PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D02

PROVIDER-
D.M. Cogdell Memorial Hospital

Provider No. 45-0073

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
May 19, 2021

Cost Reporting Period Ended –
12/31/2010

CASE NO. – 17-0274

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ISSUE STATEMENT

Whether D.M. Cogdell Memorial Hospital ("Cogdell" or the "Provider") is entitled to a Volume Decrease Adjustment ("VDA") from the Medicare Contractor for the fiscal year ending December 31, 2010 ("FY 2010").[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that Cogdell is not due a VDA payment for FY 2010.

INTRODUCTION

Cogdell is a 45-bed hospital located in Snyder, Texas[2] and, during the fiscal year at issue, Cogdell was designated as a sole community hospital ("SCH").[3] The Medicare contractor[4] assigned to Cogdell for this appeal is Novitas Solutions, Inc ("Medicare Contractor"). On October 8, 2014, Cogdell filed a timely request for VDA payment for FY 2010.[5] On May 23, 2016, the Medicare Contractor denied the request because it concluded that Cogdell's total DRG payments exceeded its total inpatient operating costs, once variable costs were removed.[6] On July 21, 2016, Cogdell submitted a Request for Reconsideration for a VDA payment in the amount of $161,128.[7] The Medicare Contractor did not respond to the Request.[8] On October 31, 2016, Cogdell timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on May 19, 2021. Cogdell was represented by Rick Morris of Discovery Healthcare Consulting Group, LLC. 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 payment adjustments. One of these payment adjustments is referred to as a VDA payment, and it

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[1] Provider Final Position Paper ("Provider FPP") at 1; Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 3.
[2] Stipulation of Facts ("Stipulations") at ¶ 1.
[3] *Id.*
[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[5] Stipulations at ¶ 3.
[6] Exhibit P-6.
[7] Exhibit P-4.
[8] Provider's FPP at 3.

is available to SCHs if, due to circumstances beyond their control, they incur a decrease in their total number of inpatient cases of more than 5 percent from one cost reporting year to the next. VDA payments are designed to fully compensate a hospital for the fixed costs it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.[9] The implementing regulations, located at 42 C.F.R. § 412.92(e), reflect these statutory requirements.

It is undisputed that Cogdell experienced a decrease in discharges greater than 5 percent from FY 2009 to FY 2010 due to circumstances beyond its control and that, as a result, Cogdell was eligible to have a VDA calculation performed for FY 2010.[10] However, when the Medicare Contractor computed the FY 2010 VDA calculation, it determined that Cogdell's DRG payment exceeded its fixed program operating costs.[11] As a result, the Medicare Contractor concluded that Cogdell did not qualify for an additional VDA payment.[12]

The regulation at 42 C.F.R. § 412.92(e) (2010) directs how the Medicare Contractor must calculate the VDA once an SCH demonstrates it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.92(e)(3) states, in pertinent part:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[13] 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[14] references the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 371), which offers further guidance related to calculating 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.

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[9] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[10] Stipulations at ¶ 2. *See also* Provider's FPP at 3; Medicare Contractor's FPP at 2.
[11] Stipulations at ¶ 4; Medicare Contractor's FPP at 2; Provider's FPP at 3.
[12] *Id.*
[13] (Emphasis added.)
[14] 71 Fed. Reg. 47870, 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.[15]

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

	Medicare Contractor calculation using fixed costs	Provider/PRM calculation using total costs[16]
a) Prior Year Medicare Inpatient Operating Costs	$2,382,208[17]	$2,382,208
b) IPPS update factor	1.021[18]	1.021
c) Prior year Updated Operating Costs (a x b)	$2,434,138	$2,432,336
d) FY 2010 Operating Costs	$2,343,208[19]	$2,343,208
e) Lower of c or d	$2,343,208	$2,343,208
f) DRG/SCH payment	$2,181,480[20]	$2,181,480
g) CAP (d-f)	$ 161,728	$ 161,728
h) FY 2010 Inpatient Operating Costs	$2,343,208[21]	$2,343,208
i) Fixed Cost percent	0.9044[22]	0.9044
j) FY 2010 Fixed Costs (h x i)	$2,119,197	$2,119,197
k) Total DRG/SCH Payments	$2,181,480[23]	$1,972,931
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$ -62,283	
m) VDA Payment Amount (The Providers VDA is based on the amount by which line j exceeds line k.)		$146,267

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[24]

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[15] (Emphasis added.)
[16] Exhibit P-1.
[17] Exhibit C-1 at 5.
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.* at 4. (Calculation = Fixed & Semi-Fixed Costs (6,860,120 + 8,579,794) = 15,439,914 divided by Adjusted Net Costs = 17,071,625; 15,439,914 / 17,071,625 =0.9044197, rounded to 0.9044.)
[23] *Id.* at 5.
[24] Stipulations at ¶¶ 5-7.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor states that "[t]he Provider does not argue that the intent of the VDA is to compensate for fixed and semi-fixed costs. Rather, it argues that since DRG payments compensate providers for fixed, semi-fixed and variable costs, these payments should also be reduced by the same 'variable' factor that was determined and used when calculating the Provider's costs."[25]

The Medicare Contractor removed variable costs by analyzing costs on Worksheet A of the Provider's cost report. Certain variable costs were excluded, as were costs related to excluded areas. This resulted in a fixed (and semi-fixed) cost percentage.[26] The Medicare Contractor contends that specific instruction to determine the fixed/semi-fixed costs are not included in the statute, regulations or Provider Reimbursement Manual. Therefore, the Medicare Contractor used the cost report to develop a method of calculating fixed/semi-fixed costs. The Medicare Contractor argues that the Administrator agreed with this approach. The Medicare Contractor also cites to the decision of the U.S. Court of Appeals for the Eighth Circuit ("Eighth Circuit") in *Unity Healthcare v. Azar* ("*Unity*"),[27] which found this approach to be "consistent with the statutory and regulatory language."[28]

The Medicare Contractor states,

> In the *Unity, Lakes Regional and Fairbanks* cases the non-salary expenses from billable medical supplies, billable and IV drugs, third party goods and services (physical therapy, reference lab, blood, diagnostic imaging), dietary and linen cost centers were categorized as variable. . . . While this listing is not exactly the same as the listings in the *Unity, Lakes Regional* and *Fairbanks* cases, it is analogous as they are services that are tied to patient demand and are expected to vary directly based on patient volume.[29]

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

Cogdell also argues that the methodology that "would" be used by the Medicare Contractor if an excess staffing calculation were performed, would result in an inaccurate result. The Provider focuses on the fact that the Medicare Contractor's calculation would use the FY 2009

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[25] Medicare Contractor's FPP at 6-7.
[26] Exhibit P-7 at 4.
[27] *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019). *See also* Medicare Contractor's FPP at 7-9.
[28] Medicare Contractor's FPP at 8-9.
[29] *Id.* at 9-10.

Occupational Mix data and the American Hospital Association annual survey for FY 2009.[30] Furthermore, Cogdell alleges that the Medicare Contractor would include nursing staff from areas within the hospital with little to no inpatient utilization (*e.g.*, Emergency Department).[31]

The Board finds that the Medicare Contractor's inclusion of the Occupational Mix in the computation of Excess Staffing was in accordance with PRM 15-I § 2810.1(C)(6) and included the most recent data available.[32] In addition, the Board finds that the Cogdell's statement that the Medicare Contractor's Excess Staffing calculation would include areas with little or no utilization to be overly generic because it does not identify the alleged departments that it suggests should be excluded from the excess staffing calculation.[33] Without more specific details *and supporting documentation*, the Board cannot address the Provider's allegation and, accordingly, based on the record before it, must reject the Provider's allegation as unfounded.

Applying the methodology adopted by the Board in previous decisions, Cogdell reasons that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs.[34] This method, Cogdell maintains, would assure an accurate matching of revenue to expenses because the DRG payment is intended to cover both fixed *and* variable costs. Cogdell also references the fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[35]

The Board identified one basic difference between the Medicare Contractor's and Cogdell's calculations of the VDA payment. There is a difference in the FY 2010 Inpatient Operating Costs used by the parties. The Medicare Contractor adjusted the Inpatient Operating Costs for variable costs before comparing these costs to the DRG revenue. Cogdell argues that the Medicare Contractor's VDA calculation methodology violates the statutes, regulations, and Provider Reimbursement Manual instructions.

This issue is 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

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[30] Provider's FPP at 7.
[31] *Id.*
[32] Exhibit C-5. PRM 15-I § 2810.1(C)(6) states, in part: "Core nursing staff is determined by comparing FTE staffing in the Adults and Pediatrics and Intensive Care Unit cost centers to FTE staffing in the prior year and FTE staffing in peer hospitals. Peer hospital information is obtained from data on nursing hours per patient day using the results of the occupational mix survey or the AHA Annual Survey for hospitals of the same size, geographic area (Census Division), and period of time. Acceptable core nursing staff for a year in which a hospital had a volume decline is the lesser of actual staffing in the prior fiscal year or core staff for the prior fiscal year as determined from the occupational mix survey or the AHA Annual Survey data from peer hospitals."
[33] Exhibit C-2. The Provider submitted an Excess staffing calculation that only included the Adults and Pediatrics and ICU areas and calculates an excess staffing adjustment of $30,778. However, the calculation does not include general service, inpatient and ancillary areas as required per PRM 15-I § 2810.1(C)(6).
[34] Provider's FPP at 5.
[35] Provider's FPP at 7-8.

amount.[36] In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

The Administrator has overturned these Board decisions, stating:

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . . In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. . . . The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[37]

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.[38]

Recently, the Eighth Circuit upheld the Administrator's VDA calculation methodology that was applied in *Unity,* and stated that the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[39] The Board notes that Cogdell is not in the Eighth

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[36] *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).

[37] *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).

[38] (Bold and italics emphasis added).

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

Circuit, thus the decision is not binding precedent. The Board further finds that 42 U.S.C. § 1395ww(d)(5)(D)(ii) and 42 C.F.R. § 412.92(e)(3) only provide a framework by which to calculate a VDA payment,[40] and the Board is not bound to apply the *specific* VDA calculation methodology that the Administrator applied in *Unity* and that the Eighth Circuit upheld.[41] 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.[42] 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 statue and regulations governing VDAs that the Administrator applied in rendering her decision in *Unity* and, as such, the Eighth Circuit's decision in Unity did not create a binding precedent that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to the FFY 2018 IPPS Final Rule,[43] 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.[44] 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."[45]

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[40] 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).

[41] *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).

[42] 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*, 587 U.S. __, 139 S.Ct. 1804, 1810, 1817 (2019) ("*Allina II*") where the Supreme Court ruled on the scope of Medicare policy issuances that are subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) by making clear that the "the government's 2014 announcement of the 2012 Medicare fractions [to be used in DSH calculations for FY 2010 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.)

[43] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

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

[45] 82 Fed. Reg. at 38180.

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As set forth below, the Board finds that the Medicare Contractor's calculation of Cogdell's VDA methodology for FY 2010 was incorrect because it was *not* based on CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preambles to the relevant Final Rules.

The Medicare Contractor calculated Cogdell's VDA payment by comparing its FY 2010 fixed costs to its total FY 2010 DRG payments. However, neither the language, nor the examples[46] 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[47] and the FFY 2009 IPPS Final Rule[48] reduce the hospital's cost *only* by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> [T]he adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

It is clear from the preambles to these Final Rules that the only permissible adjustment to the hospital's cost for calculating the VDA is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Cogdell's VDA using the methodology laid out by CMS in PRM 15-1 or by the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds that the Medicare Contractor calculated Cogdell's FY 2010 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[.]"[49] 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.[50]

It is clear that the intent of the statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) is that the VDA payment is to fully compensate the hospital for its fixed costs:

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[46] PRM 15-1 § 2810.1(C)-(D).
[47] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[48] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[49] *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).
[50] 82 Fed. Reg. at 38179-38183.

> 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.[51]

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

[51] (Emphasis added.)
[52] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[53]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which both limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the Administrator decisions, stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[54]

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."[55] Under 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 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.[56] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

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[53] (Emphasis added.)
[54] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[55] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[56] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

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.

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

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case, the Medicare Contractor determined that Cogdell's fixed costs (which includes semi-fixed costs) were 90.44 percent[58] of Cogdell's Medicare costs for FY 2010. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2009 Medicare Inpatient Operating Costs	$2,382,308[59]
Multiplied by the 2009 IPPS update factor	1.021[60]
2009 Updated Costs (max allowed)	$2,432,336

[57] 48 Fed. Reg. at 39782.
[58] Exhibit C-1 at 5.
[59] *Id*.
[60] *Id*.

2010 Medicare Inpatient Operating Costs	$2,343,208[61]
Lower of 2009 Updated Costs or 2010 Costs	$2,343,208
Less 2010 IPPS payment	$2,181,480[62]
2010 Payment Cap	**$ 161,728**

Step 2: Calculation of VDA

2010 Medicare Inpatient Fixed Operating Costs	$2,119,197[63]
Excess staffing	$ 171,496[64]
2010 Medicare Inpatient Fixed Operating Costs Less Excess Staff	$1,947,701
Less 2010 IPPS payment – fixed portion (90.44 percent)	$1,972,973[65]
Payment adjustment amount (subject to Cap)	**$ 0[66]**

Accordingly, the Board finds that Cogdell's VDA payment for FY 2010 should be $0.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that Cogdell is not due a VDA payment for FY 2010.

BOARD MEMBERS PARTICIPATING

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

FOR THE BOARD:

11/23/2021

X Clayton J. Nix

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

[61] *Id*.
[62] *Id*.
[63] *Id*. (Calculation = 2,343,208 * 0.9044 = $2,119,197.32, rounded to $2,119,197.)
[64] Exhibit C-5. The Excess staffing is computed as follows: Current Year Inpatient Operating Costs $2,343,208 – Current Year Inpatient Operating Costs with Excess staffing removed $2,171,712 = $171,496.
[65] (Calculation = 2,181,480 * 0.9044197 = $1,972,973.49, rounded to 1,972,973.)
[66] As the fixed portion of the IPPS payments exceeds the fixed portion of inpatient costs (after excess staffing adjustment), no VDA payment is due.