PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2020-D07

PROVIDER-
Woodward Regional Hospital

Provider No.: 37-0002

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators.

RECORD HEARING DATE –
November 19, 2019

Cost Reporting Period Ended –
May 31, 2011

CASE NO. – 16-2051

INDEX

ISSUE STATEMENT

The dispute in this appeal relates to the methodology and calculations used to determine the Provider's fiscal year ("FY") 2011 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 the VDA payment of Woodward Regional Hospital ("Woodward" or "Provider") for FY 2011, and that Woodward should receive an additional VDA payment for FY 2011 in the amount of $148,233, resulting in a total FY 2011 VDA of $471,498.

INTRODUCTION

Woodward is a non-profit acute care hospital located in Woodward, Oklahoma. Woodward was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Woodward for this appeal is Wisconsin Physicians Service ("Medicare Contractor").[4] Woodward requested a VDA payment in the amount of $842,117 in order to compensate it for a greater than 5 percent decrease in inpatient discharges during FY 2011.[5] On November 24, 2015, the Medicare Contractor determined that Woodward was entitled to a VDA payment in the amount of $323,265.[6] On January 19, 2016, Woodward submitted a request for reconsideration,[7] and on March 16, 2016, Medicare affirmed its initial denial.[8] Accordingly, Woodward appealed the Medicare Contractor's denial and met the jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on November 19, 2019. Woodward was represented by Ronald K. Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, 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

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[1] Stipulations of the Parties at ¶ 9 ("Stipulations"); (Sept. 26, 2019); Provider's Final Position Paper at 3 ("The only issue at appeal is the amount of the payment calculation[.]").
[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] Stipulations at ¶ 3.
[5] *Id.* at ¶ 4.
[6] *Id.* at ¶ 5. *See also* Exhibit P-2.
[7] Stipulations at ¶ 6. *See also* Exhibit P-3.
[8] Stipulations at ¶ 7. *See also* Exhibit P-4.

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 that it incurs in the period for providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.[9]

42 C.F.R. § 412.92(e) (2011) 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:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[10] 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—
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> * * *
>
> (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,[11] CMS references the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), 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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> 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*[12] with utilization such as food and laundry costs.

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[9] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[10] (Emphasis added.)
[11] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[12] (Emphasis added.)

Woodward requested a VDA payment in the amount of $842,117 for FY 2011.[13] However, on November 24, 2015, the Medicare Contractor reviewed Woodward's VDA request and determined that Woodward was entitled to a VDA payment in the amount of $323,265.[14] Woodward requested a reconsideration on January 19, 2016.[15] The Medicare Contractor denied Woodward's request for reconsideration on March 16, 2016.[16] Woodward timely appealed the Medicare Contractor's denial on July 19, 2016.[17]

The chart below depicts how the Medicare Contractor originally calculated Woodward's VDA payment[18] and how Woodward calculated its VDA payment.[19]

	Medicare Contractor calculation (including capital) [20]	Provider calculation[21]
a) Prior Year Medicare Inpatient Operating Costs		$5,830,936
b) IPPS update factor		1.026
c) Prior year Updated Operating Costs (a x b)		$5,982,540
d) FYE 2011 Operating Costs		$4,949,246
e) Lower of c or d		$4,949,246
f) DRG amount including outliers		$4,107,129
g) CAP (e-f)		$ 842,117
h) FY 2011 Inpatient Costs (worksheet D-1 line 49)	$5,940,627	
i) Fixed Cost percentage (line j ÷ line h)	84.48	
j) FY 2011 Fixed Costs (worksheet D-1 line 49 from rerun cost report)	$5,018,843	
k) Total DRG/SCH Payments (worksheet E Part A lines 49+50+70.97)	$4,695,578	
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 323,265	
m) VDA Payment Amount (Woodward's VDA is based on the amount of line g.)		$ 842,117

[13] Stipulations at ¶ 4; Exhibit P-1.
[14] Stipulations at ¶ 5; Exhibit P-2.
[15] Stipulations at ¶ 6; Exhibit P-3.
[16] Stipulations at ¶ 7; Exhibit P-4.
[17] *See* Provider's Final Position Paper at 3; Medicare Contractor's Final Position Paper at 1. The letter to file the appeal was dated July 15, 2016 and was received by the Board on July 19, 2016.
[18] Exhibit C-1 at 7.
[19] Provider's Final Position Paper at 5, Table 1.
[20] Exhibit C-1 at 7.
[21] Provider's Final Position Paper at 5, Table 1.

The Medicare Contractor recognizes that it was incorrect to include capital costs and capital payments in the VDA calculation.[22] However, the parties continue to disagree on the amount of Woodward's VDA payment. Specifically, the parties dispute the methodology used to calculate the VDA payment based on the interpretation of the applicable statute and regulation including how fixed costs should be used[23] and whether the low volume adjustment ("LVA") payment should be included when calculating Woodward's VDA.[24]

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".[25] 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,[26] Unity Healthcare,[27] St. Anthony Regional Medical Center,[28] Trinity Regional Medical Center,[29] and Fairbanks Memorial Hospital.[30] 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[.][31]

The Medicare Contractor concedes it was wrong to include capital costs and payments when it calculated Woodward's VDA calculation.[32] However, the Medicare Contractor argues that the operating portion of the LVA payment should be included in the VDA calculation. Specifically, the Medicare Contractor asserts that the LVA payment was compensation for the cost the hospital incurred in providing inpatient hospital services and that it would be contrary to the Stature not to include the operating portion of the LVA payment in the VDA calculation.[33]

Woodward disagrees with how the Medicare Contractor wants to calculate the VDA payment because the Medicare Contractor's methodology compares Woodward's fixed costs to its DRG

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[22] Medicare Contractor's Final Position Paper at 7 ("Had the MAC not have [sic] erroneously include capital costs and payments in its original determination . . ."), 10 ("The MAC asks that the Board affirm the MAC's computation methodology, with the exception of the inclusion of capital costs and payments.").
[23] Provider's Final Position Paper at 4, 7-8.
[24] *Id.* at 7-8.
[25] Medicare Contractor's Final Position Paper at 5, 9.
[26] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n,* Adm'r Dec. No. 2014-D16 (Sept. 4, 2014).
[27] *Unity Healthcare v. BlueCross BlueShield Ass'n,* Adm'r Dec. No. 2014-D15 (Sept. 4, 2014).
[28] *St. Anthony Reg'l Hosp. v. Wisconsin Physician Servs.*, Adm'r Dec. No. 2016-D16 (Aug. 29, 2016).
[29] *Trinity Reg'l Med. Ctr. v. Wisconsin Physician Servs.,* Adm'r Dec. No. 2017-D1 (Dec. 15, 2016).
[30] *Fairbanks Mem'l Hosp. v. Wisconsin Physician Servs.*, Adm'r Dec. No. 2015-D11 (Aug. 5, 2015).
[31] *See, e.g., St. Anthony Reg. Hosp.,* Adm'r *Dec.* at 11-13; *Trinity Reg'l Med. Ctr.*, Adm'r *Dec.* at 10-12.
[32] Medicare Contractor's Final Position Paper at 6.
[33] *Id.*at 8-9.

revenue, engaging in a "subtracting apples from oranges" comparison.[34] Woodward asserts that the most appropriate methodology to calculate the VDA payment can be found in PRM 15-1 § 2810.1(D).[35] Under that guidance, the Secretary requires a comparison of costs and payments, with neither adjusted by a fixed cost ratio. Woodward maintains that PRM 15-1 cannot be ignored as the Secretary has *repeatedly* endorsed the PRM in the Federal Register. For example, in the preambles 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 update factor minus any adjustment for excess staff. The [hospital] receives the difference in a lump-sum payment.[36]

Additionally, Woodward claims that its LVA payment should not be included in the VDA payment calculation. In support, Woodward points to the regulations that describe the VDA payment as 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 . . . ."[37] Woodward asserts that Worksheet E Part A line 49 of the Medicare cost report is titled "'Total payment for inpatient operating costs" and that any revenue below that line is for other purposes and should not be included in the VDA calculation.[38]

Alternatively, Woodward 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 payments for variable costs. This method, Woodward 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 Woodward, if its LVA payment is removed from the revenue used in the VDA calculation and variable costs are removed from both the revenue and cost sides of the VDA equation, Woodward would receive a VDA payment for FY 2011 of $781,606.[39]

The issue of how to calculate a VDA payment is not new to the Board. In recent decisions,[40] 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. This comparison is distorted and otherwise problematic because it results in a VDA payment only if the fixed costs

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[34] Provider's Final Position Paper at 5.
[35] *Id.* at 3-4.
[36] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006); 73 Fed. Reg. 48433, 48630-48631 (Aug. 19, 2008).
[37] 42 C.F.R. § 412.108(d).
[38] Provider's Final Position Paper at 7-8.
[39] *Id.* at 6, 9.
[40] *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 Mem'l Hosp. v. Wisconsin Physician Servs.*, PRRB Dec. No. 2015-D11 (June 9, 2015).

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 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, 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 provider . . . .[41]

Recently, the U.S. 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."[42]

At the outset, it must be recognized that Administrator decisions are not binding precedents, 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.[43]

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[41] *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).
[42] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019).
[43] (Emphasis added).

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 the 2018 IPPS Final Rule,[44] 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 hospital's fixed costs to the estimated portion of the DRG payments related to 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."[45]

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 neither of the Medicare Contractor's calculations of Woodward's VDA for FY 2011 was correct because it was neither based on CMS' stated policy as delineated in PRM 15-1 § 2810.1, nor the Secretary's endorsement of that PRM 15-1 policy in the relevant Final Rules.

First, no authority exists to include capital costs and capital payments in the VDA calculation. Furthermore, the Medicare Contractor determined Woodward's VDA payment by comparing its fixed costs to its total DRG payments. However, neither the language nor the examples[46] in 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[47] and the FFY 2009 IPPS Final Rule[48] 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 Woodward'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 Woodward's FY 2011 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her

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[44] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[45] *Id.* at 38180.
[46] PRM 15-1 § 2810.1(C), (D).
[47] 71 Fed. Reg. at 48056.
[48] 73 Fed. Reg. at 48631.

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[.]"[49] 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.[50]

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 under this subsection . . . 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 made for truly variable costs, such as food and laundry services."[51] 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.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
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> D. Determination on Requests.—. . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year*

[49] *Lakes Reg'l Healthcare*, Adm. 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.
[50] 82 Fed. Reg. at 38179-38183.
[51] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> *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***.
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> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[52]

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 DRG payment . . . subject to the ceiling[.]"[53] It is this new methodology that the Eighth Circuit found reasonably complied with the mandate to provide full compensation.[54] However, given that Woodward 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."[55] 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.

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[52] (Emphasis added).
[53] *See supra* note 31.
[54] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019).
[55] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an SCH for the fixed costs associated with a 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." 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 an SCH, eligible for a VDA payment, has been fully compensated for its fixed costs and, therefore, it is not a reasonable interpretation of the statute.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is clear that the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[56] 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 that portion of the hospital's DRG payment attributable to fixed costs.

Additionally, the Board concludes that Woodward's claim that the LVA payment should not be included in the VDA calculations is not supported by law. As stated in the statutory provisions governing the VDA at 42 U.S.C. § 1395ww(d)(5)(D)(ii), an SCH is entitled to "such adjustment to the payment amounts *under this subsection* . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs . . . ."[57] The VDA provisions are located in subsection (d) of

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[56] 48 Fed. Reg. at 39782.

[57] (Emphasis added.) The Board recognizes that this statutory provision includes the following exception: "such adjustment to the payment amounts under this subsection (*other than under paragraph (9)*)." However, the *sole*

42 U.S.C. § 1395ww. As such, all operating payments authorized by subsection (d) must be taken into account when calculating the VDA payment. The LVA provisions are also located in subsection (d) at paragraph (12) and, therefore, as subsection (d) payments, must be considered when calculating the VDA payment.

As the Board does not have the IPPS actuarial data to determine the division 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. For FY 2011, Woodward's fixed operating costs (which include semi-fixed costs) were 81.67[58] percent of its Medicare operating costs. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2010 Medicare Inpatient Operating Costs	$5,830,936[59]
Multiplied by the 2011 IPPS update factor	1.0235[60]
2010 Updated Costs (max allowed)	$5,967,963
2011 Medicare Inpatient Operating Costs	$4,949,351[61]
Lower of 2010 Updated Costs or 2011 Costs	$4,949,351
Less 2011 IPPS payment	$4,372,008[62]
2011 Payment CAP	$ 557,343

Step 2: Calculation of VDA

2011 Medicare Inpatient Operating Costs – Fixed	$4,041,977[63]
Less 2011 IPPS payment – fixed portion (81.67%)	$3,570,479[64]
Payment adjustment amount (subject to CAP)	$ 471,498

exception for Paragraph (9) of subsection (d) is not applicable since paragraph (9) addresses payments to Puerto Rico subsection (d) hospitals.

[58] The FY 2011 Fixed Inpatient Operating Costs as calculated by the Medicare Contractor of $4,041,977 (Exhibit C-1 at 31 of 35, Worksheet D-1, line 53) divided by the FY 2011 Total Inpatient Operating Costs of $4,949,351 (Exhibit C-1 at 19, Worksheet D-1, line 53) equals 81.67 percent. ($4,041,977/$4,949,351 = 0.816668084.)

[59] Provider's Final Position Paper at 5, Table 1.

[60] 75 Fed. Reg. 50041, 50676 (Aug. 16, 2010); *see also* Medicare Learning Network Matters MM7134 Revised (*available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7134.pdf).

[61] Exhibit C-1 at 19 (Worksheet D-1, Line 53).

[62] $4,107,129 (Exhibit C-1 at 22 Worksheet E, Part A, Line 49) + $264,879 (Exhibit C-1 at 23 Worksheet E, Part A, Line 70.97).

[63] *See* Exhibit C-1 at 31 (providing 2011 Medicare Inpatient Operating Costs - Fixed at Worksheet D-1 line 53 of the rerun cost report. (Note: The Medicare Contractor removed variable cost from the cost report and reran the cost report to determine Medicare Fixed Operating Costs)).

[64] The fixed portion of the DRG payments, $3,570,479 is calculated by multiplying $4,372,008 (the FY 2011 SCH payments) by the fixed cost percent of 81.6668084 percent (the fixed cost percentage was calculated by dividing the fixed operating cost of $4,041,977 by total operating cost of $4,949,351).

Since the VDA payment adjustment amount of $471,498 is less than the CAP of $557,343, the Board determines that Woodward should receive a total VDA payment for FY 2011 in the amount of $471,498. The Medicare Contractor paid Woodward $323,265 based on its previous calculation of the VDA.[65] As such, Woodward is entitled to an additional VDA payment of $148,233.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Woodward's VDA payment for FY 2011 and that Woodward should receive an additional VDA payment for FY 2011 in the amount of $148,233, resulting in a total FY 2011 VDA of $471,498.

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FOR THE BOARD:

7/1/2020

X Clayton J. Nix

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

[65] Stipulations at ¶ 5.