**PROVIDER REIMBURSEMENT REVIEW BOARD**
**DECISION**
On the Record

2022-D4

**PROVIDER-**
Marion Memorial Hospital

**Provider No.:** 14-0184

**vs.**

**MEDICARE CONTRACTOR –**
Wisconsin Physicians Service

**RECORD HEARING DATE –**
May 6, 2021

**Cost Reporting Period Ended** –
4/30/2011

**CASE NO.** 16-1924

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## ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Marion Memorial Hospital ("Marion" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending April 30, 2011 ("FY 2011").[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 Marion's VDA payment for FY 2011, and that Marion should receive a VDA payment in the amount of $222,702 for FY 2011.

## INTRODUCTION

Marion is located in Marion, Illinois.[2,3] Marion was designated as a Medicare Dependent Hospital ("MDH") during FY 2011, the fiscal year at issue.[4] The Medicare administrative contractor[5] assigned to Marion for this appeal is Wisconsin Physicians Service ("Medicare Contractor"). Marion requested a VDA in the amount of $282,858 on February 9, 2015.[6] On January 19, 2016, the Contractor issued a denial of the VDA because it concluded that Marion's inpatient prospective payment system ("IPPS") payments had exceeded Marion's allowable inpatient fixed and semi-fixed costs.[7] Marion filed a Request for Reconsideration on March 17, 2016.[8] The Medicare Contractor denied the Request for Reconsideration on May 9, 2016.[9] The Board received Marion's appeal request on June 24, 2016. Marion 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 May 6, 2021. Marion was represented by Ronald Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Provider' Final Position Paper ("Provider's FPP") at 2; Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 2-3.
[2] Stipulation ("Stipulations") at ¶ 1.
[3] When the appeal was filed, it was filed as Marion General Hospital. The underlying documents, such as the VDA request and determination all state Marion General. At some point, it appears that the hospital name changed to Heartland Regional Medical Center. However, as the appeal was filed as Marion Memorial, and it was Marion Memorial in the year under dispute, the Board will refer to the hospital as Marion Memorial in this decision.
[4] Stipulations at ¶ 1.
[5] 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.
[6] Stipulations at ¶ 4.
[7] *Id.* at ¶ 5.
[8] Exhibit P-3.
[9] Exbhibit C-1 at 23.

**STATEMENT OF FACTS AND RELEVANT LAW**

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the 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 in their total number of inpatient cases of more than 5 percent from one cost reporting year to the next.[10] 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.[11] The implementing regulations, located at 42 C.F.R. § 412.108(d), reflect these statutory requirements. When promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals ("SCHs").[12]

It is undisputed that Marion experienced a decrease in discharges greater than 5 percent from FY 2010 to FY 2011 due to circumstances beyond its control and that, as a result, Marion was eligible to have a VDA calculation performed for FY 2011.[13] When the Medicare Contractor made the FY 2011 VDA calculation, it determined that Marion was not entitled to a VDA payment because Marion's IPPS payments had exceeded Marion's allowable inpatient fixed and semi-fixed costs.[14]

42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates it experienced a qualifying decrease in total inpatient discharges. In particular, § 412.108(d)(3) (2011) 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

[10] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[11] *Id.*
[12] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[13] Stipulations at ¶ 4.
[14] *Id.* at ¶ 5.

> 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. . . .[15]

As CMS noted in the preamble to the final rule published on August 18, 2006,[16] PRM 15-1 § 2810.1 (Rev. 371) provides further guidance related to VDAs. In particular, § 2810.1(B) (Rev. 371) states, in pertinent part:

> Additional payment is made to an eligible [MDH] 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* with utilization such as food and laundry costs.[17]

The chart below depicts how the Medicare Contractor and Marion calculated the VDA payment.

[15] (Emphasis added.)
[16] 71 Fed. Reg. at 48056.
[17] (Emphasis added.)

| | Medicare Contractor calculation using fixed costs[18] | Provider/PRM calculation using total costs[19] |
|---|---|---|
| a) Prior Year Medicare Inpatient Operating Costs | | $22,253,384 |
| b) IPPS update factor | | 1.021 |
| c) Prior year Updated Operating Costs (a x b) | | $22,720,705 |
| d) FY 2011 Operating Costs | $17,920,042 | $17,920,042 |
| e) Lower of c or d | $17,920,042 | $17,920,042 |
| f) DRG/MDH payment | $17,637,184 | $17,637,184 |
| g) CAP (e-f) | $ 282,858 | $ 282,858 |
| h) FY 2011 Inpatient Operating Costs | $17,920,042 | $17,920,042 |
| i) Fixed Cost percent | .7873[20] | 1.000 |
| j) FY 2011 Fixed Costs (h x i) | $14,108,971[21] | $17,920,042 |
| k) Total DRG/SCH Payments | $17,637,184 | $17,637,184 |
| l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k) | $ (3,528,213) | |
| m) VDA Payment Amount (The Providers VDA is based on the amount line j exceeds line k.) | | $ 282,858 |

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[22]

## DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Marion asserts that the Federal Register does not specifically state that variable costs should be removed from total costs to compute the VDA.[23] The Medicare Contractor asserts that Marion "believes any potential volume decrease adjustment should ensure it is fully reimbursed for all costs, including variable costs. The MAC disagrees, and believes the regulation is clear that the volume decrease adjustment is meant to ensure a provider is fully reimbursed for the fixed costs it incurred during a cost reporting period where the hospital experienced a greater than five percent decrease in patient discharges due to circumstances beyond its control, and nothing more."[24] 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* ("*Unity*").[25]

The Medicare Contractor contends that specific instructions to determine the fixed/semi-fixed costs are not included in the statute, regulations or Provider Reimbursement Manual. Therefore, the Medicare Contractor used the cost report, removing costs identified as variable through

[18] Stipulations at ¶ 9.
[19] *Id.* at ¶ 6 .
[20] Calculation = Line J/Line E = 14,108,971/17,920,042 = 0.78732913, rounded to 0.7873.
[21] Stipulations at ¶ 10.
[22] Provider's FPP at 2-3.
[23] *Id.* at 2.
[24] Medicare Contractor's FPP at 6.
[25] 918 F.3d 571 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

Worksheet A-8 adjustments, to develop a method of calculating fixed/semi-fixed costs and argues that the Administrator agreed with this approach which was found not to be arbitrary or capricious in the *Unity* decision.[26]

Marion argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor departed from the instructions and step-by-step guidance in the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1").[27] According to Marion, the Medicare Contractor's removal of all variable costs is not supported by the Federal Register nor PRM 15-1, § 2810.1.[28]

Marion also argues that CMS changed its methodology for calculating VDA payments without going through notice-and-comment rulemaking and that the new methodology being applied by CMS to its variable costs represents a change in policy. Marion argues that it was not afforded fair notice of CMS's new methodology.[29]

Marion then contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[30] Marion maintains that the most appropriate methodology to calculate the VDA payment can be found in PRM 15-1 § 2810.1.[31]

Marion reasons 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. This method, Marion maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Marion 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.[32]

The Board identified one basic difference in the Medicare Contractor's and Marion's calculation of the VDA payment that relates to the FY 2011 Inpatient Operating Costs. The Medicare Contractor adjusted the Inpatient Operating Costs for variable costs via Worksheet A-8 adjustments on the cost report. Marion argues that the Medicare Contractor's VDA calculation methodology violates the statute, regulations, and Provider Reimbursement Manual instructions.[33]

In recent Board decisions addressing VDA payments,[34] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because that

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[26] Medicare Contractor's FPP at 8-12 (discussing *Unity Healthcare v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. 2014-D15 (Sept. 4, 2014).
[27] Provider's FPP at 2.
[28] *Id*.
[29] *Id.* at 6-7.
[30] *Id.* at 5.
[31] *Id.* at 2.
[32] *Id.* at 3-5.
[33] *Id.* at 3-6.
[34] *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.

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.

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 . . . .[35]

Recently, the Eighth Circuit upheld the Administrator's methodology in the *Unity* case, stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[36]

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

> e. Nonprecedential Nature of the Administrator's Review Decision.—Decisions by the Administrator ***are not precedents*** for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy [*sic*] having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.[37]

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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).

[35] *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).

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

[37] (Bold and italics emphasis added).

Moreover, the Board notes that Marion 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 FFY 2018 IPPS Final Rule,[38] CMS prospectively changed the methodology for calculating the VDA to one that 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.[39] 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."[40]

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 Marion'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 Marion's VDA payment by comparing its FY 2011 fixed costs to its total FY 2011 DRG payments. However, neither the language nor the examples[41] 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[42] and the FFY 2009 IPPS Final Rule[43] 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 Marion'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.

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[38] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[39] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).
[40] 82 Fed. Reg. at 38180.
[41] PRM 15-1 § 2810.1(C)-(D).
[42] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[43] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

Rather, the Board finds the Medicare Contractor calculated Marion'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[.]"[44] 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.[45]

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

> 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.[46]

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."[47] 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*

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[44] *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).
[45] 82 Fed. Reg. at 38179-38183.
[46] (Emphasis added.)
[47] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> *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.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
>
> 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***.[48]

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. As stated above, 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."[49]

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."[50] 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

[48] (Emphasis added).
[49] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[50] 42 U.S.C. § 1395ww(d)(5)(G)(iii).

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 needs and circumstances" when determining the payment amount.[51] 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)(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. 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.

Marion claims that CMS' revised VDA approval methodology runs afoul of the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA").[52] In support of its position, Marion asserts that the "[d]efinition as to the process of making the payment calculation is principally provided in PRM [15-1 §] 2810.1 and subsequently updated in the Federal Register dated August 19, 2008."[53] Marion further asserts that the Medicare Contractor's methodology "is in violation of the most recently published rules."[54] However, the

[51] 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.
[52] 5 U.S.C. Ch. 5.
[53] Provider's FPP at 2.
[54] *Id*. at 7.

Board notes that the examples given in PRM 15-1 § 2810.1 relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

> The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B) of the Manual, where the examples are located, contains "the process for determining the amount of the volume decrease adjustment." See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006). However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, *the Board found "that the examples are intended to demonstrate* ***how to calculate the adjustment limit*** as opposed to determining which costs should be included in the adjustment." See Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than "equal to," when describing the formula. *We conclude that the Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation*.[55]

Accordingly, what Marion 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."[56] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[57] This is different than the situation discussed by the Supreme Court in *Allina*, where a new substantive reimbursement policy was announced on the CMS website and was applied nationwide to all hospitals at one time.[58] The fact that CMS may have directed a Medicare Contractor to calculate the VDA in a particular case (or even on a case-by-case basis, as presented to CMS) is not inconsistent with adopting a

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[55] 918 F.3d 571, 578-9 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[56] Moreover, the fact that any Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[57] *See e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 18 F.3d 914 (D.C. Cir. 2013).
[58] *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1808, 1810 (2019).

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. §412.108(d)(3).[59] 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.[60] Accordingly, the Board rejects Marion's APA and *Allina* arguments.

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, it is clear that the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[61] 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 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.

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 Marion's fixed costs (which includes semi-fixed costs) were 78.73 percent[62] of Marion's Medicare 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 | $22,253,384[63] |
| Multiplied by the 2010 IPPS update factor | 1.021[64] |
| 2010 Updated Costs (max allowed) | $22,720,705 |
| 2011 Medicare Inpatient Operating Costs | $17,920,042[65] |

[59] 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."

[60] *See e.g., Unity Healthcare v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA*, PRRB Dec. No. 2020-D1(Jan. 31, 2020). Similarly, the Provider fails to give any examples or support to its position that CMS and/or the Medicare Contractor are substantively changing policy as it relates to determining which costs are "treated" as variable versus semi-fixed in accordance with PRM 15-1 § 2810.1. Further, the application of the PRM definitions of these terms 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.

[61] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).

[62] Stipulations at ¶ 10 (Calculation = Line H/Line E = 14,108,971/17,920,042 = 0.78732913, rounded to 0.7873).

[63] *Id.*

[64] *Id*

[65] *Id.*

| | |
|---|---|
| Lower of 2010 Updated Costs or 2011 Costs | $17,920,042 |
| Less 2011 IPPS payment | $17,637,184[66] |
| 2011 Payment Cap | $ 282,858 |

Step 2: Calculation of VDA

| | |
|---|---|
| 2011 Medicare Inpatient Fixed Operating Costs | $14,108,971[67] |
| Less 2011 IPPS payment – fixed portion (78.73 percent[68]) | $13,886,269[69] |
| **Payment adjustment amount (subject to Cap)** | **$ 222,702** |

Since the payment adjustment amount of $222,702 is less than the Cap of $282,858, the Board finds that Marion's VDA payment for FY 2011 should be $222,702.

## DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Marion's VDA payment for FY 2011, and that Marion should receive a FY 2011 VDA payment in the amount of $222,702 for FY 2011.

## BOARD MEMBERS

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FOR THE BOARD:

1/12/2022

X Clayton J. Nix

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

[66] *Id.*
[67] *Id.*
[68] *Id.* (Calculation = Line H/Line E = 14,108,971/17,920,042 = 0.78732913, rounded to 0.7873).
[69] *Id.* (Calculation = 17,637,184*0.78732913 = $13,886,268.73, rounded to $13,886,269).