PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

On the Record

2023-D11

PROVIDER-
Southwestern Vermont Medical Center

Provider No.:
47-0012

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
February 7, 2022

Cost Reporting Period Ended –
09/30/2010

CASE NO. – 17-0927

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly reopened the Original Volume Decrease Adjustment ("VDA") approval and whether the Medicare Contractor properly calculated the Revised VDA owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending September 30, 2010 ("FY 2010").[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 properly reopened the Original VDA approval for FY 2010 but improperly recalculated the VDA payment for Southwestern Vermont Medical Center ("Southwestern Vermont" or "Provider") for FY 2010, and that Southwestern Vermont should receive a VDA payment of $1,682,184 for FY 2010.

INTRODUCTION

Southwestern Vermont is an acute care hospital located in Bennington, Vermont and was designated as a Medicare dependent hospital ("MDH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Southwestern Vermont for this appeal is National Government Services, Inc. ("Medicare Contractor").

In order to compensate it for a decrease in inpatient discharges, Southwestern Vermont requested a VDA payment of $2,008,512 for FY 2010.[4] On October 9, 2015 the Medicare Contractor originally calculated Southwestern Vermont's FY 2010 VDA payment to be $2,008,512.[5] On January 22, 2016, the Medicare Contractor notified Southwestern Vermont that it was reopening the Original VDA approval "based on direction from the Center for Medicare and Medicaid Services (CMS)."[6] By letter dated September 26, 2016, the Medicare Contractor issued the Revised VDA Determination in the amount of $0 and recouped the original payment of $2,008,512.[7] Southwestern Vermont timely appealed the Medicare Contractor's Revised VDA Determination and met all jurisdictional requirements for a Board hearing.

At the parties' request, the Board approved a record hearing on February 7, 2022. Southwestern Vermont was represented by William H. Stiles, Esq. of Verrill Dana, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Second Revised Stipulations of the Parties at ¶ 18 (hereinafter "Stip.").
[2] Provider's Final Position Paper (hereinafter "Provider's FPP") at 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Exhibit (hereinafter "Ex.") P-2 at 10.
[5] Ex. P-3 at 1. *See also* Stip, at ¶ 11.
[6] Stip. at ¶ 12.
[7] *Id.* at ¶¶ 13, 14.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments. One of these payment adjustments is referred to as a VDA payment and it is available to MDHs if, due to circumstances beyond their control, they incur a decrease of more than 5 percent in the total number of inpatient discharges from one cost reporting year to the next.[8] VDA payments are designed "to fully compensate a hospital for the fixed costs that it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services."[9]

The implementing regulations are located at 42 C.F.R. § 412.108(d) (2010). When promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals ("SCHs").[10] Specifically, 42 C.F.R. § 412.108(d) (2010) states:

> (d) *Additional payments to hospitals experiencing a significant volume decrease.* (1) CMS provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, **due to circumstances as described in paragraph (d)(2) of this section, a more than 5 percent decrease in its total inpatient discharges** as compared to its immediately preceding cost reporting period . . . .
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> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement and **it must –** . . .
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> (ii) **Show that the decrease is due to circumstances beyond the hospital's control.**
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> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income

[8] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[9] *Id.*
[10] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> patients as determined under §412.106 and for indirect medical education costs as determined under §412.105).
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> (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;
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> (B) The hospital's fixed (and semi-fixed) costs . . . and
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> (C) The length of time the hospital has experienced a decrease in utilization.[11]

Significantly, § 412.108(d)(3) makes clear that, when calculating a VDA payment, the Medicare Contactor must take into account multiple factors including, but not limited to, "the individual hospital's needs and circumstances."

It is undisputed that Southwestern Vermont experienced a decrease in total discharges greater than 5 percent from FY 2009 to FY 2010 due to circumstances beyond its control and that, as a result, Southwestern Vermont was eligible to have a VDA calculation performed for FY 2010.[12] Southwestern Vermont requested a VDA payment in the amount of $2,008,512 for FY 2010.[13] The Medicare Contractor initially agreed with Southwestern Vermont and determined that Southwestern Vermont was entitled to a VDA payment of $2,008,512.[14] The Medicare Contractor later reopened and revised the VDA calculation to $0 after removing variable costs, based on direction from CMS.[15]

The chart below depicts how the Medicare Contractor and Southwestern Vermont each calculated the VDA payment leading to this appeal.

	Medicare Contractor calculation using fixed costs[16]	Provider/PRM calculation using total costs[17]
a) Prior Year Medicare Inpatient Operating Costs	$21,024,500	$21,024,500
b) IPPS update factor	1.0185	1.0185
c) Prior Year Updated Operating Costs (a x b)	$21,413,453	$21,413,453

[11] (Emphasis added.) *See also* 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[12] Stip. at ¶ 10.
[13] Medicare Contactor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 6.
[14] *Id.* at 6.
[15] *Id.* at 6-7.
[16] Ex. P-5 at 5. The Medicare Contractor's VDA calculation at P-5 was based upon the settled cost report for FYE 09/30/2010.
[17] Ex. P-2 at 35. Provider's VDA request calculation at P-2 was based upon the filed cost report for FYE 09/30/2010.

d) FY 2010 Operating Costs	$19,542,567	$19,542,567
e) Lower of c or d	$19,542,567	$19,542,567
f) DRG/MDH Payment	$17,534,055	$17,534,055
g) CAP (d-f)	$ 2,008,512	$ 2,008,512
h) FY 2010 Inpatient Operating Costs	$19,542,567	$19,542,567
i) Fixed Cost Percent	83.75[18]	N/A[19]
j) FY 2010 Fixed Costs (h x i)	$16,367,439	$19,542,567
k) Total DRG/MDH Payments	$17,534,055	$17,534,055
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$ 0	
m) VDA Payment Amount (The Providers VDA is based on the amount by which line j exceeds line k.)		$2,008,512

The parties to this appeal dispute the proper application of the statute, regulations and PRM 15-1 program instructions used to calculate a VDA payment.[20]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Southwestern Vermont states that "[f]ollowing its review of the Provider's VDA Request and any supplemental responses, the [Medicare Contractor] determined that the Provider's VDA Request satisfied the applicable statute, regulation and CMS program instructions. Accordingly, it approved the Provider's VDA Request and issued its Original VDA Approval. . . . of $2,008,512."[21]

Southwestern Vermont argues that:

> The [Medicare Contractor's] methodology for determining the Original [FY 2010] VDA Approval . . . was identical to the approach that it had consistently utilized (and reported to CMS) for over 25 years. In addition, the [Medicare Contractor's] approach was consistent with the plain language of the applicable statute, regulation, and CMS program instructions. Accordingly, the Provider did not appeal the Original VDA Approval pursuant to 42 U.S.C § 1395oo.[22]

[18] Ex. P-5 at 5. The Fixed Cost Percent was rounded from .837527585 percent to 83.75 percent.
[19] *See* the Provider's FPP at 10-11. Provider asserts that PRM 15-1 § 2810.1 and the preambles in the August 18, 2006 and August 19, 2008 Federal Registers make no mention of a removal of variable costs from the Provider's Operating Costs. Therefore, the Provider's calculation uses Total Operating Costs and Total DRG/MDH Payments.
[20] Stip. at ¶ 17.
[21] Provider's FPP at 5.
[22] *Id.*

By letter dated January 22, 2016, the Medicare Contractor notified Southwestern Vermont that it was reopening the Original VDA Approval for FY 2010.[23] Southwestern Vermont objected to the reopening, but provided the information requested. In a letter dated September 26, 2016, the Medicare Contractor issued its Revised VDA Determination, which identified a Revised VDA of $0 for FY 2010 and required the repayment of the original $2,008,512.[24]

According to Southwestern Vermont, the Medicare Contractor applied a new methodology to calculate the Revised VDA for FY 2010, as demonstrated by the workpapers attached the Revised VDA Approval.[25] Southwestern Vermont asserts that this brand new methodology was inconsistent with the plain language of the statute, regulation and CMS program instructions and was materially different from the approach taken by the Medicare Contractor, and reported to CMS, for over 25 years.[26]

The Medicare Contractor's request for revised VDA determination letter states that it was directed by CMS to review and recalculate Southwestern Vermont's Original VDA Approval to remove all variable costs.[27] Southwestern Vermont argues that the reopening did not comply with the regulation at 42 C.F.R. § 405.1885(c), and should therefore be deemed invalid, and the Revised VDA Determination deemed void.[28]

The Medicare Contractor argues that 42 C.F.R. § 405.1885(a) provides it the authority to revise a final determination under its own discretion, when it states:[29]

> (a) *General*. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision . . . .

The Medicare Contractor states that it discussed with CMS the inclusion of variable costs when calculating a VDA and determined that it needed to recalculate Southwestern Vermont's VDA.[30] As a result of these CMS discussions, the Medicare Contractor determined that variable expenses needed to be reviewed and removed from Southwester Vermont's Final VDA Determination calculation.[31] The Medicare Contractor notified Southwestern Vermont of this review and recalculation of the Revised VDA Determination in its January 22, 2016 letter.[32]

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[23] *Id. See also* Ex. P-4.
[24] Provider's FPP at 6. *See also* Ex. P-5.
[25] Provider's FPP at 6.
[26] *Id.*
[27] Ex. C-6.
[28] Provider's FPP at 13.
[29] Medicare Contractor's FPP at 9.
[30] *Id.*
[31] *Id.*
[32] *Id*. *See also* Ex. P-4.

The Medicare Contractor asserts that it "was bound to revise the VDA payments to remove the variable expenses in accordance with the plain language of [42 U.S.C. § 1395ww(d)(5)(G)(iii) and 42 C.F.R. § 412.108(d)].[33] Further, it argues that "it was authorized to make the revision to the Final VDA payment . . . under its own discretion in accordance with 42 C.F.R. § 405.1885(a)."[34]

The Medicare Contractor issued its original VDA approval on October 9, 2015.[35] The Medicare Contractor's subsequent Notice of Reopening was dated January 22, 2016,[36] in compliance with 42 C.F.R. § 405.1885(b)(1) (2010), which states:

> An own motion reopening is timely only if the notice of intent to reopen (as described in § 405.1887) is mailed no later than 3 years after the date of the determination or decision that is the subject of the reopening.

The Board finds that 42 C.F.R. § 405.1885(a) gives the Medicare Contractor the authority to reopen a determination, and the Notice of Intent to Reopen was issued within three (3) years from the prior determination. Thus, the Medicare Contractor properly reopened Southwestern Vermont's Original VDA Approval.

Southwestern Vermont claims that CMS' Revised VDA Determination methodology runs afoul of the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA")[37] and the Medicare statute at 42 U.S.C. § 1395hh(a).[38] Southwestern Vermont argues that CMS and/or the Medicare Contractor violated the APA by making a substantive change in the VDA calculation methodology that "operate[s] to the significant financial detriment of the Provider."[39] Further, Southwestern Vermont argues that "although CMS may be entitled to revise its interpretation of the VDA statute, such a drastic departure from its previous interpretation amounts to a substantive rule triggering the requirements of notice and comment rulemaking."[40] Southwestern Vermont states that, "[e]ven if the Revised VDA Approval Methodology does not amount to an improper substantive rule under the APA, the Supreme Court's recent decision in *Azar v. Allina Health Services* ("*Allina*"),[41] makes clear that the revision violates the Medicare Act's notice and comment rulemaking requirements"[42] which are found at 42 U.S.C. § 1395hh(a). The provisions of 42 U.S.C. § 1395hh(a)(2) specify, in pertinent part, that "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1)."

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[33] *Id.*
[34] *Id.*
[35] Stip. at ¶ 11.
[36] Ex. P-4 at 1.
[37] 5 U.S.C. Ch. 5. Provider's FPP at 19.
[38] Provider's FPP at 19, 29-32.
[39] *Id.* at 21.
[40] *Id.* at 28.
[41] 139 S. Ct. 1804 (2019).
[42] Provider's FPP at 29.

In support of its position, Southwestern Vermont asserts that the examples given at PRM 15-1 § 2810.1 "detail[] exactly how the [Medicare Contractor] is required to determine the VDA payment amount[,]" and that CMS and/or the Medicare Contractor improperly departed from this methodology.[43] However, the Board notes that these examples relate to the VDA cap (and not to the actual VDA calculation) as the U.S. Circuit Court for the Eighth Circuit ("Eighth Circuit") recently confirmed in *Unity HealthCare v. Azar*:

> The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B) of the Manual, where the examples are located, contains "the process for determining the amount of the volume decrease adjustment." See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006). However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, *the Board found "that the examples are intended to demonstrate* ***how to calculate the adjustment limit*** as opposed to determining which costs should be included in the adjustment." See *Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n*, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than "equal to," when describing the formula. *We conclude that the Secretary's interpretation was* ***not*** *arbitrary or capricious and was consistent with the regulation*.[44]

Accordingly, what Southwestern Vermont 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 VDA payments differently does not automatically mean there is a departure from a Medicare program *policy*.[45] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement

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[43] *Id.* at 20.

[44] 918 F.3d 571, 578-79 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019) (footnotes omitted) (bold and italics emphasis added).

[45] Moreover, the fact that this particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.

policy can be adopted through case-by-case adjudication.[46] This is different than the situation addressed 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.[47] The fact that CMS may have directed the Medicare Contractor to calculate the VDA in this particular case (or even on a case-by-case basis, as presented to CMS) is not inconsistent with adopting a substantive policy through adjudication, and is different from the *Allina* situation where CMS posted publicly on its website a "nationwide" adoption of a new substantive policy. Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as delineated at 42 C.F.R. § 412.108(d)(3).[48] Moreover, the Board has had long a standing disagreement with various Medicare contractors and the Administrator on their different interpretations and application of the relevant statulogilvietes, regulations and Manual guidance regarding the calculation of VDAs.[49] Accordingly, the Board rejects Southwestern Vermont's APA, Medicare statute, and *Allina* arguments.

Southwestern Vermont also argues that the Medicare Contractor's revised calculation of the VDA was incorrect because the methodology used guarantees that a hospital never receives full compensation for fixed costs.[50] According to Southwestern Vermont, the Medicare Contractor's Revised VDA Determination "improperly treats fixed (and semi-fixed) costs as variable costs, and confused inpatient and outpatient expenses"[51] and does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[52] Southwestern Vermont reasons that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should be a corresponding decrease to the DRG payments for variable costs. This method, Southwestern Vermont maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Specifically, Southwestern Vermont states that "basic logic requires the [Medicare Contractor] (at a minimum) to identify Medicare inpatient *fixed costs* and compare that figure to the total Medicare inpatient payments *received for those fixed costs.* The [Medicare Contractor]'s Revised VDA Approval Methodology fails to satisfy this simple, logical test."[53] Southwestern Vermont also references the fact that "CMS recently acknowledged that total MS-DRG

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[46] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius,* 718 F.3d 914 (D.C. Cir. 2013).
[47] 139 S. Ct. at 1808, 1810.
[48] 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."
[49] *See, e.g., Unity Healthcare v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA,* PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Similarly, the Provider fails to give any examples or support to its position that CMS and/or the Medicare Contractor are substantively changing policy as it relates to determining which costs are "treated" as variable versus semi-fixed in accordance with PRM 15-1 § 2810.1. *See, e.g.,* Provider's FPP at 31. Further, the application of the PRM definitions of these terms to a particular provider's VDA request seems to be the very nature of adjudicatory fact-finding and why providers may appeal Medicare contractor VDA determinations to the Board.
[50] Provider's FPP at 42.
[51] *Id*. at 14. *See also id.* at 42-45.
[52] *Id.* at 34.
[53] *Id.*

payments include a component designed to reimburse variable costs"[54] when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[55]

The Board notes that there is a difference in the FY 2010 Inpatient Operating Costs used by the parties in calculating the VDA payment. While Southwestern Vermont used the Total Inpatient Operating Costs, as reported on the cost report worksheet D-1, Part II, Line 53 in FY 2010, the Medicare Contractor calculated an adjusted amount of Inpatient Operating Costs to account for variable costs on the cost report.[56] Southwestern Vermont argues that the Medicare Contractor's VDA calculation methodology violates the statutes, regulations, and PRM 15-1 instructions.[57] The Board finds that variable costs are to be removed from Inpatient Operating costs *and* that the portion of payment related to these costs should be removed from the DRG payments.

In its recent decisions,[58] the Board has disagreed with the methodology used by various Medicare contractors (including the Medicare Contractor in this appeal) 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 hospital's VDA payment 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, resulting in 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 . . . .[59]

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[54] *Id.* at 35.
[55] 82 Fed. Reg. 37990, 38180 (Aug. 14, 2017).
[56] Medicare Contractor's FPP at 15, *See also* Ex. C-7 at 7-8.
[57] Provider's FPP at 13-14, 32-34, 43.
[58] *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).
[59] *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).

Recently, 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."[60]

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

> e. Nonprecedential Nature of the Administrator's Review Decision.—Decisions by the Administrator ***are not precedents*** for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy [*sic*] having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.[61]

Moreover, the Board notes that Southwestern Vermont 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,[62] 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 a VDA payment.[63] 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."[64]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As explained below, the Board finds that the Medicare Contractor's revised calculation of Southwestern Vermont's VDA for FY 2010 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.

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[60] *Unity HealthCare v. Azar,* 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).
[61] (Bold and italics emphasis added.)
[62] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[63] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).
[64] 82 Fed. Reg. at 38180.

The Medicare Contractor determined Southwestern Vermont's Revised VDA payment by comparing its FY 2010 fixed costs to its total FY 2010 DRG payments. However, neither the language nor the examples[65] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[66] and the FFY 2009 IPPS Final Rule[67] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> [T]he adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

It is clear from the preambles to these Final Rules that the only permissible adjustment to the hospital's cost for calculating the VDA is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Southwestern Vermont's VDA using the methodology laid out by CMS in PRM 15-1 or by the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Southwestern Vermont's Revised VDA for FY 2010 based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions. This methodology 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[.]"[68] 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.[69]

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

> In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control,

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[65] PRM 15-1 § 2810.1(C)-(D).
[66] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[67] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[68] *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 (Sep. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Feb. 9, 2017).
[69] 82 Fed. Reg. at 38179-38183.

> 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.[70]

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."[71] 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*. . . .
>
> 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.
>
> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
>
> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY

[70] (Emphasis added.)
[71] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

> 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***.[72]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule, which both 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."[73] 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."[74]

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

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an MDH for all the fixed costs associated with the qualifying volume decrease. 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 the prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 412.108(d)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[75] 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 are

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[72] (Emphasis added.)
[73] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[74] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[75] The Board recognizes that 42 C.F.R. § 412.108(d)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

payments for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year as well as its full fixed costs in that year.

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs incurred in the current year and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(G)(iii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG payment is payment for both fixed and variable costs - and deem the entire DRG payment as payment solely for fixed costs. Thus, 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.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(G)(iii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is clear that the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[76] 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 the Medicare services *actually* furnished. The Board concludes that, to ensure the hospital is fully compensated for its fixed costs and, to be consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board elects to use the Medicare Contractor's fixed/variable cost percentages as a proxy. The Board notes that Southwestern Vermont's Final Position Paper takes exception with the calculation of these percentages, stating:

> [T]he [Medicare Contractor]'s Variable Cost Proxy mistakenly included *outpatient* expenses, and then used these outpatient expenses to reduce total Medicare *inpatient* costs. Thus, even assuming that these categories of cost must be offset against total Medicare inpatient operating costs (which the Provider disputes), the [Medicare Contractor]'s Variable Cost Proxy necessarily overstated the amount of variable inpatient operating costs that should have been offset.[77]

However, both parties stipulated that:

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[76] 48 Fed. Reg. at 39782.
[77] Provider's FPP at 44-45.

> The Parties agree that, if the Board finds that the [Medicare Contractor]'s Original VDA Approval was not correct, the Provider's . . . fixed cost percentage was 83.75% as set forth in the workpaper attached to the [Medicare Contractor]'s Revised VDA Approval.[78]

Thus, the Stipulation supercedes the argument made in Southwestern Vermont's Final Position Paper. In this case, the Medicare Contractor determined that Southwestern Vermont's fixed costs (which include semi-fixed costs) were 83.75 percent[79] of Southwestern Vermont's Medicare costs for FY 2010. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2009 Medicare Inpatient Operating Costs	$21,024,500[80]
Multiplied by the 2010 IPPS update factor	1.0185[81]
2009 Updated Costs (max allowed)	$21,413,453
2010 Medicare Inpatient Operating Costs	$19,542,567[82]
Lower of 2009 Updated Costs or 2010 Costs	$19,542,567
Less 2010 IPPS payment	$17,534,055[83]
2010 Payment Cap	**$ 2,008,512**

Step 2: Calculation of VDA

2010 Medicare Inpatient Fixed Operating Costs	$16,367, 439[84]
Less Excess Staffing	
Less 2010 IPPS payment – fixed portion (83.75 percent)	$14,685, 255 [85]
Payment adjustment amount (subject to cap)	**$ 1,682,184**

Since the payment adjustment amount of $1,682,184 is less than the cap of $2,008,512, the Board concludes that Southwestern Vermont's total FY 2010 VDA payment should be $1,682,184.

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[78] Stip. at ¶ 21.
[79] *Id*.
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *Id*.
[84] The current year fixed operating costs are computed by multiplying the current year operating costs ($19,542,567) by the fixed cost percentage. The Medicare Contractor calculated the fixed costs as $16,367,439. This is based on the unrounded fixed cost percentage, per Ex. P-5, of 0.837527585, which is rounded to 83.75 percent.
[85] The $14,685,255 is calculated by multiplying $17,534,055 (the FY 2010 MDH payments; *see* Stip. at ¶ 21) by 0.837527585 (the unrounded fixed cost percentage as Stipulated at ¶ 21).

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly reopened the Original VDA Approval for FY 2010, but improperly recalculated Southwestern Vermont's VDA payment for FY 2010, and that Southwestern Vermont should receive a VDA payment of $1,682,184 for FY 2010.

Board Members:

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For the Board:

3/30/2023

X Clayton J. Nix

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