PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2025-D14

PROVIDER-
Spencer Hospital

Provider No.: 16-0112

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –
October 25, 2023

Cost Reporting Period Ended –
06/30/2011

CASE NO. – 16-0109

INDEX

ISSUE STATEMENT

Whether the Medicare Administrative Contractor, Wisconsin Physicians Service Government Health Administrators ("WPS"), correctly applied the proper method to calculate the volume decrease adjustment ("VDA") owed to Spencer Hospital ("Spencer" or "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2011.[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated the VDA payment for Fiscal Year ("FY") 2011 for Spencer Hospital, and that Spencer should receive a VDA payment in the amount of $1,422,921.

INTRODUCTION

Spencer Hospital is an acute care hospital located in Spencer, Iowa. Spencer was designated as a Medicare Dependent Hospital ("MDH") during the fiscal year at issue.[2] The Medicare administrative contractor[3] assigned to Spencer for this appeal is WPS Government Health Administrators ("Medicare Contractor").

On January 7, 2015, Spencer requested a VDA payment of $1,527,765 for operating costs in FY 2011 to compensate it for a decrease in inpatient discharges during FY 2011.[4] On July 17, 2015, the Medicare Contractor denied the request, finding that Spencer had not established that the decline in discharges was an unusual event or occurrence beyond their control and that its total Medicare fixed and semi-fixed costs were less than its total Medicare PPS payments.[5] On September 14, 2015, the Provider requested a reconsideration of the Medicare Contractor's denial.[6] On October 2, 2015, the Medicare Contractor denied the Provider's FY 2011 request for reconsideration, upholding its initial determination.[7] Spencer 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 October 25, 2023. Spencer was represented by Sven Collins, Esq. of Hooper, Lundy, & Bookman, P.C. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Stipulations of the Parties and Stipulated Alternative Decisions (hereinafter "Stipulations") at 3, Section II (Oct. 5, 2023).
[2] Stipulations at 3, Section III, ¶ 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 relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs as appropriate and relevant.
[4] Provider's Final Position Paper (hereinafter "Provider's FPP"), Exhibit (hereinafter, "Ex.") P-1; *See also,* Stipulations at 3-4, Section III, ¶¶ 3 and 8.
[5] Ex. C-1 at C0002. *See also,* Stipulations at 5, Section III, ¶ 9.
[6] Ex. P-3. *See also,* Stipulations at 5, Section III, ¶ 10.
[7] Ex. P-5. Stipulations at 5, Section III, ¶ 11.

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

Per the Stipulations, it is undisputed that Spencer experienced a decrease in discharges greater than 5 percent from FY 2010 to FY 2011 due to circumstances beyond Spencer's control and that, as a result, Spencer was eligible to have a VDA calculation performed for FY 2011.[9] Based on its internal calculations, Spencer requested a VDA payment in the amount of $1,527,765 for operating costs in FY 2011.[10] However, when the Medicare Contractor performed its FY 2011 VDA calculation, it contends that the steps it followed removed "the exact amount of variable costs from the cost centers [in which] they reside"[11] and determined that the Provider was not entitled to a VDA payment as "the hospital's total Medicare fixed and semi-fixed costs are less than the total Medicare PPS payments."[12] Accordingly, in this appeal, the sole remaining issue is the proper calculation of the VDA payment, as the parties dispute the interpretation and application of the regulation used to calculate the VDA payment.[13]

The statue governing VDA payments, found at 42 U.S.C. § 1395ww(d)(5)(G)(iii), states:

> 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 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

[8] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[9] Stipulations at 3, Section III, ¶ 2. Further, the Board notes that the original Medicare Contractor denial of the VDA (*see* Ex. P-2), dated July 17, 2015, held that it was not proved that the decline in discharges "was an unusual event or occurrence beyond [Spencer's] control . . . . [and] 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." However, per the Stipulations at 1, the parties agree that "[o]nly the second reason [of] WPS' denial – based on the method it used to calculate the volume decrease adjustment – remains at issue in the appeal, as WPS does not contest that Spencer Hospital experienced a volume decrease of over 5% due to circumstances beyond its control."
[10] Stipulations at 4, Section III, at ¶ 8.
[11] Medicare Contractor's Final Position Paper (hereinafter, "Medicare Contractor's FPP") at 15.
[12] Ex. C-1 at C0002.
[13] Stipulations at 5, Section III, ¶ 9, note 4.

> 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.

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) (effective October 1, 2010) 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 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.[14]

[14] *See also* 42 U.S.C. § 1395ww(d)(5)(G)(iii).

The chart below depicts how the Medicare Contractor and the Provider each calculated the VDA payment, as documented in the parties' stipulations.

	Medicare Contractor calculation[15]	Provider calculation[16]
a) Prior Year Medicare Inpatient Operating Costs		$ 11,173,906[17]
b) IPPS update factor		1.0188[18]
c) Prior year Updated Operating Costs (a x b)		$ 11,383,975
d) Current Year Operating Costs	$ 10,817,891	$ 10,817,891[19]
e) Lower of c or d	$ 10,817,891	$ 10,817,891
f) DRG/MDH payment	$ 8,672,436	$ 8,672,436
g) Cap (e-f)	$ 2,145,455	$ 2,145,455
h) Current Year Inpatient Operating Costs	$ 10,817,891	$ 10,817,891
i) Fixed Cost percent	71.18%[20]	76.07%[21]
j) FY 2011 Fixed Costs (h x i)	$ 7,700,522	$ 8,229,170
k) Total DRG Payments	$ 8,672,436	$ 8,672,436
l) Net DRG Fixed Payments (k x i)		$ 6,597,122
m) Core Staffing Adjustment		$ 104,283[22]
n) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ (971,914)	
o) VDA Payment Amount (The Provider's VDA is based on the amount line j exceeds line l minus line m.)		$ 1,527,765

As noted above, the parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[23]

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[15] Stipulations at 10.
[16] *Id*.
[17] Provider's FPP Ex. P-1 at 15.
[18] *Id.*
[19] Stipulations at 10.
[20] The Medicare Contractor made adjustments, via Worksheet A-8, to exclude costs it had identified as "variable." This resulted in "fixed operating costs" of $7,700,522 (see Medicare Contractor's FPP at 19). This results in a fixed cost percentage of 71.18%, as shown in the following calculation: $7,700,522/$10,817,891 = .711832094, rounded to 0.7118.
[21] Spencer, using its corporate financials, calculates a different variable cost compared to the Medicare Contractor's which leads to total fixed/semi-fixed costs of $8,229,170. The resulting Fixed Cost percentage calculation: $8,229,170/$10,817,891 = 0.7607313074, rounded to 0.7607. *See* Ex. P-1 at 25.
[22] Stipulations at 10.
[23] Stipulations at 9.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

As previously mentioned, the parties dispute the proper method for calculating the VDA payment, particularly, how variable costs should be calculated and removed from the provider's Medicare inpatient operating costs, and whether the same rationale should be applied to reduce the provider's DRG revenue for the purposes of determining whether the provider is due a VDA payment.

Citing 42 C.F.R. § 412.108(d)(3), the Medicare Contractor argues that the explicit regulatory language precludes VDA payments in excess of the difference between a provider's Medicare inpatient operating costs and its DRG revenue.[24] The Medicare Contractor contends that program policy, specifically PRM 15-1, Section 2810.1B, is consistent with the law[25] and states that:

> The law is quite clear when it states that the [VDA] payment adjustment is '… to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable costs of maintaining necessary core staff and services.' (Emphasis Added) Notable is the lack of reference to compensation for variable costs. Again, the regulations mirror the wording of the law, with no mention of variable costs.[26]

In support of its position, the Medicare Contractor cites the Administrator Decisions in *Lakes Regional Healthcare v. BCBSA*, 2014-D16, and *Unity Healthcare v. BCBSA*, 2014-D15, both dated September 4, 2014, in which the CMS Administrator affirmed this methodology. The Medicare Contractor also references the Administrator's Decision in *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association,* 2015-D11, dated August 5, 2015.[27]

The Medicare Contractor "asserts that the additional payment is to compensate for fixed and semi-fixed costs only, not variable costs."[28] The Medicare Contractor further contends that "[t]he Regulation does not specify which figures are used to calculate the VDA payment but describes the figures used to CAP the payment amount."[29] Therefore, the Medicare Contractor used the cost report to develop a means of calculating fixed/semi-fixed costs, and in the instant case, according to the Medicare Contractor, this was achieved by the removal of variable costs using worksheet A-8 adjustments on Spencer's cost report. Specifically, the Medicare Contractor cited PRM 15-1, Section 2810.1B (2011) which states that "….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

[24] Medicare Contractor's FPP at 11.
[25] *Id.* at 12.
[26] *Id.*
[27] *Id* at 12 - 13.
[28] *Id at* 12.
[29] *Id.* at 14.

costs, on the other hand, are those costs for items and services that vary directly with utilization such as ***food and laundry costs***."[30] The Medicare Contractor explains that it identified variable costs from five cost centers, including raw food costs, dietary services, laundry services, and, respectively, medical supplies, implant devices, and drugs charged directly to patients. In the case of the medical supplies, implant devices, and the drugs, these were consistent with the amounts identified by Spencer, itself, for these items.[31] The Medicare Contractor then compared the total amount of resulting fixed and semi-fixed costs (after the exclusion of the identified variable costs) to Spencer's total DRG payments – concluding that the latter exceeded the former, and thus, no VDA payment was due. The Medicare Contractor further asserts that "CMS has long considered a provider's Medicare cost report the most accurate and efficient way of reporting, calculating, and determining Medicare costs,"[32] and notes that the same method was utilized by the MAC and affirmed by the Administrator in the *Unity* and *Lakes Regional* decisions.[33]

Spencer argues that the Medicare Contractor's calculation of the VDA does not take into account the most recent Medicare guidance on calculating a volume decrease adjustment payment, and "is contrary to the governing statute, regulations and program instructions, and has previously been rejected by the Board in several recent cases [citation omitted]."[34] Spencer contends that "WPS performed an apples-to-oranges comparison of Spencer Hospital's total DRG payments (which include reimbursement both for fixed and variable costs) with Spencer Hospital's fixed/semi-fixed costs."[35] Spencer argues that, instead, "WPS should have determined Spencer Hospital's eligibility for a volume decrease adjustment payment using Spencer Hospital's total Program inpatient operating costs, compared to its total DRG payments."[36] Conversely, Spencer implies that if variable costs are to be removed in calculating the total program inpatient operating costs, then the Medicare contractor should remove the variable portion from the DRG payment. In addition, Spencer argues:

> [W]hat WPS's calculation lacks, is recognition of the fact that DRG payments compensate both for fixed and variable costs. In short, WPS's calculation was in error because it failed to "fully compensate" Spencer Hospital for its fixed costs incurred in FY 2011 that were in excess of its DRG payments for fixed costs [citation omitted].[37]

In support of its position, Spencer contends that "[t]he same result is achieved applying the formula that the Board used in the *Fairbanks Memorial Hospital* case."[38] In its calculations, Spencer used a different method to calculate its total fixed and semi-fixed costs percentage (76.07%) by "removing all variable costs from its total operating costs [based on financial

[30] *Id.* at 12-13.
[31] *Id.* at 18.
[32] *Id.* at 16.
[33] *Id.* at 15.
[34] Provider's FPP at 2.
[35] *Id.*
[36] *Id.* at 17.
[37] *Id.* at 18.
[38] *Id.*

statement descriptions]" compared to WPS' method which "removed what it determined were variable cost[s] from certain cost centers of the cost report" to calculate Spencer's total fixed and semi-fixed percentage (71.18%).[39] Spencer then applied its calculated total fixed/semi-fixed cost percentage to ***both*** the total Medicare inpatient operating costs and its total DRG payments to derive its DRG payments *attributable* to the fixed/semi-fixed costs and subtracted those payments, and a core staffing adjustment, from the total costs. The resulting difference is what Spencer claims to be the appropriate VDA payment.[40] Spencer maintains that this VDA calculation is in accordance with the law and PRM 15-1 § 2810.1.[41]

In essence, Spencer reasons that, applying the Board's apples-to-apples methodology as adopted in prior cases, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, then there should also be a corresponding decrease to the DRG payment for variable costs.[42]

The Board identified two basic differences in the Medicare Contractor's and Spencer's calculations of the Provider's VDA payment. First, the calculation of net fixed/semi-fixed costs differs and the resulting net fixed/semi-fixed costs ratio is therefore different, as well. Second, the Medicare Contractor compared the hospital's total fixed costs to the hospital's total DRG revenue that was attributable to both fixed and variable costs, rendering an understated VDA.

At the outset, the Board finds that the Medicare Contractor's method to calculate the fixed/semi-fixed percentage was consistent with PRM 15-1 Section 2810.1B. The Board notes that Spencer's method to calculate its fixed/semi-fixed percentage is procedurally inconsistent with its initial VDA payment request in that it includes total inpatient Medicare operating costs as reported on the cost report worksheet D-1, part II line 53[43] but excludes variable costs Spencer calculated using calculations outside the cost report. The Medicare Contractor's calculation is more consistent, using the same cost report calculation process to arrive at the costs before and after the exclusion of calculated variable costs.

Historically,[44] the Board has 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. 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.

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[39] Stipulations at 11.
[40] *Id.*
[41] Stipulations at 9.
[42] Provider's FPP at 19.
[43] Ex. P-1, Ex. B page 15 of 81.
[44] *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).

In apparent agreement with the methodology adopted by the Board in previous decisions, Spencer states, as noted *supra*, that "WPS's calculation lacks … recognition of the fact that DRG payments compensate both for fixed and variable costs."[45]

Until 2025, the Administrator routinely overturned Board decisions using the methodology described above for cases involving reporting periods prior to October 1, 2017,[46] 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 . . . .[47]

Additionally, in 2019, 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."[48] Here, it is important to note that Administrator decisions are not binding precedent upon the Board. PRM 15-1 § 2927.C.6.e explains:

> 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.[49]

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[45] Provider's FPP at 18.
[46] *See infra*.
[47] *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).
[48] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019). cert. denied, 140 S. Ct. 523 (2019).
[49] (Bold and italics emphasis added).

While Spencer is located in the Eighth Circuit and the statutes and regulations for VDAs for SCHs and MDHs are identical, the Board finds that the applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[50] As a result, the Board is not bound to apply the specific VDA calculation methodology that the Administrator applied (and the Eighth Circuit upheld) in *Unity*.[51] In this regard, the Board further notes that §§ 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.[52] 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,[53] CMS prospectively changed the methodology for calculating the VDA to one which is very similar to the methodology used by the Board. Under the FFY 2018 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.[54] 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."[55]

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[50] With regard to SCHs, 42 U.S.C. § 1395ww(d)(5)(D)(ii), see, e.g., *St. Anthony Reg'l Hosp. v. Azar*, 294 F. Sup. 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, 42 C.F.R. § 412.92(e)(3), see, e.g., id. at 772, 781 (adopting the Magistrate's report which found that '"[t]he regulations promulgated by the Secretary in effect during the relevant time period did not provide a specific formula for calculating the VDA payment[,]'" and '"[i]nstead, the regulation directed that the following factors be considered in determining the VDA payment amount...'"). The Board's plain reading of the regulation is confirmed by the Agency's discussion of this regulation in the preamble to rulemaking. *See*, for SCHs, e.g., 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987) (stating that "[w]e determine on a case-by-case basis whether an adjustment will be granted and the amount of that adjustment." (emphasis added)); 48 Fed. Reg. 39752, 39781-82 (Sept. 1, 1983).

[51] See, e.g., *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1107-08 (D.C. Cir. 2015) (discussing regulatory interpretations adopted through adjudication versus through rulemaking).

[52] 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 2015 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).

[53] 82 Fed. Reg. at 37990, 38179-38183 (Aug. 14, 2017).

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

[55] 82 Fed. Reg. at 38180.

Of further significance, most recently, following the D.C. Circuit's holding in the *Lake Region Healthcare Corp. v. Becerra*, 113 F.4th 1002, 1009 (D.C. Cir. 2024),[56] the Administrator has declined review of similar Board decisions, signaling acquiescence to the Board's long-standing methodology for cost reporting periods before October 1, 2017.[57]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. Accordingly, as set forth below, the Board finds that the Medicare Contractor's calculation of Spencer's VDA methodology for FY 2011 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 Spencer's VDA payment by comparing its FY 2011 fixed costs to its total FY 2011 DRG payments. However, neither the language nor the examples[58] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[59] and the FFY 2009 IPPS Final Rule[60] 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.

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 Spencer's 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, instead, that the Medicare Contractor calculated Spencer's FY 2011 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions 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[.]"[61] 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,

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[56] Not to be confused with *Lakes Regional*, referenced *supra*.
[57] *See, e.g., Tennova Healthcare – Volunteer Martin v. WPS Government Health Administrators*, PRRB Dec. 2025-D06 (Dec. 17, 2024), Administrator declined review (Jan. 8, 2025).
[58] PRM 15-1 § 2810.1(C)-(D).
[59] 71 Fed. Reg. at 47870, 48056 (Aug. 18, 2006).
[60] 73 Fed. Reg. at 48434, 48631 (Aug. 19, 2008).
[61] *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).

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.[62]

The statute at 42 U.S.C. § 1395ww(d)(5)(G)(iii) (2011) 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 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."[63] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
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> D. Determination on Requests.— . . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.

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[62] 82 Fed. Reg. at 38179-38183.
[63] 48 Fed. Reg. at 39752, 39781-39782 (Sep. 1, 1983) (italics emphasis added).

> 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***.[64]

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."[65]

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."[66] 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 the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 405.108(d)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's

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[64] PRM 15-1 § 2810.1 (rev. 356). (Emphasis added).
[65] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[66] 42 U.S.C. § 1395ww(d)(5)(G)(iii) (2011).

needs and circumstances" when determining the payment amount.[67] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

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

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs 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 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. On September 3, 2024, the United States Court of Appeals for the District of Columbia Circuit issued its decision in *Lake Region Healthcare Corporation v. Becerra,*[68] stating, "HHS's fixed total approach does not afford the requisite full compensation for fixed costs. . . . [and] "we recognize that no method for calculating the VDA is perfect. [citation omitted]. Nonetheless, a method that ignores *all* compensation for variable costs is not one that reasonably approximates full compensation for fixed costs."[69] The Board agrees with the U.S. Court of Appeals for the D.C. Circuit in these statements. The Board also notes that the parties stipulated that "the decision of the D.C. Circuit [in *Lake Region*] will govern the outcome of this appeal."[70]

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. [71] 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 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.

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[67] 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.
[68] *Lake Region Healthcare Corp. v. Becerra,* 113 F.4th 1002, 1005 (D.C. Cir. 2024).
[69] *Id.* at 1007-1008.
[70] Stipulations at 8.
[71] 48 Fed. Reg. at 39752, 39782 (Sept. 1, 1983).

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 Spencer's fixed costs (which include semi-fixed costs) were 71.18 percent[72] of the Provider's total impatient Medicare operating costs for FY 2011. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2010 Medicare Inpatient Operating Costs	$ 11,173,906[73]
Multiplied by the 2011 IPPS update factor	1.0188[74]
2010 Updated Costs (max allowed)	$ 11,383,975
2011 Medicare Inpatient Operating Costs	**$ 10,817,891**[75]
Lower of 2010 Updated Costs or 2011 Costs	$ 10,817,891
Less 2011 IPPS payment	$ 8,672,436[76]
2011 Payment Cap	**$ 2,145,455**

Step 2: Calculation of VDA

2011 Medicare Inpatient Fixed Operating Costs	$ 7,700,522[77]
Less 2011 IPPS payment – fixed portion (71.18 percent[78])	$ 6,173,318[79]
Less Core Staffing Adjustment	$ 104,283[80]
Payment adjustment amount (subject to Cap)	**$ 1,422,921**

Since the payment adjustment amount of $1,422,921 is **less** than the Cap of $2,145,455, the Board determines that Spencer's VDA payment for FY 2011 should be $1,422,921.

[72] Stipulations at 11.
[73] Ex. P-1 at 15.
[74] The Board notes that the correct IPPS update factor for FFY 2010 is 1.0185 and for FFY 2011 is 1.0235, not 1.01188 as stipulated by the parties. As the Provider's 2011 IPPS Operating Costs are less than the 2010 costs adjusted by the update factor, this has no effect on the final VDA.
[75] Stipulations at 10.
[76] *Id*.
[77] *Id.*
[78] Calculation - $7,700,522/$10,817,891 = 0.711832094, rounded to 0.7118.
[79] The Board recognizes the Medicare Contractor's determination of the fixed cost percentage, and, therefore, the $6,173,318 is calculated by multiplying $8,672,436 (the FY 2011 DRG payments) by 0.711832094 (the fixed cost percentage determined by the Medicare Contractor).
[80] Stipulations at 10 (calculated Core Staffing Adjustment agreed upon by the parties).

DECISION AND ORDER

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Spencer's VDA payment for FY 2011, and that Spencer should receive a FY 2011 VDA payment in the amount of $1,422,921.

BOARD MEMBERS:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

3/17/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A