PROVIDER REIMBURSEMENT REVIEW BOARD DECISION
On the Record

2022-D06

PROVIDER-
Blackwell Regional Hospital

Provider No.: 37-0030

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –

Cost Reporting Period Ended–
03/31/2012

CASE NO. – 17-1612

INDEX

ISSUE STATEMENT

Whether the Provider is entitled to a Volume Decrease Adjustment ("VDA") for Fiscal Year End ("FYE") 03/31/2012.[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 FY 2012 for Blackwell Regional Hospital ("Blackwell" or "Provider"), and that Blackwell should receive a VDA payment in the amount of $428,345.

INTRODUCTION

Blackwell is a non-profit acute care hospital located in Blackwell, Oklahoma. Blackwell was designated as a Medicare Dependent Hospital ("MDH") during the fiscal year at issue.[2] The Medicare administrative contractor[3] assigned to Blackwell for this appeal is Novitas Solutions, Inc. ("Medicare Contractor"). Blackwell requested a VDA payment of $592,643 for FY 2012 to compensate it for a decrease in inpatient discharges.[4] The Medicare Contractor calculated Blackwell's FY 2012 VDA payment to be $0.[5] Blackwell 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 May 11, 2021. Blackwell 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 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 in their total number of inpatient cases of more than 5 percent from one cost reporting year to the next.[6] VDA payments are designed to 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. § 412.108(d), reflect these

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[1] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 4.
[2] Corrected 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] Corrected Stipulations at ¶ 4.
[5] *Id.* at ¶ 5. Payment was denied since Blackwell was not able to provide the additional information requested by the Medicare Contractor. Additional information was submitted with Blackwell's request for reconsideration. *See id.* at ¶ 6.
[6] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[7] *Id.*

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 ("SCH").[8]

It is stipulated that Blackwell experienced a decrease in discharges greater than 5 percent from FY 2011 to FY 2012 due to circumstances beyond Blackwell's control and that, as a result, Blackwell was eligible to have a VDA calculation performed for FY 2012.[9] Blackwell requested a VDA payment in the amount of $592,643 for FY 2012.[10] However, the Medicare Contractor denied Blackwell's request for VDA payment because Blackwell could not provide the additional information requested by the Medicare Contractor.[11] Notwithstanding, the Medicare Contractor determined that a VDA payment of $370,987 would be due for FY 2012 if Blackwell had qualified for a VDA payment.[12]

42 C.F.R. § 412.108(d) (2012) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates it experienced a qualifying decrease in total inpatient discharges. In pertinent part, § 412.108(d)(3) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[13] 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 (including outlier payment for inpatient operating costs . . . .)
>
> (i) In determining the adjustment amount, the intermediary 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,[14] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356) which states, in relevant part:

> B. Additional payment is made . . . for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
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> 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

[8] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[9] Corrected Stipulations at ¶ 4.
[10] *Id.*
[11] *Id.* at ¶ 5.
[12] *Id.*
[13] (Emphasis added.)
[14] 71 Fed. Reg. at 48056.

> costs for items and services that vary *directly*[15] with utilization such as food and laundry costs.

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

	Medicare Contractor calculation using fixed costs[16]	Provider/PRM lculation using total costs[17]
a) Prior Year Medicare Inpatient Operating Costs	$1,961,580[18]	$2,040,155
b) IPPS update factor	1.021[19]	1.03
c) Prior year Updated Operating Costs (a x b)	$2,002,131[20]	$2,101,359
d) FY 2012 Operating Costs	$2,207,187	$2,207,187
e) Lower of c or d	$2,002,131	$2,101,359
f) DRG/MDH payment	$1,574,428	$1,574,428
g) CAP (d-f)	$ 427,703	$ 526,931
h) FY 2012 Inpatient Operating Costs	$2,207,187	$2,207,187
i) Fixed Cost percent	.8814[21]	1.00[22]
j) FY 2012 Fixed Costs (h x i)	$1,945,415	$2,207,187
k) Total DRG/MDH Payments	$1,574,428	$1,574,428
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$ 370,987	
m) VDA Payment Amount (The Providers VDA is based on the amount by which line e exceeds line k.)		$ 526,931

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[23] Additionally, Blackwell maintains that the Medicare Contractor should have taken into consideration the fact that Blackwell's overall discharges decreased by 16.7 percent, while its Medicare discharges decreased by 9.5 percent.[24] This type of situation, Blackwell

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[15] (Emphasis added.)
[16] Corrected Stipulations at ¶ 11.
[17] *Id.* at ¶ 8.
[18] Exhibit C-3 at 12.
[19] *See id.* The update factor for June 1, 2011 through September 30, 2011 (92 days) was 1.0235. The update factor for October 1, 2011 through March 31, 2012 (183 days, corresponding with the FYE for Blackwell in this case) was 1.019. 76 Fed. Reg. 51476, 51797 (Aug. 18, 2011). The aggregate update factor, therefore, becomes 1.021. *See also infra* note 81.
[20] *Id.*
[21] *Id.*
[22] *See* Provider's Final Position Paper (hereinafter "Provider's FPP") at 3, 10. Blackwell contends that it should be paid in accordance with the calculation on Table A which does not include a reduction in variable costs. It asserts that the calculation on Table A in Provider's FPP is in accordance with the methodology in section 2810.1 of the PRM (as formalized in the IPPS final rules for FYs 2007 and 2009) for the cost reporting period under appeal. As a result, the Fixed Cost Percentage is reported at 1.00.
[23] Corrected Stipulations at ¶ 13.
[24] Provider's FPP at 8.

asserts, is described in PRM 15-1 § 2810.1(D) as producing an "anomalous result" where the Medicare Contractor may request a review by CMS.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor initially calculated a VDA payment for Blackwell in the amount of $370,987. However, the VDA payment was denied because Blackwell failed to provide the documentation that proved the decrease in discharges was beyond their control.[25] The Medicare Contractor has since stipulated that Blackwell meets all the requirement as contained in 42 C.F.R § 412.108(d)(1) and (2) and is eligible for a VDA payment.[26] The only issue currently under dispute is the application of the regulations and the correct methodology to calculate the VDA payment.

Blackwell asserts that "[t]he methodology for calculating the volume decrease adjustment . . . is reflected in section 2810.1 of the Provider Reimbursement Manual ('PRM') as formalized through notice-and-comment rulemaking in the inpatient prospective payment system ('IPPS') final rules for fiscal years ('FYs') 2007 and 2009." [27] Blackwell claims that the Medicare Contractor "departed from CMS's established policy and did not use the policy set forth in section 2810.1 of the PRM and summarized in Federal Register rulemaking."[28] Instead the Medicare Contractor removed variable costs from the Medicare inpatient operating costs.[29]

The Medicare Contractor points out that the CMS Administrator has discussed the appropriate methodology to calculate a VDA payment in numerous Administrator decisions, including those involving Lakes Regional Healthcare,[30] Unity Healthcare,[31] St. Anthony Regional Medical Center,[32] and Fairbanks Memorial Hospital.[33] The Medicare Contractor believes its VDA calculation for Blackwell is consistent with these Administrator decisions.[34]

Blackwell also argues that the Medicare Contractor was wrong when it calculated Blackwell's VDA payment amount because it compared total fixed costs to total DRG payments. Blackwell asserts that this is like "subtracting apples from oranges" and understates the VDA payment because DRG revenue compensates a hospital for both fixed and variable costs.[35] In the alternative, Blackwell reasons that, if variable costs are to be excluded from inpatient operating cost when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. This method, Blackwell maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed and variable costs. According to Blackwell, removing variable costs from both the revenue and cost sides of the VDA equation would result in Blackwell receiving a VDA payment for FY 2012 of $487,827.[36]

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[25] Corrected Stipulations at ¶ 5.
[26] *Id.* at ¶ 4.
[27] Provider's FPP at 10.
[28] *Id.*
[29] *Id.*
[30] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. No. 2014-D16 (Sept. 4, 2014).
[31] *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. No. 2014-D15 (Sept. 4, 2014).
[32] *St. Anthony Reg'l Hosp. v. Wisconsin Physician Servs.*, Adm'r Dec. No. 2016-D16 (Oct. 3, 2016).
[33] *Fairbanks Mem'l Hosp. v. Wisconsin Physician Servs,*, Adm'r Dec. No. 2015-D11 (Aug. 5, 2015).
[34] Medicare Contractor's FPP at 11.
[35] Provider's FPP at 13.
[36] *Id.* at 10-11, 13-14.

In addition, Blackwell states that its decrease in Medicare discharges is significantly less than the decrease in total discharges and it meets the criterion for an anomaly as contained in PRM 15-1 § 2810.1(D)(2).[37] Blackwell has included an anomalous calculation supporting that the prior year Medicare Inpatient operating costs of $1,961,580[38] should be increased to $2,040,155 to reflect the FY 2012 Medicare utilization.[39] The Parties note in the Stipulations that the Medicare Contractor does not agree that an anomaly is appropriate and disagrees with the methodology advanced by Blackwell.[40]

The Board finds that there are three basic disagreements between Blackwell and the Medicare Contractor in the computation of the VDA payment. The first revolves around Blackwell's contention that they have met the criterion for an anomaly[41] and have adjusted the prior year's Medicare inpatient operating costs to reflect the current year's Medicare utilization.[42] The Board finds that the information contained in the record is insufficient for the Board to overturn the Medicare Contractor's decision to not request a review by CMS. Blackwell has not provided the cost reports, which are the most basic information needed to validate the numbers contained in the anomalous calculation. As a result, the Board declines to opine on its view of whether the calculation produced an anomalous result, especially in light of the lack of published guidance from CMS on how the Agency anticipated that discretion to be exercised.

The second difference between the parties is the computation of the fixed/semi fixed percentage to be used in the calculation of the VDA payment. The Board finds that variable costs are to be excluded from the VDA calculation. PRM 15-1 2810.1(B), the statute,[43] and regulations[44] all state that the VDA calculation is to only include fixed (semi- fixed costs) in the VDA calculation. PRM 15-1 § 2810.1 specifically states that "[a]dditional payment is made to an eligible SCH[45] for the **fixed costs**[46] 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 payment for inpatient operating costs."

The third dispute between the parties is the total IPPS inpatient payments amount used in the VDA calculation. The parties agree that Blackwell's total DRG payment for FY 2012 is $1,574,428.[47] However, the dispute is whether the total DRG payment or the reduced DRG payments adjusted by fixed/semi-fixed percentage should be included in the VDA payment calculation.

In its recent decisions,[48] 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

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[37] *Id.* at 8, Table 3. Medicare discharges decreased by 9.5 percent and total discharges by 16.7 percent.
[38] Exhibit C-3 at 12. The number was derived by adding Period previous to 10/1 of $656,238 to Period on/after October 1st of $1,305,342.
[39] Provider's FPP at 9, Table 4. The $2,040,155 was calculated by dividing Total Routine and Ancillary costs in column 9 of $2,720,206 by 12 and multiplying by 9 (months in the March 31, 2012 period).
[40] Corrected Stipulations at ¶ 8.
[41] Provider's FPP at 8.
[42] *Id.* at 9, Table 4.
[43] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[44] 42 C.F.R. § 412.108(d)(3)(i)(B).
[45] Recall that the VDA rules for MDHs are identical to those in place for SCHs. *Supra* n.8 and accompanying text.
[46] (Emphasis added.)
[47] Corrected Stipulations at ¶ 8.
[48] *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,

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. 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.[49]

Recently, the U.S. 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."[50]

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.[51]

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

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).

[49] *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).

[50] 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

[51] (Emphasis added.)

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,[52] CMS prospectively changed the methodology for calculating the VDA to one which is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated portion of the DRG payment that is related to fixed costs, to the hospital's fixed costs, when determining the amount of the VDA payment.[53] 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."[54]

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 Blackwell's VDA methodology for FY 2012 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 Blackwell's VDA payment by comparing its FY 2012 fixed costs to its total FY 2012 DRG payments. However, neither the language nor the examples[55] 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[56] and the FFY 2009 IPPS Final Rule[57] 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 Blackwell's VDA using the methodology laid out by CMS in PRM 15-1 and by the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Blackwell's FY 2012 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[.]"[58] The Board suspects that the Administrator

[52] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[53] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d).
[54] 82 Fed. Reg. at 38180.
[55] PRM 15-1 § 2810.1(C)-(D).
[56] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[57] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[58] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014); *Unity*

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.[59]

The intent of 42 U.S.C. § 1395ww(d)(5)(G)(iii) is 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.[60]

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

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

Healthcare v. Blue Cross Blue Shield 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).

[59] 82 Fed. Reg. at 38179-38183.

[60] (Emphasis added.)

[61] 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***.[62]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limits 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. The Administrator's decisions essentially state that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[63] Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[64]

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

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an MDH for all the fixed costs associated with 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. § 412.108(d)(3)(i)(A) that the Medicare contractor "consider[] . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[65] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its

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[62] (Emphasis added.)
[63] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[64] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[65] The Board recognizes that 42 C.F.R. § 412.108(d)(3)(i)(B) (2012) instructs the Medicare contractor to "consider[]" fixed (and semi-fixed) costs for determining the VDA payment amount but this instruction does not prevent

variable costs associated with the volume loss, but the hospital will always have some variable costs related to furnishing Medicare services to its *actual* patient load.

Critical to the proper application of the statute, regulation and PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished *actual* services in the current year are not part of the volume decrease, and (2) the DRG payments made to the hospital for services furnished to Medicare patients in the current year are 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.

Blackwell further alleges that "[s]ince the publication of the Federal Register in 2008 some [Medicare Contractors] began to change their methodology attempting to circumvent the notice-and comment requirement of the Medicare statute by adopting a new methodology by way of adjudication."[66] Blackwell argues that, according to the transcripts in *Unity Healthcare v. Wisconsin Physicians Services*,[67] the change was driven by Wisconsin Physician Services. Blackwell states the change in the VDA methodology is a rule that cannot take effect without going through notice and comment period. It refers to *Allina v. Burwell* (*sic Allina v. Price* ("*Allina*")) wherein the D.C. Circuit ruled that CMS unlawfully failed to provide a notice and comment period prior to instituting a substantive rule.[68]

In support of its position, Blackwell states that "the process for determining the amount of the volume decrease can be found in PRM 15-1 § 2810.1." It notes that none of the examples show variable costs being removed from the VDA calculation.[69] It goes on to state that "[g]iven how clear the Manual is, even providing several step by step examples, it is not surprising that other intermediaries" have followed the examples in computing the VDA payments for hospitals.[70] However, 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

payment through the DRG of the variable costs for those services *actually* rendered.
[66] Provider's FPP at 16.
[67] Copy at Exhibit P-11.
[68] Provider's FPP at 16 (citing *Allina v. Price*, 863 F.3d 937 (D.C. Cir. 2017)).
[69] *Id.* at 11.
[70] *Id.*

> 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.*[71]

Accordingly, what Blackwell 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."[72] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[73] This is different than the situation discussed by the Supreme Court in *Azar v. Allina Health Services* (*i.e.,* the Supreme Court's review of the D.C. Circuit's decision in *Allina*)[74] where a new substantive reimbursement policy was announced on the CMS website and was applied nationwide to all hospitals at one time.[75] 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. §412.108(d)(3).[76] Further, the Board has had long standing disagreement with Medicare contractors, including the Medicare Contractor in this

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[71] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[72] Moreover, the fact that this particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[73] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[74] 139 S. Ct. 1804 (2019).
[75] *Id.* at 1808, 1810.
[76] 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."

appeal, and the Administrator on their different interpretations and application of the relevant statutes, regulations, and Manual guidance on how to calculate VDAs.[77] Accordingly, the Board rejects Blackwell'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.[78] 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 thus 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.

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, and Blackwell agreed, that fixed costs (which include semi-fixed costs) were 92.58 percent[79] of Blackwell's Medicare costs for FY 2012. However, this calculation was based upon the Medicare Contractor's calculated 2012 fixed costs ($1,945,415) as a percentage of the 2011 Inpatient Operating Costs updated by the 2012 IPPS Update Factor ($2,101,360). The proper percentage, used below, is obtained by calculating the Medicare Contractor's calculated 2012 fixed costs ($1,945,415) as a percentage of the actual 2012 Inpatient Operating Costs (stipulated as $2,207,187). This results in a fixed cost percentage of 88.14 percent. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2011 Medicare Inpatient Operating Costs	$1,961,580[80]
Multiplied by the 2012 IPPS update factor	1.021[81]
2011 Updated Costs (max allowed)	$2,002,773

[77] *See, e.g.*, *Unity Healthcare v. Blue Cross Blue Shield Association*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Regional Medical Center v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Similarly, Blackwell 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.

[78] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).

[79] Corrected Stipulations at ¶ 12.

[80] Exhibit P-1 at 4. The total is computed by adding the period prior to October 1st of $656,238 to period on/after October 1st of $1,305,342 to derive the $1,961,580. It is noted in Stipulation ¶ 12 that both the Medicare Contractor and Blackwell have stipulated that $2,040,155 reflects Blackwell's prior year program operating costs. The $2,040,155 includes an anomalous calculation, but in Stipulation ¶ 8, the Medicare Contractor states that it does not believe the anomalous calculation is appropriate.

[81] The Corrected Stipulations at ¶¶ 8 and 12 use 1.03 as the PPS Update Factor; however, per the applicable IPPS Final Rules, Table 1A, the factor for FFY 2011 is 1.0235 and the factor for FFY 2012 is 1.019. Thus, 1.03 is not supported by the final rules in either year, nor as a calculated average. This is a 9-month cost report, with 92 days in FFY 2011 (July 1, 2011 to September 30, 2011) and 183 days in FFY 2012 (October 1, 2011 to March 31, 2012). As such, the Board will use the factor as calculated based upon applicable days in the cost report. This results in an update factor of 1.0205045 (*i.e.*, (1.0235/92 * 275) + (1.019/183 * 275)). This is rounded to 1.021.

2012 Medicare Inpatient Operating Costs	$2,207,187[82]
Lower of 2011 Updated Costs or 2012 Costs	$2,002,773
Less 2012 IPPS payment	$1,574,428[83]
2012 Payment Cap	$ 428,345

Step 2: Calculation of VDA

2012 Medicare Inpatient Fixed Operating Costs	$1,945,415[84]
Less 2012 IPPS payment – fixed portion (88.14 percent) including Hospital Specific Payment	$1,387,701[85]
Payment adjustment amount (subject to cap)	**$ 557,714**

Since the payment adjustment amount of $557,714 is greater than the cap of $428,345, the Board finds that Blackwell's VDA payment for FY 2012 should be $428,345.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Blackwell's VDA payment for FY 2012 and that Blackwell should receive a VDA payment in the amount of $428,345 for FY 2012.

Board Members Participating:

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For the Board:

1/21/2022

X Clayton J. Nix

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

[82] Corrected Stipulations at ¶ 12.
[83] *Id.*
[84] *Id.*
[85] The $1,387,701 is calculated by multiplying $1,574,428 by the Fixed Cost percentage of 88.14 percent.