PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2021-D34

PROVIDER-
Lake Regional Health System

Provider No.: 26-0186

vs.

MEDICARE CONTRACTOR –
Wisconsin Physician Services

RECORD HEARING DATE –
March 3, 2021

Cost Reporting Period Ended –
04/30/2013

CASE NO. – 16-1950

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment owed to Lake Regional Health System ("Lake" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending April 30, 2013 ("FY 2013").[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated Lake's VDA payment for FY 2013, and that Lake should receive a VDA payment in the amount of $1,972,346 for FY 2013.

INTRODUCTION

Lake is a sole community hospital ("SCH") located in Osage, Missouri,[2] and was designated as an SCH during the fiscal year at issue.[3] The Medicare contractor[4] assigned to Lake for this appeal is Wisconsin Physician Services ("Medicare Contractor").[5] Lake filed a timely request for a VDA payment for FY 2013 on August 21, 2015.[6] The Medicare Contractor denied the request because it concluded that Lake's total inpatient prospective payment system ("IPPS") payments for its operating costs exceeded its allowable inpatient fixed and semi-fixed operating costs.[7] Lake 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 March 3, 2021. Lake was represented by Ronald K. Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

The Medicare program 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

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[1] Stipulations at ¶¶ 6-7; Provider's Consolidated Final Position Paper (hereinafter "Provider's FPP") at 2; Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 5.
[2] Stipulations at ¶ 1.
[3] Medicare Contractor's FPP at 3. For the first portion of the cost reporting period (May 1, 2012 through September 30, 2012), Lake was a Medicare Dependent Hospital ("MDH"). *Id.*; Provider's FPP at n.1. VDA calculations for MDHs and SCHs are governed by the same rules. 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[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.
[7] *Id.* at ¶ 5. *See also* Exhibit C-1 at 66.

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 patient discharges of more than 5 percent from one cost reporting year to the next. VDA payments are designed to 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 Lake experienced a decrease in discharges greater than 5 percent from FY 2012 to FY 2013 due to circumstances beyond its control, and that, as a result, Lake was eligible to have a VDA calculation performed for FY 2013.[9] However, when the Medicare Contractor performed the FY 2013 VDA calculation, it determined that Lake did not qualify for a VDA payment because Lake's total DRG payments exceeded its fixed program operating costs by $667,131.[10]

The regulation at 42 C.F.R. § 412.92(e) (2013) directs how the Medicare Contractor must determine 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*[11] 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. . . .

The preamble to the final rule published on August 18, 2006[12] 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.

[8] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[9] Stipulations at ¶ 2. *See also* Provider's FPP at 2; Medicare Contractor's FPP at 11.
[10] Stipulations at ¶ 9; Medicare Contractor's FPP at 12.
[11] (Emphasis added.)
[12] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).

> 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.[13]

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

	Medicare Contractor calculation using fixed costs	Provider/PRM calculation using total costs[14]
a) Prior Year Medicare Inpatient Operating Costs		$28,673,284
b) IPPS update factor		1.026
c) Prior year Updated Operating Costs (a x b)		$29,418,789
d) FY 2013 Operating Costs		$26,203,151
e) Lower of c or d		$26,203,151
f) DRG/SCH payment		$18,558,648
g) CAP (d-f)		$ 7,644,503
h) FY 2013 Inpatient Operating Costs	$26,203,151[15]	$26,203,151
i) Fixed Cost percent	93.88 percent[16]	100 percent[17]
j) FY 2013 Fixed Costs (h x i)	$24,599,445[18]	$26,203,151
k) Total DRG/SCH Payments	$25,266,576[19]	$18,558,648[20]
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$ (667,131)	
m) VDA Payment Amount (The Providers VDA is based on the amount by which line j exceeds line k.)		$ 7,644,503

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[21]

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[13] (Emphasis added).
[14] Stipulations at ¶ 6.
[15] *Id.* at ¶ 9. The Medicare Contractor **correctly** picked up line 53 that excluded capital.
[16] The calculation resulted in a percentage of 93.8797208, which was rounded to 93.88 for the purposes of this table.
[17] Provider's FPP at 6. Lake states that "[n]owhere in the Federal Register [dated August 19, 2008 at 48630-35] does it say to subtract variable costs from the Provider's costs." As a result, the fixed cost is stated as 100 percent.
[18] Stipulations at ¶ 9. *See* also Exhibit C-2 at 40. The Medicare Contractor **incorrectly** picked up line 49 which included capital. This impacted the Fixed cost percentage as line j is divided by line h to get 93.88.
[19] *Id. See also* Exhibit C-2 at 43. The total IPPS payments include the hospital specific payment and the capital payments. The capital payments should not have been included in the VDA calculation.
[20] *Id.* at ¶ 6. *See also* Exhibit C-2 at 43, Line 47. Lake only included the DRG payment.
[21] Provider's FPP at 6; Medicare Contractor's FPP at 13.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor disagrees with Lake'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 Lake has misinterpreted the applicable VDA methodology.[22] In support of its position, the Medicare Contractor cites to cases from the Administrator of CMS, including *Unity Healthcare, St. Anthony Regional Hospital*, and *Lakes Regional Healthcare vs. Alex M Azar, II, Secretary, U.S. Department of Health and Human Services*.[23]

The Medicare Contractor removed variable costs by using Worksheet A-8 adjustments on Lake's cost report. The Medicare Contractor contends that, because specific instructions to determine the fixed/semi-fixed costs are not included in the statutes, regulations or Provider Reimbursement Manual, it is appropriate to use the cost report to calculate fixed/semi-fixed costs. The Administrator agreed with this approach in the *Unity* and *Lake Regional* decisions.[24] Lake argues that this method is "not supported by the recent CMS Administrator decisions, and the regulations do not show this method either."[25] Lake further contends that the "fixed cost of inventory" should be included with fixed costs, which was not the case in the Medicare Contractor's calculations.[26]

Lake argues that the Medicare Contractor's calculation of the VDA was wrong because the Medicare Contractor departed from Provider Reimbursement Manual step-by-step instructions and added an unauthorized extra step.[27] Lake further states that:

> [T]he methodology employed by the MAC is inherently flawed. This methodology **guarantees** that a Sole Community Hospital will **never receive** the full compensation mandated by Congress because its fixed costs will always be reduced by reimbursement attributable to both fixed and variable costs.[28]

Lake, in its VDA calculation, has included the DRG payment in lieu of the hospital specific payment ("HSP") without providing any clear explanation of why they believe the IPPS payments should include only DRG payments. In the conclusion in its position paper, Lake states that 42 C.F.R § 412.92(e) "provides guidance on determining the appropriate amount of the Medicare Inpatient Cost and the DRG Amount including outliers"[29] when it describes DRG revenue as:

> DRG-adjusted prospective payment rates for inpatient operating

[22] Medicare Contractor's FPP at 17.
[23] *Id.* at 16. *See also* discussion of these cases, *infra*.
[24] *Id.* at 14 and 16.
[25] Provider's FPP at 11.
[26] *Id.* at 12.
[27] *Id.* at 7.
[28] *Id.* at 8 (emphases in original).
[29] *Id.* at 14.

> costs (including outlier payments for inpatient operating costs determined under Subpart F of this part and additional payments made for inpatient operating costs [for] hospitals that serve a disproportionate share of low income patients as described under §412.106 and for indirect medical education costs as determined under §412.105.[30]

Lake appears to interpret this regulation as only including the DRG payments in the VDA calculation.

Lake further argues that CMS changed its methodology for calculating VDA payments without going through notice-and-comment rulemaking.[31] According to Lake, CMS's new methodology represents an unlawful change in policy and Lake was not afforded fair notice of this new methodology.[32]

Lake also contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[33] Lake maintains that the most appropriate methodology to calculate the VDA payment can be found in 42 C.F.R. § 412.92, 42 C.F.R. § 412.108(d), and PRM 15-1 § 2810.1.

Lake in essence reasons that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there must also be a corresponding decrease to the DRG payment for the portion of the payment related to variable costs. This method, Lake maintains, would ensure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Lake 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.[34]

The Board identified two basic difference between the Medicare Contractor's and Lake's calculations of the VDA payment. First, there is a disagreement over the use of the Medicare Cost Report to remove the variable costs to compute the Medicare Inpatient costs that will be used in the VDA calculation. The example in PRM 15-1 § 2810.1(C)(4) uses the Medicare Inpatient costs from Worksheet D-1, Part II, line 53 of the cost report. Therefore, the Board finds it logical, considering all the complexities of the Medicare cost report, to identify the total inpatient operating costs, excluding pass-through costs, accordingly. The Board finds that removing the variable costs through a Worksheet A-8 adjustment and re-running the cost report, thereby recomputing the Worksheet D-1, Part II, line 53 results, leads to the most accurate Medicare inpatient costs, effectively excluding variable costs.

The second difference is that Lake included the DRG but not HSP payments in the VDA calculation. The Board reviewed the VDA regulations at 42 C.F.R. § 412.92(e). These

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[30] *Id.* at 13.
[31] *Id.* .
[32] *Id.*.
[33] *Id.* at 11.
[34] *Id.* at 9.

regulations require the VDA to be calculated using "the hospital's *total DRG revenue for inpatient operating costs* based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106. . . .)"[35] The Board also reviewed the SCH payment methodology in 42 C.F.R. § 412.92(d) to determine what payments should be included in the hospital's "total DRG revenue for inpatient operating costs." 42 C.F.R. § 412.92(d) provides that SCHs are paid for inpatient operating costs based on whichever is the greatest between the "Federal payment or the hospital specific payment.[36] Based on these regulations the Board finds that an SCH's total DRG revenue for inpatient operating costs includes both DRG and HSP payments. Therefore, the Board concludes the HSP amount of $23,863,408 should be included when calculating Lake's FY 2013 VDA payment.[37]

The various issues in this case are not new to the Board. 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

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[35] (Emphasis added.)

[36] *See* 42 C.F.R. § 412.92(d). This regulation references various sections including § 412.79, the section that the Medicare Contractor used to calculate Lake's hospital specific rate payment. 42 C.F.R. § 412.79 also provides for the determination of the hospital specific rate stating in subsection (e): "[t]he applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge."

[37] Stipulations at ¶ 10.

[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).

> been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[39]

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 U.S. Court of Appeals for the Eighth Circuit ("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] While Lake is in the Eighth Circuit, the Board 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 that the Administrator applied in *Unity* and 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,

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[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).

[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 *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).

[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

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

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments *through the rulemaking process*. 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 Lake's VDA methodology for FY 2013 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 Lake's VDA payment by comparing its FY 2013 fixed costs to its total FY 2013 DRG payments. However, neither the language nor the examples[48] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[49] and the FFY 2009 IPPS Final Rule[50] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> [T]he adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second

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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 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).

> 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 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 Lake's VDA using the methodology laid out by CMS in PRM 15-1 or by the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds that the Medicare Contractor calculated Lake's FY 2013 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.

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

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

> 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***.[54]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the Administrator decisions, stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[55]

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

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

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

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

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs 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.

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[57] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) (2013) 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.

Lake claims that CMS' revised VDA approval methodology runs afoul of the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA")[58] and the Medicare program at 42 U.S.C. § 1395hh(a).[59] They argue that "[w]hen the MAC changed the VDA calculation without following the legal notice and comment period, they unlawfully changed regulations. The VDA calculation was not lawfully altered until the August 17, 2017 Federal Register was issued."[60] Lake contends that "[t]he methodology in effect during the four years under appeal was the one described in section 2810.1 of the PRM, as formally adopted and modified in the IPPS rulemakings for FYs 2007 and 2009"[61] and also contends that CMS and/or the Medicare Contractor improperly departed from this methodology. However, the Board notes that the examples in PRM 15-1 § 2810.1 relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

> The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B) of the Manual, where the examples are located, contains "the process for determining the amount of the volume decrease adjustment." See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006). However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, *the Board found "that the examples are intended to demonstrate* ***how to calculate the adjustment limit*** as opposed to determining which costs should be included in the adjustment." *See Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n*, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than "equal to," when describing the formula. *We conclude that the Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation*.[62]

[58] 5 U.S.C. Ch. 5.
[59] Provider's FPP at 13.
[60] *Id.* at 13-14.
[61] *Id.* at 14.
[62] 918 F. 3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).

Accordingly, what Lake points to as written or published CMS "policy" on how to calculate the VDA payment was not, in fact, such a policy.

Moreover, the fact that the Medicare Contractor may have previously calculated VDAs differently does not automatically mean there is a departure from a Medicare program "policy."[63] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[64] This is different than the situation discussed by the Supreme Court in *Allina*, where a new substantive reimbursement policy was announced on the CMS website and was applied nationwide to all hospitals at one time.[65] Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as delineated at 42 C.F.R. § 412.92(e)(3).[66] Moreover, the Board has had long standing disagreements with Medicare contractors and the Administrator on their different interpretations and application of the relevant statutes, regulations and Manual guidance regarding the calculation of VDAs.[67] Accordingly, the Board rejects Lake's APA argument.

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.[68] 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 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.

As the Board does not have the IPPS actuarial data to determine the allocation 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 Lake's fixed costs (which includes semi-fixed costs) were 84.30 percent[69] of Lake's Medicare costs for FY 2013. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

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[63] Moreover, the fact that any particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.

[64] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius,* 718 F.3d 914 (D.C. Cir. 2013).

[65] 139 S. Ct. at 1808, 1810.

[66] This regulation specifies that the Medicare contractor "considers" three hospital specific factors "[i]n determining the [volume decrease] adjustment amount" and that this "determination is subject to review under subpart R of part 405 of this chapter."

[67] *See, e.g., Unity Healthcare v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Further, the application of the PRM definitions of the terms "variable" and "semi-fixed" costs to a particular provider's VDA request seems to be the very nature of adjudicatory fact-finding and why providers may appeal Medicare contractor VDA determinations to the Board.

[68] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).

[69] Stipulations at ¶ 10.

Step 1: Calculation of the CAP

2012 Medicare Inpatient Operating Costs	$28,673,284[70]
Multiplied by the 2012 IPPS update factor	1.026[71]
2012 Updated Costs (max allowed)	$29,418,789
2013 Medicare Inpatient Operating Costs	$26,203,151[72]
Lower of 2012 Updated Costs or 2013 Costs	$26,203,151
Less 2013 IPPS payment	$23,863,408[73]
2013 Payment CAP	**$ 2,339,743**

Step 2: Calculation of VDA

2013 Medicare Inpatient Fixed Operating Costs	$22,088,619[74]
Less 2013 IPPS payment – fixed portion (84.30 percent)	$20,116,273[75]
Payment adjustment amount (subject to CAP)	**$ 1,972,346**

Since the payment adjustment amount of $1,972,346 is less than the Cap of $2,339,743, the Board determines that Lake's VDA payment for FY 2013 should be $1,972,346.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Lake's VDA payment for FY 2013, and that Lake should receive a total VDA payment of $1,972,346 for FY 2013.

Board Members Participating:

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

For the Board:

9/22/2021

X Clayton J. Nix

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

[70] *Id*.
[71] *Id*.
[72] *Id*.
[73] *Id*.
[74] *Id*.
[75] The $20,116,273 is calculated by multiplying $ 23,863,408 (the FY 2013 SCH payments) by 0.8429756788 (the fixed cost percentage determined by the Medicare Contractor). The fixed cost percentage has been rounded to 84.30 percent for brevity.