PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2025-D06

PROVIDER-
Tennova Healthcare - Volunteer Martin

Provider No.: 44-0061

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –
December 19, 2023

Cost Reporting Period Ended –
01/31/2015

CASE NO. – 18-1201

INDEX

ISSUE STATEMENT

Whether the Medicare Administrative Contractor, Wisconsin Physicians Service ("WPS") Government Health Administrators, properly calculated the volume decrease adjustment owed to Tennova Healthcare - Volunteer Martin ("Volunteer Martin" or "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending January 31, 2015 ("FY 2015").[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 Fiscal Year ("FY") 2015 for Tennova Healthcare - Volunteer Martin and that Volunteer Martin should receive a VDA payment in the amount of $240,507 for FY 2015.

INTRODUCTION

Tennova Healthcare - Volunteer Martin is an acute care hospital located in Martin, Tennessee. Volunteer Martin was designated as a Medicare Dependent Hospital ("MDH") during the fiscal year at issue.[2] The Medicare Administrative Contractor[3] assigned to Volunteer Martin for this appeal is WPS Government Health Administrators ("Medicare Contractor"). Volunteer Martin originally requested a VDA payment of $490,800 for FY 2015 to compensate it for a decrease in inpatient discharges during FY 2015.[4] In a final determination letter dated January 18, 2018, the Medicare Contractor denied the Provider's FY 2015 request for VDA payment "because it concluded that the Provider's inpatient prospective payment system (IPPS) payments for its operating costs exceeded the Provider's allowable inpatient fixed and semi-fixed operating costs."[5] Volunteer Martin timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board. Volunteer Martin now asserts that its VDA payment should be in the amount of $268,176.[6]

The Board approved a record hearing on December 19, 2023. Volunteer Martin was represented by Richard S. Reid, Esq. of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Provider's Final Position Paper (hereinafter "Provider's FPP") at 2. *See also,* Stipulations of the Parties (hereinafter "Stipulations") at ¶ 7.
[2] Stipulations at ¶ 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs as appropriate and relevant.
[4] Exhibit P-1 (VCH ("Volunteer Community Hospital") VDA request) at 15.
[5] Stipulations at ¶ 6. *See also* Exhibit P-2 at 1.
[6] Stipulations at ¶ 8.

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 if, due to circumstances beyond their control, they incur a decrease of more than 5 percent in the total number of inpatient cases 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."[7] The implementing regulations located at 42 C.F.R. § 412.108(d) reflect these statutory requirements.

It is undisputed that Volunteer Martin experienced a decrease in discharges greater than 5% from FY 2014 to FY 2015 due to circumstances beyond Volunteer Martin's control and that, as a result, Volunteer Martin was eligible to have a VDA calculation performed for FY 2015.[8] Volunteer Martin requested a VDA payment in the amount of $490,800 for FY 2015.[9] However, when the Medicare Contractor performed its FY 2015 VDA calculation, it determined that Volunteer Martin was not eligible for a VDA payment after removing a percentage of costs identified as variable in the Medicare Contractor's analysis.[10] In this appeal, the remaining issue is how the VDA payment should be calculated, as the parties dispute the interpretation and application of the regulation used to calculate the VDA payment.[11]

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 cases. Specifically, § 412.108(d)(3) (2015) 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).
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> (i) In determining the adjustment amount, the intermediary considers -

[7] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[8] Stipulations at ¶ 3.
[9] Provider's FPP Exhibit P-1.
[10] Stipulations at ¶ 9, 10, and 11.
[11] Provider's FPP at 2. *See also* Stipulations at ¶ 7.

> (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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> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
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> (C)The length of time the hospital has experienced a decrease in utilization.[12]

The chart below depicts how the Medicare Contractor and the Provider each propose to calculate the VDA payment, as documented in the parties' stipulations.

	Medicare Contractor calculation using fixed costs[13]	Provider/PRM calculation using total costs[14]
a) Prior Year Medicare Inpatient Operating Costs		$ 4,848,326
b) IPPS update factor		1.024
c) Prior year Updated Operating Costs (a x b)		$ 4,964,686
d) Current Year Operating Costs		$ 4,841,717
e) Lower of c or d		$ 4,841,717
f) DRG/MDH payment		$ 4,573,541
g) CAP (e-f)		$ 268,176
h) Current Year Inpatient Operating Costs	$ 4,841,717	$ 4,841,717
i) Fixed Cost percent	89.71%[15]	100.00%[16]
j) FY 2015 Fixed Costs (h x i)	$ 4,343,431	$ 4,841,717
k) Total DRG Payments	$ 4,573,541	$ 4,573,541
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ (230,110)	
m) VDA Payment Amount (The Provider's VDA is based on the amount line j exceeds line k.)		$ 268,176

[12] *See also* 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[13] Stipulations at ¶ 11 (The Medicare Contractor did not determine the cap as part of their review).
[14] *Id.* at ¶ 8.
[15] The Medicare Contractor made adjustments, via Worksheet A-8, to exclude costs it had identified as "variable." This resulted in "fixed operating costs" of $4,343,431 (see Exhibit P-2 at FPP 37 and FPP 44). This results in a fixed cost percentage of 89.71% as shown in the following calculation: $4,343,431/$4,841,717 = .897084856, rounded to 0.8971.
[16] Volunteer Martin does not remove variable costs from the VDA calculation. *See also* Stipulations at ¶ 9.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor disagrees with the Provider's assertion that the Federal Register does not specifically state that variable costs should be removed from *total* costs to compute the VDA.[17] The Medicare Contractor asserts that it has correctly interpreted the Federal Register and that the calculation is consistent with CMS Publication 15-1, The Provider Reimbursement Manual ("PRM") §2810.1B, which distinguishes fixed, semi-fixed, and variable costs.[18] In support of its position, the Medicare Contractor cites Administrator Decisions for *Lakes Regional Healthcare v. BCBSA*, PRRB Dec. No. 2014-D16 (July 10, 2014) and *Unity Healthcare v. BCBSA*, PRRB Dec. No. 2014-D15 (July 10, 2014), in which the CMS Administrator affirmed this methodology in its decisions dated September 4, 2014 in both cases.[19] The Medicare Contractor also references the Administrator's Decision in *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association,* Adm'r. Dec. 2015-D11, (Aug. 5, 2015).[20]

The Medicare Contractor removed variable costs by using worksheet A-8 adjustments on Volunteer Martin's cost report. The Medicare Contractor contends that, while specific instructions to determine the fixed/semi-fixed costs are not included in the statute, regulations or Provider Reimbursement Manual, "[t]he evidence clearly demonstrates that **variable costs** are not to be considered in the calculation of the VDA."[21] Therefore, the Medicare Contractor used the cost report to develop an accurate means of calculating fixed/semi-fixed costs. The Administrator agreed with this approach in the *Unity* and *Lakes Regional* decisions.[22]

Volunteer Martin argues that the Medicare Contractor's calculation of the VDA "does not take into account the most recent Medicare guidance on calculating a volume decrease adjustment and also violates Medicare principles against the subsidization of Medicare patients by non-Medicare payers."[23] The Provider states that the Medicare Contractor "departed from CMS's manual instructions and step-by-step guide and added an unauthorized and monumental extra step: Although the Manual specifically instructs that the 'inpatient operating costs' should be used in calculating the adjustment amount, WPS took the Provider's inpatient operating costs and removed all variable costs."[24] According to Volunteer Martin,"[n]owhere in the Federal Register does it say to subtract variable costs from the Provider's costs."[25]

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[17] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 7-9.
[18] Medicare Contractor FPP at 5-6.
[19] *Id.* at 6-7.
[20] *Id.* at 6.
[21] *Id.* at 6 (emphasis added).
[22] *Id.* at 10.
[23] Provider's FPP at 12.
[24] *Id.* at 7.
[25] *Id.* at 6. Here, the Board notes that the Final Rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule") 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." (48 Fed. Reg. 39752, 39781-82).

Volunteer Martin contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[26] Volunteer Martin 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.[27]

The Board identified two basic differences between the Medicare Contractor's and Volunteer Martin's calculations of the Provider's VDA payment. First, there is a difference in the FY 2015 Inpatient Operating Costs used by the parties. The Medicare Contractor adjusted the Inpatient Operating Costs to exclude variable costs via worksheet A-8 adjustments on the cost report.[28] Second, the Medicare Contractor compared the hospital's total fixed costs to the hospital's total DRG revenue that was attributed to both fixed and variable costs, rendering an understated VDA.[29]

In recent decisions,[30] 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. To this point, Volunteer Martin states, "DRG revenue compensates a hospital for all its expenses in treating inpatients – both fixed and variable costs. Under the MAC's methodology, therefore, reducing a hospital's total fixed costs by DRG revenue attributable to both fixed and variable costs render an understated VDA. In effect, it is subtracting apples from oranges."[31]

Referring to the methodology adopted by the Board in previous decisions, Volunteer Martin 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. Volunteer Martin states its "DRG payments would have been multiplied by the percentage of fixed program costs to all program costs 93.4% to calculate the DRG payments attributable to fixed costs."[32] Volunteer Martin 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.[33]

The Administrator has overturned these Board decisions, stating:

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[26] *Id.* at 8.
[27] *Id.* at 3.
[28] Medicare Contractor's FPP at 8.
[29] Provider's FPP at 8.
[30] *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).
[31] Provider's FPP at 9.
[32] *Id.* at 10.
[33] *Id.* at 11.

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . .
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> In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. . . . The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[34]

In 2019, 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."[35] Here, it is important to note that Administrator decisions are not binding precedent upon the Board. PRM 15-1 § 2927.C.6.e explains:

> 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.[36]

While Volunteer Martin is not in the Eighth Circuit and the statutes and regulations for VDAs for SCHs and MDHs are identical, the Board finds that the applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[37] As a result, the Board is not

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[34] *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).

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

[36] (Bold and italics emphasis added).

[37] 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. 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 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

bound to apply the specific VDA calculation methodology that the Administrator applied (and the Eighth Circuit upheld) in Unity.[38] 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.[39] 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,[40] 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.[41] 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."[42]

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 Volunteer Martin's VDA methodology for FY 2015 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 Volunteer Martin's VDA payment by comparing its FY 2015 fixed costs to its total FY 2015 DRG payments. However, neither the language nor the

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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."); 48 Fed. Reg. 39752, 39781-82 (Sept. 1, 1983).

[38] *See, e.g., Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1107-08 (D.C. Cir. 2015) (discussing regulatory interpretations adopted through adjudication versus through rulemaking).

[39] 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 (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).

[40] 82 Fed. Reg. at 37990, 38179-38183 (Aug. 14, 2017).

[41] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).

[42] 82 Fed. Reg. at 38180.

examples[43] 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[44] and the FFY 2009 IPPS Final Rule[45] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> The adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

It is clear from the preambles to these Final Rules that the only adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Volunteer Martin'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.

The Board finds, instead, that the Medicare Contractor calculated Volunteer Martin's FY 2015 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions, which is 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[.]"[46] 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.[47]

The statute at 42 U.S.C. § 1395ww(d)(5)(G)(iii) (2015) 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,

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[43] PRM 15-1 § 2810.1(C)-(D).
[44] 71 Fed. Reg. at 47870, 48056 (Aug. 18, 2006).
[45] 73 Fed. Reg. at 48434, 48631 (Aug. 19, 2008).
[46] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r. Dec. 2014-D16 at 8 (Sep. 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 (Dec. 15, 2016).
[47] 82 Fed. Reg. at 38179-38183.

> including the reasonable cost of maintaining necessary core staff and services.[48]

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."[49] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
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> D. Determination on Requests.— . . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
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> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 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***.[50]

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[48] 48 Fed. Reg. at 39781-39782.
[49] *Id.* (emphasis added).
[50] PRM 15-1 § 2810.1 (rev. 356) (Emphasis added).

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."[51]

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."[52] 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.[53] 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.

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[51] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[52] 42 U.S.C. § 1395ww(d)(5)(G)(iii) (2015).
[53] 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.

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) 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. Thus, the Board agrees with the U.S. Court of Appeals for the D.C. Circuit that "the fixed-total method used by [the Administrator] [does] not 'fully compensate' [a hospital] for its 'fixed costs[.]'"[54]

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. [55] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for Medicare services actually furnished. The Board concludes that, in order to both ensure the hospital is fully compensated for its fixed costs and be consistent with the assumption stated in PRM 15-1 § 2810.1 that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case the Medicare Contractor determined that Volunteer Martin's fixed costs (which includes semi-fixed costs) were 89.71 percent[56] of the Provider's Medicare costs for FY 2015. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2014 Medicare Inpatient Operating Costs	$ 4,848,326[57]
Multiplied by the 2015 IPPS update factor	1.024[58]
2014 Updated Costs (max allowed)	$ 4,964,686
2015 Medicare Inpatient Operating Costs	**$ 4,841,717**[59]
Lower of 2014 Updated Costs or 2015 Costs	$ 4,841,717

[54] *See Lake Region Healthcare Corp. v. Becerra*, 113 F.4th 1002, 1009 (D.C. Cir. 2024).
[55] 48 Fed. Reg. at 39781-82.
[56] Stipulations at ¶ 12.
[57] *Id*.
[58] The Board notes that the correct IPPS update factor for FY15 is 1.022, not 1.024 as stipulated by the parties. Further, the appropriate update factor would be based upon the portions of FFY 2014 (1.017) and FFY 2015 (1.022) reflected in the Provider's cost reporting period. However, as the Provider's 2015 IPPS Operating Costs are less than the 2014 costs adjusted by the update factor, this has no effect on the final VDA. The Board therefore will use the stipulated update factor for this calculation.
[59] Stipulations at ¶ 12.

Less 2015 IPPS payment	$ 4,573,541[60]
2015 Payment Cap	**$ 268,176**

Step 2: Calculation of VDA

2015 Medicare Inpatient Fixed Operating Costs	$ 4,343,431[61]
Less 2015 IPPS payment – fixed portion (89.71 percent)	$ 4,102,924[62]
Payment adjustment amount (subject to Cap)	**$ 240,507**

Since the payment adjustment amount of $240,507 is **less** than the Cap of $268,176, the Board determines that Volunteer Martin's VDA payment for FY 2015 should be $240,507.

DECISION AND ORDER

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Volunteer Martin's VDA payment for FY 2015, and that Volunteer Martin should receive a FY 2015 VDA payment in the amount of $240,507.

BOARD MEMBERS:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

12/17/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Acting Chair
Signed by: Kevin D. Smith -A

[60] *Id*.
[61] *Id.*
[62] The $4,102,924 is calculated by multiplying $4,573,541 (the FY 2015 DRG payments) by 0.8971 (the fixed cost percentage determined by the Medicare Contractor). *See* Stipulations at ¶ 12.