PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2023-D14

PROVIDER –
St. Mary's Hospital & Medical Center

Provider No. –
06-0023

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
June 23, 2022

Cost Reporting Period Ended –
12/31/2010

CASE NO.
17-2189

CONTENTS

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated and denied the Volume Decrease Adjustment ("VDA") owed to St. Mary's Hospital & Medical Center ("St. Mary's" or "Provider") as an sole community hospital ("SCH") for its cost reporting period ending December 31, 2010 ("FY 2010").[1]

DECISION

After considering Medicare law and regulations, arguments presented, and evidence admitted, the Provider Reimbursement Review Board ("PRRB" or "Board") finds that the Medicare Contractor improperly calculated St. Mary's VDA payment for FY 2010, and that St. Mary's should receive a VDA payment in the amount of $5,401,871 for FY 2010.

INTRODUCTION

St. Mary's, an acute care hospital in Grand Junction, Colorado, was designated as a SCH during the fiscal year at issue.[2] The Medicare contractor[3] assigned to St. Mary's for this appeal is Novitas Solutions, Inc. ("Medicare Contractor"). On July 31, 2015, St. Mary's requested a VDA payment to compensate it for a decrease in inpatient discharges during FY 2010.[4] The Medicare Contractor determined that St. Mary's was not eligible for an additional lump sum VDA payment, stating "the attached template clearly demonstrates that a significant negative payment would be computed regardless of whether the Provider's or MAC's interpretation of 'variable' cost is utilized to compute the VDA payment."[5] St. Mary's timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved the parties' request for a record hearing on June 23, 2022. St. Mary's was represented by Richard S. Reid of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

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 is available to SCHs if, due to circumstances beyond their control, they incur a decrease in total inpatient discharges of more than 5 percent from one cost reporting year to the next.[6] VDA payments are intended "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

[1] *See* Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3.
[2] Revised Stipulations (hereinafter "Stip.") at ¶ 1.
[3] CMS's payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs"), but these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Stip. at ¶ 5; Medicare Contractor's FPP at 2.
[5] Exhibit ("Ex.") C-1 at 1.
[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

core staff and services."[7] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that St. Mary's experienced a decrease in inpatient discharges of greater than 5 percent from FY 2009 to FY 2010 due to circumstances beyond its control and that, as a result, St. Mary's was eligible to have a VDA calculation performed for FY 2010.[8] St. Mary's requested a VDA payment in the amount of $8,693,803 for FY 2010.[9] However, when the Medicare Contractor calculated the FY 2010 VDA, it determined that St. Mary's was not entitled to a VDA payment because it was "fully compensated for its fixed (and semi-fixed) costs."[10]

Once an SCH demonstrates that it suffered a qualifying decrease in total inpatient discharges for its cost reporting period, the regulation at 42 C.F.R. § 412.92(e) directs how the Medicare Contractor must determine a lump sum VDA adjustment. In pertinent part, § 412.92(e)(3) states:

> (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 . . .

In the preamble to the final rule published on August 18, 2006,[12] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 371), which provides further guidance related to calculating VDAs stating, in relevant part:

> B. Additional payment is made . . . for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue. Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those

[7] *Id*.
[8] Stip. at ¶¶ 3, 5; Ex. C-1 at 1, 5.
[9] Ex. P-1 at 44-45.
[10] Ex. C-1 at 9.
[11] (Emphasis added.)
[12] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> costs for items and services that vary *directly*[13] with utilization, such as food and laundry costs.

The chart below depicts how the Medicare Contractor and St. Mary's each calculated the VDA payment:

	Medicare Contractor (calculation using fixed costs)[14]	Provider (calculation using total costs)[15]
a) Prior Year (2009) Medicare Inpatient Operating Costs	$ 51,368,260	$ 53,315,833[16]
b) IPPS Update Factor	1.0217562	1.021
c) Prior Year Updated Operating Costs (a x b)	$ 52,485,838	$ 54,435,465
d) FY 2010 Operating Costs	$ 55,349,455	$ 55,224,096
e) Lower of c or d	$ 52,485,838	$ 54,435,465
f) DRG/SCH Payment	$ 46,998,845	$ 45,741,662
g) CAP (e - f)	$ 5,486,993	$ 8,693,803
h) FY 2010 Inpatient Operating Costs	$55,349,455	
i) Fixed Cost Percent	77.10	
j) FY 2010 Fixed Costs (h x i)	$42,674,430	
k) Total DRG/SCH Payments	$46,998,845	
l) VDA Payment Amount (Medicare Contractor's VDA is the amount line j exceeds k)	**$0**[17]	
m) VDA Payment Amount (the Provider's VDA is based on the amount line e exceeds line f)		**$ 8,693,803**

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[18] Additionally, St. Mary's maintains that the Medicare Contractor should have taken into consideration the fact that St. Mary's had a number of specific and significant circumstances that created an anomalous situation.[19] This type of situation, St. Mary's asserts, is described in PRM 15-1 § 2810.1(D) as producing an "anomalous result" where the Medicare Contractor may request a review by CMS.

---

[13] (Emphasis added.)
[14] Ex. C-1 at 9.
[15] Ex. P-1 at 44.
[16] Exs. P-1 at 43-44, P-3, P-4 and P-5. St. Mary's has adjusted the 2009 prior year operating costs to account for an anomalous situation which it believes applies in this year. The total anomalous amount was calculated by adding the 2009 Inpatient operating costs of $51,368,260 to additional "anomalous amounts" for the cost report structure ($1,647,573) and the square footage increase ($300,000) to arrive at a total of $53,315,833. The calculation was later revised. *See* Stip. at ¶ 8.
[17] Ex. C-1 at 9 (finding that the calculated amount would be negative, the Medicare Contractor determined no (or $0) VDA payment was due).
[18] Stip. at ¶ 13.
[19] Provider's FPP at 6-8.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor and St. Mary's agree that the criteria were met for a VDA calculation to be conducted (*i.e.*, that the qualifying decrease in total patient discharges was met). However, they disagree on the proper methodology to use when calculating the VDA payment in accordance with the statute and regulations.[20]

A. The Medicare Contractor's Position:

The Medicare Contractor disagrees with St. Mary's assertion that the Federal Register does not specifically state that variable costs should be removed from total costs to compute the VDA.[21] The Medicare Contractor asserts that St. Mary's has misinterpreted the Federal Register. In support of its position, the Medicare Contractor notes that "[t]he Board and Administrator have affirmed the removal of variable costs."[22] The Medicare Contractor further cites to the U.S. Court of Appeals for the Eighth Circuit's ("Eighth Circuit") decision in *Unity Healthcare v. Azar* ("*Unity*") which found that the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[23] The Medicare Contractor also made reference to the Administrator's decision in *Fairbanks Memorial Hospital v. Wisconsin Physician Services,* Adm'r. Dec. at 8 (Aug. 5, 2015), *modifying,* PRRB Dec. No. 2015-D11 (June 9, 2015), which states: "[t]he VDA is not intended to be used as 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."[24]

The Medicare Contractor identified variable costs through an analysis of the working trial balance and Worksheet A of St. Mary's cost report. Those variable expenses were excluded from the VDA calculation.[25] The Medicare Contractor references PRM 15-1, Section 2810.1(B) as support for removing variable costs in the VDA calculation, because it states that,

> Additional payment is made to an eligible SCH for the fixed costs it incurs in the period … not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue. Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume.[26]

The Medicare Contractor notes that § 2810.1(B) continues, defining variable costs as "those costs for items and services that vary directly with utilization such as food and laundry costs."[27] The Medicare Contractor also references the regulation at 42 C.F.R. § 412.92(e)(3), which

---

[20] Stip. at ¶ 13.
[21] Medicare Contractor's FPP at 8-9.
[22] *Id.* at 9.
[23] *Id.* at 10 (citing *Unity Healthcare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019)).
[24] *Id.*
[25] Ex. C-1 at 6-9.
[26] Medicare Contractor's FPP at 5-6.
[27] *Id.* at 6.

specifically notes that intermediaries should consider fixed (and semi-fixed) costs.[28] The Medicare Contractor thus concludes that "[c]learly this shows that not all costs are to be considered in the VDA calculation."[29]

The Medicare Contractor points out that 42 U.S.C. § 1395ww(d)(5)(D)(ii) states that the VDA payment adjustment is "to fully compensate the hospital for the fixed costs it incurs."[30] Without any reference to compensation for variable costs, the VDA calculation must only consider fixed and semi-fixed cost, as agreed upon by the Administrator in the *Unity*, *Lakes Regional*, and *Fairbanks* decisions.[31] The Medicare Contractor concludes that "the statutes, regulations, and CMS instructions clearly state that variable costs will be excluded from the VDA calculation."[32]

The Medicare Contractor states that St. Mary's improperly attempts to bring "anomalous events" into the VDA calculation and that these claimed anomalous events include a change to the cost report structure, expansion of the hospital and increase in square footage. The Medicare Contractor's treatment of the alleged anomalous result is based on the following discussion in PRM 15-1 § 2810:

> If an intermediary determines that the procedures in this section, when applied to a specific adjustment request, generate an anomalous result, the intermediary may request a review by HCFA. This may occur, for example, when the decrease in Medicare discharges is significantly less than the decrease in total discharges.[33]

The Medicare Contractor continues, stating:

> In its VDA request, the Provider included what it considered to be "anomalous events", namely, change to cost report structure, expansion of the hospital and increase in square footage. The Provider purports that these items increased the Provider's prior fiscal year's (2009) costs by a total of $2,868,685.[34]

St. Mary's, in their final position paper states, "[t]here is no evidence that the item [anomalous calculation] was evaluated or considered in the payment calculation as determined by the MAC and fell short of its duty to consider the Provider's 'individual facts and circumstances.'"[35]

In response, the Medicare Contractor rejected the Provider's claims based on the following explanation:

---

[28] *Id.* at 8.
[29] *Id.*
[30] *Id*. at 4.
[31] *Id*. at 11.
[32] *Id*. at 12.
[33] *Id.* at 6-7 (quoting PRM 15-1 § 2810).
[34] *Id.* at 7.
[35] Provider's FPP at 6.

> . . . it is of no import what the Provider considers an "anomalous event". The manual clearly states that the determination of an "anomalous *result*" of the VDA calculation is to be made by the intermediary (now MAC) and no other party, including the Provider. Second, the "events" that the Provider lists all affect prior year costs and not a disparity between Medicare discharges and total discharges which would require further examination by HCFA (now CMS). The analysis here produced no such "anomalous result". Finally, as the only consideration requested by the Provider is additional prior year costs, the net result would be to only increase the calculated cap for the VDA. The cap calculation has no influence on the methodology used in the MAC's VDA calculation. Here, it only inflates St. Mary's perceived reimbursement gap that is improperly based on the Provider's persistently faulty belief that the cap represents payment amount.[36]

B. St. Mary's Position:

St. Mary's maintains that the Medicare Contractor's calculation of the VDA is wrong because the Medicare Contractor "departed from CMS' established policy and did not use the policy set forth in [§] 2810.1 of the PRM and summarized in Federal Register rulemaking."[37] St. Mary's argues that this policy does not mention the removal of variable costs and that, "[d]espite making an earlier reference to considering fixed and semi-fixed costs, none of the examples show variable costs being removed from the calculation."[38] Moreover, St. Mary's contends that the removal of variable costs would ensure that the cap would never be reached and, thereby, would render the cap, as defined in regulation, the PRM and the Final Rules, as unnecessary.[39] By removing variable costs, the Medicare Contractor "recalculated [St. Mary's] inpatient operating costs as if the Provider did not have to provide any food, any drugs, any medical supplies, or any laundry services to its inpatients."[40] As a result, St. Mary's concludes it was not fully compensated for all of its fixed costs.[41]

St. Mary's also claims the Medicare Contractor unlawfully changed the VDA payment calculation without going through notice-and-comment rulemaking, as required by the Medicare Statute and the Administrative Procedure Act.[42] St. Mary's maintains that a Medicare Contractor cannot alter its VDA calculation since "CMS is required to provide notice and a comment period" prior to changing a rule.[43] St. Mary's position is that "the applicable lawful regulations are those that were published in the Federal Register on August 19, 2008."[44]

---

[36] Medicare Contractor's FPP at 7.
[37] Provider's FPP at 9.
[38] *Id.* at 10.
[39] *Id.*
[40] *Id.* at 9.
[41] *Id.* at 11.
[42] *Id.* at 14-15.
[43] *Id.* at 14 (citing "the decision in *Allina v. Burwell* (D.C. Court of Appeals Case No. 16-5255)").
[44] *Id.*at 15.

St. Mary's points out that PRM 15-1 § 2810 recognizes that the cap described in the manual may sometimes result in an anomalous result and states:

> If an intermediary determines that the procedures in this section, when applied to a specific adjustment request, generate an anomalous result, the intermediary may request a review by HCFA. This may occur, for example, when the decrease in Medicare discharges is significantly less than the decrease in total discharges.[45]

St. Mary's continues:

> This example is the only one listed in the Manual. When the circumstances identified in the example occur, Medicare Inpatient services expenses increase at a rate beyond the allowable increase for inflation recognized by the Cap calculation. This expense increase amount is not a subjective one as it is accurately determined by a close review and highly specific analysis of the Medicare Cost report. . . . The Provider asked for relief for this issue in its original VDA request dated July 31, 2015. There is no evidence that the item was evaluated or considered in the payment calculation as determined by the MAC and fell short of its duty to consider the Provider's "individual facts and circumstances". This is a vital point as inpatient services are one of the primary reasons for maintaining this Sole Community Hospital in Grand Junction, Colorado and a vital community resource for saving patients' lives.[46]

St. Mary's asserts that a change to the cost report structure, the expansion of the hospital, and an increase in square footage caused an anomalous result in this case.[47]

C. The Board's Analysis:

The Board has identified two basic differences between the Medicare Contractor's and St. Mary's calculations of the VDA payment. The first difference relates to St. Mary's contention that they have met the criteria for an adjustment based on anomalous situation and, as a result, have proposed adjustments to the prior year's Medicare inpatient operating costs to reflect the current year's Medicare utilization.[48] The Board finds that the information contained in the record is insufficient for the Board to overturn the Medicare Contractor's decision to not request a review by CMS. St. Mary's has not provided the filed or settled cost reports, which are the most basic information needed to validate the numbers contained in the proposed adjustment for the *alleged* anomalous situation. Indeed, St. Mary's argues that "[t]his expense increase amount is not a subjective one as it is accurately determined by a close review and highly specific

[45] *Id.* at 6.
[46] *Id.*
[47] *Id.* at 6-7.
[48] Stip. at ¶ 8.

analysis of the Medicare Cost report."[49] Since no cost reports were submitted with the appeal, the Board has no means by which to verify any of the data underlying the proposed adjustment, or to consider the full details of the review or analysis. As such, there is no support in the record for the claimed anomalous adjustment and, as such, the Board declines to opine on whether the VDA produced an anomalous result. The Board's conclusion is further based on the lack of published guidance from CMS on how the Agency anticipated that discretion to be exercised.

The second difference between the parties' calculations relates to whether variable costs are to be removed from the VDA calculation. The Medicare Contractor's calculation removed variable costs from the Medicare inpatient operating costs. St. Mary's disagrees and argues that its VDA adjustment was not calculated in accordance with "[§] 2810.1 of the PRM and summarized in Federal Register rulemaking."[50]

In recent decisions, the Board has consistently 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.[51] In these cases, the Board 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 then comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so that 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. . . .[52]

Recently, the Eighth Circuit upheld the Administrator's methodology in *Unity*, stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[53]

---

[49] Provider's FPP at 6 (*supra* at note 53).
[50] Provider's FPP at 9.
[51] *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).
[52] *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).
[53] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

At the outset, the Board notes that 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.[54]

Further, the Board notes that St. Mary's is not located in the Eighth Circuit and, thus, the *Unity* decision is not binding precedent in this appeal.

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,[55] 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.[56] 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."[57]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As explained in detail below, the Board finds that the Medicare Contractor's calculation of St. Mary's VDA for FY 2010 was incorrect because it was *not* based on CMS' stated policy set forth 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 St. Mary's VDA payment by comparing its FY 2010 fixed costs to its total FY 2010 DRG payments. However, neither the language nor the examples in PRM 15-1 compare only the fixed costs to the 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 and the FFY 2009 IPPS Final Rule reduce the hospital's cost only by excess staffing (not by variable costs) when computing the VDA. Specifically, both of these preambles state:

---

[54] (Emphasis added.)
[55] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[56] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).
[57] 82 Fed. Reg. at 38180.

> [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 adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate St. Mary's VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preambles to the FFY 2007 and FFY 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated St. Mary's FY 2010 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication. This calculation 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[.]"[58] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the statute and the methodology explained in the PRM, and endorsed in the FFY 2007 and 2009 IPPS Final Rules. 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.[59]

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."[60] 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

---

[58] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D16 at 8 (Sep. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Feb. 9, 2017).
[59] 82 Fed. Reg. at 38179-38183.
[60] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments. –….
>
> 4. Cost Data. – The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*….
>
> D. Determination on Requests. –…. The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost.* Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
>
> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments.***
>
> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments.***[61]

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."[62] 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."[63]

---

[61] (Emphasis added.)
[62] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[63] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

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, 42 U.S.C. § 1395ww(a)(4) makes clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered when 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[.]"[64] 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. This is in keeping with the assumption stated in PRM 15-1 § 2810.1D 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.[65] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce the variable costs associated with the volume loss, but the hospital will always have some variable costs 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 the 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, because it takes the portion of the DRG payments 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)(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, therefore, concludes that the Administrator's methodology is not a reasonable interpretation of the statute because it does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs.

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 also clear that the VDA payment is ***not intended to fully compensate the***

---

[64] (Emphasis added.)

[65] 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.

hospital for all of its variable costs.[66] 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.

St. Mary's argues that CMS has changed the methodology for computing the VDA without providing the required legal notice and comment period and thereby unlawfully changed regulations.[67] St. Mary's contends that "the methodology in effect during the year 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."[68] 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*.[69]

---

[66] 48 Fed. Reg. at 39782.
[67] Provider's FPP at 14-15.
[68] *Id*. at 15.
[69] 918 F. 3d 571, 578-79 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019) (footnotes omitted; bold and italics emphasis added).

Accordingly, what St. Mary 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."[70] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[71] 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 applied nationwide to all hospitals at one time.[72] 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).[73] 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.[74] Accordingly, the Board rejects St. Mary's argument that CMS is in violation of the notice and comment requirements of the Medicare Act and the ADS.

The Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to each DRG payment. Accordingly, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case, the Medicare Contractor determined that St. Mary's fixed costs (which includes semi-fixed costs) were 77.10 percent[75] of St. Mary'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	$ 51,368,260[76]
Multiplied by the 2010 IPPS Update Factor	1.021[77]
2009 Updated Costs (max allowed)	$ 52,446,993
2010 Medicare Inpatient Operating Costs	$ 55,349,455[78]
Lower of 2009 Updated Costs or 2010 Costs	$ 52,446,993
Less 2010 IPPS Payment	$ 47,045,122[79]
2010 Payment Cap	**$ 5,401,871**

[70] Moreover, the fact that any particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[71] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[72] 139 S. Ct. at 1808, 1810.
[73] 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."
[74] *See, e.g., Unity Healthcare v. Blue Cross Blue Shield 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.
[75] Stip. at ¶ 11; Ex. C-1.
[76] Stip. at ¶ 11 (does not include the Provider's anomalous increase.)
[77] *Id.* at ¶ 8, 11, 12.
[78] *Id.*
[79] *Id.*

Step 2: Calculation of VDA

2010 Medicare Inpatient Fixed Operating Costs	$ 42,674,430[80]
Less 2010 IPPS Payment – fixed portion (77.10 percent)[81]	$ 36,271,789[82]
Payment adjustment amount (subject to Cap)	**$ 6,402,641**

Since the payment adjustment amount of $6,402,641 is **greater** than the Cap of $5,401,871, the Board determines that St. Mary's VDA payment for FY 2010 is limited to $5,401,871.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated St. Mary's VDA payment for FY 2010, and that St. Mary's should receive a VDA payment in the amount of $5,401,871 for FY 2010.

Board Members Participating:

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

FOR THE BOARD:

4/17/2023

X Clayton J. Nix

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

[80] *Id.* at ¶ 11, 12.
[81] *Id.*
[82] *Id.* at ¶ 12 (calculated as Total 2010 IPPS Payment of $47,045,122 x 77.10 percent = $36,271,789).