

**PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record**

2022-D01

PROVIDER –
D.M. Cogdell Memorial Hospital

Provider No.: 45-0073

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
May 6, 2021

Cost Reporting Period Ended –
12/31/2012

CASE NO. – 17-0788

INDEX

ISSUE STATEMENT	2
DECISION.....	2
INTRODUCTION.....	2
STATEMENT OF FACTS AND RELEVANT LAW	3
DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW	5
DECISION.....	14

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment owed to D.M. Cogdell Memorial Hospital (“Cogdell” or the “Provider”) for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2012 (“FY 2012”).¹

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board (“Board”) finds that: (1) the Medicare Contractor improperly calculated Cogdell’s VDA payment for FY 2012 and (2) notwithstanding, Cogdell should not receive a VDA payment for FY 2012 because, under the revised VDA calculation, the fixed portion of inpatient prospective payment system (“IPPS”) payments received exceeded the fixed portion of inpatient operating costs for FY 2012.

INTRODUCTION

Cogdell is a 45-bed hospital located in Snyder, Texas² and was designated as a sole community hospital (“SCH”) during the fiscal year at issue.³ The Medicare contractor⁴ assigned to Cogdell for this appeal is Novitas Solutions, Inc. (“Medicare Contractor”). On October 8, 2014, Cogdell filed a timely request for a VDA payment for FY 2012.⁵ On August 17, 2016, the Medicare Contractor denied the request because it concluded that Cogdell’s total DRG payments exceeded its total inpatient operating costs, once variable costs were removed.⁶ On October 14, 2016, Cogdell submitted a Request for Reconsideration for a VDA payment in the amount of \$209,531.⁷ The Medicare Contractor did not respond to the Request. On January 11, 2017, Cogdell 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 May 6, 2021. Cogdell was represented by Rick Morris of Discovery Healthcare Consulting Group, LLC. Novitas Solutions, Inc. was represented by Scott Berends, Esq. of Federal Specialized Services.

¹Provider Final Position Paper (“Provider’s FPP”) at 2; Medicare Contractor’s Final Position Paper (“Medicare Contractor’s FPP”) at 3.

² Stipulation of Facts (“Stipulations”) at ¶ 1.

³ *Id.*

⁴ 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.

⁵ Stipulations at ¶ 3.

⁶ *Id.* at ¶ 4; Medicare Contractor’s FPP at 2; Provider’s FPP at 3.

⁷ Provider’s FPP at 3-4.

STATEMENT OF FACTS AND RELEVANT LAW

The Medicare program pays certain hospitals a predetermined, standardized amount per discharge under the 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 a hospital for the fixed costs it incurs for providing inpatient hospital services in the period covered by the VDA, 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 that Cogdell experienced a decrease in discharges greater than 5 percent from FY 2011 to FY 2012 due to circumstances beyond its control, and that, as a result, Cogdell was eligible to have a VDA calculation performed for FY 2012.⁹ However, when the Medicare Contractor computed the FY 2012 VDA calculation, it determined that Cogdell’s DRG payment exceeded its fixed program operating costs.¹⁰ As a result, the Medicare Contractor concluded that Cogdell did not qualify for an additional VDA payment.¹¹

The regulation at 42 C.F.R. § 412.92(e) (2012) directs how the Medicare Contractor must calculate the VDA once an SCH demonstrates it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.92(e)(3) states, in pertinent part:

(3) The intermediary determines a lump sum adjustment amount *not to exceed*¹² the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs

(i) In determining the adjustment amount, the intermediary considers— . . .

(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. . . .

⁸ 42 U.S.C. § 1395ww(d)(5)(D)(ii).

⁹ Stipulations at ¶2. *See also* Provider’s FPP at 3.

¹⁰ Medicare Contractor’s FPP at 2.

¹¹ *Id.*

¹² (Emphasis added.)

The preamble to the final rule published on August 18, 2006¹³ references the Provider Reimbursement Manual, Pub. No. 15-1 (“PRM 15-1”) § 2810.1 (Rev. 371), which offers further guidance related to VDAs. This manual provision states, in relevant part:

B. 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* with utilization such as food and laundry costs.¹⁴

The chart below depicts how the Medicare Contractor and Cogdell each calculated the VDA payment.

	Medicare Contractor calculation using fixed costs	Provider/PRM calculation using total costs ¹⁵
a) Prior Year Medicare Inpatient Operating Costs	\$1,895,408 ¹⁶	\$1,895,508
b) IPPS update factor	1.019 ¹⁷	1.019
c) Prior year Updated Operating Costs (a x b)	\$1,930,944 ¹⁸	\$1,931,523
d) FY 2012 Operating Costs	\$1,458,549 ¹⁹	\$1,458,549
e) Lower of c or d	\$1,458,549	\$1,458,549
f) DRG/SCH payment	\$1,249,018 ²⁰	\$1,249,018
g) CAP (d-f)	\$ 209,531	\$ 209,531
h) FY 2012 Inpatient Operating Costs	\$1,359,952 ²¹	\$1,458,549
i) Fixed Cost percent	0.8745 ²²	1.00

¹³ 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

¹⁴ (Emphasis added).

¹⁵ Exhibit C-2.

¹⁶ Exhibit C-1 at 5.

¹⁷ *Id.* The Medicare Contractor multiplied the Prior Year Medicare Inpatient Operating Costs by two IPPS update factors (1.019 and 1.018). The actual update is 1.01874847 which was rounded to 1.019.

¹⁸ Exhibit C-1 at 5. The Prior Year Medicare Inpatient Operating Costs times the IPPS update factor does not exactly equal the Prior Year Updated Operating Costs. This is due to the rounding of the IPPS Update Factor.

¹⁹ *Id.*

²⁰ *Id.*

²¹ Exhibit C-1 at 9. The Medicare Contractor reduced the total Inpatient Operating Costs of \$1,458,549 by \$98,597 in excess FTE salary costs, which results in \$1,395,952 in Inpatient Operating Costs.

²² Exhibit C-1 at 4. $\$14,816,115/\$16,942,914=0.87447266$, rounded to 0.8745

j) FY 2012 Fixed Costs (h x i)	\$1,189,278 ²³	\$1,458,549
k) Total DRG/SCH Payments	\$1,249,018 ²⁴	\$1,249,018
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	\$ -59,740	
m) VDA Payment Amount (The Provider's VDA is based on the amount by which line j exceeds line k.)		\$209,531

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.²⁵

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor states, “The Provider does not argue that the intent of the VDA is to compensate for fixed and semi-fixed costs. Rather it argues that since DRG payments compensate providers for fixed, semi-fixed and variable costs these payments should also be reduced by the same ‘variable’ factor that was determined and used when calculating the Provider’s costs.”²⁶

The Medicare Contractor removed variable costs by analyzing costs on Worksheet A of the Provider’s cost report. Certain variable costs were excluded, as were costs related to excluded areas. This resulted in a fixed (and semi-fixed) cost percentage.²⁷ The Medicare Contractor contends that specific instructions to determine the fixed/semi-fixed costs are not included in the statute, regulations or Provider Reimbursement Manual. Therefore, the Medicare Contractor used the cost report to develop a method of calculating fixed/semi-fixed costs. The Medicare Contractor argues that the Administrator agreed with this approach. The Medicare Contractor also cites to the decision of the U.S. Court of Appeals for the Eighth Circuit (“Eighth Circuit”) in *Unity Healthcare v. Azar* (“Unity”),²⁸ which found this approach to be “consistent with the statutory and regulatory language.”²⁹

The Medicare Contractor states that in the *Unity*, *Lakes Regional* and *Fairbanks* cases the non-salary expenses from billable medical supplies, billable IV drugs, third party goods and services (physical therapy, reference lab, blood, diagnostic imaging), dietary and linen cost centers were categorized as variable. While the costs removed in this case are not exactly the same listing as

²³ Exhibit C-1 at 9. The Medicare Contractor applied the fixed cost percentage of 87.45 percent to the reduced Inpatient Operating Costs, resulting in \$1,189,278 of fixed costs.

²⁴ *Id.*

²⁵ Stipulations at ¶¶ 4-7.

²⁶ Medicare Contractor’s FPP at 6-7.

²⁷ Exhibit C-5 at 2-3.

²⁸ 918 F.3d 571, 579 (8th Cr. 2019), *cert. denied*, 140 S. Ct. 523, 205 L. Ed. 2d 335 (2019). See Medicare Contractor’s FPP at 7-9.

²⁹ Medicare Contractor’s FPP at 7-8 (discussing *Unity Healthcare v. Blue Cross Blue Shield Ass’n*, Adm’r Dec. 2014-D15 (Sept. 4, 2014) and *Unity HealthCare v. Eric D. Hargan*).

in the *Unity*, *Lakes Regional* and *Fairbanks* cases, they are analogous as the services included are tied to patient demand and are expected to vary directly based on patient volume.³⁰

The Board notes that Cogdell disagrees with the Medicare Contractor's methodology of computing the variable cost but did not provide an alternative calculation. Since the methodology used by the Medicare Contractor resembles the calculations that have been found acceptable in the *Unity*, *Lakes Regional* and *Fairbanks* cases, the Board finds that the Medicare Contractor's calculation is acceptable.

With regard to core staffing, Cogdell notes that "[t]he CMS manual states that peer hospital information is obtained from 'Hospital Administrative Services Monitrend' reports, which is currently unavailable. The most current substitute data published on the CMS website is from American Hospital Association annual survey for FY 2009 and FY 2009 Occupational Mix data."³¹ Thus, they note that "all available core staffing data published by CMS is based on outdated information that is not contemporaneous with the VDA period under review."³² They also contend that the Medicare Contractor's methodology includes nursing staff from areas of the hospital outside of the cost report centers identified as "Adults and Pediatrics" and "Intensive Care Unit" which is not consistent with PRM 15-1 § 2810.1(C)(6).³³

The Medicare Contractor states that, since the occupational mix data used in the excess staffing analysis was from 2009, they were concerned and forwarded Cogdell's inquiry to CMS. CMS instructed the Medicare Contractor that, since no similar updated data was available, the Medicare Contractor was to use the 2009 information. The Medicare Contractor notes that the use of the older data would most likely benefit Cogdell as it is apparent that staffing levels are declining and people are doing more with less by employing technology and developing other efficiencies. The Medicare Contractor responds to Cogdell's objection to using nursing staff beyond the "Adults and Pediatrics" and "Intensive Care Unit" cost centers of the cost report by arguing that Cogdell's objections are unsupported and references PRM-1 § 2810.1.C.6 which states "[t]he intermediary's analysis of core staff is limited to those cost centers (General Service, Inpatient, Ancillary, etc.)"³⁴ whose costs are components of Medicare inpatient operating cost."

The Board finds that the PRM 15-1 § 2810.1 specifically requires that a provider's staffing levels are to be compared to occupational mix survey or AHA Annual Survey data. In this regard the Board finds that the FY 2009 Occupational Mix data was the best available data to use when computing excess staffing. Also, the Board agrees with the Medicare Contractor that PRM -1 § 2810.1(C)(6) states that the excess staffing analysis is limited to "general service, inpatient, ancillary, etc." which would include inpatient cost centers outside of the "Adults and Pediatrics" and "Intensive Care Unit" cost centers.³⁵

³⁰ Medicare Contractor's FPP at 9.

³¹ Provider's FPP at 7.

³² *Id.*

³³ *Id.*

³⁴ (Emphasis added.)

³⁵ Medicare Contractor's FPP at 11-12.

Applying the methodology adopted by the Board in previous decisions, Cogdell reasons 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.³⁶ Cogdell maintains that this method would assure an accurate matching of revenue to expenses because the DRG payment is intended to cover both fixed *and* variable costs. Cogdell also references the fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.³⁷

The Board identified one basic difference between the Medicare Contractor's and Cogdell's calculation of Cogdell's VDA payment. There is a difference in the FY 2012 Inpatient Operating Costs used by the parties. The Medicare Contractor adjusted the Inpatient Operating Costs for variable costs and for excess staffing costs before comparing these costs to the DRG revenue. Cogdell argues that the Medicare Contractor's VDA calculation methodology violates the statutes, regulations, and Provider Reimbursement Manual instructions.

In recent decisions, the Board has disagreed with the methodology used by various Medicare contractors, including the Medicare Contractor in this case, to calculate VDA payments because this 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.³⁸ 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 provider³⁹

³⁶ Provider's FPP at 5-6.

³⁷ *Id.* at 7-8.

³⁸ *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Servs.*, 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 Servs.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).

At the outset, the Board notes that the CMS 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 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

Recently, the Eighth Circuit upheld the Administrator's VDA calculation methodology that was applied in *Unity HealthCare v. Azar* (“*Unity*”) and, in this regard, stated that the “Secretary’s interpretation was not arbitrary or capricious and was consistent with the regulation.”⁴¹ The Board notes that Cogdell is not in the Eighth Circuit, thus the decision is not binding precedent. The Board further finds that 42 U.S.C. § 1395ww(d)(5)(D)(ii) and 42 C.F.R. § 412.92(e)(3) only provide a framework by which to calculate a VDA payment,⁴² and the Board is not bound to apply the *specific* VDA calculation methodology which the Administrator applied in *Unity* and which the Eighth Circuit upheld.⁴³ 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 appeals process.⁴⁴ Thus, the Board finds that the Eighth Circuit’s *Unity* decision was simply

⁴⁰ (Bold and italics emphasis added).

⁴¹ *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

⁴² With regard to 42 U.S.C. § 1395ww(d)(5)(D)(ii), *see, e.g., St. Anthony Reg’l Hosp. v. Azar*, 294 F. Supp. 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 purposes.”), *aff’d*, *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019). With regard to 42 C.F.R. § 412.92(e)(3), *see, e.g., id.* at 772, 780 (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, e.g.,* 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987) (stating that “[w]e determine *ona 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).

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 “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

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* and, as such, the Eighth Circuit's decision in *Unity* did not create a binding precedent that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to the FFY 2018 IPPS Final Rule,⁴⁵ 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 Cogdell's VDA methodology for FY 2012 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 calculated Cogdell's VDA payment by comparing its FY 2012 fixed costs to its total FY 2012 DRG payments. However, neither the language nor the examples⁴⁸ 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 Rule⁴⁹ and the FFY 2009 IPPS Final Rule⁵⁰ reduce the hospital's cost *only* by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

[T]he 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

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).

⁴⁶ This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).

⁴⁷ 82 Fed. Reg. at 38180.

⁴⁸ PRM 15-1 § 2810.1(C)-(D).

⁴⁹ 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

⁵⁰ 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

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 permissible adjustment to the hospital's cost for calculating the VDA is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Cogdell'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 Cogdell's FY 2012 VDA based on an otherwise *new* methodology that the Administrator apparently adopted through adjudication in her decisions, which is best 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[.]"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 intent of 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 costs:

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.⁵³

In the Final Rule published on September 1, 1983 ("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:

⁵¹ *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014); *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm'r Dec. 2017-D1 at 12 (Feb. 9, 2017).

⁵² 82 Fed. Reg. at 38179-38183.

⁵³ (Emphasis added.)

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

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 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*.⁵⁵

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which both 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, 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 Under the

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).

Administrator's approach, 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 rationale necessarily 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 the 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.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, 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 incurred in the current year 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, the Administrator's methodology is not a reasonable interpretation of the statute.

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.

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, it is clear that the VDA payment is *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 ensure the hospital is fully compensated for its fixed costs and to be consistent with the PRM 15-1 assumption 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.

The Board notes that the DRG payments used by Cogdell and the Medicare Contractor in their calculations reflect the Hospital Specific amount from Line 49 of Worksheet E Part A of the cost report.⁶⁰ However, PRM 15-1 § 2810.1(C)(4) states:

The hospital must demonstrate that the total Program inpatient operating cost, excluding pass-through costs, exceeds total payment for inpatient operating costs (the higher of the federal payment amount or the hospital-specific payment amount) plus the operating portion of a provider’s low volume hospital payment adjustment (42 C.F.R. § 412.101). For example, total program inpatient operating cost excluding pass-through costs, reported on Form CMS-2552-10, Worksheet D-1, part II, line 53, must exceed the total payment for inpatient operating costs reported on Form CMS-2552-10, Worksheet E, Part A, line 49, ***plus the operating portion of a provider’s low volume hospital payment adjustment.***⁶¹

Thus, based on this PRM instruction, the payments must include not only amounts from Worksheet E Part A, Line 49, but also the operating portion of Worksheet E Part A, Lines 70.96 and 70.97, which are the low volume adjustments. The Board’s final calculations accordingly include these payments.

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 Cogdell’s fixed costs (which includes semi-fixed costs) were 87.45 percent⁶² of Cogdell’s Medicare costs for FY 2012. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

⁵⁹ 48 Fed. Reg. at 39782.

⁶⁰ Exhibit C-1 at 5; Exhibit C-2.

⁶¹ (Emphasis and italics added.)

⁶² Exhibit C-1.

Step 1: Calculation of the Cap

2011 Medicare Inpatient Operating Costs	\$1,895,508 ⁶³
Multiplied by the 2012 IPPS update factor	<u>1.019⁶⁴</u>
2011 Updated Costs (max allowed)	\$1,931,523
2012 Medicare Inpatient Operating Costs	\$1,458,549 ⁶⁵
Lower of 2011 Updated Costs or 2012 Costs	\$1,458,549
Less 2012 IPPS payment (includes low volume)	<u>\$1,497,883⁶⁶</u>
2012 Payment Cap	\$ -39,334

Step 2: Calculation of VDA

2012 Medicare Inpatient Fixed Operating Costs	\$1,313,278 ⁶⁷
Less Excess Staffing	<u>\$ -98,597⁶⁸</u>
2012 Medicare Inpatient Fixed Op. Costs less Excess Staff	\$1,214,681
Less 2012 IPPS payment – fixed portion (90.04 percent ⁶⁹)	<u>\$1,348,694⁷⁰</u>
Payment adjustment amount (subject to Cap)	\$ -134,013

As calculated above, Cogdell's total IPPS payments (inclusive of the low volume payments) exceed the total inpatient operating costs and, thus, Cogdell is not eligible for a VDA payment. Similarly, the second step indicates that the fixed portion of the IPPS payment *exceeds* the fixed portion of inpatient operating costs. Thus, the Board finds that the Medicare Contractor was correct in denying a VDA payment to Cogdell, albeit for different reasons than those identified in the final VDA determination.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that: (1) the Medicare Contractor improperly calculated Cogdell's VDA payment for FY 2012 and (2) notwithstanding, Cogdell should not receive a VDA payment

⁶³Exhibit P-1.

⁶⁴ Exhibit C-1 at 5. (Calculation = 274 days at FY2012 update factor of 1.019 and 92 days at FY 2013 update factor of 1.018, divided by 366 = ((1.019 x 274) + (1.018 x 92)) / 366 = 1.01874863387; rounded to 1.019.)

⁶⁵ *Id.*

⁶⁶ Exhibit P-9 at 5. (Non-Capital Percentage calculated as line 49 divided by (line 49 + line 50) = 1,249,018 / (1,249,018 + 75,463) = 94.30 percent) (Applying Non-Capital Percentage to the Low Volume Payments = (199,719 + 64,189) x 94.30 percent = 248,865) (Total Operating Payments = 1,249,018 + 248,865 = 1,497,883).

⁶⁷ Exhibit C-1. (Total Inpatient Operating costs from Exhibit C-1 at 5 (1,458,549) x fixed cost percentage from Exhibit C-1 at 4 (90.04 percent) = Fixed Operating Costs (1,313,278)).

⁶⁸ Exhibit C-1. Total Fixed Operating Costs from Exhibit C-1 at 5 (1,458,549) less Operating Costs net of Excess Staffing from Exhibit C-1 at 9 (1,359,952) = Excess Staffing (98,597).

⁶⁹ The stipulated fixed cost percentage of 87.45 percent was calculated after the exclusion of excess staffing costs. The Board's handling calculates this percentage before excess staffing costs are excluded. This percentage is reflected on Exhibit C-1 at 4.

⁷⁰ Calculation = 1,497,883 * 0.9004 = 1,348,693.85, rounded to 1,348,694.

for FY 2012 because, under the revised VDA calculation, the fixed portion of IPPS payments received exceeded the fixed portion of inpatient operating costs for FY 2012.

BOARD MEMBERS

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

10/26/2021

X Clayton J. Nix

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