PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2024-D21

PROVIDER-
Mayo Clinic Health System Fairmont

Provider No.:
24-0166

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
September 15, 2023

Cost Reporting Period Ended –
12/31/2014

CASE NO. –
19-0263

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ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Mayo Clinic Health System - Fairmont ("Mayo Clinic Fairmont" or "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 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 the VDA payment for FY 2014 for Mayo Clinic Fairmont, and that Mayo Clinic Fairmont should receive a VDA payment in the amount of $1,461,110.

INTRODUCTION

Mayo Clinic Fairmont is a non-profit acute care hospital located in Fairmont, Minnesota. Mayo Clinic Fairmont was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Mayo Clinic Fairmont for this appeal is National Government Services, Inc. ("Medicare Contractor"). On June 20, 2016, Mayo Clinic Fairmont requested a VDA payment of either $2,110,607 or $2,035,154, depending on the treatment of its "Excludable Program cost"[4], to compensate it for a "decrease in inpatient discharges during FY 2014."[5] On September 13, 2016, The Medicare Contractor sent a tentative final determination letter stating that it approved a "low volume adjustment [*sic* VDA]" of $596,876, it made an interim payment of $589,816, and noted that the "calculation will be revisited when the 12/31/2014 cost report is finalized."[6] On January 14, 2020, the Medicare Contractor sent its final determination, resulting in the final payment of the Provider's FY 2014 VDA to be $0 and its interim payment of $589,816 to be recouped.[7] Mayo Clinic Fairmont timely appealed the Medicare Contractor's final determination and met all jurisdictional requirements for a hearing before the Board.

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[1] *See* Provider's Supplemental Preliminary Position Paper (hereinafter "Provider's SPPP") at 2-3 (Feb. 25, 2021); Medicare Contractor's Supplemental Preliminary Position Paper (hereinafter "Medicare Contractor's SPPP") at 4 (Jun. 22, 2021).
[2] Provider's SPPP at 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Exhibit ("Ex.") P-1 at 11.
[5] Provider's SPPP at 3. The Provider originally requested $2,035,154 in its June 20, 2016 request letter, per Revised Stipulations Ex. P-1. However, the Provider has since modified the VDA payment amount it is seeking to $2,110,607. *See also* Stipulations ("Stip.") at ¶ 7 (July 16, 2021); Revised Stipulations ("Rev. Stip.") at ¶ 7 (Sept. 14, 2023).
[6] Medicare Contractor's SPPP Ex. C-3 at 9.
[7] Medicare Contractor's SPPP at 6-7. *See also* Ex. C-3 at 1-8.

The Board approved a record hearing on September 15, 2023. Mayo Clinic Fairmont was represented by Daniel F. Miller, Esq. of Hall, Render, Killian, Heath & Lyman, P.C. 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 total inpatient cases of more than 5 percent from one cost reporting year to the next. VDA payments are designed to "fully compensate the hospital for the fixed costs it incurs in the period [covered by the VDA] in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services."[8] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

While not specifically addressed in the tentative or final VDA determination, it is implicit in them (and also undisputed by the Parties) that Mayo Clinic Fairmont experienced a decrease in discharges greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond Mayo Clinic Fairmont's control and that, as a result, the Provider was eligible to have a VDA calculation performed for FY 2014.[9] Mayo Clinic Fairmont requested a VDA payment in the amount of $2,035,154 for FY 2014.[10] However, when the Medicare Contractor made its tentative final determination of the 2014 VDA calculation, it determined that Mayo Clinic Fairmont was entitled to an interim VDA payment of $589,816, after removing a percentage of fixed/semi-fixed costs.[11] Following its tentative final determination, the Medicare Contractor issued a final determination after factoring in low volume payments made to the Provider, which eliminated the VDA payment for 2014. [12] Thus, this appeal revolves around whether Mayo Clinic Fairmont is due a VDA payment and, in particular, the parties' dispute 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 that it experienced a qualifying decrease in total inpatient discharges. In pertinent part, § 412.92(e)(3) (2014) 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

[8] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[9] Rev. Stip. at ¶ 4; Medicare Contractor's SPPP at 8. The Board notes that the Medicare Contractor would not have made a tentative VDA payment if it had not determined that the Provider otherwise qualified for a VDA payment, including meeting the requirement that it experience a decrease in discharges greater than 5 percent beyond its control.
[10] Rev. Stip., Ex. P-1.
[11] Rev. Stip. at ¶ 5.
[12] *Id.*

> 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* –
>
> (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.[13]

In the preamble to the final rule published on August 18, 2006,[14] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), 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 the Provider each calculated the VDA payment, in the Revised Stipulations which the parties filed on September 14, 2023.

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[13] (Emphasis added). *See* also 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[14] 71 Fed. Reg. 47870, 48056.
[15] (Emphasis added).

	Medicare Contractor calculation using fixed costs[16]	Provider/PRM calculation using total costs[17]
a) Prior Year Medicare Inpatient Operating Costs	$ 9,208,457	$ 9,208,457
b) IPPS update factor	1.017	1.020
c) Prior year Updated Operating Costs (a x b)	$ 9,365,001	$ 9,392,626
d) Current Year Operating Costs	$ 9,861,020	$ 9,602,412
e) Lower of c or d	$ 9,365,001	$ 9,392,626
f) DRG/SCH payment	$ 7,915,860	$ 6,888,242
g) Cap (e-f)	$ 1,449,141	$ 2,504,384
h) Current Year Inpatient Operating Costs	$ 9,861,020	
i) Fixed Cost percent	79.41%[18]	84.28%[19]
j) FY 2014 Fixed Costs (h x i)	$ 7,830,636	
k) Total DRG Payments	$ 7,915,860	
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 0	
m) VDA Payment Amount (The Provider's VDA is based on the calculated Cap multiplied by the fixed cost percentage)		$ 2,110,607

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[20]

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.'"[21] The Medicare Contractor states the adjustments were made in accordance with 42 C.F.R. § 412.92(e)(3)[22] and cites to PRM 15-1 § 2810.1(B) (rev. 479), which states:

> 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

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[16] Rev. Stip. at ¶ 9.
[17] *Id.* at ¶ 7.
[18] Rev. Stip., Ex. P-6 at 5. (Calculation = Total Expense $42,745,796 – Variable Expense $8,800,325 = Fixed Costs $33,945,471; Fixed Costs $33,945,471/Total Expense $42,745,796 = Fixed Cost Percentage 0.794124199, rounded to 0.7941.)
[19] Mayo Clinic Fairmont removes variable costs, as it calculates them, from its VDA calculation. *See* Rev. Stip., Ex. P-1 at 10.
[20] Rev. Stip. at ¶ 6.
[21] Medicare Contractor's SPPP at 9.
[22] Medicare Contractor's PPP at 8-9.

> Medicare inpatient operating cost and the hospital's total payment for inpatient operating costs.
>
> Fixed costs are operating costs that remain constant and do not vary with short-term changes in hospital operations and business practices. **Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food, laundry costs, billable medical supplies, and billable drug costs**.
>
> 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 utilization. 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.
>
> In evaluating semi-fixed costs, the contractor considers the length of time the hospital has experienced a decrease in utilization. For a short 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 to align them with revised expectations for volume projections. 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.
>
> The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The contractor 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.[23]

The Medicare Contractor contends the intent of the VDA is to compensate qualified hospitals for their fixed/semi-fixed costs only, and not their variable costs.[24] This result, according to the Medicare Contractor, is achieved by subtracting the DRG revenue from the fixed costs, thereby assuring full compensation for the fixed costs. [25]

In support of its position, the Medicare Contractor cites to the Administrator's decisions in *Unity Healthcare vs. BCBSA/Wisconsin Physician Services ("Unity"),*[26] *Lakes Regional Healthcare v.*

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[23] *Id.* at 9-10 (bold emphasis added by Medicare Contractor).
[24] *Id.* at 10.
[25] Medicare Contractor's SPP. at 15-16.
[26] *Id.* at 10 (citing *Unity Healthcare v. BlueCross BlueShield Ass'n.*, Adm'r Dec. (Sept. 4, 2014), *modifying* PRRB Dec. No. 2014-D15 (July 10, 2014)). *See also* Medicare Contractor's SPPP, Ex. C-10.

BCBSA/Wisconsin Physicians Services,[27] and *Fairbanks Memorial Hospital v. Wisconsin Physician Services*.[28, 29]

Mayo Clinic Fairmont argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor's VDA calculation is not supported by applicable law or facts, and contradicts the language of the VDA Statute in 42 U.S.C § 1395ww(d)(5)(D)(ii).[30] According to Mayo Clinic Fairmont, the Medicare Contractor "disregarded the fact that the total payments for Inpatient Operating Costs are intended to not only compensate Provider for its fixed costs, but also for its semi-fixed and variable costs."[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]

Mayo Clinic Fairmont contends that the Medicare Contractor's approach "does not fully compensate [the hospital] for its fixed costs."[34] Mayo Clinic Fairmont, in essence, reasons that, 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. This method, Mayo Clinic Fairmont maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs.[35]

Mayo Clinic Fairmont also references the fact that CMS essentially adopted a methodology which compares fixed inpatient costs to fixed MS-DRG revenue, and clarified these calculations to reflect that the same ratio is used for costs and payments when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[36]

The Board identified two basic differences in the Medicare Contractor's and Mayo Clinic Fairmont's calculation of the Provider's VDA payment. First, there is a difference in the DRG payments used to determine the "CAP" amount. Second, there is a difference in the FY 2014 Inpatient Operating Costs used by the parties. The Medicare Contractor reduced the Inpatient Operating Costs, excluding variable costs it had identified. Mayo Clinic Fairmont argues that the

[27] *Id.* (citing *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*., Adm'r Dec. (Sept. 4, 2014), *modifying* PRRB Dec. No. 2014-D16 (Jul. 10, 2014)). *See also* Medicare Contractor's SPPP, Ex. C-9.
[28] *Id.* (citing *Fairbanks Mem'l Hosp. v. Wisconsin Physician Serv*., Adm'r Dec. (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (Jun. 9, 2015)). *See also* Medicare Contractor's SPPP, Ex. C-13.
[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 SPPP at 10.
[30] Provider's SPPP at 5.
[31] *Id.* at 8.
[32] 48 Fed. Reg. 39752, 39781-82 (Sept. 1, 1983).
[33] (Emphasis added.)
[34] Provider's SPPP at 9.
[35] *Id.* at 10-11.
[36] *Id.* at 16-17.

Medicare Contractor's VDA calculation methodology violates the statutes, regulations, and Provider Reimbursement Manual instructions.[37]

In recent Board decisions addressing VDA payments,[38] the Board has disagreed with the methodology used by various Medicare Contractors to calculate VDA payments because it compares fixed costs to total DRG payments 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 (based on the hospital's fixed cost percentage as determined by the Medicare contractor) and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

The Administrator has overturned these Board decisions, 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 . . . .[39]

Recently, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[40]

At the outset, the Board notes that the Administrator decisions are not binding precedent, as explained by PRM 15-1 § 2927(C)(6)(e):

> e. Nonprecedential Nature of the Administrator's Review Decision. - Decisions by the Administrator ***are not precedents*** for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to

[37] *Id.* at 9.
[38] *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).
[39] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[40] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir.), *cert. denied*, 140 S. Ct. 523 (2019).

> whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy [*sic*] having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.[41]

While Mayo Clinic Fairmont is located in the Eighth Circuit and the statutes and regulations for VDAs for SCHs and MDHs are identical, the Board finds that the applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[42] 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*.[43] In this regard, the Board further notes that §§ 412.92(e)(3) and 412.108(d)(3) make clear that the VDA payment determination is subject to review through the Board's appeal process.[44] 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,[45]

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[41] (Bold and italics emphasis added).

[42] 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. at 39781-82 (Sept. 1, 1983).

[43] *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).

[44] 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).

[45] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

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.[46] 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."[47]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As set forth below, the Board finds that the Medicare Contractor's calculation of Mayo Clinic Fairmont's VDA methodology 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 Mayo Clinic Fairmont's VDA payment by comparing its FY 2014 fixed costs to its total FY 2014 DRG payments. However, neither the language nor the examples[48] 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[49] and the FFY 2009 IPPS Final Rule[50] 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 Mayo Clinic Fairmont'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 Mayo Clinic Fairmont'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

[46] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e)(3).
[47] 82 Fed. Reg. at 38180.
[48] PRM 15-1 § 2810.1(C)-(D).
[49] 71 Fed. Reg. at 48056.
[50] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[51] 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.[52]

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

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (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."[53] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

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

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[51] *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 (Feb. 9, 2017).
[52] 82 Fed. Reg. at 38179-38183.
[53] 48 Fed. Reg. at 39781-39782 (emphasis added).

> *utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
>
> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
>
> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[54]

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."[55]

Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[56] 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

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[54] (Emphasis added).
[55] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[56] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

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.[57] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

Critical to the proper application of the statute, regulation and PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished *actual* services in the current year are not part of the volume decrease, and (2) the DRG payments made to the hospital for services furnished to Medicare patients in the current year is payment for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year as well as its full fixed costs in that year.

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(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.[58] 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 to 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 Mayo Clinic Fairmont's fixed costs (which includes semi-fixed costs) were 79.41 percent[59] of

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[57] 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.
[58] 48 Fed. Reg. at 39782.
[59] Rev. Stip. at ¶¶ 9, 10.

the Provider's Medicare costs for FY 2014. Applying the rationale described above, the Board finds that the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2013 Medicare Inpatient Operating Costs	$ 9,208,457[60]
Multiplied by the 2014 IPPS update factor	1.0183[61]
2013 Updated Costs (max allowed)	$ 9,376,972
2014 Medicare Inpatient Operating Costs	$ 9,861,020[62]
Lower of 2013 Updated Costs or 2014 Costs	$ 9,376,972
Less 2014 IPPS payment	$ 7,915,862[63]
2014 Payment Cap	$ 1,461,110

Step 2: Calculation of VDA

2014 Medicare Inpatient Fixed Operating Costs	$ 7,830,636[64]
Less 2014 IPPS payment – fixed portion (79.41 percent)	$ 6,285,986[65]
Payment adjustment amount (subject to Cap)	$ 1,544,650

Since the payment adjustment amount of $1,544,650 is **greater** than the Cap of $1,461,110, the Board determines that Mayo Clinic Fairmont's VDA payment for FY 2014 should be $1,461,110.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Mayo Clinic Fairmont's VDA payment for FY 2014, and that Mayo Clinic Fairmont should receive a FY 2014 VDA payment in the amount of $1,461,110.

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[60] *Id*. at ¶ 9.

[61] The parties stipulated to an IPPS update factor of 1.017. This is the Federal Fiscal Year (FFY) update factor, for the period from 10/1/2013 to 9/30/2014. However, the Provider's actual cost reporting period is from 1/1/2014 to 12/31/2014. Thus, it reflects 273 days in FFY 2014 and 92 days in FFY 2015, which has an IPPS update factor of 1.022. The appropriate update factor for this cost reporting period is calculated as follows: ((273/365) * 1.017) + ((92/365) * 1.022) = 1.0183.

[62] Rev. Stip. at ¶ 9.

[63] The total payments are calculated as follows: IP Operating Cost Payment (Worksheet E, Part A, Line 49) $7,103,285 + Operating Portion of the Low Volume Payments $812,577 = $7,915,862. The Low Volume Payments reported on Worksheet E, Part A, Lines 70.96 and 70.97 are reduced for the capital portion, which is based on the capital percentage of payments based on total payments on Worksheet E, Part A, Lines 49 and 50). (Capital payments = Worksheet E, Part A, Line 50 = $400,722, Operating payments = Worksheet E, Part A, Line 49 = $7,103,285) Operating percentage = 7,103,285/7,504,007 = 0.9466 rounded. Low Volume Payments = $858,417 * 94.66% (Operating percentage) = 812,577).

[64] (Total Operating Costs of $9,861,020 multiplied by fixed cost percentage of 79.41% = $7,830,636).

[65] The $6,285,986 is calculated by multiplying $ 7,915,862 (the FY 2014 DRG payments per note 63) by 0.7941 (the fixed cost percentage determined by the Medicare Contractor).

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6/28/2024

X Clayton J. Nix

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Signed by: PIV