¹⁸ Provider's Final Position Paper at 4, Table 1.

¹⁹ Baptist initially identified an excess staffing amount of \$135,419 (*see* Exhibit P-1 at 34 and the Medicare Contractor's Final Position Paper at 8). However Baptist revised its VDA request, *agreeing* with the Medicare Contractor's excess staffing calculation of \$87,458 (*see* Baptist Final Position Paper at 8). As a result, excess staffing is not in dispute in this case.

²⁰ Stipulations at ¶ 9.

²¹ Medicare Contractor's Final Position Paper at 9.

²² *Id.*

includes the following excerpt from the Administrator's decision involving Fairbanks Memorial Hospital:²³

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 for their variable costs. Therefore, pursuant to the statute, regulation and CMS guidance from the Federal Register and PRM, variable costs are to be excluded from the VDA calculation. This is consistent with the statute, CMS regulations and the Board's previous decision regarding VDAs in the case of Greenwood County Hospital, PRRB Decision No. 2006-D43.²⁴

Further, the Medicare Contractor points out that for this cost reporting period, Baptist was paid a hospital specific payment determined under 42 C.F. R. § 412.79 and that this amount should be used in calculating the VDA.²⁵

Baptist argues that the Medicare Contractor's calculation of the VDA was wrong because the Medicare Contractor improperly changed the Medicare rules by calculating Baptist's VDA payment based on a comparison of Baptist's fixed costs to its total DRG payments.²⁶ Baptist asserts that this approach guarantees that an MDH "will never receive the full compensation mandated by Congress because its fixed costs will always be reduced by reimbursement attributable to both fixed and variable costs."²⁷ Baptist maintains that the most appropriate methodology to calculate the VDA payment can be found in 42 C.F.R. § 412.92, the FFY 2009 IPPS Final Rule, and PRM 15-1 § 2810.1B. Baptist's methodology results in a VDA payment to Baptist of \$741,954.²⁸

In the alternative, Baptist 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, Baptist maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Baptist also references the fact that, in the FFY 2018 Final Rule,²⁹ CMS essentially adopted this approach when it prospectively changed the methodology for calculating VDA payments.³⁰ Indeed, Baptist claims that removing variable costs from both the revenue and

²³ *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r Dec. (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015) ("*Fairbanks*") (Copy at Exhibit C-6).

²⁴ Medicare Contractor's Final Position Paper at 10 (citing *Faribanks* at 5).

²⁵ *Id.* at 12. See also Exhibit C-10 at 4.

²⁶ Provider's Final Position Paper at 3.

²⁷ *Id.*

²⁸ *Id.* at 8.

²⁹ 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

³⁰ Provider's Final Position Paper at 5.

cost sides of the VDA equation would result in Baptist receiving a VDA payment for FY 2011 of \$402,223.³¹

The Board identified three basic differences in the Medicare Contractor's and Baptist's calculation of the Provider's VDA payment. First, there is a difference in the IPPS update factor used by the parties. PRM 15-1 § 2810.1D states that "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."³² Based on the FFY 2011 Final Rule, the inpatient PPS update factor is 1.0235.³³ Therefore, the Board finds the Medicare Contractor was correct to update Baptist's 2010 operating costs by 1.0235.

The second difference is the total DRG payment amount used in the VDA calculation. Baptist used \$3,921,511 for its total DRG payment for FY 2011 based on cost report Worksheet E, Part A, line 47 (Subtotal of inpatient operating costs). This amount includes Baptist's DRG payment (based on the federal rate), its outlier payments, and its DSH payment, but does not include its hospital specific rate payment.³⁴ The Medicare Contractor used \$4,318,650 from Worksheet E, Part A, line 49 (Total payment for inpatient operating costs), which includes the \$3,921,511 Baptist calculated plus Baptist's hospital specific rate payment.³⁵ The parties agree on the amount Baptist was paid based on its hospital specific rate, but disagree if the hospital specific payment amount should be used in the calculation of the VDA.

The Board reviewed the VDA regulations at 42 C.F.R. § 412.92(e). These regulations require the VDA to be calculated using "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 for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106. . . .)"³⁶ The Board also reviewed the MDH payment methodology in 42 C.F.R. § 412.108(c) to determine what payments should be included in the hospital's "total DRG revenue for inpatient operating costs." 42 C.F.R. § 412.108(c) provides that MDHs are paid for inpatient operating costs based on the *sum* of the federal rate plus the amount, if any, that is determined based on the hospital specific rate.³⁷ Based on these regulations the Board finds that an MDH's total DRG revenue for inpatient operating costs includes both the amount paid based on the federal rate and the amount paid based on the hospital specific rate. Therefore, the Board concludes the Medicare Contractor was correct to use

³¹ *Id.* at 6.

³² Exhibit C-5 at 10. *See also* 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

³³ 75 Fed. Reg. 50041, 50431-50432 (Aug. 16, 2010).

³⁴ Provider's Final Position Paper at 6.

³⁵ Exhibit C-10 at 4-5.

³⁶ (Emphasis added.)

³⁷ *See* 42 C.F.R. § 412.108(c). 42 C.F.R. § 412.108(c) references various sections including § 412.79, the section that the Medicare Contractor used to calculate Baptist hospital specific rate payment. *See* Medicare Contractor's Final Position Paper at 12. 42 C.F.R. § 412.79 provides for the determination of the hospital specific rate stating in subsection (e) "[t]he applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge."

\$4,318,650 as Baptist's "total DRG revenue for inpatient operating costs" when calculating Baptist's FY 2011 VDA payment.

The third issue is the use of fixed costs (which includes semi-fixed costs) in calculating Baptist's VDA payment. This issue is not new to the Board. In recent decisions³⁸ 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. This comparison is distorted and otherwise problematic because it results in a VDA payment only if the fixed costs *alone* exceed the total DRG payment amount even though DRG payments are for both fixed *and* variable costs. 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 and, in this regard, has stated the following:

[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 provider³⁹

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."⁴⁰

At the outset, the Board notes that the 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

³⁸ *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).

³⁹ *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).

⁴⁰ *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019).

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.⁴¹

Moreover, the Board notes that the Provider 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*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,⁴² CMS prospectively changed the methodology for calculating the VDA, which 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.⁴³ 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."⁴⁴

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 Baptist's VDA methodology for FY 2011 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 Baptist's VDA payment by comparing its FY 2011 fixed costs to its total FYE 2011 DRG payments. However, neither the language nor the examples⁴⁵ 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 Rule⁴⁶ and the FFY 2009 IPPS Final Rule⁴⁷ reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA.

⁴¹ (Emphasis added.)

⁴² 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

⁴³ This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).

⁴⁴ 82 Fed. Reg. at 38180.

⁴⁵ PRM 15-1 § 2810.1(C), (D).

⁴⁶ 71 Fed. Reg. at 48056.

⁴⁷ 73 Fed. Reg. at 48631.

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

Rather, the Board finds the Medicare Contractor calculated Baptist's FY 2011 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[.]"⁴⁸ 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 & 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.⁴⁹

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

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.

In the 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."⁵⁰ 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

⁴⁸ *Lakes Reg'l Healthcare*, Adm'r Dec. No. 2014-D16 at 8; *Unity Healthcare*, Adm'r Dec. No. 2014-D15 at 8; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. No. 2017-D1 at 12.

⁴⁹ 82 Fed. Reg. at 38179-38183.

⁵⁰ 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

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*.⁵¹

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."⁵² 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."⁵³ 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 include payment for both fixed *and* variable costs of the services rendered because it defines operating

⁵¹ (Emphasis added).

⁵² *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.

⁵³ 42 U.S.C. § 1395ww(d)(5)(G)(iii).

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 the fixed costs associated with the qualifying volume decrease (which must be greater than 5 percent). 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. § 412.108(d)(3)(i)(A) that the Medicare contractor “considers . . . [t]he individual hospital’s needs and circumstances” when determining the payment amount.⁵⁴ 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 a 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 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 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.⁵⁵ Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay both variable and fixed costs for Medicare services *actually* furnished. The Board concludes that, in order to ensure the hospital is fully

⁵⁴ 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.

⁵⁵ 48 Fed. Reg. at 39782.

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 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 Baptist’s fixed costs (which includes semi-fixed costs) were 93.05 percent⁵⁶ of the Provider’s Medicare costs for FY 2011. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the CAP

2010 Medicare Inpatient Operating Costs	\$4,834,090 ⁵⁷
Multiplied by the 2011 IPPS update factor	<u>1.0235⁵⁸</u>
2010 Updated Costs (max allowed)	\$4,947,691
2011 Medicare Inpatient Operating Costs	\$4,750,923 ⁵⁹
Lower of 2010 Updated Costs or 2011 Costs	\$4,750,923
Less 2011 IPPS payment	\$4,318,650 ⁶⁰
2011 Payment CAP	\$ 432,273

Step 2: Calculation of VDA

2011 Medicare Inpatient Fixed Operating Costs	\$4,420,653 ⁶¹
Less Excess Staffing	<u>\$ 87,458⁶²</u>
2011 Medicare Inpatient Fixed Operating Costs less Excess Staff	\$4,333,195
Less 2011 IPPS payment – fixed portion (93.05 percent)	\$4,018,504 ⁶³
VDA Payment adjustment amount (subject to CAP)	<u>\$ 314,691</u>

Since the payment adjustment amount of \$314,691 is less than the CAP of \$432,237, the Board determines that Baptist’s total VDA payment for FY 2011 should be \$314,691. Since Baptist

⁵⁶ Exhibit P-2 at 40.

⁵⁷ *Id.* at 39 (FY 2010 Program Operating Costs Worksheet D-1, Part II, Line 53).

⁵⁸ *Id.* (FY 2011 IPPS update factor as 102.35 percent).

⁵⁹ *Id.* (FY 2011 Program Operating Cost Worksheet D-1, Part II, Line 53).

⁶⁰ *Id.* (FY 2011 MDH Payments Worksheet E, Part A, Line 49).

⁶¹ *Id.* at 40 (FY 2011 Fixed costs).

⁶² *See supra* note 19.

⁶³ The Medicare fixed operating cost of \$4,420,653 is divided by the total Medicare operating costs of \$4,750,923 to get the fixed cost percentage of 93.05 percent. The fixed cost percentage of 93.05 percent is multiplied by the FY 2011 DRG/MDH payments of \$4,318,650 (the FY 2011 MDH payments - Worksheet E, Part A, Line 49 (*see* Exhibit C-10 at 5)) resulting in fixed DRG/MDH payment for FY 2011 of \$4,018,504.

has already received a VDA payment in the amount of \$14,545, then Baptist should be paid an additional payment of \$300,146.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Baptist's VDA for FY 2011, and that Baptist should receive an additional VDA payment in the amount of \$300,146 resulting in a total FY 2011 VDA of \$314,691.

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FOR THE BOARD:

7/31/2020

X Clayton J. Nix

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