CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Trinity Regional Medical Center	**Reimbursement Determination for Period Ending:**
	December 31, 2007
Provider	
vs.	**Review of:**
Wisconsin Physician services	**PRRB Dec. No. 2017-D1**
Medicare Contractor	**Dated: December 15, 2016**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. The Center for Medicare (CM) submitted comments, requesting that the Administrator reverse, in part, the Board's decision. The Medicare Administrative Contractor (MAC) submitted comments, requesting that the Board's decision be partially reversed. The Provider submitted comments, requesting that the Administrator modify or affirm the decision of the Board. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Medicare Administrative Contractor (MAC), [1] correctly determined the amount of the Sole Community Hospital (SCH) volume decrease

[1] Formerly known as Fiscal Intermediaries (FIs), CMS's payment and audit functions under the Medicare program are now contracted to organizations known as Medicare Administrative Contractors (MACs). However, the term "intermediary" is still used in various statutes and regulations, and is

adjustment (VDA) in accordance with the regulations and Program instructions per 42 C.F.R. § 412.92(e)(3), and the Provider Reimbursement Manual (PRM), CMS Pub. 15-1 at § 28101.1.

The Board noted that the dispute in this case involved the proper classification of costs as fixed, semi-fixed, and variable, and the related issue of the proper method for calculation of the VDA. First, the Board held that the MAC correctly identified and eliminated variable costs from the VDA calculation for the Provider for fiscal year (FY) 2007. The Board stated that fixed costs are generally considered costs over which management has no short term control, such as rent, interest, depreciation and capital costs. Variable costs are those costs for items and services that vary directly with utilization, such as food and laundry costs. The Board noted that the PRM 15-1 §§ 2810.1(C) and (D) provide several examples of how to calculate the low volume adjustment. In this case, the Provider disputed the MAC's determination of five categories of costs as variable costs: (1) billable medical supplies; (2) billable drugs; (3) housekeeping; (4) dietary; and (5) laundry expenses. While the Provider argued that these costs, and all patient care costs are dependent upon physician orders and patient acuity over which the hospital management has no control, and thus should be considered "semi-fixed", the Board found that the MAC properly classified these costs as variable costs. The Board determined that these costs are directly and indirectly related to patient volume and the Provider failed to demonstrate otherwise in this case.

Regarding the related issue of the proper method for calculation of the VDA the Board found that neither the MAC nor the Provider's proposed calculations met requirements of the controlling Federal statute, regulation and interpretative guidance. The Board concluded that the VDA calculation should take into account the fact that the Inpatient Prospective Payment (IPPS)/Diagnosis Related Group (DRG) payment is intended to compensate a hospital for both fixed and variable costs, Recognizing that it did not have the IPPS actuarial data to determine the IPPS split between the fixed and variable costs, the Board opted to use the MAC's fixed/variable cost percentage split as a proxy. The MAC determined that fixed costs (including semi-fixed costs) were 71.582 percent of the Medicare inpatient operating costs.[2] The Board found that the payment amount should be calculated as follows:

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interchangeable with the terms "Medicare Administrative Contractor" or "Medicare Contractor".

[2] See Medicare Contractor Exhibit I-5 (listing $19,720,756 as the Total Fixed/Semi-fixed Operating Cost (D-1 Part II, Line 53)); Provider Exhibit P-5 (listing $27,549,808 as the Total Program Operating Costs (Adjusted FY 6/30/07 Final Reopened NPR Dated 7/27/12, D-1, Part II, Line 53)).

Step 1:

2006 Medicare Inpatient Operating Costs	$29,475,624[3]
Multiplied by the 2007 IPPS update factor	1.034[4]
Updated Costs (Max Allowed)	$30,477,795
2007 Medicare Inpatient Operating Costs	$27,549,808[5]
Lower of Updated Costs or 2007 Medicare Inpatient Operating Costs	$27,549,808
Less 2007 DRG payments	$26,737,475[6]
2007 Payment Cap	$812,333

Step 2:

2007 Audited Medicare Inpatient **Fixed** Operating Costs (excluding pass through costs)	$19,720,756[7]
Less 2007 DRG payments- **Fixed** Portion	$19,139,219[8]
Payment Adjustment Amount	$581,537

The Board found that, in order to determine the Provider's VDA amount, the Board compared the payment adjustment amount of $581,537 to the cap of $812,333 and since the payment adjustment amount is less than the CAP amount, the Provider should receive a VDA for FY 2007 in the amount of $581,537.

SUMMARY OF COMMENTS

CM submitted comments stating that, while it agreed with the Board that the MAC properly identified and eliminated variable costs, it disagreed with the Board regarding its finding that the MAC improperly calculated the VDA payment for the Provider. As such, CM recommended that the Administrator reverse the Board's decision and uphold the MAC's determination in regard to the VDA payment

[3] The Board cited Provider Exhibit P-5.
[4] The Board cited Provider Exhibit P-5.
[5] The Board cited Provider Exhibit P-5.
[6] The Board cited Provider Exhibit P-5.
[7] The Board cited Intermediary Exhibit I-5 at 7.
[8] The Board calculated this figure by the total IPPS payments of $26,737,475 by 0.71582 (the fixed cost percentage).

calculation. CM stated that the Board properly concluded that, pursuant to the statute, regulation, and CMS guidance from the *Federal Register* and PRM, variable costs are to be excluded from the VDA calculation.

However, CM argued that in its finding that the Board improperly calculated the VDA payment, using a fixed cost percentage in its calculation which is not supported by any prior CMS guidance. CM noted that the VDA methodology present by the Board in this case is inconsistent with the methodology affirmed by the Board in *Greenwood County Hospital*, PRRB Dec. No. 2006-D43, as it introduces a new factor into the calculation: a fixed cost percentage applied as a proxy to the total DRG payment. CM noted that even if the statute could be interpreted as permitting this alternative methodology, it is not a methodology that CMS has adopted.

CM stated that the correct methodology is as follows:

1. Cap Calculation	
2007 Medicare Inpatient Operating Costs	$27,549,808
Less 2007 DRG Payments	$26,941,009[9]
2007 Payment Cap	$608, 799
2. Payment Calculation	
Lower of Fixed Costs from 2006 Updated or 2007	$22,035,582
Less 2007 DRG Payments	$26,941,009
Payment Adjustment Amount	$-$4,905,427

The MAC submitted comments stating that it disagreed with the Board's finding that it had improperly calculated the VDA payment for the Provider. The MAC noted that for guidance in calculating the VDA and the ceiling, it had relied on the Administrator's decisions in *Unity Healthcare*, PRRB Dec. No. 2014-D15, *Lakes Regional Healthcare*, PRRB Dec. No. 2014-D16 and *St. Anthony Regional Hospital*, PRRB Dec. No. 2016-D16. Following the methodology in these cases, the VDA and ceiling were calculated as follows:

Calculation of the VDA

Provider's total operating costs	$27,549,808[10]

[9] CM noted that the DRG payment of $28,939,219, originally used in the MAC's calculation and cited in the Board's decision, incorrectly included pass through costs (e.g., capital costs). The correct 2007 DRG payment is $26,941,009, as shown here.

Net variable costs	$5,514,226[11]
Provider's fixed costs	$22,035,582
Provider's DRG payments	$28,939,219[12]
VDA Payment Amount	<$6,903,637>[13]

Calculation of Ceiling

Provider's total operating costs	$27,549,808 (above)
Provider's DRG payments	$28,939,219 (above)
Ceiling	N/A[14]

Thus, the MAC noted that following the computation method in the Administrator's decisions in *Unity, Lakes Regional Healthcare*, PRRB Dec, No. 2014-D16 and *St. Anthony Regional Hospital*, PRRB Dec. No. 2016-D16, the Provider is not entitled to a VDA, since the DRG payments were sufficient to cover its fixed costs.

The MAC further asserted that upon review of the Board's calculation, it appeared that the Board erred by attempting to apply a computed fixed costs percentage to the DRG payments. The MAC pointed out that the Administrator has overturned this same approach used by the Board for appeals involving the providers referenced in the cases above. This approach is not supported by any regulations or instructions.

The Provider submitted comments requesting the Administrator reverse the Board's decision that certain costs were variable and excluded for purposes of calculating the VDA and accordingly, that the Administrator modify the Board's decision regarding the proper calculation of the VDA relief.

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[10] The MAC cited PRRB Dec. 2017-D1, at 6, using the figure for "total operating costs" from the top of the page.

[11] Id. using the figure for "variable costs."

[12] The Administrator notes that the MAC appeared to inadvertently omit the line, "Provider's DRG payments" from the equation in Step 1, as evident from Step 2 where the MAC refers to the amount "$28,939,219 (above)". The amount $28,939,219 for DRG payments can also be found in MAC's final position paper, pages 8 and 10.

[13] The MAC noted that, where the DRG payments received are greater than its fixed costs, the Provider is not entitled to a VDA, as the VDA is intended to cover only the provider's fixed costs.

[14] The MAC noted that a ceiling cannot be negative and thus is not applicable in this case because the Provider's DRG payments exceeded its fixed costs.

Regarding the Board's calculation, the Provider argued that the Board properly calculated the ceiling limit, but did not properly determine which costs should be included in the VDA relief portion of the calculation. The Provider asserted that, while the Provider agrees with the Board's methodology of using Medicare inpatient fixed costs minus DRG payments related to those fixed costs, the Provider disagrees with the costs that the Boards determined were variable. The Provider stated that all of its costs should be included as fixed or semi-fixed costs which would result in a VDA payment of $812,333 instead of the $581,537 payment the Board determined was due to the Provider. The Provider stated that fixed costs are those costs over which management has no control. Thus, these costs at issue are not dependent on patient volume but vary based on patient acuity, need and physicians orders (medical supplies, drugs, food ordered and used). Billable medical supplies, billable drugs, housekeeping duties, and laundry should be considered semi –fixed as at least some portion involves an unavoidable expense.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments were received timely and are included in the record and have been considered.

In this case, the Provider, is a 116-bed acute care hospital located in Fort Dodge, Iowa. The Provider participates in the Medicare program as a Sole Community Hospital (SCH). Section 1886 (d)(5)(D)(iii) defines a SCH as any hospital:

> (I) that the Secretary determines is located more than 35 road miles from another hospital,
> (II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A of this subchapter, or
> (III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(v)(i) of this title as in effect on September 30, 1997.

The Provider requested an additional payment of approximately $800,000 to compensate it for a decrease in inpatient discharges. The MAC denied this request

for a VDA and the Provider timely appealed and met the jurisdiction requirements for a hearing before the Board. The Board conducted a hearing on June 4, 2015. The Board determined that the Provider was due a VDA payment of $581,537.

Section 1886(d)(5)(D)(ii) of the Act authorizes the Secretary of DHHS to adjust the payment of SCHs that incur a decrease in discharges of more than 5 percent from one cost reporting year to the next, stating:

> 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, …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 core staff and services.

The regulations implementing this statutory adjustment are located at 42 C.F.R. §412.92(e). In particular, subsection (e)(1) specifies the following regarding low volume adjustment:

> The intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances [beyond the hospital's control] a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period.

Once an SCH demonstrates that it has suffered a qualifying decrease in total inpatient discharges, the MAC must determine the appropriate amount, if any, due to the provider as an adjustment. The regulation at 42 C.F.R. §412.92(e)(3) specifies the following regarding the determination of low volume adjustment amount:

> (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 ….
>
> (i) In determining the adjustment amount, the intermediary considers –
>
> (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; and
> (C) The length of time the hospital has experienced a decrease in utilization.

In addition to the controlling regulation, CMS also provides interpretive guidelines in the Provider Reimbursement Manual, (PRM 15-1). The Manual is intended to ensure that Medicare reimbursement standards "are uniformly applied nationally without regard to where covered services are furnished.[15] Specifically, §2810.1 provides guidance to assist MACs in the calculation of VDAs for sole community hospitals (SCHs). In this regard, § 2810.1(B) states the following regarding the amount of a low volume adjustment:

> B. Amount of Payment Adjustment. Additional payment is made to an eligible SCH for *fixed costs* it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, *not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.*
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> 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.
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> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.
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> In evaluating semi-fixed costs, the MAC considers the length of time the hospital has experienced a decrease in utilization. For a short

[15] See CMS Pub. 15-1, Foreword.

> period of time, most semi-fixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semi-fixed costs may not be included in determining the amount of the payment adjustment. (Emphasis added.)

In the discussion included in the preamble to the August 18, 2006 final rule[16], the Secretary stated that:

> The process for determining the amount of the volume decrease adjustment can be found in section 2810.1 of the Provider Reimbursement Manual. Fiscal intermediaries are responsible for establishing whether an SCH or MDH is eligible for a volume decrease adjustment and, if so, the amount of the adjustment. To qualify for this adjustment, the SCH or MDH must demonstrate that: (a) A 5 percent or more decrease of total discharges has occurred; and (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal intermediary has established that the SCH or MDH satisfies these two requirements, it will calculate the adjustment. *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 SCH or MDH receives the difference in a lump-sum payment. (Emphasis added.)

The core issue in this case centers on the application of the statute and regulation to the proper classification and treatment of costs and the proper calculation of the amount for the volume decrease adjustment. The Administrator's examination of the governing statutes and implementing regulations and guidance clearly recognize three categories of costs, i.e., fixed, semi-fixed and variable. The guidance only considers fixed and semi-fixed costs within the calculation of the volume adjustment but not variable costs.

The Board properly accepted the MAC's determination and elimination of variable costs for FY 2007. The MAC's exclusion of the Provider's billable medical supplies, billable drugs, housekeeping, dietary and laundry as variable was proper and consistent with the regulation, guidance and intent of the adjustment. The Administrator finds that the Board properly determined that these costs, not only were specifically identified as variable in the PRM, but that the types of cost

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[16] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).

associated with all of the categories of costs cited by the MAC would generally be expected to be inherently correlated to some degree with patient volume as they are tied directly or indirectly to patient services and hence patient volume. Moreover, the record supports the Board's finding that, even assuming *arguendo* such costs could be considered semi-fixed or fixed, the Provider failed to provide convincing evidence (e.g., contracts) demonstrating that any portion of these costs was fixed or semi-fixed.

The treatment of variable cost within the calculation of the VDA is well established. 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. This position is also supported by past decisions, such as *Greenwood County*, PRRB Dec. No. 2006-D43, where the Board correctly eliminated variable costs from the calculation. Therefore the Administrator affirms the Board's decision regarding the elimination of variable costs from the Provider's VDA payment adjustment request.

However, the Administrator disagrees with the methodology adopted by the Board. Regarding the methodology and proper calculation of the Provider's payment adjustment, the Administrator finds that the Board improperly calculated the Provider's adjustment and reverses that portion of the Board's decision. The VDA calculation methodology used by the Board is in direct contradiction to the statute and CMS' regulations and guidance wherein the intent is to compensate qualified hospitals for their fixed costs and not their variable costs. The Board's methodology uses a VDA payment that takes into account the fact that the IPPS payments include reimbursement for both fixed and variable costs. The Board noted that it did not have IPPS actuarial data to determine the IPPS split between the fixed and variable costs, but instead, opted to use the MACs fixed/variable cost percentage split (71.582 percent[17]) as a proxy.

Board's Calculation of Payment Adjustment:

Step 1:

2006 Medicare Inpatient Operating Costs	$29,475,624[18]
Multiplied by the 2007 IPPS update factor	1.034[19]
Updated Costs—(Max Allowed)	$30,477,795

[17] See Board's decision at 8.

[18] The Board cited to Provider's Exhibit P-5.

[19] The Board cited Provider's Exhibit P-5, (listing the 2007 IPPS update factor as 103.40 percent as published in 71 Fed. Reg. 47870, 48154 (Aug. 18, 2006)).

2007 Medicare Inpatient Operating Costs	$27,549,808[20]
Lower of Updated Costs or 200t Medicare Inpatient Operating Costs	$27,549,808
Less 2007 DRG payments	$26,737,475[21]
2007 Payment CAP	$812,333
Step 2:	
2007 Audited Medicare Inpatient Fixed Operating Costs (excluding pass through costs)	$19,720,756[22]
Less 2009 DRG payment—fixed portion	$19,139,219[23]
Payment Adjustment Amount	$581,537

The Board's calculation incorrectly concludes that the payment amount for the VDA is $581,537. To reach this amount, effectively, the Board used the ratio of fixed/semi-fixed to total costs, that the MAC found, as a proxy for the share of the Provider's IPPS payment that it assumed were attributable to fixed costs. As the MAC had determined that 71.582 percent of the Provider's costs were fixed and semi-fixed costs, the Board assumed that 71.582 percent of the Provider's DRG payments were for fixed costs. The Board's creation of a "fixed portion" of the DRG payment is unsupported by the statute, regulations, manual, and prior case law. Moreover, the statute states that the Secretary is to provide for such an adjustment to the payment amount "as may be necessary to fully compensate the hospital for the fixed costs it incurred." CMS has reasonably concluded that when a SCH experiences a five percent decrease in patient volume due to circumstances

[20] The Board cited Provider's Exhibit P-5 (listing $27,549,808 as the FY 2007 Program Operating Cost Worksheet D-1, Part II, Line 53 of Adjusted FY 6/30/2007 Final Reopened NPR Dated 7/27/12 (as referenced by the Provider as cost report schedule not part of the administrative record)).

[21] The Board cited Provider's Exhibit P-5 (listing $26,737,475 as the FY 2007 DRG Operating Payments Worksheet E, Part A, Line 8 of Adjusted FY 6/30/07 Final Reopened NPR Dated 7/27/12 (as referenced by the Provider as cost report schedule in not part of the administrative record)).

[22] The Board cited Medicare Contractor Exhibit I-5 at 7 (listing $19,720,756, as Trinity's FY 2007 audited net Medicare fixed/semi-fixed costs as reflected on D-1, Part II, Line 53)).

[23] The Board stated that it calculated the ratio figure by multiplying the total IPPS payments of $26,737,475 for FY 2007 by the fixed/semi-fixed cost percentage of 71.582.

beyond its control the total Medicare payments to the SCH which would be made up of the volume adjustment payment and the subsection (d) IPPS payments (e.g., DRG revenue received) which the SCH has received, must be at least equal to the SCH "fixed costs". This is achieved by subtracting the DRG revenue from the fixed costs, thereby assuring "full compensation" for the fixed costs. By carving out a portion of the DRG revenue as related to variable costs, the Board's method in fact provides for variable costs to also be compensated.

The Administrator finds that the correct payment adjustment, which follows the controlling statute, regulations and is also reflected in *Greenwood* and *Unity*, cited *supra*, is as follows:

Calculation of the VDA

Provider's total operating costs	$27,549,808[24]
Net Variable Costs	$ 5,514,226[25]
Provider's fixed costs	$22,035,582
Provider's DRG payments	$26,941,009[26]
VDA Payment Amount	<$4,905,427>[27]

Calculation of Ceiling Cap

Provider's total operating costs	$27,549,808
Provider's DRG payments	$26,941,009[28]
Ceiling	$608,799

Thus, the Provider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG payment, which in this case equates to (minus) -- $4,905,427, subject to the ceiling of $608,799. As the Provider has already received $26,941,009 in DRG payments, thus, creating a negative adjustment amount, the net amount due to the Provider is $0.

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[24] *See* n. 10.
[25] *See* n. 11.
[26] *See* n. 9.This amount correctly shows the amount after removing pass through costs.
[27] Where the DRG payments received by the Provider is greater than its fixed costs, the Provider is not entitled to a VDA as the VDA is intended to cover only the Provider's fixed costs.
[28] *See* n. 9.

In sum, the Administrator finds that the Board properly found that the MAC correctly identified and eliminated variable costs in determining the Provider's fixed costs for FY 2006 for purposes of the determination on the Provider's request for an SCH VDA, and affirms the Board on that portion of the decision. However, as discussed above, the Administrator finds that the Board's calculation of the VDA amount was improper. Therefore the Administrator modifies the Board's decision as it specifically relates to the calculation of the Provider's volume decrease adjustment amount.

DECISION

The decision of the Board is modified in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 2/9/17

/s/

Patrick H. Conway, M.D., MSc
Acting Administrator
Centers for Medicare & Medicaid Services