PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2022-D27

PROVIDER-
Ridgecrest Regional Hospital

HEARING DATE –
October 20, 2021

PROVIDER No.: 05-0448

Cost Reporting Period Ended –
08/07/2012

vs.

MEDICARE CONTRACTOR –
Noridian Health Solutions c/o Cahaba Safeguard Administrators

CASE NO. 16-1817

CONTENTS

ISSUE STATEMENT

Whether the Medicare Contractor properly determined the sole community hospital ("SCH") volume decrease adjustment ("VDA") granted for the short fiscal year ending August 7, 2012 ("Short Period 2012").[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor did not properly calculate the VDA payment for the Short Period 2012, and that Ridgecrest Regional Hospital ("Ridgecrest" or "Provider") should receive an additional VDA payment in the amount of $238,211 for the Short Period 2012.

INTRODUCTION

Ridgecrest is an acute care hospital located in Ridgecrest, California[2] and was designated as an SCH during the Short Period 2012.[3] The Medicare contractor[4] assigned to Ridgecrest for this appeal is Noridian Healthcare Solutions ("Medicare Contractor"). Ridgecrest requested a VDA in the amount of $1,215,676 for the Short Period 2012.[5] The Medicare Contractor issued a VDA in the amount of $596,430 for the Short Period 2012.[6] Ridgecrest timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board held a video hearing on October 20, 2021. Ridgecrest was represented by Ronald 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 SCHs if, due to circumstances beyond their control, they incur a decrease in their total number of inpatient discharges of more than 5 percent from one cost reporting year to the next.[7] VDA payments are designed to compensate an SCH for the fixed costs it incurs in providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.[8] The implementing regulations, located at 42 C.F.R. § 412.92(e), reflect these statutory requirements.

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[1] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3.
[2] Stipulations of the Parties (hereinafter "Stipulations") at ¶ 1.
[3] *Id.*
[4] 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.
[5] Exhibit C-5 at 2.
[6] Stipulations at ¶¶ 5, 10.
[7] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[8] *Id.*

It is undisputed that Ridgecrest experienced a decrease in total discharges greater than 5 percent during the Short Period 2012 due to circumstances beyond its control and that, as a result, Ridgecrest was eligible to have a VDA calculation performed.[9] At the request of Ridgecrest, the Medicare Contractor performed the VDA calculation and it determined that Ridgecrest was entitled to a VDA payment in the amount of $596,430 for the Short Period 2012.[10]

The regulation at 42 C.F.R. § 412.92(e) 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) (2012) states:

> (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 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).
>
> (i) In determining the adjustment amount, the intermediary *considers –*
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> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter. . . .[11]

As CMS noted in the preamble to the final rule published on August 18, 2006, the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2810.1 (Rev. 371) provides further guidance related to VDAs.[12] Specifically, § 2810.1(B) (Rev. 371) states:

> B. Amount of Payment Adjustment.—Additional payment is made to an eligible SCH 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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[9] Provider's Consolidated Final Position Paper (hereinafter "Provider's FPP") at 2; Stipulations at ¶ 4; Exhibit C-7 at 2.
[10] Stipulations at ¶¶ 5, 10.
[11] (Emphasis added.)
[12] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).

> 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.[13]

The chart below depicts how the Medicare Contractor and Ridgecrest each originally calculated the VDA payment for the Short Period 2012.

	Medicare Contractor calculation using fixed costs[14]	Provider calculation using total costs[15]
a) Prior Year Medicare Inpatient Operating Costs	$4,579,499[16]	$4,923,909
b) IPPS update factor	1.019	1.019
c) Prior year Updated Operating Costs (a x b)	$4,666,510	$5,017,463
d) Short Period 2012 Operating Costs	$4,979,823	$4,979,923
e) Lower of c or d	$4,979,923[17]	$4,979,923
f) DRG/SCH payment	$3,450,836	$3,450,836
g) Cap (e-f)	$1,529,087	$1,529,087
h) Short Period 2012 Inpatient Operating Costs	$4,666,510[18]	$4,979,923
i) Fixed Cost percent	.8673[19]	1.000[20]
j) Short Period 2012 Fixed Costs (h x i)	$4,047,266	$4,979,923
k) Total DRG/SCH Payments	$3,450,836	$3,450,836
l) VDA Payment Amount (Note, the Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 596,430	
m) VDA Payment Amount (The Provider's VDA is based on the amount line j exceeds line k.)		$1,529,087

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[21] Additionally, Ridgecrest maintains that the Medicare Contractor should have taken into consideration the fact that Ridgecrest's overall discharges decreased by 10.3 percent,while its Medicare discharges decreased by 3.3 percent, thereby creating an alleged anomalous result for the

[13] (Emphasis added.)
[14] Stipulations at ¶ 10.
[15] Stipulations at ¶ 7.
[16] This is a partial-year calculation – based upon the full prior year costs ($8,844,010) and the portion of the current short period (from February 1, 2012 to August 7, 2012, which is 189 days). The Medicare Contractor divided the 189 days by 365 days, to arrive at a fraction of 0.517808. ($8,844,010 x 0.517808 = $4,579,499).
[17] The Medicare Contractor incorrectly used the Current Year costs to calculate the Ceiling on Exhibit P-2, even though the lesser was the Prior Year Updated costs.
[18] Stipulations at ¶ 10. The Medicare Contractor used the inpatient operating costs from the prior year. The prior year amount is only used to establish the cap. The Short Period 2012 amount should have been included on this line.
[19] Stipulations at ¶ 10. The Medicare Contractor used the fixed cost to charge ratio from the prior year.
[20] Provider's FPP at 10. Ridgecrest states that "[n]owhere in the Federal Register [dated August 19, 2008 at 48630-35] does it say to subtract variable costs from the Provider's costs." As a result, the fixed cost is stated as 100 percent.
[21] Stipulations at ¶ 12.

VDA adjustment.[22] The Medicare Contractor disagrees that these facts result in an anomalous result for the VDA adjustment.[23]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Ridgecrest asserts that the Federal Register does not specifically state that variable costs should be removed from total costs to compute the VDA.[24] In contrast, the Medicare Contractor asserts that Ridgecrest has misinterpreted the Federal Register and, in support of its position, it cites to the decision underlying that of the U.S. Court of Appeals for the Eighth Circuit ("Eighth Circuit") in *Unity Healthcare v. Azar* ("*Unity*").[25]

The Medicare Contractor identified fixed and variable costs on Ridgecrest's cost report for the Short Period 2012, through its analysis of Ridgecrest's expense summary. The Medicare Contractor contends that specific instructions to determine the fixed/semi-fixed costs are not included in the statute, regulations or PRM 15-1. Therefore, the Medicare Contractor contends that it used the cost report to develop a reasonable method of calculating fixed/semi-fixed costs and argues that the Administrator agreed with this approach which was found to be consistent with the regulation and not arbitrary or capricious in the *Unity* decision.[26]

The Medicare Contractor insists it properly calculated and processed Ridgecrest's request for VDA payment for the Short Period 2102, including limiting the VDA payment to Ridgecrest's fixed costs. The Medicare Contractor states that the adjustments were made in accordance with 42 C.F.R. §4 12.92 . The Medicare Contractor also cites to CMS Pub. 15-1, § 2810.1(B) which states

> Additional payment is made to an eligible SCH 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 payment for inpatient operating costs.[27]

The Medicare Contractor further contends that, "[t]he intent of the VDA is to compensate qualified hospitals for their fixed costs and not their variable costs"[28] and that "[t]his is achieved by subtracting the DRG revenue from the fixed costs, thereby assuring `full compensation' for the fixed costs."[29] The Medicare Contractor has determined that Ridgecrest's fixed and semi-fixed cost percentage is 88.06 percent (11.94 percent variable),[30] and states this determination was based upon Ridgecrest's summary of its expenses by category.[31]

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[22] *Id*. at ¶ 6.
[23] *Id*.
[24] Provider's FPP at 10.
[25] 918 F.3d 571 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019); Medicare Contractor's FPP at 15.
[26] Medicare Contractor's FPP at 14-16 (discussing *Unity Healthcare v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. 2014-D15 (Sept. 4, 2014)).
[27] *See* Medicare Contractor's FPP at 7.
[28] *Id.* at 11.
[29] *Id.* at 12.
[30] Exhibit C-8.
[31] Medicare Contractor's FPP at 11.

In support of its position, the Medicare Contractor cites several CMS Administrator decisions, and also to the decision of the U.S. Court of Appeals in the Eighth Circuit for *Unity Healthcare v. Azar*.[32]

Ridgecrest argues that the Medicare Contractor's calculation of the VDA was wrong because the Medicare Contractor "departed from CMS' [PRM 15-1] manual instructions and step-by-step guide and added an unauthorized and monumental extra step."[33] Ridgecrest argues the Medicare Contractor's methodology for calculating the VDA was flawed, and "did not fully compensate the Provider for all of its fixed costs as Congress requires."[34] According to Ridgecrest, the Medicare Contractor improperly calculated Ridgecrest's Medicare fixed costs, and included an additional adjustment by removing variable costs in the VDA payment calculation.[35]

Ridgecrest states the Medicare Contractor changed the VDA payment calculation without going through notice-and-comment rulemaking, and this unlawfully changed the regulation. Ridgecrest's position is that the "[VDA payment] methodology in effect during the four years under appeal was the one described in section 2810.1 of the PRM, as formally adopted and modified in the IPPS rulemakings for FYs 2007 and 2009."[36]

Ridgecrest reasons that, in applying the methodology previously adopted by the Board, the DRG component of the VDA calculation is multiplied by the percentage of fixed program costs to total program costs to calculate the fixed portion of the DRG payments. Then, fixed DRG payments are deducted from fixed program costs to calculate the VDA payment. Ridgecrest also references the fact that CMS adopted a nearly identical methodology in the IPPS Final Rule for FFY 2018.[37]

The Board finds that there are three disagreements between Ridgecrest and the Medicare Contractor regarding the computation of the VDA payment for the Short Period 2012. First, Ridgecrest asserts that it fits the criteria for consideration of an adjustment for an anomalous result pursuant to PRM 15-1 § 2810.1(D)(2),[38] and has provided a calculation to adjust the prior year's Medicare inpatient operating costs to reflect the current year's Medicare utilization.[39] Ridgecrest revised the Medicare Inpatient operating cost for the Short Period 2012 to be included in the VDA calculation utilizing certain information from the cost reports for the fiscal year ending January 31, 2012 and the Short Period 2012.[40] The Board asked a number of questions during the hearing to understand, among other information points: (1) the large increase in costs between the periods;[41] (2) why total revenue increased so drastically between the periods;[42] (3) what caused the increase in the Medicare utilization in the Short Period 2012.[43] Ridgecrest was unable to answer many of the questions regarding the information that it used to revise its Medicare Inpatient operating costs for the Short Period 2012. Ridgecrest also identified certain statistical changes to support its

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[32] *Id*. at 14-16.
[33] Provider's FPP at 11.
[34] *Id.* at 12.
[35] *Id.*
[36] *Id.* at 15.
[37] *Id*. at 13.
[38] *Id*. at 6.
[39] *Id.* at 8, Table 2.
[40] Exhibit P-7.
[41] Transcript (hereinafter "Tr.") at 52, 53, 76. Questions were posed by the Board related to large increase in costs associated with Lab and implant devices.
[42] *Id.* at 59-62, 72.
[43] *Id*. at 59, 66, 76.

proposed adjustment to account for the alleged anomalous result. However, Ridgecrest failed to address other changes which could undermine that same calculations.[44]

Significantly, the Board also notes that Ridgecrest converted from an acute care PPS hospital, which qualified as an SCH, to a Critical Access Hospital, which was not paid under IPPS as of the cost report end date of August 7, 2012.[45] This transition relates to Ridgecrest's alleged anomalous situation contention because the change resulted in a hospital with significantly fewer beds, contributing to the substantial changes between the cost report periods.[46] The instructions at PRM 15-1 § 2810.1(D) state 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." As Ridgecrest was preparing to convert, on August 8, 2012, to a CAH, knowing that a reduction to 25 or less beds[47] is required for a CAH designation, it could be expected that Ridgecrest would have budgeted for lower utilization, rather than budgeting simply based on the prior year when the hospital's operations were significantly different. This also indicates Ridgecrest's apparent intent to the inflate prior year operating costs for the purposes of the increasing the potential VDA payment through capitalizing on the process of converting to CAH status. Thus, at a minimum, a part of the significant changes between the cost report periods ***was*** within Ridgecrest's control. Accordingly, in light of the lack of guidance from CMS regarding the Medicare Contractor's exercise of discretion, Board declines to opine whether or not the VDA calculation produced an anomalous result to thereby trigger consideration of whether an adjustment would be justified.

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[48] and the regulations[49] all state that the VDA is only to include fixed (and semi fixed) costs in the VDA calculation. PRM 15-1 § 2810.1(B) states that "[a]dditional payment is made to an eligible SCH 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 payment for inpatient operating costs."[50]

The third dispute between the parties is the portion of the IPPS inpatient payment amount that should be used in the VDA calculation. These parties, as well as numerous other providers and Medicare Contractors, dispute whether the IPPS payment should be reduced to exclude that portion of the DRG payments related to variable costs. Ridgecrest believes that, because the Medicare Contractor reduced the Medicare inpatient operating costs for variable costs, it must do the same to the IPPS payments.[51]

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[44] *Id*. at 78.
[45] *Id*. at 35.
[46] *Id*. at 70-75.
[47] *Id*. at 70.
[48] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[49] 42 C.F.R. § 412.92(e)(3)(i)(B).
[50] (Emphasis added.)
[51] Provider's FPP at 12-13.

In recent Board decisions addressing VDA payments,[52] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because that methodology compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. 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 the underlying purpose of the VDA amount. . . . The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[53]

Recently, the 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."[54]

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.[55]

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

[53] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).

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

[55] (Bold and italics emphasis added.)

Moreover, the Board notes that Ridgecrest 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,[56] 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.[57] 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."[58]

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 Ridgecrest's VDA methodology for the Short Period 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 Ridgecrest's VDA payment by comparing the fixed costs from the Short Period 2012 to its total DRG payments. However, neither the language nor the examples[59] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[60] and the FFY 2009 IPPS Final Rule[61] reduce the hospital's cost *only* by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> [T]he adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or SCH 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 Ridgecrest'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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[56] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[57] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e)(3).
[58] 82 Fed. Reg. at 38180.
[59] PRM 15-1 § 2810.1(C)-(D).
[60] 71 Fed. Reg. at 48056.
[61] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

Rather, the Board finds the Medicare Contractor calculated Ridgecrest's VDA for the Short Period 2012 based on an otherwise *new* methodology that, apparently, the Administrator adopted through adjudication in her decisions. This calculation can be described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling . . . ."[62] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the methodology explained in the FFY 2007 and 2009 IPPS Final Rules/PRM and the statute. Notably, in applying this new methodology through adjudication, CMS did not otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[63]

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

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

In the final rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule"), the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[65] However, the VDA payment methodology, as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 (rev. 356), 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,

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[62] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm'r Dec. 2017-D1 at 12 (Feb. 9, 2017).
[63] 82 Fed. Reg. at 38179-38183.
[64] (Emphasis added.)
[65] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> 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***.[66]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule both of which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing, through adjudication, a new methodology in the Administrator decisions stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling . . . ."[67]

Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs . . . ."[68] Using the Administrator's rationale, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment ***only*** *for the* ***fixed*** *costs* of the services actually furnished to Medicare patients. However, the statute at 42 U.S.C. § 1395ww(a)(4) makes clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines operating costs of inpatient services as "**all** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]" The Administrator cannot simply ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments solely for the fixed cost of the Medicare services actually rendered when the hospital, in fact, incurred both fixed and variable costs for those services.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an SCH for all the fixed costs associated with the qualifying volume decrease. 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

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

the directive in 42 C.F.R. § 405.92(e)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[69] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable 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 is payment for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year, *as well as* its full fixed costs in that year.

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

Ridgecrest also argues that "[s]ince the publication of the Federal Register in 2008 some . . . [Medicare Contractors] began to change their methodology . . . . without following the legal notice and comment period . . . ."[70] of the Medicare Statue by adopting a new methodology of adjudication. According to the Board hearing transcripts in *Unity Healthcare v. Wisconsin Physicians Services*,[71] the change was driven by Wisconsin Physician Services. Ridgecrest argues that the change in the VDA methodology is a rule that cannot take effect without going through the notice and comment process. In its Final Position Paper, Ridgecrest refers to the "*Allina v. Burwell* (D.C. Court of Appeals Case No. 16-5255) ruling that `HHS unlawfully failed to provide for notice and comment.'"[72]

In support of its position, Ridgecrest states that "[t]he process for determining the amount of the volume decrease adjustment can be found in Section 2810.1 of the Provider Reimbursement Manual . . . ."[73] It notes that none of the examples show variable costs being removed from the VDA calculation. However, the Board notes that these examples relate to the cap and not the actual VDA calculation as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

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[69] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) instructs the Medicare contractor to "consider []" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.
[70] Provider's FPP at 15.
[71] Exhibit P-8 (at transcript pages 319-323).
[72] Provider's FPP at 15.
[73] *Id.* at 10 (*quoting* 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008)).

> 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.*[74]

Accordingly, what Ridgecrest 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."[75] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[76] 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.[77] 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) is not inconsistent with adopting a substantive policy through adjudication; which is different than when CMS posted on its website a "nationwide" adoption of new substantive policy as discussed in *Allina*.[78] Indeed, the Board notes that VDA calculations by their very nature are provider specific and subject to appeal as delineated at 42

[74] 918 F.3d 571, 578-79 (8th Cir. 2019) *cert. denied*, 140 S. Ct. 523 (2019) (footnotes omitted; bold and italics emphasis added).
[75] Moreover, the fact that this particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[76] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[77] *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1808, 1810 (2019).
[78] *Id.*

C.F.R. § 412.92(e)(3).[79] The Board has had long standing disagreements with Medicare contractors and the Administrator on the different interpretations and the application of the relevant statutes, regulations and Manual guidance on how to calculate VDAs.[80] Accordingly, the Board rejects Ridgecrest's APA and *Allina* arguments.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5) 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.[81] 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. Thus, 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 § 2810.1 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 Ridgecrest's fixed costs (which included semi-fixed costs) were 88.06 percent[82] of Ridgecrest's Medicare costs for the Short Period 2012. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

Short Period 2012 Medicare Inpatient Operating Costs	$8,844,010[83]
Multiplied by the IPPS update factor	1.019[84]
Prorated Portion for Short Period 2012	0.517808[85]
Short Year 2012 Updated Costs (max allowed)	$4,666,510
Short Year 2012 Medicare Inpatient Operating Costs	$4,979,923[86]

[79] 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."
[80] *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, application of the PRM definitions of the terms "fixed" "semi-fixed" and "variable" costs 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.
[81] 48 Fed. Reg. at 39782.
[82] Exhibit C-7.
[83] Exhibit C-7; Exhibit P-3 at 99. This amount does not include an adjustment for an anomalous result per PRM 15-1 § 2810.1(D)(2). The amount reported in line A in Stipulation ¶ 11 includes an adjustment for an anomalous result. However, the Board notes that Stipulation ¶ 11 states that the "MAC [Medicare Contractor] does not believe that an adjustment for an anomaly is appropriate."
[84] Stipulations at ¶ 11.
[85] *Id.*
[86] *Id;* Exhibit P-4 at 210.

Lower of Updated Costs	$4,666,510
Less Short Year 2012 IPPS payments	$3,831,869[87]
Short Year 2012 Payment Cap	**$ 834,641**

Step 2: Calculation of VDA

Short Year 2012 Medicare Inpatient Fixed Operating Costs	$4,385,320[88]
Less Short Year 2012 IPPS payments – fixed portion (88.06 percent[89])	$3,374,344[90]
Payment adjustment amount (subject to Cap)	**$1,010,976**

Since the payment adjustment amount of $1,010,976 is greater than the cap of $834,641, the Board determines that Ridgecrest's VDA payment for the Short Period 2012 should be $834,641 (*i.e.*, the cap). Since Ridgecrest was already awarded a VDA payment of $596,430, Ridgecrest is due an additional payment in the amount of $238,211 for the Short Period 2012.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor did not properly calculate the VDA payment for the Short Period 2012, and that Ridgecrest should receive an additional VDA payment in the amount of $238,211 for the Short Period 2012.

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FOR THE BOARD:

9/12/2022

X Clayton J. Nix

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

[87] Exhibit P-4 at 217. Added Worksheet E ,Part A, Line 49, Total payment for inpatient operating costs of $3,450,836 to Worksheet E, Part A, Line 70.96, Low volume adjustment of $381,033.
[88] Exhibit C-7 at 2;Stipulations at ¶ 11.
[89] Exhibit C-8.
[90] Calculation = $33,831,869 * 0.8806 = $3,374,344.