PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2024-D20

PROVIDER-
Owensboro Health Regional Hospital

Provider No.: 18-0038

vs.

MEDICARE CONTRACTOR –
CGS Administrators

RECORD HEARING DATE –
August 17, 2023

Cost Reporting Period Ended –
5/31/2014

CASE NO. – 18-0120

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Owensboro Health Regional Hospital ("Owensboro Health" or the "Provider") for the significant decrease in inpatient discharges that occurred during its fiscal year ending May 31, 2014 ("FY 2014").[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated Owensboro Health's VDA payment for FY 2014, and that Owensboro Health should receive a VDA payment in the amount of $6,578,597 for FY 2014.

INTRODUCTION

Owensboro Health is a sole community hospital ("SCH") located in Owensboro, Kentucky.[2] The Medicare contractor[3] assigned to Owensboro Health for this appeal is CGS Administrators ("Medicare Contractor").

On February 6, 2017, Owensboro Health requested a VDA payment to compensate it for a decrease in inpatient discharges during FY 2014.[4] On August 8, 2017, the Medicare Contractor issued a final determination which calculated the Provider's FY 2014 VDA payment to be $0.[5] Owensboro Health timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on August 17, 2023. Owensboro Health was represented by Stephen R. Price, Sr. and Jennifer L. Wintergerst of Wyatt, Tarrant & Combs, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments. One of these payment adjustments is referred to as a VDA payment and it is available to SCHs if, due to circumstances beyond their control, they incur a decrease in their total number of inpatient cases of more than 5 percent from one cost reporting year to the next. VDA payments are

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[1] Provider's Final Position Paper (hereinafter "Provider's FPP") at 1. *See also* Stipulations at 18.
[2] Provider's FPP at 2.
[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 and relevant.
[4] Exhibit (hereinafter "Ex.") P-1.
[5] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 5; Ex. C-1.

designed 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."[6] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

The Final VDA determination confirms (and it is also undisputed) that Owensboro Health experienced a decrease in discharges greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond Owensboro Health's control.[7] As a result, Owensboro Health was eligible to have a VDA calculation performed for FY 2014.[8] Owensboro Health requested a VDA payment in the amount of $4,494,399 for FY 2014, which included an adjustment to remove excess core staffing costs.[9] However, when the Medicare Contractor made its FY 2014 VDA calculation, it determined that Owensboro Health was entitled to a VDA payment of $0, after removing costs for both excess core staffing and variable costs.[10] Ultimately, the Provider argued that "no excess core staff adjustment was needed or appropriate."[11] The Medicare contractor agreed that "no core staffing adjustment was needed in computing the VDA."[12] Thus, what remains at issue in this case is whether Owensboro Health is due a VDA payment and, in particular, the parties disagreement as to how that payment should be calculated.

The regulation at 42 C.F.R. § 412.92(e) (2014) directs how the Medicare Contractor must determine the VDA, once an SCH demonstrates it experienced 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 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).
>
> (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;

[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[7] The VDA determination specifically states that the documentation submitted "show[s] that the decrease was due to circumstances beyond your facilities control" (Ex. P-4 at 1) and the calculation attached to that determination further details the auditor's finding (*id.* at 4-5).
[8] Stipulations at ¶ 9.
[9] Ex. P-1 at 3.
[10] Ex. P-4 at 6.
[11] Provider's FPP at 21.
[12] Stipulations at ¶13.

> (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
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> (C) The length of time the hospital has experienced a decrease in utilization.[13]

In the preamble to the final rule published on August 18, 2006,[14] CMS referenced the Provider Reimbursement Manual, CMS Pub.15-1 ("PRM 15-1") § 2810.1 (Rev. 371), which provides further guidance related to VDAs, and states, in relevant part:

> Additional payment is made . . . for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
>
> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary *directly*[15] with utilization such as food and laundry costs.

The chart below depicts how the Medicare Contractor and Owensboro Health each calculated the VDA payment for FY 2014.

	Medicare Contractor calculation using fixed costs[16]	Provider/PRM calculation using total costs[17]
a) Prior Year Medicare Inpatient Operating Costs	$ 83,292,317	$ 83,292,317
b) IPPS update factor	1.018[18]	1.018
c) Prior year Updated Operating Costs (a x b)	$ 84,791,579	$ 84,791,579
d) Current Year Program Operating Costs	$ 78,071,803	$ 78,071,803
e) Lower of c or d	$ 78,071,803	$ 78,071,803
f) DRG/SCH payment	$ 69,936,552	$ 69,936,552
g) VDA Payment Cap (e-f)	$ 8,135,251	$ 8,135,251

[13] (Emphasis added.) *See also* 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[14] 71 Fed. Reg. at 47870, 48056 (Aug. 18, 2006).
[15] (Emphasis added.)
[16] Medicare Contractor's FPP at Ex. C-19.
[17] Provider's FPP at 8.
[18] Both parties used an IPPS update factor of 1.018 in their calculations. This is the factor for the Federal Fiscal Year ("FFY") ended 9/30/2013. The Provider's cost reporting period began in that FFY, but ended in FFY 2014, which had an IPPS update factor of 1.017. As the Provider's actual FYE 5/31/2014 operating costs were less than the updated FYE 5/31/2013 costs, the variance in the update factor has no effect on the final calculation.

h) Current Year Inpatient Operating Costs	$ 78,071,803	$ 78,071,803
i) Fixed Cost percent	80.87%[19]	100.00%[20]
j) FY 2014 Fixed Costs (h x i)	$ 63,133,019	$ 78,071,803
k) Total DRG Payments	$ 69,936,552	$ 69,936,552
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 0[21]	
m) VDA Payment Amount (The Provider's VDA is based on the amount line d exceeds line f.)		$ 8,135,251

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[22]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that the regulation is "quite clear…that the [VDA] payment adjustment is '… to fully compensate the hospital 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.'"[23] The Medicare Contractor states that the payment adjustment calculation was made in accordance with 42 C.F.R. § 412.92(e)[24] and cites to PRM 15-1 § 2810.1, stating that both the regulation and the instructions "explicitly dictate the adjustment is limited to fixed and semifixed costs."[25]

In support of its position, the Medicare Contractor cites to United States Court of Appeals for the Eight Circuit ("Eighth Circuit") in *Unity Healthcare vs. Azar ("Unity")* [26] and the Administrator's decisions in *Lakes Regional Healthcare v. BCBSA/Wisconsin Physicians Services*, [27] and *Fairbanks Memorial Hospital v. Wisconsin Physician Services*.[28, 29]

Owensboro Health contends it is "undisputed that [Owensboro Health] more than satisfied all . . . conditions to qualify for a VDA (payment)," in accordance with 42 U.S.C. § 1395ww(d)(5)(D)(ii).[30] Owensboro Health argues that the Medicare Contractor's calculation of

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[19] Calculation = $333,018,942 (fixed costs) /$411,819,197 (total costs) = 0.808653272, rounded to 0.8087. *See* Ex. C-19 at 1.
[20] Owensboro Health does not remove variable costs from the VDA calculation. Provider's FPP at 8-9.
[21] Ex. C-19 (finding that the calculated amount would be negative, the Medicare Contractor determined no (or $0) VDA payment was due).
[22] Stipulations at ¶ 18.
[23] Medicare Contractor's FPP at 13.
[24] *Id*. at 13-15.
[25] *Id.* at 14.
[26] *Id.* at 19-20 (citing *Unity Healthcare v. Azar*, 918 F.3d 571 (8th Cir. 2019)), *cert. denied*, 140 S. Ct. 523 (2019)).
[27] *Id.* at 14 (citing *Lakes Reg'l Healthcare v. BCBSA., Adm'r Dec.* 2014-D16 (Sept. 4, 2014).
[28] *Id.*
(citing *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs*, PRRB Dec. No. 2015-D11 (June 9, 2015), *modified by*, Adm'r Dec. (Aug. 5, 2015).
[29] The Medicare Contractor uses these cases as support for its proposition that it correctly removed the provider's variable costs from the VDA calculation. Medicare Contractor's FPP at 14.
[30] Provider's FPP at 5.

the VDA is contrary to the statue and regulation and that it "simply relies on non-binding precedent set by the Administrator and the *Unity Healthcare* case."[31] The Board notes that the Final Rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule") [32] states that "[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." [33]

Owensboro Health contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[34] Owensboro Health argues the policy for calculating the VDA payment has changed, and "[a]fter finally employing notice and comment in 2017 CMS has now agreed that MACs should be required to 'compare estimated Medicare revenue for fixed costs to the hospital's fixed costs to remove any conceivable possibility that a hospital that qualifies for the [VDA] could ever be less than fully compensated for fixed costs as a result of the application of the adjustment.'" [35] Owensboro Health, in essence, reasons that by applying the methodology adopted by the Board, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. [36] The VDA payment, Owensboro Health maintains, "is intended to be an additional payment when patient volume shrinks but fixed costs do not shrink correspondingly. By attributing all current DRG payments to the fixed costs, the MAC, in effect, penalized the [Provider], treating it as if it had irresponsibly expanded its fixed costs in a period of decreasing patient volume"[37]

The Board has identified one basic difference between the Medicare Contractor's and Owensboro Health's calculations of the Provider's VDA payment. The parties have identified a different amount of FY 2014 Inpatient Operating Costs in each of their calculations. The Medicare Contractor adjusted the Inpatient Operating Costs to remove variable costs, using amounts obtained from its analysis of the Provider's working trial balance.[38] Owensboro Health argues that the Medicare Contractor's VDA calculation methodology violates the statutes, regulations, and Provider Reimbursement Manual instructions.

In recent Board decisions addressing VDA payments,[39] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because the methodology compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments

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[31] *Id.* at 18.
[32] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983).
[33] (Emphasis added.)
[34] Provider's FPP at 17-19.
[35] *Id.* at 17.
[36] *Id.*
[37] *Id.*at 18.
[38] Ex. C-19 at 1.
[39] *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2017-D1 (Dec. 15, 2016), *modified by*, Adm'r Dec. (Feb. 9, 2017); *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs*, PRRB Dec. No. 2015-D11 (June 9, 2015), *modified by*, Adm'r Dec. (Aug. 5, 2015).

(based on the hospital's fixed cost percentage as determined by the Medicare contractor) and then comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so that there is an apples-to-apples comparison.

The Administrator has overturned these Board decisions, stating:

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . .
>
> In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. . . . The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[40]

Recently, as noted above, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[41]

Initially, the Board notes that the Administrator decisions are not binding precedent, as explained by PRM 15-1 § 2927(C)(6)(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.[42]

Moreover, noting that Owensboro Health is not located in the Eighth Circuit and that the statutes and regulations for VDAs for SCHs and MDHs are identical, the Board finds that these applicable statutes and regulations only provide a framework by which to calculate a VDA

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[40] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[41] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied,* 140 S. Ct. 523 (2019).
[42] (Bold and italics emphasis added).

payment.[43] As a result, the Board is not bound to apply the specific VDA calculation methodology that the Administrator applied (and the Eighth Circuit upheld) in *Unity*.[44] In this regard, the Board further notes that §§ 412.92(e)(3) makes it clear that the VDA payment determination is subject to review through the Board's appeal process.[45] Thus, the Board finds that the Eighth Circuit's *Unity* decision was simply adjudicating a dispute regarding the reasonableness of the Administrator's interpretation of the statute and regulations governing VDAs that the Administrator applied in rendering her decision in *Unity*. As such, the Eighth Circuit's decision in *Unity* did not create a binding precedent as to the specific VDA calculation methodology that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[46] CMS prospectively changed the methodology for calculating the VDA to one which is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated portion of the DRG payment that is related to fixed costs, to the hospital's fixed costs, when determining the amount of the VDA payment.[47] The preamble to the FFY 2018 IPPS Final Rule makes this change effective for cost reporting periods beginning on or after October 1, 2017, explaining that it will "remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment."[48]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As set forth below, the Board finds that the Medicare Contractor's

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[43] With regard to SCHs, 42 U.S.C. § 1395ww(d)(5)(D)(ii), *see, e.g.*, *St. Anthony Reg'l Hosp. v. Azar*, 294 F. Sup. 3d 768, 779 (N.D. Iowa 2018) (stating that § 1395ww(d)(5)(D)(ii) contains a gap as it directs that "the Secretary shall provide for such . . . payment . . . as may be necessary" and that "[t]he Secretary has filled that gap in a manner that I find to be reasonable in light of the statutory framework and purpose."), *aff.d, Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019). With regard to SCHs, 42 C.F.R. § 412.92(e)(3), *see, e.g., id.* at 772, 781 (adopting the Magistrate's report which found that '"[t]he regulations promulgated by the Secretary in effect during the relevant time period did not provide a specific formula for calculating the VDA payment[,]'" and '"[i]nstead, the regulation directed that the following factors be considered in determining the VDA payment amount...'"). The Board's plain reading of the regulation is confirmed by the Agency's discussion of this regulation in the preamble to rulemakings. *See*, for SCHs, *e.g.*, 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987) (stating that "[w]e determine on a case-by-case basis whether an adjustment will be granted and the amount of that adjustment." (emphasis added)); 48 Fed. Reg. 39752, 39781-82 (Sept. 1, 1983).

[44] *See, e.g.*, *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1107-08 (D.C. Cir. 2014) (discussing regulatory interpretations adopted through adjudication versus through rulemaking).

[45] Moreover, the Board notes that, subsequent to the Eighth Circuit's decision in Unity, the U.S. Supreme Court issued its decision in *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1810, 1817 (2019) ("*Allina II*") where the Supreme Court ruled on the scope of Medicare policy issuances that are subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) by making clear that "the government's 2014 announcement of the 2012 Medicare fractions [to be used in DSH calculations for FY 2012 where the Agency] 'le[t] the public know [the agency's] current adjudicatory approach' to a critical question involved in calculating payments for thousands of hospitals nationwide" was a "statement of policy that establishes or changes a substantive legal standard" as that phrase is used in 42 U.S.C. § 1395hh(a)(2) and, thus, was subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) (citations omitted).

[46] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

[47] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).

[48] 82 Fed. Reg. at 38180.

calculation of Owensboro Health's VDA for FY 2014 was incorrect because it was *not* based on CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preambles to the relevant Final Rules.

The Medicare Contractor determined Owensboro Health's VDA payment by comparing its FY 2014 fixed costs to its total FY 2014 DRG payments. However, neither the language nor the examples[49] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[50] and the FFY 2009 IPPS Final Rule[51] 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 lesser of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

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

Rather, the Board finds the Medicare Contractor calculated Owensboro Health's FY 2014 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[52] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the methodology explained in the FFY 2007 and 2009 IPPS Final Rules/PRM and the statute. Notably, in applying this new methodology through adjudication, CMS did not otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[53]

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

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[49] PRM 15-1 § 2810.1(C)-(D).
[50] 71 Fed. Reg. at 48056.
[51] 73 Fed. Reg. at 48631.
[52] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D16 at 8 (Sep. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Dec. 15, 2016), *modified by*, Adm'r Dec. (Feb. 9, 2017).
[53] 82 Fed. Reg. at 38179-38183.

> decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

In the FFY 1984 IPPS Final Rule, the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[54] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments.—. . . .
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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 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

[54] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

> 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***.[55]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the Administrator decisions stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[56]

Based on its review of the statute, the 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."[57] Using the Administrator's rationale, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment ***only*** *for the* ***fixed*** *costs* of the services actually furnished to Medicare patients. However, the statute at 42 U.S.C. § 1395ww(a)(4) makes it clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines operating costs of inpatient services as "**all** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]" The Administrator cannot simply ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments solely for the fixed cost of the Medicare services actually rendered when the hospital in fact incurred both fixed and variable costs for those services.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate a SCH for all the fixed costs associated with the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption, stated in PRM 15-1 § 2810.1(D), that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 412.92(e)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[58] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

Critical to the proper application of the statute, the regulation and the PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished *actual* services in the current year are not part of the volume decrease, and (2) the DRG payments made to the hospital for services furnished to Medicare patients in the current year is

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[55] (Emphasis added).
[56] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[57] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[58] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

payment for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year as well as its full fixed costs in that year.

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(D)(ii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG payment is payment for both fixed and variable costs - and deem the entire DRG payment as payment solely for fixed costs. The Board concludes that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment, the VDA payment is clearly not intended to fully compensate the hospital for its variable costs.[59] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for Medicare services actually furnished. The Board concludes that, in order to both ensure the hospital is fully compensated for its fixed costs and be consistent with the assumption stated in PRM 15-1 § 2810.1 that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case the Medicare Contractor determined that Owensboro Health's 2014 fixed costs (which includes semi-fixed costs) were 80.87 percent[60] of its Medicare costs for FY 2014. Further, the parties are in agreement that "no core staffing adjustment [is] needed in computing the VDA."[61] Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2013 Medicare Inpatient Operating Costs	$ 83,292,317[62]
Multiplied by the 2013 IPPS update factor	1.018[63]
2013 Updated Costs (max allowed)	$ 84,791,579

[59] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).
[60] Stipulations at ¶ 15.
[61] *Id.* at ¶ 13.
[62] Exs. C-19 at 2, P-15 at 5.
[63] *Id*. The IPPS Update Factor for Federal Fiscal Year (FFY) 2014 is 1.017 and for FFY 2013 is 1.018. As the Provider's fiscal year has 243 days (10/1/13 to 5/31/14) in FFY 2014 and 122 days (6/1/13 to 9/30/13) in FFY 2013, the proper factor is as follows ((243 x 1.017) + (122 x 1.018)) / 365 = 1.017 rounded. As the Provider's actual FY 2014 costs are less than the FY 2013 costs, the cap calculation has no effect on the final VDA payment calculation for FY 2014.

2014 Medicare Inpatient Operating Costs	$ 78,071,803[64]
Lower of 2013 Updated Costs or 2014 Costs	$ 78,071,803
Less 2014 IPPS payment	$ 69,936,552[65]
2014 Payment Cap	$ 8,135,251

Step 2: Calculation of VDA

2014 Medicare Inpatient Fixed Operating Costs	$ 63,133,019[66]
Less 2014 IPPS payment – fixed portion (80.87 percent)	$ 56,554,422[67]
Payment adjustment amount (subject to Cap)	$ 6,578,597

Since the payment adjustment amount of $6,578,597 is ***less*** than the CAP of $8,135,251, the Board determines that Owensboro Health's VDA payment for FY 2014 should be $6,578,597.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Owensboro Health's VDA payment for FY 2014, and that Owensboro Health should receive a FY 2014 VDA payment in the amount of $6,578,597.

BOARD MEMBERS:

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FOR THE BOARD:

6/28/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Board Chair
Signed by: PIV

[64] Stipulations at ¶ 12; Ex. P-14 at 5.
[65] Stipulations at ¶¶ 16-17; Ex. P-14 at 24.
[66] Stipulations at ¶ 15. (2014 Medicare IP Fixed Costs Calculation = $78,071,803 x 0.808653272 percent = 63,133,019, rounded), Ex. C-19 at 2.
[67] The 2014 IPPS fixed portion of $56,554,422 is calculated by multiplying $69,936,552 (the FY 2014 DRG payments) by 0.808653272 (the fixed cost percentage determined by the Medicare Contractor).