PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2024-D10

PROVIDER-
Nathan Littauer Hospital

Provider No.: 33-0276

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
June 28, 2023

Cost Reporting Period Ended –
12/31/2014

CASE NO. – 18-0547

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Nathan Littauer Hospital ("Nathan Littauer" or the "Provider") for the significant decrease in inpatient discharges that occurred during its cost reporting period ending December 31, 2014 ("FY 2014").[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated Nathan Littauer's VDA payment for FY 2014, and that Nathan Littauer should receive an additional VDA payment of $1,017,127 for FY 2014, resulting in a total FY 2014 VDA payment of $1,254,644.

INTRODUCTION

Nathan Littauer is located in Gloversville, New York and was designated as a Medicare dependent hospital ("MDH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Nathan Littauer for this appeal is National Government Services, Inc. ("Medicare Contractor").

Nathan Littauer requested a VDA payment of $1,282,543 for FY 2014 based on its contention that it experienced a qualifying decrease in inpatient discharges for FY 2014.[4] On July 28, 2017, the Medicare Contractor approved Nathan Littauer for a VDA and issued a final determination in which it calculated the Provider's FY 2014 VDA payment to be $237,517.[5] Nathan Littauer timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on June 28, 2023. Nathan Littauer was represented by William H. Stiles, Esq. of Verrill Dana, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments. One of these payment adjustments is referred to as a VDA payment and it is available to MDHs if, due to circumstances beyond their control, they incur a decrease in their total number of

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[1] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3; Stipulations at ¶¶ 15, 16.
[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 1.
[5] Ex. P-3 at 1. *See also* Stipulations at ¶ 11.

inpatient discharges of more than 5 percent from one cost reporting year to the next.[6] VDA 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. § 412.108(d) reflect and implement these statutory requirements.

It is undisputed that Nathan Littauer experienced a decrease in discharges greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond its control and that, as a result, Nathan Littauer was eligible to have a VDA calculation performed for FY 2014.[8] Nathan Littauer requested a VDA payment in the amount of $1,282,543 for FY 2014.[9] However, when the Medicare Contractor performed its FY 2014 VDA calculation, it determined that Nathan Littauer was entitled to a VDA payment of $237,517, after removing the cost it had identified as variable.[10] Thus, this appeal addresses whether Nathan Littauer is due an additional VDA payment and, in particular, the parties' disagreement regarding how that payment should be calculated.[11]

The implementing regulations are located at 42 C.F.R. § 412.108(d). 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").[12] The regulation at 42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates that it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.108(d)(3) (2014) states, in pertinent part:

> (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 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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[6] 42 C.F.R § 412.108(d)(1).
[7] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[8] Stipulations at ¶ 14.
[9] Medicare Contractor's FPP at 7-8; Ex. P-2 at 1.
[10] Medicare Contractor's FPP at 8-11; Ex. P-3 at 5.
[11] Stipulations at ¶¶ 14, 15.
[12] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> (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; and
>
> (C)The length of time the hospital has experienced a decrease in utilization.[13]

In the preamble to the final rule published on August 18, 2006,[14] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 371), which provides further guidance related to VDAs and states, in relevant part:

> B. Additional payment is made . . . for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
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> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary *directly* with utilization such as food and laundry costs.[15]

The chart below depicts how the Medicare Contractor and Nathan Littauer each calculated the VDA payment.[16]

	Medicare Contractor calculation using fixed costs[17]	Provider/PRM calculation using total costs[18]
a) Prior Year Medicare Inpatient Operating Costs	$ 9,409,851	$ 9,423,625
b) IPPS update factor	1.017	1.022
c) Prior year Updated Operating Costs (a x b)	$ 9,569,818	$ 9,630,945
d) Current Year Program Operating Costs	$ 9,488,972	$ 9,456,726
e) Lower of c or d	$ 9,488,972	$ 9,456,726
f) DRG/MDH payment	$ 8,052,960	$ 8,009,487
g) VDA Payment Cap (e-f)	$ 1,436,012	$ 1,447,239

[13] (Emphasis added.) See also 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[14] 71 Fed. Reg. at 47870, 48056 (Aug. 18, 2006).
[15] (Emphasis added).
[16] Ex. P-3.
[17] Ex. P-3 at 5.
[18] Ex. P-2 at 13. Provider's VDA request was based upon its filed cost report for FYE 09/30/2014. The Board notes that the parties have stipulated amounts/rates which are based upon the settled FYE 09/30/2014 cost report, which was used by the Medicare Contractor for its calculation. This variance in cost reports accounts for the variances in the Provider's calculation.

h) Current Year Inpatient Operating Costs	$ 9,488,972	$ 9,456,726
i) Fixed Cost percent	87.37%[19]	88.62%[20]
j) FY 2014 Fixed Costs	$ 8,290,477	$ 8,380,551
k) Total DRG Payments	$ 8,052,960	$ 7,098,007
l) VDA Payment Amount (The VDA is based on the amount line j exceeds line k)	$ 237,517	$ 1,282,543[21]
m) Lessor of Cap or VDA Payment	$ 237,517	$ 1,282,543

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[22]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor, after reviewing Nathan Littauer's VDA request (plus any supplements), calculated a VDA payment of $237,517, which Nathan Littauer argues "was approximately $1,045,026 lower than it should have been."[23] Nathan Littauer states that the "methodology for determining the VDA Approval was not consistent with its historical VDA Approval Methodology, the approach the [Medicare Contractor] had consistently utilized (and reported to CMS) for over 25 years."[24] Nathan Littauer also contends that the Medicare Contractor's "approach was *not* consistent with the plain language of the applicable statute, regulation, and CMS program instruction."[25]

Nathan Littauer also claims that the Medicare Contractor's VDA methodology is not only "arbitrary and capricious, but it also runs afoul of the notice and comment rulemaking requirements of the Administrative Procedures Act ("APA") and the Medicare Act."[26]

Nathan Littauer 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."[27] Further, Nathan Littauer contends 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."[28] Nathan Littauer 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*, . . . 139 S. Ct. 1804 (2019) ("Allina"), makes clear that the revision violates the Medicare Act's notice and comment rulemaking requirements."[29] Nathan Littauer notes that the provisions of 42 U.S.C. § 1395hh(a)(2) specify, in pertinent part, that "[n]o rule,

[19] Calculation = $60,272,206/$68,985,326 = 0.873696044, rounded to 0.8737. *See also* Ex. P-3 at 5.
[20] Calculation = $80,841,964/91,227,370 = 0.8861590995 rounded to 0.8862 (non-variable costs as a percentage of total costs). *See* Ex. P-2 at 46.
[21] Difference due to rounding ($8,380,550.58 - $7,098,007.38 = $1,282,543.20)
[22] Stipulations at ¶¶ 15, 16.
[23] Provider's FPP at 1.
[24] *Id.* at 4.
[25] *Id.*
[26] *Id.* at 14.
[27] *Id.* at 16.
[28] *Id.* at 22.
[29] *Id*. at 23.

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)."

In support of its position, Nathan Littauer 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[,]"[30] and that CMS and/or the Medicare Contractor improperly departed from this methodology.[31] However, the Board notes that these examples relate to the VDA cap and not 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, *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.*[32]

Accordingly, what Nathan Littauer 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, itself, may have previously calculated VDA payments differently does not automatically mean there is a departure from a Medicare program

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[30] *Id.* at 9.
[31] *Id.* at 15.
[32] 918 F.3d 571, 578-79 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019) (footnotes omitted) (bold and italics emphasis added).

policy.[33] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[34] 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 applied nationwide to all hospitals at one time.[35] 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 at42 C.F.R. § 412.108(d)(3).[36] Moreover, the Board has had long-standing disagreements with Medicare Contractors and the Administrator on their different interpretations and the application of the relevant statutes, regulations and Manual guidance regarding the calculation of VDAs.[37] Accordingly, the Board rejects Nathan Littauer's APA, Medicare statute, and Allina arguments.

Nathan Littauer 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.[38] According to Nathan Littauer, the Medicare Contractor's revised VDA determination "improperly treats fixed (and semi-fixed) costs as variable costs, and confuses inpatient and outpatient expenses."[39] Nathan Littauer contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[40] Nathan Littauer reasons that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. This method, Nathan Littauer maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed and variable costs. Specifically, Nathan Littauer 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."[41] Nathan Littauer also references the fact that "CMS recently acknowledged that total MS-DRG

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[33] Moreover, the fact that this particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[34] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius,* 718 F.3d 914 (D.C. Cir. 2013).
[35] 139 S. Ct. at 1808, 1810.
[36] This regulation specifies that the Medicare contractor "considers" three hospital specific factors "[i]n determining the [VDA] amount" and that this "determination is subject to review under subpart R of part 405 of this chapter."
[37] *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 27-28. 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.
[38] Provider's FPP at 34.
[39] *Id.* at 11.
[40] *Id.* at 27.
[41] *Id.* at 27-28.

payments include a component designed to reimburse variable costs"[42] when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[43]

The Board takes note of the fact that the exclusion of variable costs is not in contention, as both parties' calculations include a reduction in costs for calculated variable costs. Indeed, the amount of calculated variable costs are comparable, as Nathan Littauer identified 11.38 percent as the variable cost percentage,[44] while the Medicare Contractor identified 12.63% as the variable cost percentage.[45] The Medicare Contractor excludes the cost of the Skilled Nursing Facility excluded unit and the Outpatient Clinic in order to calculate the percentages for only the inpatient units and services, as evidenced by the calculations on page 8 of Exhibit P-3. Further, the Stipulations at ¶ 21 indicate that the parties have agreed to use the Medicare Contractor's fixed cost percentage of 87.37 percent (the inverse of the variable cost percentage). Accordingly, the Board finds that the Medicare Contractor was correct in removing variable costs from the inpatient operating costs and that the method used to identify and remove these costs was reasonable, based on the operations of the cost report and the data Nathan Littauer provided to the Medicare Contractor. However, the Board also finds that the comparable portion of the DRG payment related to variable costs should have been removed from the total DRG payment. The statute states that the VDA payment is to be adjusted "as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services."[46] The regulations state that to determine the payment the intermediary considers "[t]he hospital's fixed (and semi fixed) costs."[47] Further, the PRM states that "[a]dditional payment is made to an eligible [MDH] for the fixed costs it incurs in the period in providing inpatient hospital services."[48]

In recent decisions,[49] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because it 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 relevant Medicare contractor), then 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. . . .

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[42] *Id.* at 28
[43] 82 Fed. Reg. 37990, 38180 (Aug. 14, 2017).
[44] Ex. P-2 at 13.
[45] Ex. P-3 at 8.
[46] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[47] 42 C.F.R. § 412.108(d)(3)(i)(B).
[48] PRM 15-1 § 2810.1(B).
[49] *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).

> 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 . . . .[50]

Recently, as noted above, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[51]

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.[52]

Noting that Nathan Littauer is not in the Eighth Circuit and the statutes and regulations for VDAs for SCHs and MDHs are identical, the Board finds that these applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[53] As a result, the Board is not

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[50] *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).

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

[52] (Bold and italics emphasis added).

[53] With regard to SCHs, 42 U.S.C. § 1395ww(d)(5)(D)(ii), see, e.g., *St. Anthony Reg'l Hosp. v. Azar*, 294 F. Sup. 3d 768, 779 (N.D. Iowa 2018) (stating that § 1395ww(d)(5)(D)(ii) contains a gap as it directs that "the Secretary shall provide for such . . . payment . . . as may be necessary" and that "[t]he Secretary has filled that gap in a manner that I find to be reasonable in light of the statutory framework and purpose."), *aff.d*, *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019). With regard to SCHs, 42 C.F.R. § 412.92(e)(3), *see, e.g., id*. at 772, 781 (adopting the Magistrate's report which found that '"[t]he regulations promulgated by the Secretary in effect during the relevant time period did not provide a specific formula for calculating the VDA payment[,]'" and '"[i]nstead, the regulation directed that the following factors be considered in determining the VDA payment amount...'"). The Board's plain reading of the regulation is confirmed by the Agency's discussion of this regulation in the preamble to rulemakings. *See*, for SCHs, *e.g.*, 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987) (stating that "[w]e determine on a case-by-case basis whether an adjustment will be granted and the amount of that adjustment." (emphasis added)); 48 Fed. Reg. 39752, 39781-82 (Sept. 1, 1983).

bound to apply the specific VDA calculation methodology that the Administrator applied (and the Eighth Circuit upheld) in *Unity*.[54] In this regard, the Board further notes that §§ 412.92(e)(3) and 412.108(d)(3) make clear that the VDA payment determination is subject to review through the Board's appeal process.[55] Thus, the Board finds that the Eighth Circuit's *Unity* decision was simply adjudicating a dispute regarding the reasonableness of the Administrator's interpretation of the statute and regulations governing VDAs that the Administrator applied in rendering her decision in *Unity*. As such, the Eighth Circuit's decision in *Unity* is not binding precedent as to the specific VDA calculation methodology that the Board is obligated to follow.

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,[56] 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.[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 Nathan Littauer's VDA for FY 2014 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 Nathan Littauer's VDA payment by comparing its FY 2014 fixed costs to its total FY 2014 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 hospital's 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

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[54] *See*, *e.g.*, *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1107-08 (D.C. Cir. 2014) (discussing regulatory interpretations adopted through adjudication versus through rulemaking).

[55] Moreover, the Board notes that, subsequent to the Eighth Circuit's decision in *Unity*, the U.S. Supreme Court issued its decision in *Azar v. Allina Health Servs*, 139 S. Ct. 1804, 1810, 1817 (2019) ("Allina II") where the Supreme Court ruled on the scope of Medicare policy issuances that are subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) by making clear that "the government's 2014 announcement of the 2012 Medicare fractions [to be used in DSH calculations for FY 2012 where the Agency] 'le[t] the public know [the agency's] current adjudicatory approach' to a critical question involved in calculating payments for thousands of hospitals nationwide" was a "statement of policy that establishes or changes a substantive legal standard" as that phrase is used in 42 U.S.C. § 1395hh(a)(2) and, thus, was subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) (citations omitted).

[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. § 412.108(d)(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. at 48631.

hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

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

Rather, the Board finds the Medicare Contractor calculated Nathan Littauer's FY 2014 VDA based on an otherwise *new* methodology that the Administrator apparently adopted through adjudication. The Administrator describes this methodology 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]

42 U.S.C. § 1395ww(d)(5)(G)(iii) is clear that the VDA payment is to fully compensate the hospital for its fixed cost:

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

In the FFY 1984 IPPS Final Rule, the Secretary further explained the purpose of the VDA payment as follows: "The 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

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[62] *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).

[63] 82 Fed. Reg. at 38179-38183.

made for truly variable costs, such as food and laundry services."[64] 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 PRM 15-1 § 2810.1 states, in pertinent part:

> C. Requesting Additional Payments.—. . . .
>
> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
>
> 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 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***.[65]

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."[66]

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[64] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).
[65] (Emphasis added).
[66] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.

Based on its review of the statute, the 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."[67] 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 MDH for all the fixed costs associated with the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 405.108(d)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[68] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

Critical to the proper application of the statute, the regulation and the 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 and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(G)(iii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG payment is payment for both fixed and variable costs - and deem the entire DRG payment as payment solely for fixed costs. The Board concludes that the Administrator's methodology does

[67] 42 U.S.C. § 1395ww(d)(5)(G)(iii).

[68] The Board recognizes that 42 C.F.R. § 405.108(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.

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, the VDA payment is clearly not intended to compensate the hospital for its variable costs.[69] 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 both ensure the hospital is fully compensated for its fixed costs and be consistent with the assumption stated in PRM 15-1 § 2810.1 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 percentage as a proxy. In this case the Medicare Contractor determined that Nathan Littauer's FY 2014 fixed costs (which includes semi-fixed costs) were 87.37 percent[70] of the Provider's Medicare total costs for FY 2014. Applying the rationale described above, the Board finds that the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2013 Medicare Inpatient Operating Costs	$ 9,409,851[71]
Multiplied by the 2013 IPPS update factor	1.017[72]
2013 Updated Costs (max allowed)	$ 9,569,818
2014 Medicare Inpatient Operating Costs	$ 9,488,972[73]
Lower of 2013 Updated Costs or 2014 Costs	$ 9,488,972
Less 2014 IPPS payment	$ 8,052,960[74]
2014 Payment Cap	**$ 1,436,012**

Step 2: Calculation of VDA

2014 Medicare Inpatient Fixed Operating Costs	$ 8,290,515[75]
Less 2014 IPPS payment – fixed portion (87.37 percent)[76]	$ 7,035,871[77]
Payment adjustment amount (subject to Cap)	**$ 1,254,644**

[69] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).
[70] Stipulations at ¶ 21.
[71] *Id*.
[72] *Id*. (The Board notes that the IPPS Update Factors are based on the federal fiscal year end, and thus cover the period from 10/1 to 9/30. In the instant case, the Factor for 10/1/2013 to 9/30/2014 is 1.017 while the Factor for 10/1/2014 to 9/30/2015 is 1.022. As the cap calculation determines that the current year costs are the lesser of the two calculations, it is not necessary to calculate the actual update factor based on the months in both federal fiscal years.)
[73] *Id*.
[74] *Id*.
[75] 2014 Medicare Inpatient Operating Costs of $9,488,972 x Fixed Cost Percentage of 0.8737 (rounded) = $8,290,477.
[76] Stipulations at ¶ 21. The full number is 0.873696044, rounded to 0.8737.
[77] Calculation = $8,052,960 x 0.8737 (rounded) = $7,035,871.

Since the payment adjustment amount of $1,254,644 is **less** than the CAP of $1,436,012, the Board determines that Nathan Littauer's VDA payment for FY 2014 should be $1,254,644. A VDA payment in the amount of $237,517 was issued by the Medicare Contractor on July 28, 2017[78]; therefore, Nathan Littauer should receive an additional payment for its VDA in the amount of $1,017,127 for FY 2014.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Nathan Littauer's VDA payment for FY 2014, and that Nathan Littauer should receive an additional payment of $1,017,1271 for FY 2014 resulting in a total FY 2014 VDA payment of $1,254,644.

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3/19/2024

X Clayton J. Nix

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

[78] *See also* Stipulation at ¶ 11; Ex. P-3 at 1.