PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D52

PROVIDER-
St. Mary's Regional Hospital

Provider No.: 24-0101

vs.

MEDICARE CONTRACTOR –
National Government Services

RECORD HEARING DATE –
January 11, 2018

Cost Reporting Period Ended –
June 30, 2009

CASE NO. – 14-3942

INDEX

ISSUE STATEMENT:

Whether the Medicare Administrative Contractor[1] was correct when it calculated the Provider's volume decrease adjustment ("VDA") by prorating the amount of the VDA according to the portion of the year during which the Provider maintained sole community hospital ("SCH") status.[2]

DECISION:

After considering the Medicare law and regulations, the evidence admitted, and the parties' contentions, the Provider Reimbursement Review Board ("Board") majority finds that St Mary's VDA should be prorated based on discharges beginning on or after May 30, 2009. Since the Medicare Contractor prorated St. Mary's VDA based on days, the Board majority remands the VDA back to the Medicare Contractor for recalculation using a proration based on discharges.

INTRODUCTION:

St. Mary's Regional Hospital ("St. Mary's" or "Provider") is an SCH located in Detroit Lakes, Minnesota. By a letter dated April 30, 2009, the Centers for Medicare & Medicaid Services' ("CMS") Regional Office recommended that the Provider be approved for SCH status because there is no "like" hospital within 35 miles of the Provider.[3] Accordingly, the Medicare Contractor notified St. Mary's on June 3, 2009, that it had been approved for SCH status, with an effective date of May 30, 2009.[4]

St. Mary's timely filed a request for a VDA for its 6/30/2009 fiscal year end.[5] The Medicare Contractor issued a determination prorating St. Mary's VDA for the period it was a SCH.[6] On September 26, 2013, St. Mary' submitted a timely request for reconsideration,[7] and on February 16, 2014, the Medicare Contractor issued a reconsideration determination upholding the proration of the VDA.[8]

The Provider appealed the decision to prorate the VDA calculation to the Board and met the jurisdictional requirements for a hearing.[9] The Board conducted a Record hearing on January 11, 2018. The Provider was represented by Eric Zimmerman, Esq., of McDermott, Will & Emery, LLP. The Medicare Contractor was represented by Jerrod Olszewski, Esq., of Federal Specialized Services.

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[1] Noridian Healthcare Solutions was the servicing Medicare Administrative Contractor ("MAC") at the time the Sole Community Hospital status was approved. Effective August 10, 2013, National Government Services, Inc. became the servicing MAC for the Provider. The term "Medicare Contractor" will be used to identify either of these MACs. *See* Medicare Contractor's Final Position Paper at 4.
[2] Joint Statement of the Issue.
[3] Exhibit P-1 at 3.
[4] *Id* at 2.
[5] Exhibit P-2.
[6] Exhibit P-4 at 11-14
[7] *Id.* at 2.
[8] Exhibit P-5 at 3, 8.
[9] Exhibit P-18.

STATEMENT OF FACTS AND RELEVANT LAW:

42 USC § 1395ww(d)(5)(D)(iii) defines the term SCH to mean 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…is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A; or
> (III) is located in a rural area that has been designated as an essential access community hospital under 42 U.S.C. § 1395i-4(i)(1).

42 USC § 1395ww(d)(5)(D)(ii) authorizes the Secretary to adjust the Medicare payment to 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, the Secretary shall provide for such adjustment to the payment amounts… as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

CMS regulations implementing the SCH provisions are located at 42 C.F.R. § 412.92. Paragraph (b) of this section relates to classification procedures for SCHs and states in pertinent part:

> (2) *Effective dates of classification*.
> (i) Sole community hospital status is effective 30 days after the date of CMS' written notification of approval…
> ***
> (iv) A hospital classified as a sole community hospital receives a payment adjustment as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS's approval of the classification.

Paragraph (d) of this section relates to the determination of perspective payment rates. Significantly, 42 C.F.R. § 412.92(d)(3)[10] states:

> (3) *Adjustment to payments*. A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in the number of discharges, as described in paragraph (e) of this section.

[10] *See* 65 Fed Reg. 47084 (Aug. 1. 2000) (redesignating 42 C.F.R. § 412.92(d)(2) to 42 C.F.R. § 412.92(d)(3)).

St. Mary's and the Medicare Contractor have stipulated that the Provider's SCH status was effective May 30, 2009, and that the Provider qualified for a VDA for 2009.[11] However, the parties disagree on whether St Mary's should receive a VDA for the entire cost reporting period or if the VDA should begin 30 days after the date of CMS' approval of the SCH classification.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

St. Mary's contends it experienced a decrease of more than five percent in its discharges for reasons beyond its control, and therefore in accordance with the statute, regulations, and Provider Reimbursement Manual ("PRM"), it was entitled to a VDA for the entire cost reporting period.[12] St. Mary's maintains the statute does not direct the Medicare Contractor to prorate the VDA, rather it requires such adjustment to the payment amount "necessary to fully compensate the hospital for the fixed costs it incurs in the period."[13]

Similarly, St. Mary's asserts the regulations require the Medicare Contractor to "provide[] for a payment adjustment … for any cost reporting period" in which the SCH incurs a qualifying volume decrease.[14] The Provider points out that the PRM, which goes into great detail regarding the VDA calculation, does not include any discussion regarding whether, or how, to prorate the VDA.[15] Given all of the detail in the PRM as to how to calculate the VDA, St. Mary's believes CMS's silence on how to prorate a VDA is a strong indication that CMS did not intend for Medicare contractors to prorate a hospital's VDA. Without instruction in the statute, regulation, or manual, the Provider concludes the Medicare Contractor does not have the authority to prorate the VDA.[16]

St. Mary's is adamant that the statute and regulations[17] both establish an implicit "if, then" construct for purposes of the VDA: if a hospital meets the three eligibility requirements for a VDA, then the hospital is entitled to a VDA. The three eligibility requirements are: (a) the hospital must be a SCH; (b) the hospital must have experienced a five percent decrease in discharges in the cost reporting period; and (c) the decrease in discharges must be due to factors beyond the hospital's control.[18] St. Mary's points out that the second two criteria are not at issue in this case. The Provider asserts the only criteria at issue in this case is the first criteria as the Medicare Contractor attempts to infer this eligibility criteria means that a hospital must have been a SCH for the entire cost reporting period in order to be entitled to a VDA for the entire cost reporting period.[19] The Provider insists this is directly contrary to the language in the PRM which states that a hospital may qualify for a VDA if it has been "approved as a SCH for at least a part of the cost reporting period."[20]

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[11] Joint Stipulations of Facts.
[12] Provider's Final Position Paper at 10-11.
[13] *Id.* at 11-12 (*citing* 42 U.S.C. § 1395ww(d)(5)(D)(ii)).
[14] Provider's Final Position Paper at 12 (citing 42 C.F.R. § 412.92(e)(1)).
[15] Provider Reimbursement Manual, CMS Pub. 15-1, § 2810.1.
[16] Provider's Final Position Paper at 16-17.
[17] *See* 42 U.S.C. § 1395ww(d)(5)(D)(ii); 42 C.F.R. § 412.92(e)(1).
[18] Provider's Final Position Paper at 13-14.
[19] *Id.* at 14.
[20] Provider Reimbursement Manual, CMS Pub. 15-1, § 2810.1.

The Provider also asserts that the Medicare Contractor is interpreting the term "cost reporting period" as it appears in the regulations to mean two different things. It is the Medicare Contractor's position is that while discharges from the full cost reporting period should be used for purposes of qualifying for the VDA, the relief to be provided by the VDA should only be available for the portion of the cost reporting period after the hospital is designated as a SCH. St. Mary's insists there is no support for this inconsistent interpretation of the words, "cost reporting period" in the statute or regulations.[21]

Finally, St. Mary's believes the precision with which CMS determines the effective date of a hospital's SCH status is specifically intended to address administrative issues under the prospective payment system, in particular the need to update the claims payment process to implement the change and eliminate the need to reprocess claims.[22] Since the VDA is not a prospective payment, St. Mary's insists that the precise date on which the hospital is considered a SCH is not relevant to determining the VDA.[23]

The Medicare Contractor disagrees and believes the VDA is afforded to a provider that is classified as a SCH and St. Mary's was only classified as a SCH for 32 days of its cost reporting period. The Medicare Contractor insists that prorating the VDA is necessary because the Provider was not a SCH for the entire cost reporting period.[24]

The Board majority reviewed the statute, regulations and manual to determine if the VDA should be prorated for the period the Provider was a SCH. The regulations at 42 C.F.R. § 412.92(b)(2)(iv) specifically address the effective dates for SCH payments adjustments stating that "a hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS's approval of the classification." Paragraph (d) addresses how SCHs are paid and includes three subsections. Section (d)(1) states that a hospital is paid the greater of the federal rate or the hospital specific rate, section (d)(2) addresses the hospital specific rate calculations, and section (d)(3) addresses the VDA. Specifically section (d)(3) states:

> (3) *Adjustment to payments*. A sole community hospital may receive an adjustment to its payments **to take into account a significant decrease in the number of discharges**, as described in paragraph (e) of this section.

[21] Provider's Final Position Paper at 14.

[22] In response to a comment requesting that SCH status be effective immediately as opposed to 30 days after approval, CMS noted that "[o]ften it is extremely difficult to ascertain the exact date that a hospital meets the criteria for SCH designation. This is particularly true of those hospitals qualifying because no more than 25 percent of the service area patients utilize alternative sources of care. Moreover, for those hospitals that first apply for SCH status during or after the second year of the prospective payment system, SCH designation will result in different prospective payment rates. If we were to make the SCH date retroactive, we would need to reprocess every inpatient hospital claim submitted for the hospital and make adjustment payments at a new rate. It is not in keeping with the basis of the prospective payment system or the concept of budget neutrality to permit retrospective adjustment of Medicare prospective payment rates." 49 Fed. Reg. 234, 271 (Jan. 3, 1984).

[23] Provider's Final Position Paper at 15-16.

[24] Medicare Contractor Final Position Paper at 5-6.

The Board majority finds that all the payment methodologies in section (d), which includes the VDA are effective 30 days after the date of CMS's approval of the classification. Had CMS not put the VDA under paragraph (d) then the effective date in C.F.R. § 412.92(b)(2)(iv) would not have clearly applied to calculating the VDA.

Section (d)(3) references paragraph (e)[25] which is broken down into three subsections. Section (e)(1) is the calculation to determine if the hospital qualifies for a VDA, section (e)(2) addresses the procedural requirements and documentation that must be submitted with a VDA request, and section (e)(3) provides information related to the calculation of the VDA. Section (e)(1) requires a comparison of the change in discharges between two full costing reporting periods stating "[i]f either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply by 12 to estimate the total number of discharges for a 12-month cost reporting period." The Board majority finds the use of section (e)(1) is limited to determining if a provider meets the criterion to receive a VDA, and does not address how to determine the amount of the VDA. The Board majority points out that section (e)(3) which describes how to calculate the amount of the VDA does not specifically address the time period to be used in the calculation. While the Board majority understands how the language in 42 C.F.R. § 412.92(e)(1) might lead the Provider to believe the VDA should be made for the entire cost reporting period, the Board majority finds that 42 C.F.R. § 412.92(e) must be read in connection with 42 C.F.R. § 412.92(b)(2)(iv), requiring that the VDA be prorated based on discharges occurring 30 days after the date of CMS's approval of SCH classification.

Likewise the Board majority disagrees with the Provider's contention that the precision with which CMS determines the effective date of a hospital's SCH status is specifically intended to eliminate the need to reprocess claims.[26] While it is clear that CMS did not want to make a hospital's SCH status retroactive because of the need to reprocess claims,[27] the Board majority also finds that the effective date in 42 C.F.R. § 412.92(b)(2)(iv) applies to all of paragraph (d) which includes:

> (d)(1) *General rule*…a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period…
> (d)(2) *Transition of the FY 1996 hospital specific rate*…
> (d)(3) *Adjustment to payments*. A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in the number of discharges, as described in paragraph (e) of this section.

The record shows that CMS approved St. Mary's SCH status on April 30, 2009, with an effective date May 30, 2009.[28] Therefore based on 42 C.F.R. § 412.92(b)(2)(iv) the Board majority concludes that St. Mary's VDA should be prorated for discharges beginning on or after May 30,

[25] 42 C.F.R. § 412.92(e)
[26] Provider's Final Position Paper at 15.
[27] 49 Fed. Reg. 234, 271 (Jan. 3, 1984).
[28] Exhibit P-1 at 2-3.

2009. As the Medicare Contractor prorated St. Mary's VDA based on days rather than discharges,[29] the Board majority remands St. Mary's 6/30/2009 VDA back to the Medicare Contractor to calculate the VDA using a proration based on discharges.

DECISION:

After considering the Medicare law and regulations, the evidence admitted, and the parties' contentions, the Board majority finds that St Mary's VDA should be prorated based on discharges beginning on or after May 30, 2009. Since the Medicare Contractor prorated St. Mary's VDA based on days, the Board majority remands the VDA back to the Medicare Contractor for recalculation using a proration based on discharges.

BOARD MEMBERS PARTICIPATING:

Charlotte F. Benson, C.P.A.
Gregory Ziegler, C.P.A, C.P.C-A
Robert Evarts, Esq. (Dissenting)

FOR THE BOARD:

/s/
Board Member

DATE: September 28, 2018

[29]Exhibit P-4 at 13-14; Exhibit P-5 at 8.

Robert A. Evarts, Esquire - Dissenting

For the reasons explained below, I dissent from the Board Majority's decision and would grant St. Mary's Regional Hospital ("St. Mary's") a volume decline adjustment ("VDA") lump sum payment for the cost report period ending June 30, 2009.

By way of background, in a letter dated April 30, 2009, the Centers for Medicare & Medicaid Services ("CMS") granted St. Mary's sole community hospital ("SCH") status effective May 30, 2009 (30 days from the date of the letter).[30] As a result of a significant decrease in admissions for its cost reporting period ending June 30, 2009, St. Mary's timely filed a request for a VDA. The Medicare Contractor[31] issued a determination prorating the VDA for the period (May 30, 2009 through June 30, 2009) that St. Mary's was an approved SCH.[32] St. Mary's requested reconsideration of the Medicare Contractor's determination[33] which was denied on February 16, 2014[34] and St. Mary's appealed this final determination to the Board.

The statute establishing the VDA, 42 U.S.C.A. § 1395ww(d)(5)(D)(ii), and Congressional intent reflected therein, must be examined when determining the appropriate method for awarding a VDA to a SCH.

> **(ii)** 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 (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.
>
> [Emphasis added].

Statutory construction begins by examining the language of the statute, considering the entire language of the statute in its plain, ordinary, and popular sense. The intention of the legislature is to be ascertained primarily from the language used in the statute because that is the best evidence of legislative intent. If the statutory language is unambiguous and the statutory scheme is coherent and consistent, that ends the inquiry. If the language of a statute is clear and

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[30] Exhibit P-1 at 3.
[31] Noridian Healthcare Solutions was the servicing Medicare Administrative Contractor ("MAC") at the time the Sole Community Hospital status was approved. Effective August 10, 2013, National Government Services, Inc. became the servicing MAC for the Provider. The term "Medicare Contractor" will be used to identify either of these MACs. See Medicare Contractor's Final Position Paper at 4.
[32] Exhibit P-3 at 4.
[33] Exhibit P-4.
[34] Exhibit P-5 at 3 and 8.

unambiguous, a court need not apply any rules of construction other than to require that words and phrases be given their plain, ordinary, and usual meanings.[35]

Furthermore, when construing a statute to effect the legislative purpose, the statutory language should be given a reasonable construction, meaning one that is sensible, practical, and workable. If a statute is susceptible of more than one construction, it must be given that which will best effect its purpose rather than one that would defeat it even though both constructions are equally reasonable. Any ambiguity or uncertainty as to the legislative intent should receive the interpretation that best accords with the public benefit and the interpretation that operates most equitably, justly, and reasonably is the one that should be accepted.[36]

Another tenet of statutory construction is that the word "shall" is imperative, operating to impose an enforceable duty, against the party to whom the statute is directed. That is, in the absence of a showing of a contrary intent on the part of the legislature, the word "shall" is considered mandatory and inconsistent with the idea of discretion.[37]

Where the legislature has made no exception to the positive terms of a statute, the presumption is that it intended to make none. It is especially true that the power to create exceptions may not be exercised where the words of the statute are free from ambiguity. It is declared that if statutes are too rigid in their provisions, the remedy is with the legislature.[38]

The language of 42 U.S.C.A. § 1395ww(d)(5)(D)(ii) is clear and unambiguous when it states that, if a SCH experiences a greater than 5% decrease in discharges from one cost report period to the next cost report period, the Secretary ***shall fully compensate the hospital for the fixed costs it incurs in the period.*** The statute does not contain any language that requires a SCH to be qualified as a SCH for the entire cost report period at issue in order to qualify for a VDA. The sensible, practical and workable construction of the statute reveals that Medicare beneficiaries would benefit by granting St. Mary's the VDA for the entire cost report period. Furthermore, the Medicare Contractor, by prorating the VDA, exercised discretion and carved out an exception to the obligation of the Secretary to fully compensate the SCH for its fixed costs during the cost report period.

This interpretation of the VDA statute is supported by the stated purpose of the SCH program generally, and the VDA in particular. As CMS stated, "[t]he intent of the SCH provision is to ensure the availability of short-term acute care services to Medicare beneficiaries by providing special payment provisions for those hospitals located in remote areas."[39] The SCH program achieves this goal, in part, by providing SCHs with special payment protections under the Inpatient Prospective Payment System ("IPPS"). In particular, the VDA is intended to ensure that SCHs remain viable and reliable sources of care for Medicare beneficiaries in their area.

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[35] 82 C.J.S. Statutes § 396
[36] 82 C.J.S. Statutes § 400
[37] 82 C.J.S. Statutes § 498
[38] 73 Am. Jur. 2d Statutes § 204
[39] 49 Fed. Reg. 234, 271 (Jan. 3, 1984).

The regulation implementing the VDA leads to the same conclusion. Specifically, 42 C.F.R. § 412.92(e) states:

> (e) *Additional payments to sole community hospitals experiencing a significant volume decrease.*
>
> (1) For cost reporting periods beginning on or after October 1, 1983, 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 as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.
>
> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement—
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> (i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and
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> (ii) Show that the decrease is due to circumstances beyond the hospital's control.
>
> (3) Effective for cost reporting periods beginning before October 1, 2017, 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 for 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). Effective for cost reporting periods beginning on or after October 1, 2017, the

> MAC determines a lump sum adjustment amount equal to the difference between the hospital's fixed Medicare inpatient operating costs and the hospital's total MS-DRG revenue based on MS-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 and for indirect medical education costs as determined under §412.105) multiplied by the ratio of the hospital's fixed inpatient operating costs to its total inpatient operating costs.
>
> (i) In determining the adjustment amount, the intermediary considers—
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> (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.
>
> (ii) The intermediary makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.
>
> (iii) The intermediary determination is subject to review under subpart R of part 405 of this chapter.

The language of 42 C.F.R. § 412.92(e) tracks the statutory language and does not grant the Medicare Contractor discretion to prorate the VDA. To the contrary, the regulation provides the formula to calculate the VDA amount[40] designed to pay for all of the SCH's Medicare inpatient operating costs. This formula upholds the clear and stated intent of the VDA statute.

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[40] ". . . 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 for 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)." 42 C.F.R. § 412.92(e)(3).

The relevant sections of Provider Reimbursement Manual ("PRM") reinforce this conclusion stating:

> § 2810.1 - Additional Payments To SCHs That Experience A Decrease In Discharges.--If a hospital that is classified as an SCH experiences, due to circumstances beyond its control, a decrease of more than 5 percent in its total number of discharges compared to the immediately preceding cost reporting period, the hospital may receive a payment adjustment. . . .
>
> PRM § 2810.1 B - Amount of Payment Adjustment.--Additional payment is made to an eligible SCH 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.
>
> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed 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 semifixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.
>
> In evaluating semifixed costs, the intermediary considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed 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 semifixed costs may not be included in determining the amount of the payment adjustment.
>
> The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The intermediary reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

By referencing the difference between the SCH's "Medicare inpatient operating cost and the hospital's ***total DRG revenue***" as the basis for the VDA payment, the PRM also reflects the conclusion that a VDA payment is intended to fully compensate the SCH for the entire cost report period. This conclusion is also supported by the preamble to a 1983 revision to 42 C.F.R § 412.92(e)(3) in which CMS states:

> Based on our experience with this provision and the applications we have received from SCHs for a volume adjustment, we believe that it is appropriate at this time to clarify the regulations at § 412.92(e). Section 1886(d)(5)(C)(ii) of the Act provides that if an SCH experiences a decrease of more than five 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." We believe that this language makes it clear that a hospital that has continued to receive payments under the prospective payment system that are greater than its inpatient operating costs, even though there has been a decline in occupancy, is not entitled to receive a payment adjustment. Hospitals that receive payments that are greater than the hospitals' Medicare inpatient operating costs have been "fully compensated" for those costs by the prospective payment system. Consequently, we believe that no further adjustment should be granted to these hospitals. Therefore, we proposed to ***revise § 412.92(e)(3) to make it clear that any adjustment amounts granted to SCHs for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and total payments made under the prospective payment system, including outlier payments and indirect medical education payments***.[41]

It is odd for CMS to reference "total payments" and include "outlier payments and indirect medical education payments" in the VDA calculation if the intent of the statute was to compensate a SCH for only that portion of the year in which it was certified as a SCH.[42] This language clearly demonstrates an intent to fully compensate a SCH for its lost revenue during the full cost report period due to a 5% decrease in volume.

Finally, although no longer available, Congress made the VDA available to hospitals not receiving payment as a SCH. PRM § 2810.2 states:

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[41] 52 Fed. Reg. 33034-01 (Aug. 29, 1988). Emphasis added.
[42] *Id.*

> In addition, section 4005(c) of Pub. L. 100-203 also amended section 1886(d)(5)(C)(ii) of the Act to extend the payment adjustment discussed above to those hospitals that meet the criteria to qualify as SCHs but do not receive payment under the prospective payment system as an SCH (that is, payment equal to 75 percent of the hospital-specific portion and 25 percent of the Federal regional portion). Therefore, if a hospital meets the criteria to qualify as an SCH, it may file for the volume decline adjustment regardless of whether it is being paid as an SCH. Of course, in order to receive the volume adjustment, the hospital must meet all the criteria necessary to qualify for a volume adjustment. This provision is effective for cost reporting periods beginning on or after October 1, 1987.[43]

A hospital that does not receive payment as a SCH, is not approved as a SCH. Yet Congress and CMS made the VDA available to such hospitals if they experienced a decrease in admissions and retroactively met the criteria for a SCH. If Congress intended that a VDA payment be prorated for only that portion of a fiscal year "on or after 30 days after the date of CMS's approval of the classification", it would be impossible to implement this statute.[44] Given that the VDA was made available to hospitals not in the SCH program, and that none of the relevant statutes, regulations or PRM provisions have changed since that time, the only conclusion is that the VDA is intended to compensate SCHs for the entire cost report period in which it experiences a 5% decrease in admissions.

In its decision, the majority points to 42 C.F.R. § 412.92(b)(2)(iv) which states, "A hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS's approval of the classification." The majority then points to a reference to the VDA in 42 C.F.R. § 412.92(d) to support its finding that "CMS made the effective date of the VDA the same as the effective date for the other payment adjustments applicable to SCHs." I disagree.

First, 42 C.F.R § 412.92(d) is entitled "*Determining prospective payment rates for inpatient operating costs for sole community hospitals"*. A VDA payment is not a prospective payment rate. Rather, it is a lump sum payment to reimburse a SCH for its lost Medicare operating costs due to a decrease in admissions from one cost report period to the next.

Second, to accept this reasoning, one has to ignore the clear Congressional intent of the VDA to "***fully compensate the hospital for the fixed costs it incurs in the period."***[45] The statutory

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[43] *See also*, 53 Fed. Reg. 38476-01 (Sept. 30, 1988). *See also* PRM § 1028.2 Additional Payments To Other Qualifying Hospitals That Experience A Decrease In Discharges, which states, "A hospital that qualifies as an SCH (see §2810) but is not receiving payment as such may apply for a payment adjustment under the provisions of §2810.1. This additional payment provision applies to cost reporting periods beginning on or after October 1, 1987 and before October 1, 1990. In order to qualify for a payment adjustment, the hospital must complete the following steps"

[44] 42 C.F.R. § 412.92(b)(2)(iv).

[45] 42 U.S.C.A. § 1395ww(d)(5)(D)(ii).

language, the regulatory framework, the PRM and the now extinct VDA for non-SCHs, all support the conclusion that Congress intended the VDA to ensure the financial viability of SCHs and make healthcare services available to all Medicare beneficiaries regardless of their location. CMS reiterated this when it stated, "[t]he intent of the SCH provision is to ensure the availability of short-term acute care services to Medicare beneficiaries by providing special payment provisions for those hospitals located in remote areas."[46] The only way for this goal to be accomplished is for a SCH to receive a VDA payment based on its Medicare operating costs for the entire cost report period affected by a significant decrease in admissions.

Accordingly, I dissent from the Board Majority's decision and would grant St. Mary's a VDA lump sum payment for the cost report period ending December 31, 2008 "not to exceed the difference between [St. Mary's] Medicare inpatient operating costs and [St. Mary's] total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs."[47] The Medicare Contractor would base its calculation on: (a) St. Mary'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) St. Mary's fixed (and semi-fixed) costs; and (c) The length of time St. Mary's experienced a decrease in utilization.[48]

/s/
Robert A. Evarts, Esq.
Board Member

[46] 49 Fed. Reg. 234, 271 (Jan. 3, 1984).
[47] 42 C.F.R. § 412.92(e)(3).
[48] *Id.*