

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

2024-D11

**PROVIDER-**  
Sunbury Community Hospital

**Provider No.:** 39-0084

**vs.**

**MEDICARE CONTRACTOR –**  
WPS Government Health Administrators

**RECORD HEARING DATE –**  
June 28, 2023

**Cost Reporting Period Ended –**  
06/30/2014

**CASE NO. –** 17-1312

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## **ISSUE STATEMENT**

Whether the Medicare Administrative Contractor, Wisconsin Physicians Service (“WPS”), properly calculated the volume decrease adjustment owed to Sunbury Community Hospital (“Sunbury” or “Provider”) for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2014.<sup>1</sup>

## **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 Fiscal Year (“FY”) 2014 for Sunbury, and that Sunbury should receive a VDA payment in the amount of \$168,755 for FY 2014.

## **INTRODUCTION**

Sunbury is a non-profit acute care hospital located in Sunbury, Pennsylvania. Sunbury was designated as a Medicare Dependent Hospital (“MDH”) during the fiscal year at issue.<sup>2</sup> The Medicare administrative contractor<sup>3</sup> assigned to Sunbury for this appeal is WPS Government Health Administrators (“Medicare Contractor”). On August 1, 2016, Sunbury requested a VDA payment of \$239,193 for FY 2014 to compensate it for a decrease in inpatient discharges during FY 2014.<sup>4</sup> On January 27, 2017, the Medicare Contractor determined that the Provider’s FY 2014 VDA payment to be \$0 based on its finding that the “provider’s DRG payments exceeded the fixed and semi-fixed costs” and, in so doing, implicitly confirmed that the Provider qualified for a VDA adjustment calculation (*i.e.*, had a qualifying decrease in discharges).<sup>5</sup> Sunbury 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 June 28, 2023. Sunbury was represented by Richard S. Reid of The Rybar Group, Inc. 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 MDHs

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<sup>1</sup> Provider’s Final Position Paper (hereafter, “Provider’s FPP”) at 2.

<sup>2</sup> Stipulations at ¶ 1.

<sup>3</sup> 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.

<sup>4</sup> Provider’s FPP at 3; Stipulations at ¶ 5.

<sup>5</sup> Exhibit C-1 at 4; Stipulations at ¶ 6.

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.”<sup>6</sup> The implementing regulations located at 42 C.F.R. § 412.108(d) reflect these statutory requirements.

It is undisputed that Sunbury experienced a decrease in discharges greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond Sunbury’s control and that, as a result, Sunbury was eligible to have a VDA calculation performed for FY 2014.<sup>7</sup> Sunbury requested a VDA payment in the amount of \$239,193 for FY 2014.<sup>8</sup> However, when the Medicare Contractor made the FY 2014 VDA calculation, it determined that Sunbury was not entitled to a VDA payment because it was fully compensated for its fixed/semi-fixed costs.<sup>9</sup> Thus, this appeal addresses whether Sunbury is due a VDA payment and, in particular, the parties’ dispute regarding how the VDA payment should be calculated.

The implementing regulations are located at 42 C.F.R. § 412.108(d). When promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals (“SCHs”)<sup>10</sup>. The regulation at 42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates that it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.108(d)(3) (2014) states, in pertinent part:

(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 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;

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<sup>6</sup> 42 U.S.C. § 1395ww(d)(5)(G)(iii).

<sup>7</sup> Stipulations at ¶ 5.

<sup>8</sup> *Id* at ¶ 7.

<sup>9</sup> Exhibit C-1 at 4.

<sup>10</sup> 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

(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.<sup>11</sup>

In the preamble to the final rule published on August 18, 2006,<sup>12</sup> CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 (“PRM 15-1”) § 2810.1 (Rev. 371), which provides further guidance related to VDAs and 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*<sup>13</sup> with utilization such as food and laundry costs.

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

	Medicare Contractor calculation using fixed costs <sup>14</sup>	Provider/PRM calculation using total costs <sup>15</sup>
a) Prior Year Medicare Inpatient Operating Costs		\$ 4,204,975
b) IPSS update factor		1.026
c) Prior year Updated Operating Costs (a x b)		\$ 4,314,304
d) Current Year Operating Costs		\$ 4,097,533
e) Lower of c or d		\$ 4,097,533
f) DRG/MDH payment		\$ 3,858,340
g) Cap (e-f)		\$ 239,193
h) Current Year Inpatient Operating Costs	\$ 4,097,533	\$ 4,097,533

<sup>11</sup> (Emphasis added.) See also 42 U.S.C. § 1395ww(d)(5)(G)(iii).

<sup>12</sup> 71 Fed. Reg. at 47870, 48056 (Aug. 18, 2006).

<sup>13</sup> (Emphasis added).

<sup>14</sup> Stipulations at ¶ 10 (the Medicare Contractor did not determine the cap as part of their review).

<sup>15</sup> *Id* at ¶ 7.

i) Fixed Cost percent	83.66% <sup>16</sup>	100.00% <sup>17</sup>
j) FY 2014 Fixed Costs (h x i)	\$ 3,428,151	\$ 4,097,533
k) Total DRG Payments	\$ 3,858,340	\$ 3,858,340
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 amount line j exceeds line k.)		\$ 239,193

The parties to this appeal dispute the application of the statute and the regulation used to calculate the VDA payment.<sup>18</sup>

### **DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW**

The Medicare Contractor disagrees with the Provider's assertion the Federal Register does not specifically state that variable costs should be removed from total costs to compute the VDA. The Medicare Contractor asserts that Sunbury has misinterpreted the Federal Register.<sup>19</sup> In support of its position, the Medicare Contractor cites to United States Court of Appeals for the Eighth Circuit, *Unity Healthcare, St. Anthony Regional Hospital and Lakes Regional Healthcare vs. Alex M Azar, II, Secretary, U.S. Department of Health and Human Services*.<sup>20</sup>

The Medicare Contractor removed variable costs by using worksheet A-8 adjustments on Sunbury's cost report. The Medicare Contractor contends that specific instructions to determine the fixed/semi-fixed costs is not included in the statutes, regulations or Provider Reimbursement Manual. Therefore, the Medicare Contractor used the cost report to develop an accurate means of calculating fixed/semi-fixed costs.<sup>21</sup> The Administrator agreed with this approach in the *Unity and Lakes Regional* decisions.<sup>22</sup>

Sunbury argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor "departed from CMS' [Provider Reimbursement] Manual instructions and step-by-step guide and added an unauthorized and monumental extra step."<sup>23</sup> According to Sunbury, "[n]owhere in the Federal Register does it say to subtract variable costs from the [p]rovider's costs."<sup>24</sup> The Board notes that the Final Rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule")<sup>25</sup> 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."<sup>26</sup>

<sup>16</sup> Calculation =  $\$3,428,151 / 4,097,533 = 0.836637801$ , rounded to 0.8366.

<sup>17</sup> Sunbury does not remove variable costs from the VDA calculation. Sunbury states that variable costs are not removed in any of the examples in PRM 2810.1 nor in the Federal Register published in 2008. Provider's FPP at 6.

<sup>18</sup> Stipulations at ¶¶ 11, 12.

<sup>19</sup> Medicare Contractor's Final Position Paper (hereafter, "Medicare Contractor's FPP") at 21.

<sup>20</sup> *Id.* at 9, 17.

<sup>21</sup> *Id.* at 11-12.

<sup>22</sup> *Id.* at 11.

<sup>23</sup> Provider's FPP at 7.

<sup>24</sup> *Id.* at 6.

<sup>25</sup> 48 Fed. Reg. 39782 (Sept. 1, 1983).

<sup>26</sup> (Emphasis added).

Sunbury contends that the Medicare Contractor’s approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.<sup>27</sup> Sunbury also maintains that its current VDA calculation is in accordance with PRM 15-1 § 2810.1 and that this was the methodology “in effect during the cost reporting period under appeal.”<sup>28</sup>

The Board identified two basic differences in the Medicare Contractor’s and Sunbury’s calculation of the Provider’s VDA payment. First, there is a difference in the FY 2014 Inpatient Operating Costs used by the parties. The Medicare Contractor adjusted the Inpatient Operating Costs for variable costs via worksheet A-8 adjustments on the cost report. Sunbury argues that the Medicare Contractor’s VDA calculation methodology violates the statutes, regulations, and Provider Reimbursement Manual instructions. Secondly, the Medicare Contractor reduced the hospital’s total fixed costs by the hospital’s total DRG revenue that was attributed to both fixed and variable costs, rendering an understated VDA.

In recent decisions,<sup>29</sup> 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, Sunbury 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. Sunbury states its “DRG payments would have been multiplied by the percentage of fixed program costs to all program costs to calculate the DRG payments attributable to fixed costs.”<sup>30</sup> Sunbury 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.<sup>31</sup>

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,

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<sup>27</sup> Provider’s FPP at 10.

<sup>28</sup> *Id.* at 6.

<sup>29</sup> *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. 20015-D11 (June 9, 2015), *modified by*, Adm’r Dec. (Aug. 5, 2015).

<sup>30</sup> Provider’s FPP at 10.

<sup>31</sup> *Id.* at 9.

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 . . . .<sup>32</sup>

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.”<sup>33</sup>

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 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.<sup>34</sup>

Noting that Sunbury is not 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.<sup>35</sup> As a result, the Board is not bound to apply the specific VDA calculation methodology that the Administrator applied (and

<sup>32</sup> *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).

<sup>33</sup> *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019) *cert. denied*, 140 S. Ct. 523 (2019).

<sup>34</sup> (Bold and italics emphasis added).

<sup>35</sup> 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).

the Eighth Circuit upheld) in *Unity*.<sup>36</sup> 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.<sup>37</sup> 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,<sup>38</sup> 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.<sup>39</sup> 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."<sup>40</sup>

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 Sunbury'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 Sunbury's VDA payment by comparing its FY 2014 fixed costs to its total FY 2014 DRG payments. However, neither the language nor the examples<sup>41</sup> 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<sup>42</sup> and the FFY 2009 IPPS Final Rule<sup>43</sup> reduce the hospital's cost only

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<sup>36</sup> 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).

<sup>37</sup> 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).

<sup>38</sup> 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

<sup>39</sup> This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).

<sup>40</sup> 82 Fed. Reg. at 38180.

<sup>41</sup> PRM 15-1 § 2810.1(C)-(D).

<sup>42</sup> 71 Fed. Reg. at 48056.

<sup>43</sup> 73 Fed. Reg. at 48631.

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 Sunbury'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 Sunbury'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[.]"<sup>44</sup> 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.<sup>45</sup>

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

In the case of a Medicare dependent, small rural 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.<sup>46</sup>

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

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<sup>44</sup> *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).

<sup>45</sup> 82 Fed. Reg. at 38179-38183.

<sup>46</sup> (Bold and italics emphasis added.)

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.”<sup>47</sup> 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 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.*<sup>48</sup>

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

<sup>47</sup> 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

<sup>48</sup> (Emphasis added).

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.”<sup>49</sup>

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.”<sup>50</sup> 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 MDH 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. § 405.108(d)(3)(i)(A) that the Medicare contractor “considers . . . [t]he individual hospital’s needs and circumstances” when determining the payment amount.<sup>51</sup> 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)(G)(iii)

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<sup>49</sup> *St. Anthony Reg’l Hosp.*, Adm’r Dec. at 13; *Trinity Reg’l Med. Ctr.*, Adm’r Dec. at 12.

<sup>50</sup> 42 U.S.C. § 1395ww(d)(5)(G)(iii).

<sup>51</sup> The Board recognizes that 42 C.F.R. § 405.108(d)(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.

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)(G)(iii) 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.<sup>52</sup> 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 Sunbury’s fixed costs (which includes semi-fixed costs) were 83.66 percent<sup>53</sup> of the Provider’s 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	\$ 4,204,975 <sup>54</sup>
Multiplied by the 2014 IPPS update factor	<u>1.026<sup>55</sup></u>
2013 Updated Costs (max allowed)	\$ 4,314,304
2014 Medicare Inpatient Operating Costs	<b>\$ 4,097,533<sup>56</sup></b>
Lower of 2013 Updated Costs or 2014 Costs	\$ 4,097,533
Less 2014 IPPS payment	<u>\$ 3,896,003<sup>57</sup></u>
2014 Payment Cap	<b>\$ 201,530</b>

<sup>52</sup> 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).

<sup>53</sup> Stipulations at ¶ 11.

<sup>54</sup> *Id.*

<sup>55</sup> *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 1.026 was not correct. 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.)

<sup>56</sup> *Id.*

<sup>57</sup> Exhibit C-1 at 10. (The Board notes that the parties stipulated the total PPS payments to be \$3,858,340, while citing to cost report Worksheet E Part A, line 49. In fact, Exhibit C-1 indicates that line 49 reflects an amount of \$3,896,003. The difference is due to the inclusion of the HRR and HVBP adjustments from lines 70.93 and 70.94. This is not appropriate. The Board has therefore used the amount per Exhibit C-1.)

**Step 2: Calculation of VDA**

2014 Medicare Inpatient Fixed Operating Costs	\$ 3,428,151 <sup>58</sup>
Less 2014 IPPS payment – fixed portion (83.66 percent)	\$ <u>3,259,396<sup>59</sup></u>
Payment adjustment amount (subject to Cap)	\$ <b>168,755</b>

Since the payment adjustment amount of \$168,755 is less than the Cap of \$201,530, the Board determines that Sunbury's VDA payment for FY 2014 should be \$168,755.

**DECISION**

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Sunbury's VDA payment for FY 2014, and that Sunbury should receive a VDA payment in the amount of \$168,755 for FY 2014.

**BOARD MEMBERS:**

Clayton J. Nix, Esq.  
 Ratina Kelly, CPA  
 Kevin D. Smith, CPA

**FOR THE BOARD:**

4/8/2024

**X** Clayton J. Nix

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

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<sup>58</sup> Stipulations at ¶ 11.

<sup>59</sup> The \$3,259,306 is calculated by multiplying \$3,896,003 (the corrected FY 2014 DRG payments) by 0.8366 (the rounded fixed cost percentage determined by the Medicare Contractor).