PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2024-D23

PROVIDER-
Marion General Hospital

Provider No.: 15-0011

vs.

MEDICARE CONTRACTOR –
WPS Government Health Adminstrators

RECORD HEARING DATE –
September 29, 2023

Cost Reporting Period Ended –
6/30/2014

CASE NO. – 16-2591

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Marion General Hospital ("Marion General" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 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 Marion General, and that Marion General should receive a VDA payment in the amount of $389,843 for FY 2014.

INTRODUCTION

Marion General Hospital is a sole community hospital ("SCH") located in Marion, Indiana.[2] The Medicare contractor [3] assigned to Marion General for this appeal is WPS Government Health Administrators ("Medicare Contractor").

On October 19, 2015, Marion General requested a VDA payment of $1,580,598 for FY 2014 to compensate it for a decrease in inpatient discharges during FY 2014.[4] On April 5, 2016 and July 12, 2016, the Medicare Contractor denied the Provider's VDA request and its VDA reconsideration request, respectively, for the reason that it "did not establish that the decline in discharges was due to an ususual event or occurrence beyond its control."[5] In the reconsideration denial, the Medicare Contractor calculated the Provider's FY 2014 VDA payment to be $0 because "[w]hen variable costs . . . are removed, the DRG payments exceeded the operating costs."[6] While the Medicare Contractor maintains that "its determination was in accordance with regulations and program policy, the MAC is no longer contesting the circumstance portion. Thus, the remaining controversy is the payment determination."[7] Marion General 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 September 29, 2023. Marion General was represented by Richard. S. Reid of The Rybar Group. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Stipulations at ¶ 7.
[2] Provider's Final Position Paper (hereinafter "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] Provider's Exhibit P-1.
[5] Exhibit C-1 at 1, 3.
[6] *Id.* at 3. *See also* C-2.
[7] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 2. Stipulations at ¶ 6.

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

It is undisputed between the parties that Marion General experienced a decrease in discharges greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond Marion General's control and that, as a result, Marion General was eligible to have a VDA calculation performed for FY 2014.[9] Marion General believes it is entitled to a VDA payment in the amount of $423,766 for FY 2014.[10] However, per the Medicare Contractor's FY 2014 VDA calculation, it believes that Marion General is not entitled to a VDA payment because the Provider was fully compensated for its fixed/semi-fixed costs.[11] Thus, what remains at issue in this case is whether Marion General is due a VDA payment and, in particular, the parties do not agree as to how that payment should be calculated.

The regulation at 42 C.F.R. § 412.92(e) 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 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 –

[8] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[9] Stipulations at ¶ 6.
[10] *Id* at ¶ 8.
[11] *Id* at ¶ 11; Exhibit C-2.

> (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.[12]

The chart below depicts how the Medicare Contractor and Marion General each calculate the VDA payment, as per the parties' stipulations.

	Medicare Contractor calculation using fixed costs[13]	Provider/PRM calculation using total costs[14]
a) Prior Year Medicare Inpatient Operating Costs		$ 16,480,115
b) IPPS update factor		1.02
c) Prior year Updated Operating Costs (a x b)		$ 16,809,717
d) Current Year Operating Costs		$ 15,846,131
e) Lower of c or d		$ 15,846,131
f) DRG/MDH payment		$ 15,422,365
g) Cap (e-f)		$ 423,766
h) Current Year Inpatient Operating Costs	$ 15,846,131	$ 15,846,131
i) Fixed Cost percent	91.99%[15]	100.00%[16]
j) FY 2014 Fixed Costs (h x i)	$ 14,577,643	$ 15,846,131
k) Total DRG Payments	$ 15,422,365	$ 15,422,365
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ (844,722)	
m) VDA Payment Amount (The Provider's VDA is based on the amount line j exceeds line k.)		$ 423,766

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[17]

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[12] See also 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[13] Stipulations at ¶ 11. (the Medicare Contractor did not determine the cap as part of their review).
[14] *Id.* at 8.
[15] Calculation = $14,577,643 / $15,846,131 = 0.919949671, rounded to 0.9199.
[16] Provider's FPP at 3. (Marion General does not remove variable costs from the VDA calculation.)
[17] Stipulations at ¶¶ 7, 13.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that the law "is quite clear when it states that the 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.'"[18] The Medicare Contractor states that the adjustments were made in accordance with 42 C.F.R. § 412.92[19] 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 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*.
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> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with *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

[18] Medicare Contractor's FPP at 8.
[19] *Id.* at 7.

> determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.[20]

The Medicare Contractor contends that the intent of the VDA is to compensate qualified hospitals for their fixed/semi-fixed costs only, and not their variable costs.[21] In order to eliminate these costs, the Medicare Contractor removed the variable costs from the cost report by using worksheet A-8 adjustments on Marion General's cost report.[22] The Medicare Contractor contends that "the specific means of removing variable costs (Worksheet A-8 adjustments and recalculation of the cost report or some other means) was not addressed in the Board Decision or any following decision by the Administrator or the Courts."[23] The Medicare Contractor states that "CMS has long considered a provider's Medicare cost report the most accurate and efficient way of reporting, calculating, and determining Medicare costs."[24] Therefore, the Medicare Contractor believes its methodogy "provides the most accurate determination of Medicare inpatient operating fixed and semi-fixed costs" and that "[t]he Provider's claim that this method somehow distorts the true costs applicable to Medicare patients is unsubstantiated."[25] In support of its position, the Medicare Contractor cites to United States Court of Appeals for the Eighth Circuit ("Eighth Circuit") in *Unity Healthcare vs. Azar ("Unity")*[26] and the Administror's decisions in *Lakes Regional Healthcare v. BCBSA/Wisconsin Physicians Services*,[27] and *Fairbanks Memorial Hospital v. Wisconsin Physician Services*.[28, 29]

Marion General contends the Medicare Contractor's calculation is inherently flawed, arguing the Medicare Contractor's methodology "**guarantees** that a Sole Community Hospital will **never receive** the full compensation mandated by Congress because its fixed costs will always be reduced by reimbursement attributable to both fixed and variable costs."[30] The Board notes that the Final Rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule")[31] 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."[32]

Marion General contends the Medicare Contractor's approach "does not fully compensate the Provider for the fixed costs incurred."[33] Marion General argues the policy for calculating the

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[20] *Id.* at 8-9 (emphasis added).
[21] *Id.* at 9.
[22] *Id.* at 23-24.
[23] *Id.* at 21-22.
[24] *Id.* at 14.
[25] *Id.*
[26] *Id.*at 12 (citing *Unity Healthcare v. Azar*, 918 F.3d 571 (8th Cir. 2019)), *cert. denied*, 140 S. Ct. 523 (2019)).
[27] *Id.* at 9 (citing Lakes Reg'l Healthcare v. BCBSA., Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014).
[28] *Id.* (citing Fairbanks Mem'l Hosp. v. Wisconsin Physician 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 9.
[30] Provider's FPP at 10 (emphasis in original).
[31] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983).
[32] (Emphasis added.)
[33] Provider's FPP at 10.

VDA payment changed with the FY 2018 IPPS Final Rule, and "[i]n doing so the Administrator has effectively admitted that the methodology in use by the MAC does not meet the Congressional intent of the VDA." [34]

The Board identified one basic difference in the Medicare Contractor's and Marion General's calculation of the Provider's VDA payment. The FY 2014 Medicare Inpatient Operating Costs used in the VDA payment differ between the parties. The Medicare Contractor adjusted the Inpatient Operating Costs to remove variable costs via worksheet A-8 adjustments on the cost report to determine the Provider's allowable Medicare operating costs. Marion General argues that the Medicare Contractor's VDA calculation "does not fully compensate the Provider for its fixed costs and is inconsistent with what the Final rule establishes as the CMS method for calculating a VDA."[35]

In recent Board decisions addressing VDA payments,[36] 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.

Referring to the methodology adopted by the Board in previous decisions, Marion General implies that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. Marion General references the fact that recent Board decisions show that MS-DRG payments include a variable component. [37]

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

[34] *Id.* at 13.
[35] *Id.*
[36] *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).
[37] Provider's FPP at 12-13.

> 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 . . . .[38]

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."[39]

At the outset, 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.[40]

Noting that Marion General 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 the applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[41] 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*.[42] In this regard, the Board further notes that §§ 412.92(e)(3) makes clear that the VDA payment determination is subject to

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[38] *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).

[39] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

[40] (Bold and italics emphasis added).

[41] 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).

[42] *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).

review through the Board's appeal process.[43] 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,[44] 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.[45] 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."[46]

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 Marion General'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 Marion General's VDA payment by comparing its FY 2014 fixed costs to its total FY 2014 DRG payments. However, neither the language nor the examples[47] 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[48] and the FFY 2009 IPPS Final Rule[49] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

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[43] 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).

[44] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

[45] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e)(3).

[46] 82 Fed. Reg. at 38180.

[47] PRM 15-1 § 2810.1(C)-(D).

[48] 71 Fed. Reg. at 48056.

[49] 73 Fed. Reg. at 48631.

> 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 Marion General'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 that the Medicare Contractor calculated Marion General'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[.]"[50] 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.[51]

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."[52] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a

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[50] *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).
[51] 82 Fed. Reg. at 38179-38183.
[52] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

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***.
>
> 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***.[53]

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."[54]

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[53] (Emphasis added).
[54] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.

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."[55] 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 an 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.[56] 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.

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[55] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

[56] 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.

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.[57] 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 that 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 Marion General's fixed costs (which includes semi-fixed costs) were 91.99 percent[58] of its Medicare costs for FY 2014. 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	$ 16,480,115[59]
Multiplied by the 2014 IPPS update factor	1.02[60]
2013 Updated Costs (max allowed)	$ 16,809,717
2014 Medicare Inpatient Operating Costs	$ 15,846,131[61]
Lower of 2013 Updated Costs or 2014 Costs	$ 15,846,131
Less 2014 IPPS payment	$ 15,422,365[62]
2014 Payment Cap	**$ 423,766**

Step 2: Calculation of VDA

2014 Medicare Inpatient Fixed Operating Costs	$ 14,577,643[63]
Less 2014 IPPS payment – fixed portion (91.99 percent)	$ 14,187,800[64]
Payment adjustment amount (subject to Cap)	**$ 389,843**

[57] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).
[58] Stipulations at ¶ 12.
[59] *Id*. at ¶¶ 8, 12.
[60] *Id*. The Board notes that the IPPS update factor for FFY 2013 was 1.018 and for FFY 2014 was 1.017. Thus, the stipulated factor of 1.02 is incorrect. However, noting that the 2014 Operating Costs were less than the 2013 Operating Costs, the IPPS update factor will not affect the calculation of the cap, and therefore the Board passes use of the correct factor, which would be calculated based on the number of days in each FFY.
[61] *Id*. at ¶¶ 8, 11, 12.
[62] *Id*.
[63] *Id.* at ¶¶ 11, 12.
[64] The $14,187,800 fixed portion of payment is calculated by multiplying $15,422,365 (the FY 2014 DRG payments) by 0.919949671 (the fixed cost percentage determined by the Medicare Contractor).

Since the payment adjustment amount of $389,843 is ***less*** than the Cap of $423,766, the Board determines that Marion General's VDA payment for FY 2014 should be $389,843.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Marion General's VDA payment for FY 2014, and that Marion General should receive a FY 2014 VDA payment in the amount of $389,843.

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FOR THE BOARD:

7/24/2024

X Clayton J. Nix

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Board Chair
Signed by: PIV