PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D10

PROVIDER-
West Branch Regional Medical Center

Provider No.: 23-0095

vs.

MEDICARE CONTRACTOR –
Wisconsin Physician Services

RECORD HEARING DATE –

February 4, 2021

Cost Reporting Period Ended –
03/31/2009

CASE NO. – 13-3788

INDEX

ISSUE STATEMENT

Whether the West Branch Regional Medical Center ("West Branch" or "Provider") is entitled to a volume decrease adjustment ("VDA") payment for a sole community hospital ("SCH") for the fiscal year ending March 31, 2009 ("FY 2009").[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 2009 for West Branch, and that West Branch should receive a VDA payment in the amount of $1,339,230 for FY 2009.

INTRODUCTION

West Branch is an acute care hospital located in West Branch, Michigan and was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to West Branch for this appeal is Wisconsin Physician Services ("WPS" or "Medicare Contractor"). Prior to the appointment of WPS in July, 2012, West Branch's Medicare contractor was National Government Services ("NGS").[4] NGS issued an initial VDA for the FYE March 31, 2009 cost report, and paid West Branch $2,384,137.[5] WPS issued a denial and rescinded the payment.[6] WPS' denial was based on a conclusion that West Branch's inpatient prospective payment system ("IPPS") payments exceeded its allowable inpatient fixed and semi-fixed operating costs.[7] West Branch 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 February 4, 2021. West Branch 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

The Medicare program pays certain hospitals a predetermined, standardized amount per discharge under 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 SCHs if, due to circumstances

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[1] Medicare Contractor's Consolidated Final Position Paper (hereinafter "Medicare Contractor's FPP") at 2.
[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.
[4] Stipulations at ¶ 3.
[5] *Id.* at ¶ 5.
[6] *Id.*
[7] *Id.* *See* Exhibit C-1.

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.[8] VDA payments are designed to fully compensate a hospital for the fixed costs 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.[9] The implementing regulation, located at 42 C.F.R. § 412.92(e), reflect these statutory requirements.

It is undisputed that West Branch experienced a decrease in discharges greater than 5 percent from FY 2008 to FY 2009 due to circumstances beyond its control, and that, as a result, it was eligible to have a VDA calculation performed for FY 2009.[10] NGS initially approved West Branch for a VDA payment in the amount of $2,384,137 for FY 2009.[11] NGS then issued a revised VDA payment of $1,777,295.[12] However, when WPS recalculated the FY 2009 VDA, it determined that West Branch's DRG payment exceeded its fixed program operating costs by $562,139.[13] Therefore, WPS concluded that West Branch did not qualify for a VDA payment.[14]

The regulation at 42 C.F.R. § 412.92(e) (2009) directs how the Medicare Contractor must determine the VDA once an SCH demonstrates it experienced a qualifying decrease in total inpatient discharges. In pertinent part, § 412.92(e)(3) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[15] 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 intermediary considers— . . .
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> (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. . . .

The preamble to the Final Rule published on August 18, 2006[16] references the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 371), which offers further guidance related to VDAs, stating in relevant part:

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[8] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[9] *Id*.
[10] Stipulations at ¶ 4. *See also* Provider's Consolidated Final Position Paper ("Provider's FPP") at 2.
[11] Stipulations at ¶ 5; Provider's FPP at 3. *See also* Exhibit P-1.
[12] Provider's FPP at 3.
[13] Stipulations at ¶ 9. *See also* Exhibit C-1 at 10.
[14] Medicare Contractor's FPP at 5.
[15] (Emphasis added.)
[16] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> 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 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 West Branch each calculated the VDA payment.

	Medicare Contractor calculation using fixed costs	Provider/PRM calculation using total costs[18]
a) Prior Year Medicare Inpatient Operating Costs	$ 0[19]	$13,082,786
b) IPPS update factor		1.036
c) Prior year Updated Operating Costs (a x b)	$ 0	$13,553,766
d) FY 2009 Operating Costs	$12,815,362[20]	$11,767,438
e) Lower of c or d	$12,815,362	$11,767,438
f) DRG/SCH payment	$10,813,733[21]	$9,465,806
g) Cap (e-f)	$ 2,001,629	$ 2,301,632
h) FY 2009 Inpatient Operating Costs	$12,815,362	$11,767,438
i) Fixed Cost percent	79.99%[22]	100%[23]
j) FY 2009 Fixed Costs (h x i)	$10,251,594[24]	$11,767,438
k) Total DRG/SCH Payments	$10,813,733	$9,465,806

[17] (Emphasis added).
[18] Stipulations at ¶ 6; Provider's FPP at 4.
[19] Stipulations at ¶ 9. The Medicare Contractor did not stipulate to the prior year amount in their calculation.
[20] *Id. See also* Medicare Contractor's FPP at 7 (WPS states that they erroneously included capital costs in operating costs).
[21] Stipulations at ¶ 9.
[22] *Id.* The Medicare Contractor's calculation incorrectly included capital on lines D-1 Part II line 49. The Fixed Cost percentage was calculated by dividing $10,251,594 (Exhibit P-1 at 36) by $12,815,362 (Exhibit P-1 at 85) resulting in a fixed cost percentage of 79.99457214 percent which was rounded to 79.99 percent.
[23] *See* the Provider's FPP at 7. West Branch asserts that PRM 15-1 § 2810.1 and the August 19, 2008 Federal Register make no mention of a removal of variable costs from the Provider's Operating Costs. As a result, the Fixed Cost Percentage is reported here as 1.00.
[24] Stipulations at ¶ 9. FY 2009 Inpatient Operating Costs multiplied by the Fixed cost percent is not exactly $10,251,594 as a result of the rounding of the Fixed cost percentage to 79.99 percent.

l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$ (562,139)[25]	
m) VDA Payment Amount (The Provider's VDA is based on the amount by which line j exceeds line k.)		$ 2,301,632

The parties to this appeal dispute the application of the statute, regulation, and manual provisions used to calculate the VDA payment.[26]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

West Branch submitted its request for a VDA using a calculation that did not remove variable costs, asserting that the method for conducting the VDA payment calculation is set forth in PRM 15-1 § 2810.1 and does not remove variable costs from the VDA calculation.[27] In addition to the PRM, West Branch points to the description of a VDA calculation in the August 19, 2008 Federal Register, which describes how to calculate the VDA payment.[28] West Branch further claims that nowhere in the Federal Register does it mention the removal of variable costs when calculating a VDA payment.

The Medicare Contractor disagrees with West Branch's assertion that the Federal Register does not specifically state that variable costs should be removed from total costs to compute the VDA. The Medicare Contractor counters by stating that the VDA is to be calculated based on fixed costs, not total costs.[29] In support of its position, the Medicare Contractor cites to the decision of the U.S. Court of Appeals for the Eighth Circuit in *Unity Healthcare v. Azar* ("*Unity*").[30]

Based on its position that the VDA calculation is based only on fixed costs, the Medicare Contractor removed variable costs by using Worksheet A-8 adjustments on West Branch's cost report. The Medicare Contractor contends that, because specific instructions to determine the fixed/semi-fixed costs are not included in the statutes, regulations or Provider Reimbursement Manual, it is appropriate to use the cost report to calculate fixed/semi-fixed costs. The Administrator also agreed with this approach in the *Unity* decision.[31]

West Branch argues that this method is "not supported by the recent CMS Administrator decisions, and the regulations do not show this method either."[32] West Branch objects to the

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[25] A negative calculated payment results to $0 in payments made to the hospital.
[26] Stipulations at ¶¶ 6, 9-10.
[27] Provider's FPP at 7.
[28] PRM § 2810 and 73 Fed. Reg. 48631 describe how to calculate a VDA by simply "subtracting the second year's MS-DRG payment from the lesser of: (a) the second year's costs minus any adjustment for excess staff; or, (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustments for excess staff."
[29] Medicare Contractor's FPP at 9.
[30] *Id.* at 13 (citing to 918 F.3d 571 (8th Cir. 2019) which reviewed three different Administrator decisions involving Unity Healthcare, Lakes Regional Healthcare and St. Anthony Regional Hospital). *See also* discussion of the *Unity* case, *infra*.
[31] *Id.* at 11-13.
[32] Provider's FPP at 12.

Medicare Contractor's use of Worksheet A-8 to calculate the Medicare Inpatient costs.[33] West Branch points to the Board's 2016 decision in *St. Anthony Regional Hospital v. Wisconsin Physicians Service* ("*St. Anthony*"),[34] and states that this "is the only case in which the question of how to remove variable costs from the [Medicare inpatient operating costs] was directly raised."[35]

In *St. Anthony*, the Medicare Contractor offset the pharmacy and cafeteria revenue against fixed costs. Offsetting this revenue against only fixed costs resulted in a lower fixed cost percentage and a lower VDA payment. In *St. Anthony*, the Board found that it was incorrect to offset the cafeteria and pharmacy revenue against fixed costs only.[36] This decision was upheld by the Administrator.[37] West Branch refers to the *St. Anthony* decision as further evidence that the method utilized by the Medicare Contractor in the calculation of the fixed cost decision is not accepted CMS policy.[38]

The Board finds that the Medicare regulations do not specify how variable costs are to be calculated as part of the VDA calculation. The calculations in the Federal Register, as referenced by West Branch, are more general in nature and would not exclude the Medicare Contractor from using the cost report to remove variable costs from Medicare Inpatient Operating costs. In fact, the VDA calculation examples in PRM 15-1 § 2810.1 use the Medicare Inpatient costs from Worksheet D-1, Part II, Line 53 of the cost report. Therefore, considering the complexities of the Medicare cost report, the Board finds that removing variable costs through a Worksheet A-8 adjustment, then re-running the cost report to compute a revised Worksheet D-1, Part II, Line 53, will result in the most accurate Medicare Inpatient costs.

However, the Board recognizes that certain revenue offsets are related to variable as well as fixed costs, and that the portion related to the variable costs should be removed when re-running the cost report, as it decided in *St. Anthony*. The Board agrees with the logic behind, and the conclusion reached, in its *St. Anthony* decision. However, the Board notes that West Branch did not request any revisions to the Medicare Contractor's cost report calculations, as took place in *St. Anthony*.

West Branch, in its VDA calculation, used the DRG payment instead of the hospital specific payment ("HSP"). However, West Branch failed to provide a clear explanation of why it believes the IPPS payments should include only DRG payments. In the conclusion of its position paper, West Branch states that 42 C.F.R § 412.92(e) "provides guidance on determining both the appropriate amount of Medicare Inpatient Cost and the DRG Amount including outliers"[39] when it describes DRG revenue as:

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[33] *Id.*
[34] PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by* Adm'r Dec. (Oct. 3, 2016), *aff'd by Unity Healthcare v. Azar*, 918 F.3d 571 (8th Cir. 2019) (copy at Exhibit P-10).
[35] Provider's FPP at 12-13.
[36] Exhibit P-10.
[37] *Id.*
[38] Provider's FPP at 13.
[39] *Id.* at 15.

> 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 determined under §412.105.[40]

West Branch appears to interpret this regulation as only including the DRG payments in the VDA calculation.

West Branch included the DRG but not HSP payments in the VDA calculation. The Board reviewed the VDA regulations at 42 C.F.R. § 412.92(e) (2009). These regulations 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 . . . .)"[41] 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." 42 C.F.R. § 412.92(d) provides that SCHs are paid for inpatient operating costs based on whichever is the greatest between the Federal payment or the hospital specific payment.[42] Based on these regulations the Board finds that an SCH's total DRG revenue for inpatient operating costs includes both DRG and HSP payments. Therefore, the Board concludes the HSP is properly included in the amount of $10,056,089 used by the Medicare Contractor when calculating West Branch's FY 2009 VDA payment.[43]

West Branch also argues that CMS' revised VDA approval methodology runs afoul of the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA")[44] and the Medicare statute at 42 U.S.C. § 1395hh(a).[45] West Branch further argues that when the Medicare Contractor changed the VDA calculation without following the legal notice and comment period they unlawfully changed regulations. West Branch asserts that the VDA calculation was not lawfully altered until the August 17, 2017 Federal Register was issued.[46]

West Branch contends that the only valid methodology in effect during the fiscal year at issue was described in PRM 15-1 § 2810.1, as formally adopted and modified in the IPPS rulemakings

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[40] *Id.* at 13.
[41] (Emphasis added.)
[42] *See* 42 C.F.R. § 412.92(d). This regulation references various sections including § 412.78, the section that the Medicare Contractor used to calculate West Branch's hospital specific rate payment. 42 C.F.R. § 412.78 also 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."
[43] Stipulations at ¶ 10.
[44] 5 U.S.C. Ch. 5.
[45] Provider's FPP at 13.
[46] *Id.* at 14.

for FYs 2007 and 2009.[47] West Branch further contends that CMS and/or the Medicare Contractor improperly departed from this methodology. However, the Board notes that the examples in PRM 15-1 § 2810.1 relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity*:

> 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*.[48]

West Branch finally argues that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[49] West Branch maintains that the most appropriate methodology to calculate the VDA payment can be found in 42 C.F.R. §§ 412.92 and 412.108(d), and PRM 15-1 § 2810.1.

However, West Branch also reasons that if variable costs are to be excluded from inpatient operating costs when calculating the VDA there must also be a corresponding decrease to the DRG payment for the portion of the payment related to variable costs. West Branch maintains that this method would ensure an accurate matching of revenue with expenses, because the DRG payments are intended to cover both fixed *and* variable costs. The Provider also references the

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[47] *Id.*
[48] 918 F. 3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[49] *Id.* at 9.

fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[50]

In recent decisions, the Board has disagreed with the methodology used by various Medicare contractors, including the one in this appeal, to calculate VDA payments because this methodology compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount.[51] 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 that 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 . . . .[52]

As noted above, the 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."[53]

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

[50] *Id.* at 10.
[51] *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).
[52] *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).
[53] 918 F.3d 571, 579 (8th Cir. 2019).

> 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.[54]

Moreover, the Board notes that West Branch 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,[55] 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.[56] 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."[57]

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 West Branch's VDA for FY 2009 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 West Branch's VDA payment by comparing its FY 2009 fixed costs to its total FY 2009 DRG payments. However, neither the language nor the examples[58] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Like the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[59] and the FFY 2009 IPPS Final Rule[60] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

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[54] (Bold and italics emphasis added).
[55] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[56] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).
[57] 82 Fed. Reg. at 38180.
[58] PRM 15-1 § 2810.1(C)-(D).
[59] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[60] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

> [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 West Branch's VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds that the Medicare Contractor calculated West Branch's FY 2009 VDA based on an otherwise *new* methodology that the Administrator apparently adopted through adjudication in her decisions, which is best described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[61] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the methodology explained in the FFY 2007 and 2009 IPPS Final Rules/PRM and the statute. Notably, in applying this new methodology through adjudication, CMS did not otherwise alter its written policy statements in either the PRM or the Federal Register until it issued the FFY 2018 IPPS Final Rule.[62]

The intent of the statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) is clear that the VDA payment is 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.

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."[63] However, the VDA payment methodology as explained in the FFY 2007 and 2009

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[61] *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).
[62] 82 Fed. Reg. at 38179-38183.
[63] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
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> D. Determination on Requests.— . . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> 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***.[64]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the Administrator decisions, stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[65]

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[64] (Emphasis added.)

[65] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.

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."[66] Under 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 rationale necessarily 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 the 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. § 412.92(e)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[67] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

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

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs 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

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[66] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

[67] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) (2009) 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.

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, the Administrator's methodology 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.[68] 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 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 West Branch's fixed costs (which include semi-fixed costs) were 78.26 percent[69] of West Branch's Medicare costs for FY 2009.

Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2008 Medicare Inpatient Operating Costs	$13,082,786[70]
Multiplied by the 2008 IPPS update factor	1.036[71]
2008 Updated Costs (max allowed)	$13,553,766
2009 Medicare Inpatient Operating Costs	$11,767,438[72]
Lower of 2008 Updated Costs or 2009 Costs	$11,767,438
Less 2009 IPPS payment	$10,056,089[73]
2009 Payment Cap	**$ 1,711,349**

Step 2: Calculation of VDA

[68] 48 Fed. Reg. at 39782.
[69] Stipulations at ¶ 10.
[70] *Id.*
[71] *Id.* (The Board notes that the stipulated 2008 IPPS update factor is actually the 2009 IPPS update factor, which relates to the federal fiscal year ("FFY") 2009, which covers the period from October 1, 2008 to September 30, 2009. West Branch's fiscal year does not align with the FFY, however, as the 2009 costs are less than the 2008 costs, this has no effect on the calculation of the VDA.)
[72] *Id.*
[73] *Id.*

2009 Medicare Inpatient Fixed Operating Costs	$9,208,707[74]
Less 2009 IPPS payment – fixed portion (78.26[75] percent)	$7,869,477[76]
Payment adjustment amount (subject to cap)	**$ 1,339,230**

As the calculated payment adjustment amount of $1,339,230 is less than the cap of $1,711,349, the Board determines that West Branch's VDA payment for FY 2009 should be $1,339,230.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated West Branch's FY 2009 VDA payment and that West Branch should receive a total VDA payment of $1,339,230 for FY 2009.

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2/22/2022

X Clayton J. Nix

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

[74] *Id.*
[75] *See* Exhibit P-1 at 36. The cost report was re-run to remove variable costs and the Medicare IP operating costs were calculated to be $9,208,707 (also reported in Stipulations at ¶ 10). This amount reflects 78.2558361 percent of the 2010 Inpatient Operating Costs of $11,767,438. This fixed cost percentage was rounded to 78.26 percent in the Stipulations at ¶ 10.
[76] The $7,869,477 is calculated by multiplying $10,056,089 (the FY 2009 SCH payments) by 0.7825583615 (the fixed cost percentage determined by the Medicare Contractor). The fixed cost percentage has been rounded to 78.26 percent for brevity.