PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2024-D06

PROVIDER-
Sandhills Regional Medical Center

Provider No.: 34-0106

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –
June 29, 2023

Cost Reporting Period Ended –
09/30/2013

CASE NO. – 17-2113

INDEX

Page No.

Issue Statement……. 2
Decision……... 2
Introduction……... 2
Statement of Facts and Relevant Law…...…….. 3
Discussion, Findings of Facts, and Conclusions of Law…… 5
Decision……..... 14

ISSUE STATEMENT

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

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated Sandhills' VDA payment for FY 2013, and that Sandhills should receive a VDA payment in the amount of $350,661 for FY 2013.

INTRODUCTION

Sandhills is a Medicare Dependent Hospital ("MDH") located in Hamlet, North Carolina.[2] The Medicare contractor[3] assigned to Sandhills for this appeal is WPS Government Health Administrators ("Medicare Contractor"). On October 15, 2016, Sandhills requested a VDA payment of $215,936 for FY 2013 to compensate it for a decrease of more than 5 percent in inpatient discharges during FY 2013.[4] On April 19, 2017, the Medicare Contractor calculated Sandhills' FY 2013 VDA payment to be $0 because "the provider's DRG payments exceeded their operating costs after variable costs were removed."[5] Sandhills requested reconsideration of the denial on June 14, 2017.[6] However, on July 18, 2017, the Medicare Contractor denied the reconsideration request.[7] Sandhills 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 June 28, 2023. Sandhills was represented by Ronald K. Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq., of Federal Specialized Services.

---

[1] Provider's Final Position Paper (hereinafter "Provider's FPP") at 2 (Dec. 13, 2022); Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3 (Jan. 12, 2023).
[2] Stipulations at ¶ 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare Contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Medicare Contractor's FPP at 6. *See also* Exhibit P-1 at 30-31 (copy of the VDA request).
[5] Exhibit C-1 at 1 (copy of the VDA denial). *See also* Exhibit C-1 at 2 (stating: "After removing the variable costs we have found that the hospital's total Medicare fixed and semi-fixed costs are less than the total Medicare PPS payments. Therefore, the hospital does not qualify for a volume decrease adjustment.").
[6] Medicare Contractor's FPP at 5.
[7] Exhibit C-2 (copy of the Medicare Contractor's reconsideration determination).

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 an MDH if, due to circumstances beyond its control, it incurs a decrease in its total number of inpatient cases of more than 5 percent from one cost reporting year to the next. VDA payments are designed and intended to fully compensate a hospital for the fixed costs it incurs providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services, during the relevant time period.[8] The implementing regulations located at 42 C.F.R. § 412.108(d) reflect these statutory requirements.

While not specifically addressed in either the initial VDA determination, or the VDA reconsideration, it is now stipulated that Sandhills experienced a qualifying decrease in inpatient discharges greater than 5 percent from FY 2012 to FY 2013 due to circumstances beyond its control[9] and that, as a result, Sandhills was eligible to have a VDA calculation performed for FY 2013. Sandhills requested a VDA payment in the amount of $415,709 for FY 2013.[10] However, when the Medicare Contractor performed the FY 2013 VDA calculation, it performed a VDA calculation and determined that Sandhills was not entitled to a VDA payment (*i.e.*, was entitled to $0) because it was fully compensated for its fixed/semi-fixed costs.[11] Thus, what remains at issue in this case is whether Sandhills is due a VDA payment and, if so, specifically, how that payment should be calculated.

As mentioned above, the implementing regulation is located at 42 C.F.R. § 412.108(d). When promulgating § 412.108(d), CMS made clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals ("SCHs").[12] The regulation at 42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates that it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.108(d)(3) (2013) states, in pertinent part:

> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income

[8] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[9] Stipulations at ¶ 5.
[10] *Id* at ¶ 7. The original VDA request was for $215,936, but the Stipulations include the Provider's current calculation, resulting in a VDA payment of $415,709.
[11] *Id* at ¶ 6.
[12] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> patients as determined under §412.106 and for indirect medical education costs as determined under §412.105).
>
> (i) In determining the adjustment amount, the intermediary considers –
>
> (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;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter...; and
>
> (C)The length of time the hospital has experienced a decrease in utilization.[13]

In the preamble to the final rule published on August 18, 2006,[14] CMS referenced the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2810.1 (Rev. 371), which provides further guidance related to VDAs and 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.
>
> 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*[15] with utilization such as food and laundry costs.

The chart below depicts how the Medicare Contractor and Sandhills each calculated the VDA payment for FY 2013 in their Stipulations.

[13] (Emphasis added.) *See also* 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[14] 71 Fed. Reg. at 47870, 48056 (Aug. 18, 2006).
[15] (Emphasis added.)

	Medicare Contractor calculation using fixed costs[16]	Provider/PRM calculation using total costs[17]
a) Prior Year Medicare Inpatient Operating Costs		$ 8,130,912
b) IPPS update factor		1.026
c) Prior year Updated Operating Costs (a x b)		$ 8,342,316
d) FY 2013/Current Year Operating Costs		$ 8,370,738
e) Lower of c or d		$ 8,342,316
f) DRG/MDH payment		$ 7,926,607
g) Cap (e-f)		$ 415,709
h) Lower of Prior or Current Year Inpatient Operating Costs	$ 8,370,738	$ 8,342,316
i) Fixed Cost percent	90.14%[18]	100.00%[19]
j) FY 2013 Fixed Costs (h x i)	$ 7,545,474	$ 8,342,316
k) Total DRG Payments	$ 7,926,607	$ 7,926,607
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ (381,133)	
m) VDA Payment Amount (The Providers VDA is based on the amount line j exceeds line k.)		$ 415,709

The dispute in this case involves the application of the statute and regulation in the calculation of the VDA payment.[20]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that the regulation is clear that the "additional [VDA] payment is to compensate for fixed and semi-fixed costs only, not variable costs."[21] The Medicare Contractor disagrees with Sandhills' belief that "any potential volume decrease adjustment should ensure it is fully reimbursed for all costs, including variable costs."[22] In support of its position, the Medicare Contractor cites to the decision of the U.S. Court of Appeals for the Eighth Circuit ("Eighth Circuit") in *Unity Healthcare v. Azar, St. Anthony Regional Hosp. v. Azar,* and *Lakes Regional Healthcare v. Azar* (the "*Unity, St. Anthony and Lakes* Opinion").[23]

[16] Stipulations at ¶ 10 (the Contractor's stipulated calculation did not address the cap on the VDA payment).
[17] *Id.* at ¶ 7.
[18] The Medicare Contractor determined the fixed costs by making adjustments via Worksheet A-8 and then re-running the cost report to result in the fixed costs of $7,545,474 on the adjusted Worksheet D-1. Therefore, the imputed fixed cost percentage calculation is $7,545,474 / 8,370,738 = 0.901410843, rounded to 0.9014.
[19] Sandhills did not remove any variable costs from the VDA calculation as it contends variable costs are not removed in any of the examples in PRM 15-1 § 2810.1 or the Federal Register published in 2008. *See* Provider's FPP at 6.
[20] Provider's FPP at 6. Medicare Contractor's FPP at 6-7.
[21] Medicare Contractor's FPP at 9.
[22] *Id*.
[23] Stipulations at ¶ 13.

The Medicare Contractor removed variable costs through Worksheet A-8 adjustments on Sandhills' cost report.[24] The Administrator affirmed this approach in the decisions which were similarly affirmed by the Eighth Circuit in the *Unity, St. Anthony and Lakes* Opinion.[25]

Sandhills argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor "departed from CMS's manual [PRM] instructions and step-by-step guide and added an unauthorized, and monumental, extra step."[26] According to Sandhills, "[n]owhere in the Federal Register does it say to subtract variable costs from the [p]rovider's costs" and "[a]ny confusion as to whether the Federal Register is referring to total costs net of variable costs is unwarranted."[27] The Board notes that the Final Rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule")[28] states that, "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[29]

Sandhills contends that the Medicare Contractor's approach does not "fully compensate the Provider for all of its fixed costs, as Congress requires."[30] Sandhills also maintains that its current VDA calculation is in accordance with PRM 15-1 § 2810.1[31] and that this was the methodology in effect during the cost reporting period under appeal.[32] Therefore, Sandhills states "[t]he [Medicare Contractor]'s decision and payment calculation warrants reversal on two independent grounds: (i) the application of an inherently flawed methodology for calculating the Provider's VDA, which did not fully compensate the Provider for all of its fixed costs as Congress requires; and (ii) an improper calculation of the Provider's Medicare fixed costs."[33]

First, Sandhills contends that the Medicare Contractor's VDA calculation is flawed by failing to recognize that "DRG revenue compensates a hospital for *all* its expenses in treating inpatients – both fixed and variable costs."[34] The Medicare Contractor's methodology improperly understates the VDA payment because it reduces "a hospital's total fixed costs by DRG revenue attributable to both fixed and variable costs"[35] and, "in effect, it is subtracting apples from oranges."[36]

Secondly, in its calculation, the MAC used total Medicare operating costs from Worksheet D-1, as filed, and total Medicare fixed/semi-fixed operating costs from Worksheet D-1, after applicable variable costs were eliminated via Worksheet A-8 adjustments to arrive at its fixed cost percentage.[37] Sandhills argues that the FY 2018 IPPS Final Rule "specifically states that the

---

[24] Stipulations at ¶ 10.
[25] Medicare Contractor's FPP at 9.
[26] Provider's FPP at 7.
[27] *Id.*at 6.
[28] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983).
[29] (Emphasis added).
[30] Provider's FPP at 8.
[31] *Id.*at 3.
[32] *Id.* at 6.
[33] *Id.* at 8.
[34] *Id.* at 9 (italics emphasis added).
[35] *Id.*
[36] *Id.*
[37] *Id.* at 10.

calculation uses total fixed costs, and not total Medicare fixed costs."[38] Thus, Sandhills maintains that total costs from Worksheet A should be used, and then fixed/semi-fixed costs would also be reflected from Worksheet A, after the variable expenses identified were excluded.[39]

Finally, Sandhills references the fact that, in the FY 2018 IPPS Final Rule, CMS essentially adopted a VDA methodology which compares fixed inpatient costs to fixed MS-DRG revenue, and clarified these calculations to reflect that the same ratio is used for costs and payments. Sandhills contends that, "[i]n modifying the regulations for the VDA calculation the Administrator has effectively admitted that the methodology in use by the [Medicare Contractor] does not meet the Congressional intent of the VDA."[40] Sandhills recognizes that the FY 2018 IPPS Rule states that it is not to be applied retroactively, but contend that "the rationale for declining to do so is flawed."[41]

The Board identified one basic difference between the Medicare Contractor's and Sandhills' calculation of the FY 2013 VDA payment. This difference relates to whether variable costs are to be removed from the VDA calculation. The Medicare Contractor removed variable costs via Worksheet A-8 adjustments to arrive at Sandhills' fixed/semi-fixed inpatient operating costs on the adjusted Worksheet D-1. Sandhills disagrees and argues that the Medicare Contractor's VDA calculation methodology is flawed.[42]

In its recent decisions addressing VDA payments,[43] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because this methodology compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. 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.

Referring to the methodology adopted by the Board in previous decisions, Sandhills implies that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. Sandhills states that, under the Board's methodology in prior cases, its "DRG payments would have been multiplied by the percentage of fixed program costs to all program costs to calculate the DRG payments attributable to fixed costs."[44]

---

[38] *Id.* at 10.
[39] *Id.* at 9. Sandhills' Table D in its FPP at 9 reflects an error in this argument as their fixed cost percentage reflects Fixed/Semi-Fixed Costs over Total Reimbursable Costs (92 percent) rather than using Total Costs as the denominator, which would result in a percentage of 91.63 percent. The Medicare Contractor's calculation, which is comparable with the Board's handling in past, would be 90.14 percent, using filed and adjusted program costs on Worksheet D-1.
[40] *Id* at 10.
[41] *Id.*
[42] *Id.*
[43] *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-D21 (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).
[44] Provider's FPP at 10.

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 . . . .[45]

Recently, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology for VDA calculations as it relates to SCHs in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[46]

At the outset, the Board notes that the 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.[47]

While Sandhills is not in the Eighth Circuit, the statutes and regulations for VDAs for SCHs and MDHs are identical and the Board finds that those applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[48] Accordingly, the Board is not bound to

---

[45] *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).

[46] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019).

[47] (Bold and italics emphasis added).

[48] With regard to SCHs, *see* 42 U.S.C. § 1395ww(d)(5)(D)(ii); *St. Anthony Reg'l Hosp. v. Azar*, 294 F. Supp. 3d 768, 779 (N.D. Iowa 2018) (stating that § 1395ww(d)(5)(D)(ii) contains a gap as it directs that "the Secretary shall provide for such . . . payment . . . as may be necessary" and that "[t]he Secretary has filled that gap in a manner that I find to be reasonable in light of the statutory framework and purpose."), *aff.d*, *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019). With regard to SCHs, *see* 42 C.F.R. § 412.92(e)(3); *St. Anthony*, 294 F. Supp. 3d at 772, 781 (adopting the

apply the specific VDA calculation methodology that the Administrator applied (and the Eighth Circuit upheld) in *Unity*.[49] In this regard, the Board further notes that 42 C.F.R. §§ 412.92(e)(3) and 412.108(d)(3) make clear that the VDA payment determination is subject to review through the Board's appeal process.[50] Thus, the Board finds that the Eighth Circuit's *Unity* decision was simply adjudicating a dispute regarding the reasonableness of the Administrator's interpretation of the statute and regulations governing VDAs that the Administrator applied in rendering her decision in *Unity*. As such, the Eighth Circuit's decision in *Unity* did not create a binding precedent as to the specific VDA calculation methodology that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[51] 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.[52] 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."[53]

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 Sandhills' VDA methodology for FY 2013 was incorrect because it was *not* based on CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preambles to the relevant Final Rules.

The Medicare Contractor determined Sandhills' VDA payment by comparing its FY 2013 fixed costs to its total FY 2013 DRG payments. However, neither the language nor the examples in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a

---

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 for SCHs 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).

[49] *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).

[50] Moreover, the Board notes that, subsequent to the Eighth Circuit's decision in *Unity*, the U.S. Supreme Court issued its decision in *Azar v. Allina Health Servs*, 139 S. Ct. 1804, 1810, 1817 (2019) ("Allina II") where the Supreme Court ruled on the scope of Medicare policy issuances that are subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) by making clear that "the government's 2014 announcement of the 2012 Medicare fractions [to be used in DSH calculations for FY 2012 where the Agency] 'le[t] the public know [the agency's] current adjudicatory approach' to a critical question involved in calculating payments for thousands of hospitals nationwide" was a "statement of policy that establishes or changes a substantive legal standard" as that phrase is used in 42 U.S.C. § 1395hh(a)(2) and, thus, was subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) (citations omitted).

[51] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

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

[53] 82 Fed. Reg. at 38180.

hospital's VDA payment.[54] Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[55] and the FFY 2009 IPPS Final Rule[56] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> The adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.[57]

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 Sandhills' 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 the Medicare Contractor calculated Sandhills' FY 2013 VDA based on an otherwise *new* methodology that the Administrator apparently adopted through adjudication in her decisions.[58] That methodology can best be described as the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[59] 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.[60]

The statute at 42 U.S.C. § 1395ww(d)(5)(G)(iii) is clear that the VDA payment is to fully compensate the hospital for its fixed cost:

> In the case of a Medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than five 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

---

[54] PRM 15-1 § 2810.1(C)-(D).
[55] 71 Fed. Reg. at 47870, 48056 (Aug. 18. 2006).
[56] 73 Fed. Reg. at 48434, 48631 (Aug. 19, 2008).
[57] *See* 71 Fed. Reg. at 48056 and 73 Fed. Reg. at 48631.
[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] *Id.*
[60] 82 Fed. Reg. at 38179-38183.

> 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."[61] 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.—. . . .
>
> 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***.[62]

---

[61] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).
[62] (Emphasis added).

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the Administrator decisions, stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[63]

Based on its review of the statute, the 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."[64] Using the Administrator's rationale, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment ***only*** *for the* ***fixed*** *costs* of the services actually furnished to Medicare patients. However, the statute at 42 U.S.C. § 1395ww(a)(4) makes it clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines operating costs of inpatient services as "**all** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]" The Administrator cannot simply ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments solely for the fixed cost of the Medicare services actually rendered when the hospital in fact incurred both fixed and variable costs for those services.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an MDH for all the fixed costs associated with a qualifying, five percent or more, 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. § 412.108(d)(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 its 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 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.

---

[63] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[64] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[65] The Board recognizes that 42 C.F.R. § 405.108(d)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

The Administrator's methodology does not do this, because it takes the portion of the DRG payment intended for variable costs and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(G)(iii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes 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.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(G)(iii) do not fully address how to remove variable costs when calculating a VDA adjustment, the VDA payment is clearly not intended to fully compensate the hospital for its variable costs.[66] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended as payment for both the variable and fixed costs of the Medicare services actually furnished. The Board concludes that in order to both ensure the hospital is fully compensated for its fixed costs, and be consistent with the assumption stated in PRM 15-1 § 2810.1 that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case the Medicare Contractor determined that Sandhills' fixed costs (which includes semi-fixed costs) were 90.14 percent[67] of its Medicare costs for FY 2013. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

FY 2012 Medicare Inpatient Operating Costs	$ 8,130,912[68]
Multiplied by the 2013 IPPS update factor	1.018[69]
FY 2012 Updated Costs (max allowed)	$ 8,277,268
FY 2013 Medicare Inpatient Operating Costs	**$ 8,370,738** [70]

[66] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).
[67] The Stipulations at ¶ 10 calculated using current year fixed program cost after adjustments over current year total program operating costs (Fixed Pgm. Operating Costs of $7,545,474 divided by Total Program Operating Costs of $8,370,738 = 0.901410843, rounded to 0.9014). This calculation was necessary as the stipulated percentage in the Stipulations at ¶ 11 improperly calculates the Current Year Fixed Program Operating Costs as a percentage of the updated Prior Year Total Program Operating Costs, rather than using current year amounts in both the numerator and the denominator.
[68] *Id*.
[69] The Stipulations at ¶¶ 7 and 11 use 1.026 as the PPS Update Factor. However, per the applicable IPPS Final Rule, Table 1A, the factor for FFY2013 is 1.018. Thus, the parties' stipulated amount of 1.026 is not supported by the Final Rule. As such, the Board will make the calculation using the factor reported in the applicable Final Rule.
[70] Stipulations at ¶ 10

Lower of FY 2012 Updated Costs or FY 2013 Costs	$ 8,277,268
Less FY 2013 IPPS payments	$ 7,926,607[71]
FY 2013 Payment Cap	**$ 350,661**

Step 2: Calculation of VDA

FY 2013 Medicare Inpatient Fixed Operating Costs	$ 7,545,474[72]
Less FY 2013 IPPS payments – fixed portion (90.14 percent)[73]	$ 7,145,044[74]
Payment adjustment amount (subject to cap)	**$ 400,430**

Since the payment adjustment amount of $400,430 exceeds the payment cap of $350,661, the Board determines that Sandhills' VDA payment for FY 2013 should be $350,661.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Sandhills' FY 2013 VDA payment, and that Sandhills should receive a VDA payment in the amount of $350,661 for FY 2013.

BOARD MEMBERS:

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

FOR THE BOARD:

1/26/2024

X Clayton J. Nix

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

[71] *Id*.
[72] *Id.*
[73] *Supra* note 67 and accompanying text.
[74] The $7,145,044 is calculated by multiplying $ 7,926,607 (the FY 2013 DRG payments) by 0.9014 (the fixed cost percentage, as determined by the Medicare Contractor).