PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2023-D16

PROVIDER –
Mimbres Memorial Hospital

Provider No.
32-0014

vs.

MEDICARE CONTRACTOR –
WPS Government Health
Administrators (J-5)

RECORD HEARING DATE –
March 11, 2022

Cost Reporting Period Ended –
03/31/2010

CASE NO.
15-1092

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly determined the sole community hospital ("SCH") volume decrease adjustment ("VDA") granted for the fiscal year ending March 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 the Medicare Contractor improperly calculated the VDA payment for Mimbres Memorial Hospital ("Mimbres") for FY 2010, and that Mimbres should receive a VDA payment in the amount of $323,850 for FY 2010.

INTRODUCTION

Mimbres is located in Deming, New Mexico, and was designated as an SCH during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Mimbres for this appeal is WPS Government Health Administrators ("Medicare Contractor").

On September 12, 2013, Mimbres requested a VDA payment in the amount of $341,776 because it experienced a decrease in inpatient discharges of greater than 5 percent.[4] The Medicare Contractor calculated Mimbres' FY 2010 VDA payment to be $0.[5] Mimbres 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 11, 2022. Mimbres was represented by Richard S. Reid of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments. One of these payment adjustments is referred to as a VDA payment, and it is available to SCHs if, due to circumstances beyond their control, they incur a decrease in their total number of inpatient discharges of more than 5 percent from one cost reporting year to the next.[6] VDA payments are designed "to fully compensate a hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services."[7] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

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[1] Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 4.
[2] Stipulations of the Parties ("Stip.") at ¶ 1 (March 1, 2022).
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Exhibit ("Ex.") P-1 at 40; Stip. at ¶ 5.
[5] Stip. at ¶ 6; Ex. C-1; Ex. P-2.
[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[7] *Id*.

It is undisputed that Mimbres experienced a decrease in total inpatient discharges of greater than 5 percent from FY 2009 to FY 2010 due to circumstances beyond its control and that, as a result, Mimbres was eligible to have a VDA calculation performed for FY 2010.[8] Mimbres requested a VDA payment in the amount of $341,776 for FY 2010.[9] At the request of Mimbres, the Medicare Contractor performed the FY 2010 VDA calculation and it determined that Mimbres was not entitled to a VDA payment because Mimbres' "inpatient prospective payment system (IPPS) payments for its operating costs exceeded the Provider's allowable inpatient fixed and semi-fixed operating costs."[10]

The regulation at 42 C.F.R. § 412.92(e) (2010) directs how the Medicare Contractor must determine the VDA, once an SCH demonstrates it experienced a qualifying decrease in total inpatient discharges. 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—
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> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
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> (B) The hospital's fixed (and semifixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
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> (C) The length of time the hospital has experienced a decrease in utilization.

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

> Additional payment is made to an eligible SCH 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,

[8] Stip. at ¶¶ 3, 5.
[9] Ex. P-1 at 40; Stip. at ¶ 5.
[10] Stip. at ¶ 6.
[11] (Emphasis added.)
[12] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
>
> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary *directly*[13] with utilization such as food and laundry costs.

The following chart depicts how the Medicare Contractor and Mimbres each calculated the VDA payment.

	Medicare Contractor calculation using fixed costs[14]	Provider/PRM calculation using total costs[15]
a) Prior Year Medicare Inpatient Operating Costs		$ 6,010,714
b) IPPS update factor		1.021
c) Prior year Updated Operating Costs (a x b)		$ 6,136,939
d) FY 2010 Operating Costs		$ 4,823,551
e) Lower of c or d	$ 5,256,228[16]	$ 4,823,551[17]
f) DRG/SCH payment	$ 4,770,011[18]	$ 4,444,594[19]
g) CAP (e-f)	$ 486,217	$ 378,957
h) FY 2010 Inpatient Operating Costs	$ 5,256,228	
i) Fixed Cost percent (j divided by h)	86.57%	
j) FY 2010 Fixed Costs (h x i)	$ 4,550,287[20]	
k) Total DRG/SCH Payments	$ 4,770,011	
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ (219,724)	
m) VDA Payment Amount (The Provider's VDA is based on the amount line e exceeds line f.)		$ 378,957

[13] (Emphasis added.)
[14] Stip. at ¶ 10. The Board notes that the Medicare Contractor states in its Final Position Paper at 8, that it erroneously included the Provider's capital costs and capital DRG payment. The correct fixed operating costs and DRG payments should have been $4,123,089 and $4,444,594, respectively.
[15] *Id.* at ¶ 7.
[16] This amount reflects the Inpatient operating cost on Worksheet D-1, Part II, Line 49 before the Medicare Contractor excluded variable costs and recomputed the cost report. Neither of the parties submitted the cost report previous to the variable costs being excluded.
[17] This amount reflects the Inpatient operating cost on Worksheet D-1, Part II, Line 53 before the Medicare Contractor excluded variable costs and recomputed the cost report. Neither of the parties submitted the cost report previous to the variable costs being excluded.
[18] Ex. C-1 at 17.
[19] Stip. at ¶ 7 (reflects the latest NPR).
[20] Ex. C-1 at 14.

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

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor insists that it properly calculated and processed Mimbres' request for VDA payment, including limiting the VDA payment "to compensate for fixed and semi-fixed costs only, not variable costs."[22] The Medicare Contractor states the adjustments were made in accordance with 42 C.F.R. § 412.92[23] and cites to PRM 15-1 § 2810.1(B) (rev. 479), which states:

> Additional payment is made to an eligible SCH 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.[24]

The Medicare Contractor contends the intent of the VDA is to compensate qualified hospitals for their fixed/semi-fixed costs only, and not their variable costs.[25] This result, according to the Medicare Contractor, is achieved by subtracting the DRG revenue from the fixed costs, thereby assuring full compensation for the fixed costs.[26]

In support of its position, the Medicare Contractor cites to the U.S. Court of Appeals for the Eighth Circuit's ("Eighth Circuit") decision in *Unity Healthcare v. Azar* ("*Unity*")[27] and the Administrator's decisions in *Fairbanks Memorial Hospital v. Wisconsin Physician Services*,[28] *Lakes Regional Healthcare v. BCBSA*,[29] and *Trinity Regional Medical Center v. Wisconsin Physician Services.*[30,31]

Mimbres contends that it is entitled to a VDA payment adjustment calculated in accordance with the methodology in Section 2810.1 of the PRM (as formalized in the IPPS final rules for FYs 2007 and 2009).[32] Mimbres contends that the methodology used by the Medicare Contractor is contrary to the statute and the regulation and that "[t]here is no mention in this section of removing variable costs. The Federal Register is very specific in defining the costs as either the costs in the year of the decline minus any adjustment for excess staff, or the previous year's cost

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[21] Stip. at ¶ 12.
[22] Medicare Contractor's FPP at 8.
[23] *Id.*
[24] *See also id*. at 7.
[25] *Id*. at 8.
[26] *Id*. at 11.
[27] *Id.* at 13 (citing *Unity Healthcare v. Azar*, 918 F.3d 571 (8th Cir. 2019)).
[28] *Id.* at 8-9 (citing *Fairbanks Mem'l Hosp. v. Wisconsin Physician Serv.*, Adm'r Dec. (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015)).
[29] *Id.* (citing *Lakes Reg'l Healthcare v. BCBSA.*, Adm'r Dec. (Sept. 4, 2014), *modifying* PRRB Dec. No. 2014-D16 (July 10, 2014)).
[30] *Id.* (citing *Trinity Reg'l Med. Ctr. v. Wisconsin Physician Serv.*, Adm'r Dec. (Feb. 9, 2017), *modifying*, PRRB Dec. No. 2017-D1 (Dec. 15, 2016)).
[31] The Medicare Contractor uses these cases as support for its proposition that it correctly removed the provider's variable costs from the VDA calculation. Medicare Contractor's FPP at 13-14.
[32] Provider's Final Position Paper ("Provider's FPP") at 6.

multiplied by the PPS update factor minus any adjustment for excess staff." Mimbres maintains that the August 19, 2008 Federal Register[33] contains "no mention in this section of removing variable costs" and that "[t]he Federal Register is very specific in defining the costs as either the costs in the year of the decline minus any adjustment for excess staff, or the previous year's cost multiplied by the PPS update factor minus any adjustment for excess staff."[34]

Mimbres notes that "[i]n PRM 2810.1 there are several examples of VDA calculations, each one uses either the hospital's current year 'Program Inpatient Operating Cost' or the prior year's "Program Inpatient Operating Cost" increased by the PPS update factor."[35] Mimbres further remarks that "none of the examples show variable costs being removed from the calculation."[36] Mimbres contends that the Medicare Contractor "departed from CMS's manual instructions and step-by-step guide and added an unauthorized and monumental extra step"[37] when they removed variable costs from the VDA calculation.

Mimbres requests that, if the Board does not agree with their interpretation of the regulations, they be paid under the Board's methodology in *St. Anthony* and *Trinity*.[38] Mimbres contends that the Medicare Contractor's methodology of only subtracting variable costs from the Medicare inpatient operating costs is flawed.[39] Mimbres notes that Medicare DRG payments include payment for both variable and fixed costs. In order to have an "apples to apples" comparison, the variable costs need to be removed from *both* the Medicare inpatient operating costs *and from* the total DRG payments.[40] Mimbres also references the fact that CMS adopted an almost identical methodology in the IPPS Final Rule for FFY 2018.[41]

The Board identified two basic differences between the calculations of the VDA payment made by the Medicare Contractor's and Mimbres. The first is the fact that the Medicare Contractor erroneously included capital costs and capital payments in their VDA calculation.[42] The second difference is a variance in the amount of FY 2010 Inpatient Operating Costs used by the parties. The Medicare Contractor applied adjustments to exclude variable costs via cost report Worksheet A-8 and re-computed the cost report to arrive at a fixed cost amount, reported on Worksheet D-1, Part II, which was used in the VDA calculation.[43] Mimbres argues that the Medicare Contractor's VDA calculation methodology "recalculated its 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 [and] is contrary to the statute and the regulation."[44]

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[33] Copy at Ex. P-3.
[34] Provider's FPP at 6.
[35] *Id*. at 6-7.
[36] *Id.* at 7.
[37] *Id.*
[38] *Id*. at 6.
[39] *Id*. at 8-9.
[40] *Id*.
[41] *Id.* at 5 n.4.
[42] Medicare Contractor's FPP at 8. The Medicare Contractor states in their final position paper that they "erroneously included the provider's capital costs and capital DRG payment."
[43] Medicare Contractor's FPP at 11-12.
[44] Provider's FPP at 6.

In recent decisions,[45] the Board has consistently disagreed with the methodology used by various Medicare contractors to calculate VDA payments because it compared fixed costs to total DRG payments and only resulted in a VDA payment if the fixed costs exceeded the total DRG payment amount. 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 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 the 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. . . .[46]

The Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[47]

Initially, 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

[45] *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).

[46] *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).

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

> regulations may be generally known and applied by providers, intermediaries, and other interested parties.[48]

Further, Mimbres is not located in the Eighth Circuit and, thus, the *Unity* decision is also 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,[49] 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.[50] 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."[51]

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 Mimbres' 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 determined Mimbres' VDA payment by comparing its FY 2010 fixed costs to its total FY 2010 DRG payments. However, neither the language nor the examples[52] in PRM 15-1§ 2810.1 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[53] and the FFY 2009 IPPS Final Rule,[54] 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.

The preambles to these Final Rules make clear that the only allowable adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not

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[48] (Bold and italics emphasis added.)
[49] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[50] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92 (e)(3).
[51] 82 Fed. Reg. at 38180.
[52] PRM 15-1 § 2810.1(C)-(D).
[53] 71 Fed. Reg. at 48056.
[54] 73 Fed. Reg. at 48631.

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

Rather, the Board finds that the Medicare Contractor calculated Mimbres' FY 2010 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication. This calculation is best described as follows: the hospital's "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling . . . ."[55] The Board suspects that the Administrator developed this new methodology using only 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.[56]

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 cost:

> 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 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."[57] However, the VDA payment methodology, as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 (rev. 356), compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .

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[55] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. at 8 (Sep. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm'r Dec. at 12 (Feb, 9, 2017).

[56] 82 Fed. Reg. at 38179-38183.

[57] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

> 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***.[58]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule both of 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."[59]

Based on its review of the statute, regulations, PRM 15-1, and the Eighth Circuit's decision in *Unity*, 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 . . . ."[60] 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, this position directly conflicts with the statute at 42 U.S.C. § 1395ww(a)(4) which states that a DRG payment includes payment for both the fixed ***and*** variable costs of the services rendered because it defines operating costs of inpatient services as "**all** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]" The Administrator cannot simply ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as solely for the fixed cost of the Medicare services actually provided, when the hospital in fact incurred both fixed and variable costs for those services.

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[58] (Emphasis added.)
[59] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[60] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

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 § 2810.1(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 "consider[] . . . [t]he individual hospital's needs and circumstances" when determining the VDA payment amount.[61] 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 indisputable 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 are payments 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 does not do this, as it takes the portion of the DRG payment intended for variable costs and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(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, is not a reasonable interpretation of the statute.

Mimbres also argues that "the only subsequent change to the payment calculation that followed the requirements of notice and a comment period are the final rule published in August 2017."[62] Mimbres states that, "[s]ince the publication of the Federal Register in 2008 some [Medicare contractors] began to change their methodology attempting to circumvent the notice and comment requirements of the Medicare statute by adopting a new methodology by way of adjudication."[63] Since the change did not go through a notice and comment period, Mimbres maintains the Medicare Contractor is "to calculate the VDA based on published regulations and guidance, not decide on their own to make a change to the program."[64] As a result, Mimbres contends that "the methodology in effect during the four years under appeal was the one described in section 2810.1 of the PRM."[65] However, the Board notes that the examples in PRM 15-1 § 2810.1 relate to the payment cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

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[61] 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.
[62] Provider's FPP at 11.
[63] *Id.*
[64] *Id.*
[65] *Id.*

> 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).
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> 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*.[66]

Accordingly, what Mimbres 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 VDA payments differently does not automatically mean there is a departure from a Medicare program "policy."[67] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[68] 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.[69] Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as explained in 42 C.F.R. § 412.108(d)(3).[70] Moreover, the Board has had long standing disagreements with Medicare contractors and the Administrator on their different interpretations and application of the

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[66] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[67] Moreover, the fact that any particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[68] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[69] 139 S. Ct. at 1808, 1810.
[70] 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."

relevant statutes, regulations and PRM guidance regarding the calculation of VDAs.[71] Accordingly, the Board rejects Mimbres' argument regarding lack of notice or comment opportunity.

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, the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[72] 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 of the Medicare services *actually* furnished. Thus, the Board concludes that, in order to ensure Mimbres 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.

The Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment. Therefore, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case the Medicare Contractor determined that Mimbres' fixed costs (which includes semi-fixed costs) were 85.48 percent[73] of Mimbres' 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	$6,010,714[74]
Multiplied by the 2010 IPPS update factor	1.021
2009 Updated Costs (max allowed)	$6,136,939
2010 Medicare Inpatient Operating Costs	$4,823,551
Lower of 2009 Updated Costs or 2010 Costs	$4,823,551
Less 2010 IPPS payment	$4,444,594
2010 Payment CAP	**$ 378,957**

Step 2: Calculation of VDA

2010 Medicare Inpatient Fixed Operating Costs	$4,123,089
Less 2010 IPPS payment – fixed portion (85.48 percent)	$3,799,239[75]
Payment adjustment amount (subject to Cap)	**$ 323,850**

[71] *See, e.g., Unity Healthcare vs. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg' 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.

[72] 48 Fed. Reg. at 39782.

[73] Stip. at ¶ 11.

[74] *Id.*

[75] The $3,799,239 is calculated by multiplying $4,444,594 (the total FY 2010 DRG payments) by 0.8548 (the fixed cost percentage determined by the Medicare Contractor). Difference between Stipulation ¶ 11 and the Board's calculations is due to rounding.

Since the payment adjustment amount of $323,850 is less than the Cap of $378,957, the Board determines that Mimbres' VDA payment for FY 2010 should be $323,850.

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor did not properly calculate the VDA payment for Mimbres for FY 2010, and that Mimbres should receive a VDA payment of $323,850 for FY 2010.

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5/12/2023

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Chair
Signed by: PIV