PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D40

PROVIDER-

Riverside Shore Memorial Hospital

Provider No.: 49-0037

vs.

MEDICARE CONTRACTOR –
Palmetto GBA

RECORD HEARING DATE –
April 4, 2022

Cost Reporting Period Ended –

12/31/2013

CASE NO. 17-1544

CONTENTS

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated and denied the Volume Decrease Adjustment ("VDA") owed to Riverside Shore Memorial Hospital ("Riverside" or "Provider") for its cost reporting period ending December 31, 2013 ("FY 2013").[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("PRRB" or "Board") finds that the Medicare Contractor improperly calculated Riverside's VDA payment for FY 2013, and that Riverside should receive a VDA payment in the amount of $185,881 for FY 2013.

INTRODUCTION

Riverside, an acute care hospital in Nassawadox, Virginia, was designated as a sole community hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Riverside for this appeal is Palmetto GBA ("Medicare Contractor"). Riverside requested a VDA payment of $206,031 for FY 2013 to compensate it for a decrease in inpatient discharges during FY 2013.[4] The Medicare Contractor found that Riverside's was not eligible for an additional lump sum VDA payment because "the Provider's inpatient prospective payment system (IPPS) payments for its operating costs exceeded the Provider's allowable inpatient fixed and semi-fixed operating costs."[5] Riverside timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved the parties' request for a record hearing on April 4, 2022. Riverside was represented by Ronald Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Wilson C. Leong of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

The Medicare program 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 total inpatient discharges of more than 5 percent from one cost reporting year to the next.[6] VDA

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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(March 7, 2022).
[3] CMS's payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs"), but 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] Medicare Contractor's FPP at 9; Stipulations at ¶ 7.
[5] Stipulations at ¶ 6.
[6] Exhibit C-4 at 4. *See also* 42 C.F.R. § 412.92(e)(1).

payments are designed "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."[7] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that Riverside experienced a decrease in inpatient discharges of greater than 5 percent from FY 2012 to FY 2013 due to circumstances beyond Riverside's control and that, as a result, Riverside was eligible to have a VDA calculation performed for FY 2013.[8] The Provider requested a VDA payment in the amount of $206,031 for FY 2013.[9] However, when the Medicare Contractor calculated the FY 2013 VDA, it determined that Riverside was not entitled to a VDA payment because it was fully compensated for its fixed/semi-fixed costs.[10]

Once an SCH demonstrates it suffered a qualifying decrease in total inpatient discharges for its cost reporting period, the regulation at 42 C.F.R. § 412.92(e) directs how the Medicare Contractor must determine a lump sum VDA adjustment. In pertinent part, § 412.92(e)(3) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[11] the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs . . . .
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> (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; . . . .

In the preamble to the final rule published on August 18, 2006,[12] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 371), which provides further guidance related to calculating VDAs stating, in relevant part:

> B. Amount of Payment Adjustment.—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.

[7] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[8] Stipulations at ¶ 3.
[9] Provider's Consolidated Final Position Paper (hereinafter "Provider's FPP") at 3.
[10] Exhibit C-2 at 1.
[11] (Emphasis added.)
[12] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary *directly*[13] with utilization, such as food and laundry costs.

The chart below depicts how the Medicare Contractor and Riverside each calculated the VDA payment:

	Medicare Contractor (calculation using fixed costs)[14]	Provider (calculation using total costs)[15]
a) Prior Year (2012) Medicare Inpatient Operating Costs	$ 12,650,039	$ 12,650,039
b) IPPS Update Factor[16]	1.019	1.026
c) Prior Year Updated Operating Costs (a x b)	$ 12,890,390	$ 12,978,940
d) FY 2013 Operating Costs	$ 10,833,487	$ 10,833,487
e) Lower of c or d	$ 10,833,487	$ 10,833,487
f) DRG/SCH Payment	$ 10,627,456	$ 10,627,456
g) CAP (e - f)	$ 206,031	$ 206,031
h) FY 2013 Inpatient Operating Costs	$ 10,833,487[17]	
i) Fixed Cost Percent	90.22 percent[18]	
j) FY 2013 Fixed Costs (h x i)	$ 9,773,972	
k) Total DRG/SCH Payments	$ 10,627,456[19]	
l) VDA Payment Amount (Medicare Contractor's VDA is the amount line j exceeds k)	**$ 0**[20]	
m) VDA Payment Amount (the Provider's VDA is based on the amount line e exceeds line f)		**$ 206,031**

The parties to this appeal dispute the application of the statute and regulations used to calculate the VDA payment.[21]

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[13] (Emphasis added.)
[14] Stipulations at ¶ 10.
[15] *Id.* at ¶ 7.
[16] The parties do not agree on the correct IPPS Update Factor. However, the update factor does not impact the VDA payment calculations since current year operating expenses are lower than prior year operating expenses. *See* Stipulations at ¶ 12.
[17] Stipulations at ¶ 10.
[18] *Id.* (Percentage of current year fixed program costs to current year total program costs).
[19] *Id.*
[20] Exhibit C-3 at 1 (finding that the calculated amount would be negative, the Medicare Contractor determined no (or $0) VDA payment is due)).
[21] Stipulations at ¶ 13.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor and the Provider do not dispute that the criteria were met to qualify Riverside for a VDA calculation to be conducted, but they disagree on the proper methodology to use when calculating the VDA payment in accordance with the statute and regulations.[22]

The Medicare Contractor's Position

The Medicare Contractor disagrees with Riverside's assertion that the Federal Register does not specifically state that variable costs should be removed from total costs to compute the VDA.[23] The Medicare Contractor asserts that Riverside has misinterpreted the Federal Register. In support of its position, the Medicare Contractor cites to the U.S. Court of Appeals for the Eighth Circuit's ("Eighth Circuit") decision in *Unity Healthcare v. Azar* ("*Unity*")[24] and the Administrator's decisions in *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross Blue Shield Association*,[25] *St. Anthony Regional Medical Center v. Wisconsin Physician Service*,[26] and *Trinity Regional Medical Center v. Wisconsin Physician Services*.[27,28]

The Medicare Contractor identified variable costs through an analysis of the working trial balance and Worksheet A of Riverside's cost report. Those variable expenses were excluded from the VDA calculation.[29] The Medicare Contractor references PRM 15-1 § 2810.1(B) as support for removing variable costs in the VDA calculation, because it states that, "[a]dditional payment is made to an eligible SCH for the fixed costs it incurs in the period … not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue."[30] The Medicare Contractor utilizes Section 2810.1(B) which defines variable costs as "those costs for items and services that vary directly with utilization such as food and laundry costs."[31] The Medicare Contractor also references the regulation at 42 C.F.R. § 412.92(e)(3), which specifically notes that intermediaries should consider fixed (and semi-fixed) costs.[32] The Medicare Contractor thus asserts that this "explicit wording" shows that not all costs are to be considered in the VDA calculation.[33]

The Medicare Contractor states "[n]either the statute nor the regulation include a reference to

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[22] Medicare Contractor's FPP at 8.
[23] *Id.* at 12.
[24] *Id.* at 13 (citing *Unity Healthcare v. Azar*, 918 F.3d 571 (8th Cir. 2019)).
[25] *Id.* at 13-14 (citing *Fairbanks Mem'l Hosp. v. Wisconsin Physician Servs.* ("*WPS*"), Adm'r Dec. (Aug. 5, 2015) *modifying* PRRB Dec. 2015-D11 (June 9, 2015).
[26] *Id.* at 14 (citing *St. Anthony Reg'l Med. Ctr. v. WPS*, Adm'r Dec. (Oct. 3, 2016) *modifying* PRRB Dec 2016-D16 (Aug. 29, 2016).
[27] *Id.* at 14 (citing *Trinity Reg'l Med. Ctr. v. WPS*, Adm'r Dec. (Feb. 9, 2017) *modifying* PRRB Dec. No. 2017-D1 (Dec. 15, 2016).
[28] The Medicare Contractor uses these cases as support for its proposition that it correctly removed the provider's variable costs from the VDA calculation. Medicare Contractor's FPP at 13-14.
[29] Exhibit C-3 at 1-3.
[30] Medicare Contractor's FPP at 10.
[31] *Id.* at 11 (emphasis omitted).
[32] *Id.* at 11-12.
[33] *Id.* at 11.

compensation for variable costs," and further contends that 42 U.S.C. § 1395ww(d)(5)(D)(ii) "is quite clear when it states that the payment adjustment is '… to fully compensate the hospital for the fixed costs it incurs.'"[34] Without any reference to compensation for variable costs, the VDA calculation must only consider fixed and semi-fixed cost, as agreed upon by the Administrator in the *Unity*, *Lakes Regional*, and *Fairbanks* decisions.[35] The Medicare Contractor concludes that "[t]he evidence clearly demonstrates that variable costs are not to be considered in the calculation of the VDA."[36]

The Provider's Position

Riverside maintains that the Medicare Contractor's calculation of the VDA is wrong because the Medicare Contractor "departed from CMS' established policy and did not use the policy set forth in section 2810.1 of the PRM and summarized in Federal Register rulemaking."[37] This policy does not mention the removal of variable costs and, despite its earlier reference to fixed and semi-fixed costs, "none of the examples show variable costs being removed from the calculation . . . ."[38] Moreover, the Provider contends that "[r]emoving variable costs from the calculation would make the cap defined in the Regulations, in PRM 2810.1 and the calculation in the Federal Register unnecessary, as the cap would never be reached."[39] By removing variable costs, the Medicare Contractor "recalculated [Riverside's] inpatient operating costs as if the Provider did not have to provide any food, any drugs, any medical supplies, or any laundry services to its inpatients."[40] In doing so, the Provider argues that it was not fully compensated for all of its fixed costs.[41]

Riverside also claims the Medicare Contractor unlawfully changed the VDA payment calculation without going through notice-and-comment rulemaking, as required by the Medicare Statute and the Administrative Procedure Act.[42] The Provider finds this significant because a Medicare Contractor cannot alter its VDA calculation since "CMS is required to provide notice and a comment period" to change a rule.[43] Riverside's position is that "the applicable lawful regulations are those that were published in the Federal Register on August 19, 2008."[44]

The Board's Analysis

In recent decisions, the Board has consistently disagreed with the methodology used by various Medicare contractors to calculate VDA payments because it compares fixed costs to total DRG

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[34] *Id.* at 12 (emphasis omitted).
[35] *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D15 at 8 (Sept. 4, 2014); *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014); *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. 2015-D11 (August 5, 2015).
[36] Medicare Contractor's FPP at 16 (emphasis omitted).
[37] Provider's FPP at 6.
[38] *Id.* at 7.
[39] *Id.* .
[40] *Id.* at 6.
[41] *Id.* at 8.
[42] *Id.* at 11.
[43] *Id.*
[44] *Id.*

payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount.[45] In these cases, the Board recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and then 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 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 ….[46]

Recently, the Eighth Circuit ruled that the Administrator's methodology in *Unity*, "was not arbitrary or capricious and was consistent with the regulation."[47]

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.[48]

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[45] *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Serv.*, 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).

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

[47] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir.), *cert. denied*, 140 S. Ct. 523, 205 L. Ed. 2d 335 (2019).

[48] (Emphasis added.)

Further, the Board notes that Riverside 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*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[49] 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.[50] 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."[51]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As explained in detail below, the Board finds that the Medicare Contractor's calculation of Riverside's VDA for FY 2013 was incorrect because it was *not* based on CMS' stated policy set forth 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 Riverside's VDA payment by comparing its FY 2013 fixed costs to its total FY 2013 DRG payments. However, neither the language, nor the examples, in PRM 15-1 compare only the fixed costs to the 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 and the FFY 2009 IPPS Final Rule reduce the hospital's cost only by excess staffing (not by 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 adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Riverside's VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preambles to the FFY 2007 and FFY 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Riverside's FY 2013 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication. This

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[49] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[50] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).
[51] 82 Fed. Reg. at 38180.

calculation 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 . . . ."[52] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the statute and the methodology explained in the PRM, and endorsed in the FFY 2007 and 2009 IPPS Final Rules. 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.[53]

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 cost:

> 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."[54] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments. –….
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> 4. Cost Data. – The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost.*
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> D. Determination on Requests. – The payment adjustment is calculated under the same assumption used to evaluate core staff,

[52] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D16 at 8 (Sep. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Feb. 9, 2017).
[53] 82 Fed. Reg. at 38179-38183.
[54] 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.***[55]

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 . . . ."[56] 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 . . . ."[57]

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, 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 when 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

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[55] (Emphasis added.)
[56] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[57] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

assumption stated in PRM 15-1 § 2810.1D 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.[58] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce the 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 the 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 payments intended for variable costs, 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, therefore, concludes that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is also clear that the VDA payment is ***not intended to fully compensate the hospital for all of its variable costs***.[59] 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.

The Board reviewed the VDA regulations at 42 C.F.R. § 412.92(e). 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

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[58] 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.

[59] 48 Fed. Reg. at 39782.

payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 . . .).”[60] To determine which payments should be included in the hospital’s “total DRG revenue for inpatient operating costs,” the Board reviewed 42 C.F.R. § 412.92(d), which provides that SCHs are paid for inpatient operating costs based on:

> [W]hichever of the following amounts yields the greatest aggregate payment for these cost reporting period:
>
> i) The Federal payment rate applicable to the hospitals as determined under subpart D of this part.
>
> * * * *
>
> v) For cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate as determined under § 412.78.

Further, based on the language of the regulations at 42 C.F.R. §§ 412.64, 412.73, 412.75, 412.77 and 412.78(a), the Board finds that an SCH’s total DRG *revenues* for inpatient operating costs for FY 2013 includes both the amount paid for the DRGs *and* any potential additional amount paid based on the hospital-specific rate.

In addition, Riverside claims that CMS has changed the methodology for computing the VDA without following the legal notice and comment period and unlawfully changed regulations. [61] Riverside contends that the methodology in effect during the year 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.[62] 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 HealthCare v. Azar*:

> The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B) of the Manual, where the examples are located, contains “the process for determining the amount of the volume decrease adjustment.” See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006). However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is “not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.” In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, *the Board found “that the examples are intended to demonstrate* ***how to calculate the adjustment limit*** as opposed to

[60] 42 C.F.R. § 412.92(e)(3) (emphasis added.)
[61] Provider’s FPP at 11.
[62] *Id.* at 6.

> 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*.[63]

Accordingly, what the Provider 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."[64] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[65] 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.[66] Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as delineated at 42 C.F.R. § 412.92(e)(3).[67] Moreover, the Board has had long standing disagreements with Medicare contractors and the Administrator on their different interpretations and application of the relevant statutes, regulations and Manual guidance regarding the calculation of VDAs.[68] Accordingly, the Board rejects the Provider's argument.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to each DRG payment. Therefore, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case, the Medicare Contractor determined that Riverside's fixed costs (which includes semi-fixed costs) were 90.22 percent[69] of Riverside's Medicare costs for FY 2013. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

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[63] 918 F. 3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[64] Moreover, the fact that any particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[65] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[66] *Azar v. Allina Health Servs*., 139 S. Ct. 1804, 1808, 1810 (2019).
[67] 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."
[68] *See, e.g., Unity Healthcare v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Further, the application of the PRM definitions of the term's "variable" and "semi-fixed" 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.
[69] Stipulations at ¶ 10.

Step 1: Calculation of the Cap

2012 Medicare Inpatient Operating Costs	$ 12,650,039[70]
Multiplied by the 2013 IPPS Update Factor	1.019[71]
2012 Updated Costs (max allowed)	$ 12,890,390
2013 Medicare Inpatient Operating Costs	$ 10,833,487[72]
Lower of 2012 Updated Costs or 2013 Costs	$ 10,833,487
Less 2013 IPPS Payment	$ 10,627,456[73]
2013 Payment Cap	**$ 206,031**

Step 2: Calculation of VDA

2013 Medicare Inpatient Fixed Operating Costs	$ 9,773,972[74]
Less 2013 IPPS Payment – fixed portion (90.22 percent)[75]	$ 9,588,091[76]
Payment adjustment amount (subject to Cap)	**$ 185,881**

Since the payment adjustment amount of $185,881 is less than the Cap of $206,031, the Board determines that Riverside's VDA payment for FY 2013 should be $185,881.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Riverside's VDA payment for FY 2013, and that Riverside should receive a VDA payment in the amount of $185,881 for FY 2013.

Board Members Participating:

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For the Board:

9/30/2022

X Clayton J. Nix

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

[70] Stipulations at ¶ 11.
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.* (Calculated as Total 2010 IPPS Payment of $9,407,082 x 92.50 percent = 8,701,550).