PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2021-D29

PROVIDER-
Scenic Mountain Medical Center

Provider No.: 45-0653

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –

January 22, 2021

Cost Reporting Period Ended –
12/31/2013

CASE NO. – 17-1311

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") payment for a Scenic Mountain Medical Center for the cost reporting period ending December 31, 2013 ("FY 2012").[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 Fiscal Year ("FY") 2013 for Scenic Mountain Medical Center ("Scenic" or "Provider"), and that Scenic should receive a VDA payment in the amount of $225,372 for FY 2013.

INTRODUCTION

Scenic is a non-profit acute care hospital located in Big Spring, Texas. Scenic was designated as a sole community hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Scenic for this appeal is WPS Government Health Administrators. ("Medicare Contractor"). In order to compensate it for a decrease in inpatient discharges, Scenic requested a VDA payment of $575,467 for FY 2013.[4] The Medicare Contractor calculated the Provider's FY 2013 VDA payment to be $0.[5] Scenic timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The parties requested and the Board approved a record hearing on January 22, 2021. Scenic was represented by Ronald K. Rybar 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 (including SCHs) a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to each 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

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[1] Medicare Contractor's Consolidated Final Position Paper (hereinafter "Contractor FPP") at 2. The Medicare Contractor submitted a consolidated Final Position Paper for fiscal years 2011 – 2014. However, this decision only pertains to Case No. 17-1311 for FY 2013.
[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] Stipulations at ¶¶ 4, 6.
[5] *Id.* at ¶ 5.

total number of inpatient cases 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 that it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.[7] The implementing regulations, located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that Scenic experienced a decrease in discharges greater than 5 percent from FY 2012 to FY 2013 due to circumstances beyond Scenic's control and that, as a result, Scenic was eligible to have a VDA calculation performed for FY 2013.[8] Scenic requested a VDA payment in the amount of $575,467 for FY 2013.[9] However, when the Medicare Contractor made the FY 2013 VDA calculation, it determined that Scenic was not entitled to a VDA payment because it had already been fully compensated for its fixed/semi-fixed costs.[10]

42 C.F.R. § 412.92(e) (2013) directs how the Medicare Contractor must determine the VDA once an SCH demonstrates it experienced a qualifying decrease in total inpatient cases. 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 [i]ntermediary considers— . . .
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter. . . .

In the preamble to the final rule published on August 18, 2006,[12] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), 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,

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[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[7] *Id.*
[8] Stipulations at ¶ 4.
[9] *Id.* at ¶ 6.
[10] *Id.* at ¶¶ 5, 9.
[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 chart below depicts how the Medicare Contractor and Scenic 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	$6,580,947[16]	$6,580,947
b) IPPS update factor	1.026[17]	1.026
c) Prior year Updated Operating Costs (a x b)	$6,752,052	$6,752,052
d) FY 2013 Operating Costs	$6,131,032[18]	$6,131,032
e) Lower of c or d	$6,131,032	$6,131,032
f) DRG/MDH payment	$ 5,865,325[19]	$5,555,565
g) CAP (d-f)	$ 265,707	$ 575,467
h) FY 2013 Inpatient Operating Costs	$6,131,005[20]	$6,131,032
i) Fixed Cost percent	90.87	1.00[21]

[13] (Emphasis added.)
[14] Stipulations at ¶¶ 9, 10.
[15] *Id.* at ¶ 6.
[16] *Id.* at ¶ 10. Scenic and the Medicare Contractor have stipulated that this is the Prior Year Medicare Inpatient Operating Costs.
[17] *Id.*. Scenic and the Medicare Contractor have stipulated that this is the appropriate update factor.
[18] *Id.* at ¶¶ 6, 9, 10. Scenic and the Medicare Contractor have stipulated the current year program operating costs as $6,131,032 in ¶ 6 and as $6,131,005 in ¶¶ 9 and 10. The variance between these figures is immaterial and due to rounding.
[19] *Id.* at ¶¶ 9, 10. *See also* Exhibit C-1 pages 43 to 46; payments were derived from adding together the following lines on E Part A, Total payment for inpatient operating costs, line 49 of $5,555,565, HVBP payment adjustment amount, line 79.93 of $3,324, HRR adjustment amount, line 70.94 of ($20,903), and the low volume operating costs found on Stipulations ¶ 10 of, $327,329. This computes to $5,865,315 and is immaterially different from the $5,865,325 calculated by the Medicare Contractor.
[20] *Supra* note 18. Note there is an immaterial difference between the Provider's value and the Medicare Contractor's value listed here.
[21] Provider's Consolidated Final Position Paper (hereinafter "Provider's FPP") at 6. Scenic asserts that PRM § 2810.1 and the Federal Register at Exhibit P-5 make no mention of a removal of variable costs from the Provider's Operating Costs. As a result, the Fixed Cost Percentage is reported at 1.00.

j) FY 2013 Fixed Costs (h x i)	$5,571,158[22]	$6,131,032
k) Total DRG/SCH Payments	$5,865,324[23]	$5,555,565
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$ (294,166)[24]	
m) VDA Payment Amount (The Provider's VDA is based on the amount by which line j exceeds line k.)		$575,467

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[25]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Scenic asserts that the Medicare Contractor's VDA calculation is an inherently flawed methodology, because it subtracts the total DRG revenue, including payments for both variable and fixed/semi-fixed costs, from Medicare fixed/semi-fixed inpatient operating costs. Scenic argues that this methodology will result in the Provider not being fully compensated for their fixed/semi fixed costs.[26] The Provider also argues that the flaw in this methodology becomes obvious when one compares the Medicare Contractor's VDA calculation to the CMS revised calculation that became effective October 1, 2017, which reduces both the DRG and the Medicare inpatient costs by the fixed/semi fixed percentage in the computation of the VDA payment.[27] The correct methodology, according to Scenic, would be to subtract the total DRG revenue from the Medicare inpatient operating costs, reduced only for excess staffing.[28]

In response, the Medicare Contractor contends that the VDA calculation is only intended to compensate a provider when the Medicare inpatient costs, with variable costs removed, exceeds the total DRG revenue. In support of their calculation, they refer to 42 CFR § 412.92(e)(3), which states that "a lump sum adjustment amount [is] not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue."[29] In determining the VDA adjustment amount, the Medicare Contrator contends that it is to consider "[t]he hospital's fixed (and semi fixed) costs, other than those costs paid on a reasonable cost basis under part 413."[30] In addition, the Medicare Contractor refers to PRM 15-1 § 2810.1B which states that "[a]dditional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient services including the reasonable cost of maintaining necessary

[22] Stipulations at ¶ 9. The FY 2013 Inpatient Operating Costs times the Fixed Cost percentage of .9087 is $5,571,244. The difference is related to a rounding up of the Fixed Cost Percentage from 90.86859 to 90.87.
[23] *Id.*
[24] *Id.* When the resulting amount is negative no VDA payment is made to the provider.
[25] *Id.* at ¶ 11.
[26] Provider's FPP at 8.
[27] *Id.* at 9.
[28] *Id.* at 6.
[29] Medicare Contractor's FPP at 4.
[30] *Id.*.

core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total payment for inpatient operating costs."[31]

Scenic also does not agree with the Medicare Contractor's use of a Worksheet A-8 ("A-8") adjustment to remove variable costs from the cost report in order to determine the Medicare Inpatient Operating costs to be included in the VDA calculation. Scenic's argument relies on PRRB Decision 2016-D16, *St. Anthony Regional Hospital v. Wisconsin Physicians Service*,[32] in which the Medicare Contractor contended that the provider's method of computing the fixed/semi fixed percentage was incorrect, and the use of an A-8 adjustment to remove the variable costs through the cost report was a more accurate methodology. The Board, in the *St. Anthony* decision, did not accept the Medicare Contractor's methodology, and this decision was upheld by the Administrator.[33] Scenic, in further support of their position, points to the Federal Register and notes that the fixed/semi fixed costs percentage computed in the Federal Register was computed by dividing the fixed/semi fixed costs by the total costs, and not through the cost report. [34]

The Medicare Contractor argues that the Medicare inpatient costs used in the VDA calculation are computed on the cost report and come from Worksheet D-1, part II, line 53 ("D-1, part II, line 53"). As a result, the Medicare Contractor contends that the most accurate method to calculate the Inpatient Medicare costs is to remove variable costs on A-8, rerun the cost report, and compute the fixed/semi fixed Inpatient Medicare Costs on D-1, part II, line 53. The Medicare Contractor states that "CMS has long considered a provider's Medicare cost report the most accurate and efficient way of reporting, calculating, and determining Medicare costs.[35] Finally, the Medicare Contractor argues that the Administrator agreed with this approach and, further, that this approach was found not to be arbitrary or capricious in the *Unity*[36] decision. [37]

The Medicare Contractor and Scenic also disagree on which payments are to be included in the VDA calculation. Scenic has included the DRG related revenue; whereas, the Medicare Contractor has included the Hospital Specific amount on line 49 of the cost report, the low volume adjustments ("LVA") reported on line 70.96 and 70.97, and the adjustments for Value Based Purchasing and Readmission Reduction Program add-ons reported on lines 70.93 and 70.94.[38] Scenic asserts that payments included by the Medicare Contractor's VDA calculation are not listed in the regulations. Scenic points to 42 CFR § 412.108(d) that states the DRG payments to be included in the VDA calculation include "total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates (including outlier payments for inpatient operating costs determined under Subpart F of this part and additional payments made for inpatient operating costs [for] hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as

[31] *Id.* at 5.
[32] PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016).
[33] Provider's FPP at 11, 12.
[34] *Id.* at 11.
[35] Medicare Contractor's FPP at 9-10.
[36] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir.), cert. denied, 140 S. Ct. 523, 205 L. Ed. 2d 335 (2019).
[37] Medicare Contractor's FPP at 12-14.
[38] *See* Exhibit C-1.

determined under § 412.105)."[39] Scenic appears to interpret this as only the DRG payments should be included in the VDA calculation. In addition, Scenic contends that if it was CMS' intent to include the Low Volume, the Value Based Purchasing and the Readmission Reduction Program add-ons in the VDA payments, CMS "would have explicitly stated so in the final rule."[40]

In further support of its position, the Medicare Contractor refers to PRM 15-1 § 2810.1 which states:

> The hospital must demonstrate that the total Program inpatient operating cost, excluding pass-through costs, exceeds total payment for inpatient operating costs (the higher of the federal payment amount or the hospital-specific payment amount) plus the operating portion of a provider's low volume hospital payment adjustment (42 C.F.R. § 412.101). For example, total program inpatient operating cost excluding passthrough costs, reported on Form CMS-2552-10, Worksheet D-1, part II, line 53, must exceed the total payment for inpatient operating costs reported on Form CMS-2552-10, Worksheet E, Part A, line 49, plus the operating portion of a provider's low volume hospital payment adjustment.[41]

Lastly, Scenic contends that the Medicare Contractor adopted a new methodology of calculating the VDA payment with the publication of the new regulation on August 17, 2017.[42] Scenic states that this was a significant change in the calculation that cannot take effect absent notice-and-comment rulemaking.[43] According to the Provider, the methodology the Medicare Contractor should have used is described in PRM 15-1 § 2810.1, as was formally adopted and modified in the IPPS rulemaking for FYs 2007 and 2009.[44]

In response, the Medicare Contractor states that their revised calculation of the VDA calculation was not the result of a rule change but a more accurate interpretation of the existing PRM guidance and regulations. The Medicare Contractor acknowledges that, in the past, it "had previously performed some calculations improperly by making hospitals completely whole where they met the criteria to qualify for a VDA."[45] They state that since this time, they have corrected their calculation to comply with the statute and regulations.[46]

The Board identified four differences between the Medicare Contractor's and Scenic's calculation of the Provider's VDA payment. First, there is a disagreement over the use of the

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[39] Provider's FPP at 12.
[40] *Id.*
[41] Medicare Contractor's FPP at 16-17.
[42] Provider's FPP at 12 - 13.
[43] *Id.* at 13.
[44] *Id.*
[45] Medicare Contractor's FPP at 22.
[46] *Id.*

Medicare Cost Report to remove the variable costs to recompute the Medicare Inpatient costs that will be used in the VDA calculation. The example in PRM 15-1 § 2810.1(C)(4) uses the Medicare Inpatient costs from Worksheet D-1, Part II, line 53 of the cost report. Therefore, the Board finds it logical, considering all the complexities of the Medicare cost report, to identify the total inpatient operating costs, excluding pass-through costs, accordingly. The Board finds that removing the variable costs through a Worksheet A-8 adjustment and re-running the cost report, thereby recomputing the Worksheet D-1, Part II, line 53 results, leads to the most accurate Medicare inpatient costs, effectively excluding variable costs.

The parties' second disagreement involves the correct Medicare payment amount to be used in the VDA calculation. The parties agree on the amounts that Scenic was paid, but disagree regarding whether the hospital specific payment amount or the IPPS payment amount should be used in the VDA calculation. In addition, the parties do not agree on whether the low volume, hospital readmission, and value-based purchasing payments should be included in the VDA payment calculation.

The VDA regulations at 42 C.F.R. § 412.92(e)(3) require the VDA to be calculated using:

> . . . 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 for 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).[47]

The Board also reviewed the SCH payment methodology in 42 C.F.R. § 412.92(d) to determine which payments should be included in the hospital's "total DRG revenue for inpatient operating costs." This regulation provides that SCHs are paid for inpatient operating costs based upon whichever "yields the greatest aggregate payment for the cost reporting period" between the Federal payment and the hospital-specific payment.[48] Based on these regulations, the Board finds that an SCH's total DRG revenue for inpatient operating costs could include either the amount paid based on the federal rate or the amount paid based on the hospital specific rate. Therefore, the Board concludes the Medicare Contractor was correct to use $5,555,565[49] as Scenic's "total DRG revenue for inpatient operating costs" when calculating Scenic's FY 2013 VDA payment.

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[47] (Emphasis added.)

[48] 42 C.F.R. § 412.92(d) references various sections including § 412.79, the section that the Medicare Contractor used to calculate Scenic's specific rate payment. 42 C.F.R. § 412.79 provides for the determination of the hospital specific rate stating in subsection (e) "[t]he applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge."

[49] Exhibit C-1 at 43.

Additionally, the Board finds that Scenic's claim that the Low Volume Adjustment ("LVA") payment should not be included in the VDA calculations is not supported by law. As stated in 42 U.S.C. § 1395ww(d)(5)(D)(ii), an SCH is entitled to "such adjustment to the payment amounts *under this subsection* . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs . . . ."[50] The VDA provisions are located in subsection (d) of 42 U.S.C. § 1395ww. As such, all operating payments authorized by subsection (d) must be taken into account when calculating the VDA payment, including the LVA provisions which are located in subsection (d)(12). Therefore, as a subsection (d) payment, the LVA payment must be considered when calculating the VDA payment. In contrast, the value-based purchasing provisions are located in 42 U.S.C. § 1395ww(o) and the hospital readmission requirements are located in subsection (q). Accordingly, readmissions and value-based purchasing payments are not authorized under subsection (d), and are not to be included in VDA payments.

As discussed above, Scenic asserts that the Medicare Contractor's VDA payment calculation methodology is flawed. Scenic argues 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 the portion of the payment related to variable costs. This method, Scenic maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Scenic also references the fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[51]

In its recent decisions, the Board has disagreed with the methodology used by various Medicare contractors, including the methodology used by the Medicare Contractor in this appeal, to calculate VDA payments because that 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.[52] In those appeals, 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 those 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

[50] (Emphasis added.) The Board recognizes that this statutory provision includes the following exception: "such adjustment to the payment amounts under this subsection (*other than under paragraph (9)*)." However, the *sole* exception for Paragraph (9) of subsection (d) is not applicable since paragraph (9) addresses payments to Puerto Rico subsection (d) hospitals.

[51] Provider's FPP at 9.

[52] *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D1 (Dec. 15, 2016), *modified by*, Adm'r Dec. (Feb. 9, 2017); *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2015-D11 (June 9, 2015), *modified by*, Adm'r Dec. (Aug. 5, 2015).

> 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 . . . .[53]

Recently, the Circuit Court for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity*, stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[54]

At the outset, the Board notes that the CMS Administrator decisions are not binding precedent, as explained by PRM 15-1 § 2927.C.6.e:

> e. Nonprecedential Nature of the Administrator's Review Decision.—Decisions by the Administrator ***are not precedents*** for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy [*sic*] having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.[55]

Moreover, the Board notes that Scenic is not located in the Eighth Circuit and, thus, the *Unity* decision is not binding precedent in this appeal.

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to the FFY 2018 IPPS Final Rule,[56] CMS prospectively changed the methodology for calculating the VDA payment 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.[57] The preamble to the FFY 2018 IPPS Final Rule makes this change effective for cost

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[53] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[54] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir.), cert. denied, 140 S. Ct. 523, 205 L. Ed. 2d 335 (2019).
[55] (Bold and italics emphasis added.)
[56] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[57] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).

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."[58]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As explained below, the Board finds that the Medicare Contractor's calculation of Scenic's VDA payment 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 Scenic's VDA payment by comparing its FY 2013 fixed costs to its total FY 2013 DRG payments. However, neither the language nor the examples[59] 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[60] and the FFY 2009 IPPS Final Rule[61] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

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

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

Rather, the Board finds that the Medicare Contractor calculated Scenic's FY 2013 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[.]"[62] 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

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[58] 82 Fed. Reg. at 38180.
[59] PRM 15-1 § 2810.1(C)-(D).
[60] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[61] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[62] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm'r Dec. 2017-D1 at 12 (Feb. 9, 2017).

otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[63]

The statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) is intended to fully compensate the hospital for its fixed costs:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be **necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services**, including the reasonable cost of maintaining necessary core staff and services.[64]

In the final rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule"), the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[65] 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.

[63] 82 Fed. Reg. at 38179-38183.
[64] (Emphasis added.)
[65] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (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***.
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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***.[66]

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."[67] Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[68]

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 SCH for all the fixed costs associated with the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 412.02(e)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when

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[66] (Emphasis added.)
[67] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[68] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

determining the payment amount.[69] 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 incurred in the current year and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(D)(ii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG payment is payment for both fixed and variable costs - and deem the entire DRG payment as payment solely for fixed costs. The Board concludes that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is clear that the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[70] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for Medicare services *actually* furnished. The Board concludes that, in order to ensure the hospital is fully compensated for its fixed costs and be consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

Scenic essentially claims that the Contractor's revised VDA approval methodology runs afoul of the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA") and the Medicare program at 42 U.S.C. § 1395hh(a). It argues that CMS and/or the Medicare Contractor violated the APA by making a substantive change in the VDA calculation methodology and "unlawfully failed to provide for notice and comment."[71]

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[69] 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.
[70] 48 Fed. Reg. at 39782.
[71] Provider's FPP at 13.

In support of its position, Scenic essentially asserts that the examples given at PRM 15-1 § 2810.1 detai exactly how the Medicare Contractor is required to determine the VDA payment.[72] However, the Board notes that these examples relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

> The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B) of the Manual, where the examples are located, contains "the process for determining the amount of the volume decrease adjustment." See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006). However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, *the Board found "that the examples are intended to demonstrate* ***how to calculate the adjustment limit*** as opposed to determining which costs should be included in the adjustment." *See Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n*, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than "equal to," when describing the formula. *We conclude that the Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation*.[73]

Accordingly, what Scenic points to as written or published CMS "policy" on how to calculate the VDA payment was not, in fact, such a policy.

Moreover, the fact that the Medicare Contractor may have previously calculated VDAs differently does not automatically mean there is a departure from a Medicare program "policy."[74] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[75] This is different than the situation discussed by the Supreme Court in Allina,where a new substantive reimbursement policy was

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[72] *Id.* at 6-7.
[73] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[74] Moreover, the fact that a particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[75] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).

announced on the CMS website and was applied nationwide to all hospitals at one time.[76] The fact that CMS may have directed the Medicare Contractor to calculate the VDA *in this particular case* (or even on a case-by-case basis, as presented to CMS) is not inconsistent with adopting a substantive policy through adjudication, and is different than the *Allina* situation where CMS posted publicly on its website a "nationwide" adoption of new substantive policy. Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as delineated at 42 C.F.R. §412.92(e)(3).[77] Moreover, the Board has had long standing disagreements with Medicare contractors and the Administrator on their different interpretations and application of the relevant statutes, regulations and Manual guidance regarding the calculation of VDAs.[78] Accordingly, the Board rejects Scenic's APA and *Allina* argument.

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 Scenic's fixed costs (which includes semi-fixed costs) were 90.87 percent[79] of the Provider's 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

2012 Medicare Inpatient Operating Costs	$6,580,947[80]
Multiplied by the 2013 IPPS update factor	1.026[81]
2013 Updated Costs (max allowed)	$6,752,052
2013 Medicare Inpatient Operating Costs	$6,131,005[82]
Lower of 2012 Updated Costs or 2013 Costs	$6,131,005
Less 2014 IPPS payment (includes low volume payment)	$5,882,894[83]
2013 Payment CAP	$ 248,111

[76] 139 S. Ct. at 1808, 1810.
[77] 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."
[78] *See, e.g., Unity Healthcare v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Further, the application of the PRM definitions of the terms "variable" and "semi-fixed" and "fixed" costs in PRM 15-1 § 2810.1 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.
[79] Stipulations at ¶ 10.
[80] *Id*.
[81] *Id*.
[82] *Id*.
[83] *Id.* Includes the payments as stipulated by the Medicare Contractor and the Provider – the DRG Payment of $5,555,565 and the operating portion of the Low Volume Payments of $327,329. This excludes line 70.93, HVBP payments, of $3,324 and line 70.94, HRR adjustment of ($20,903) which are not to be included in the IPPS payments. HVBP payments is included under 42 U.S.C. § 1395ww(o) and HRR adjustment amount is included in § 1395ww(q). Only the payments that are included in § 1395ww(d) are included in payments for VDA calculation.

Step 2: Calculation of VDA

2013 Medicare Inpatient Costs – fixed portion (90.87 percent)	$5,571,158[84]
Less 2013 IPPS payment – fixed portion (90.87 percent)	$5,345,786[85]
Payment adjustment amount (subject to CAP)	$ 225,372

Since the payment adjustment amount of $225,372 is less than the CAP of $248,111, the Board concludes that Scenic's VDA payment for FY 2013 should be $225,372.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Scenic's VDA payment for FY 2013, and that Scenic should receive a FY 2013 VDA payment in the amount of $225,372 for FY 2013.

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[84] Stipulations at ¶ 10. The 2013 Medicare Inpatient Operating Costs of $6,131,005 multiplied by the fixed cost percentage as determined by the Medicare Contractor of 0.9087 equals $5,571,244. The difference between the amount stipulated of $5,571,158 and $5,571,244 is immaterial and is related to rounding the fixed cost percentage determined by the Medicare Contractor.

[85] The $5,345,786 is calculated by multiplying $5,882,894 by 0.9087 (the fixed cost percentage determined by the Medicare Contractor). The difference between the $5,345,786 and the number on Stipulations ¶ 10 of $5,329,738 is the removal of HVBP payments, line 70.93 and HRR adjustment, line 70.94 from the Medicare Contractor's payments as well as the rounding of the fixed cost percentage.