PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D14

PROVIDER-
Skiff Medical Center

Provider No.: 16-0032

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

RECORD HEARING DATE –
April 6, 2021

Cost Reporting Period Ended –
6/30/2008

CASE NO. 11-0501

CONTENTS

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Skiff Medical Center ("Skiff" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2008 ("FY 2008").[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated the VDA payment for FY 2008 for Skiff, and that Skiff should receive an additional VDA payment in the amount of $406,220, resulting in a total VDA payment of $832,339 for FY 2008.

INTRODUCTION

Skiff is a Medicare Dependent Hospital ("MDH") located in Newton, Iowa.[2] The Medicare contractor[3] assigned to Skiff for this appeal is Wisconsin Physicians Service Government Health Administrators ("Medicare Contractor").[4] Skiff initially requested a VDA adjustment on February 5, 2010.[5] On September 17, 2010, a Revised Notice of Program Reimbursement ("RNPR") was issued which included a VDA adjustment. In the RNPR, the Medicare Contractor calculated the Skiff's FY 2008 VDA payment to be $426,119.[6] On February 23, 2011, Skiff 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 April 6, 2021. Skiff was represented by Ronald Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments. One of these payment adjustments is referred to as a VDA payment and it is available to MDHs if, due to circumstances beyond their control, they incur a decrease in their total number of inpatient cases of more than 5 percent from one cost reporting year to the next.[7] VDA payments are

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[1] Provider's Consolidated Final Position Paper (hereinafter "Provider's FPP"), 2 (Dec. 29, 2020); MAC's Consolidated Final Position Paper (hereinafter "Medicare Contractor's FPP"), 3 (Jan. 27, 2021).
[2] Stipulations at ¶ 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Stipulations at ¶ 3.
[5] *Id.* at ¶ 4.
[6] *Id.* at ¶ 6; Exhibit P-1 at 19, 23.
[7] 42 U.S.C. § 1395ww(d)(5)(G)(iii).

designed to fully compensate a hospital for the fixed costs it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.[8] The implementing regulations, located at 42 C.F.R. § 412.108(d), reflect these statutory standards. 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").[9]

Initially, the Medicare Contractor denied a VDA payment because it concluded that Skiff's evidence supporting the *Inability to Recruit and Retain Essential Physician Staff* and *Regional Use Rate Decline* did not meet the 5 percent discharge decrease threshhold. However, the Medicare Contractor has since concluded that Skiff met the 5 percent criteria and is eligible for a VDA calculation for FY 2008.[10] Although Skiff requested a VDA payment in the amount of $945,487, when the Medicare Contractor made the FY 2008 VDA calculation, it determined that Skiff was entitled to a VDA payment of $426,119.[11]

The regulation at 42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.108(d)(3) (2008) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed* the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs 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* –
>
> (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, other than those costs paid on a reasonable cost basis under part 413 of this chapter. . . .[12]

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[8] *Id.*
[9] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[10] Stipulations at ¶ 5.
[11] Medicare Contractor's FPP at 4-5; Provider's FPP at 4.
[12] (Emphasis added.)

As CMS noted in the preamble to the final rule published on August 18, 2006,[13] the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2810.1 (Rev. 371) provides further guidance related to VDAs. In particular, § 2810.1(B) (Rev. 371) states, in pertinent part:

> Additional payment is made to an eligible [MDH] 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.[14]

The chart below depicts how the Medicare Contractor and Skiff each calculated the VDA payment.

	Medicare Contractor calculation using fixed costs	Provider/PRM calculation using total costs
a) Prior Year Medicare Inpatient Operating Costs		$7,310,921[15]
b) IPPS update factor		1.033
c) Prior year Updated Operating Costs (a x b)		$7,552,181
d) FY 2008/Current Year Operating Costs		$7,373,937[16]
e) Lower of c or d		$7,373,937
f) DRG/MDH payment		$5,484,284[17]
g) Cap (e-f)		$1,889,653
h) FY 2008 Inpatient Operating Costs	$7,373,937[18]	$7,339,118[19]
i) Fixed Cost percent	.932[20]	1.000[21]

[13] 71 Fed. Reg. at 48056.
[14] (Emphasis added.)
[15] Stipulations at ¶ 6; Exhibit C-1 at 12.
[16] Stipulations at ¶ 6; Exhibit P-1 at 94.
[17] Stipulations ¶ 6; Exhibit P-1 at 99.
[18] Stipulations at ¶¶ 9,10; Exhibit P-1 at 94. In the Stipulation, the Medicare Contractor stipulates in ¶ 9 on Line A that the current year program operating costs are $7,895,961. This amount is taken from is Worksheet D-1, Line 49 and includes passthrough costs. The Medicare Contractor should have picked up the amount from Worksheet D-1, Line 53 of $7,373,937 that excludes pass through costs. The Medicare Contractor in the Stipulations at ¶ 10 stipulates to $7,373,937 as being the current year operating costs, before variable costs are removed. *See also* Medicare Contractor's FPP at 18. The Medicare Contractor confirms that the current year program operating costs were $7,373,937 and that, after the variable costs were removed, they were $6,909,296.
[19] FY 2008 Inpatient Operating Costs of $7,373,937 minus excess staffing of $34,819 equals $7,339,118. *See* Exhibit C-1 at 12 (Skiff inadvertently excluded excess staffing of $34,819 related to FYE 6/30/2007 instead of excess staffing of $35,234).
[20] Calculation = $6,874,062/$7,373,937 = 0.932210568 rounded to 0.932.
[21] Skiff does not remove variable costs from the VDA calculation Skiff states that variable costs are not removed in any of the examples in PRM 15-1 § 2810.1 nor in the Federal Register published in 2008. Provider's FPP at 9.

j) FY 2008 Fixed Costs (h x i)	$6,874,062[22]	$7,339,118
k) Total DRG/MDH Payments[23]	$6,447,943[24]	$5,484,284[25]
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$426,119[26]	
m) VDA Payment Amount (The Provider's VDA is based on the amount by which line j exceeds line k.)		$1,428,715[27]

The parties to this appeal dispute the application of the statute and regulations used to calculate the VDA payment.[28]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that, "the additional [VDA] payment is to compensate for fixed and semi-fixed costs only, not variable costs. To be clear, the Provider's position is that it be made whole by the VDA, while the MAC contends that the VDA is meant to ensure the Provider received reimbursement totaling its fixed costs. . . . The provider believes any potential volume decrease adjustment should ensure it is fully reimbursed for all costs, including variable costs."[29]

The Medicare Contractor removed variable costs through Worksheet A-8 adjustments on Skiff's cost report. As specific instructions to determine the fixed/semi-fixed costs are not included in the statute, regulations, or Provider Reimbursement Manual, the Medicare Contractor used the cost report as a method of calculating fixed/semi-fixed costs, and argues that this is "the most accurate determination of Medicare inpatient fixed and semi-fixed costs."[30] The Medicare Contractor argues that this "was the methodology used in the *Greenwood, Unity,* and *Lakes* cases. . . . [and] if CMS disagreed with the MAC's methodology, the Administrator would not have affirmed the *Unity* and *Lakes* calculations."[31]

Skiff argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor departed from the instructions and step-by-step guidance in PRM 15-1, and added an unauthorized and monumental extra step.[32] According to Skiff, "[n]owhere in the Federal Register does it say to subtract variable costs from the Provider's costs."[33] The Board disagrees and notes that the Final Rule published on September 1, 1983 ("FFY 1984 IPPS Final

[22] Stipulations at ¶ 9; Exhibit C-1 at 12. *See also* Medicare Contractor's FPP at 18 (FY 2008 Fixed Operating Costs of $6,909,296 minus excess staffing of $35,234 equals $6,874,062).
[23] There is a dispute as to the proper payment calculation; Skiff is using Worksheet E, Part A, Line 6 (DRG and outlier amounts only) while the Medicare Contractor is using Worksheet E, Part A, Line 8 (which includes the hospital specific portion of the payment paid to MDHs).
[24] Stipulations at ¶ 9; Exhibits P-1 at 99, C-1 at 12.
[25] Stipulations at ¶ 6.
[26] *Id.* at ¶ 9; Exhibit C-1 at 12.
[27] Stipulations at ¶ 6. Excludes amount already received of ($426,119).
[28] Provider's FPP at 9; Medicare Contractor's FPP at 6-7.
[29] Medicare Contractor's FPP at 8.
[30] *Id.* at 12.
[31] *Id.* at 16 (referencing *Unity Healthcare v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. 2014-D15 (Sept. 4, 2014) and *Lakes Reg'l Healthcare v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. 2014-D16 (Sept. 4, 2014)).
[32] Provider's FPP at 10.
[33] *Id.* at 9.

Rule")[34] states that "[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.[35]

Skiff contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed inpatient operating costs.[36] Skiff also maintains that their current VDA calculation is in accordance with PRM 15-1 § 2810.1.C,[37] and that this was the methodology in effect during the cost reporting periods under appeal.[38]

Skiff 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, Skiff maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Finally, Skiff also references the fact that CMS essentially adopted a methodology which compares fixed inpatient costs to fixed MS-DRG revenue, and clarified these calculations to reflect that the same ratio is used for costs and payments when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[39]

The Board identified three basic differences between the Medicare Contractor's and Skiff's calculation of the VDA payment. The first is related to excess staffing. The Medicare Contractor deducted $35,234 for excess staffing, whereas the Provider deducted $34,819.[40] The difference in the excess staffing is related to Skiff including the excess staffing for FYE 2007 as opposed to FYE 2008.[41]

The second issue is Skiff included in the VDA calculation the DRG payments on Line 6 of the cost report whereas, the Medicare Contractor included the total payments on Line 8, that includes a percentage of the DRG and Hospital Specific Rate ('HSR") payment. The Board reviewed the VDA regulations at 42 C.F.R. § 412.108(d). These regulations require the VDA to be calculated using "the hospital's *total DRG revenue for inpatient operating costs* based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106. . . .)"[42] The Board also reviewed the MDH payment methodology in 42 C.F.R. § 412.108(c) to determine what payments should be included in the hospital's "total DRG revenue for inpatient operating costs." 42 C.F.R. § 412.108(c) provides that MDHs are paid for inpatient operating costs based on whichever is the greatest between the Federal payment or the hospital specific payment.[43] Based on these regulations the Board finds

[34] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983).
[35] (Emphasis added.)
[36] Provider's FPP at 11.
[37] *Id.* at 3.
[38] *Id.* at 8.
[39] *Id.* at 14.
[40] Stipulations at ¶¶ 6, 9.
[41] Exhibit C-1 at 12.
[42] (Emphasis added.)
[43] 42 C.F.R. § 412.108(c) references various sections including § 412.79, the section that the Medicare Contractor used to calculated Skiff's hospital specific rate payment. 42 C.F.R. § 412.79 provides for the determination of the

that an MDH's total DRG revenue for inpatient operating costs includes both the amount paid based on the federal rate and the amount paid based on the hospital specific rate. Therefore, the Board concludes the Medicare Contractor was correct to use $6,447,943 as Skiff's "total DRG revenue for inpatient operating costs" when calculating Skiff's FY 2008 VDA payment.

The last issue relates to whether variable costs are to be removed from the VDA calculation. The Medicare Contractor removed variable costs from the Medicare inpatient operating costs, Skiff argues that its VDA calculation methodology was calculated in accordance with the statute, regulations, and PRM instructions.[44]

In recent Board decisions addressing VDA payments,[45] the Board has disagreed with the methodology used by various Medicare contractors (including the one involved in this appeal) to calculate VDA payments because the methodology used compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

Referring to the methodology adopted by the Board in previous decisions, Skiff implies 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. Skiff states "the Provider's DRG payments would have been multiplied by the percentage of fixed program costs to all program costs to calculate the DRG payments attributable to fixed costs."[46] Skiff also references the fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[47]

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

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hospital specific rate, stating in subsection (e): "[t]he applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge."

[44] Provider's FPP at 16.

[45] *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).

[46] Provider's FPP at 12.

[47] *Id.* at 14.

> been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider . . . .[48]

Recently, the Eighth Circuit upheld the Administrator's methodology in the *Unity* case, stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[49]

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.[50]

While Skiff is in the Eighth Circuit and the statutes and regulations for VDAs for SCHs and MDHs are identical, the Board finds that the applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[51] As a result, the Board is not bound to apply the *specific* VDA calculation methodology that the Administrator applied (and the Eighth Circuit upheld) in *Unity*.[52] 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.[53] Thus, the Board finds that the Eighth Circuit's *Unity* decision was simply adjudicating

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[48] *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).

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

[50] (Bold and italics emphasis added).

[51] 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, 780 (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).

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

[53] 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

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* did not create a binding precedent as to the specific VDA calculation methodology that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[54] CMS prospectively changed the methodology for calculating the VDA to one that is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated fixed-costs portion of the DRG payment to the hospital's fixed costs, when determining the amount of the VDA payment.[55] 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."[56]

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 Skiff's VDA methodology for FY 2008 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 Skiff's VDA payment by comparing its FY 2008 fixed costs to its total FY 2008 DRG payments. However, neither the language nor the examples[57] 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[58] and the FFY 2009 IPPS Final Rule[59] 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.

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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.)

[54] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

[55] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).

[56] 82 Fed. Reg. at 38180.

[57] PRM 15-1 § 2810.1(C)-(D).

[58] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

[59] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

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 Skiff'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 Skiff's FY 2008 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions 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[.]"[60] 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.[61]

The statute at 42 U.S.C. § 1395ww(d)(5)(G)(iii) is clear that the VDA payment is intended 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, 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.[62]

In the FFY 1984 IPPS Final Rule, the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[63] However, the VDA payment methodology as explained in the FFY 2007 and 2009 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*

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[60] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm'r Dec. 2017-D1 at 12 (Feb. 9, 2017).
[61] 82 Fed. Reg. at 38179-38183.
[62] (Emphasis added.)
[63] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> *payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost. . . .*
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> D. Determination on Requests.— . . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost.* Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
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> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[64]

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

Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[66] 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 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

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

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

Critical to the proper application of the statute, regulation and PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished *actual* services in the current year are not part of the volume decrease, and (2) the DRG payments made to the hospital for services furnished to Medicare patients in the current year are 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 finds 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 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.

Skiff further argues that "[w]hen the [Medicare Contractor] changed the VDA calculation without following the legal notice and comment period, they unlawfully changed regulations." Skiff also alleges that "[t]he VDA calculation was not lawfully altered until the August 17, 2017 Federal Register was issued."[68] Skiff contends that "[t]he methodology in effect during the four years under appeal was the one described in section 2810.1 of the PRM, as formally adopted and modified in the IPPS rulemakings for FYs 2007 and 2009"[69] and also contends that CMS and/or the Medicare Contractor improperly departed from this methodology. However, the Board notes that the examples in PRM 15-1 § 2810.1 relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

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[67] 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.

[68] Provider's FPP at 15.

[69] *Id*. at 16.

> 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.*[70]

Accordingly, what Skiff 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."[71] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[72] 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.[73] Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as explained by 42 C.F.R. § 412.108(d)(3).[74] Moreover, the Board has had long standing disagreements with Medicare contractors and the Administrator on their different

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[70] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[71] Moreover, the fact that any particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[72] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[73] 139 S. Ct. at 1808, 1810.
[74] This regulation specifies that a 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."

interpretations and application of the relevant statutes, regulations and PRM 15-1 guidance regarding the calculation of VDAs.[75] Accordingly, the Board rejects Skiff's argument regarding lack of notice or comment opportunity.

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 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 PRM 15-1 § 2810.1 reasonable statement 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 noted above, Skiff's stipulated VDA calculation identifies an adjustment for excess staffing of $34,819 for FYE 6/30/08,[77] while the Medicare Contractor's stipulated VDA calculation for the same FY identifies an adjustment for excess staffing in the amount of $35,234.[78] The Stipulation at ¶ 10 reflects the parties' agreed upon "PRRB calculation" but does not address excess staffing at all. Review of Exhibit C-1 deomnstrates that $34,819 reflects the excess staffing amount from the prior year (FYE 6/30/07), while $35,234 is the current year excess staffing amount.[79] Therefore, the Board will use $35,234 as excess staffing in the calculation below.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case, the Medicare Contractor determined that Skiff's fixed costs (which includes semi-fixed costs) were 93.70 percent[80] of Skiff's Medicare costs for FY 2008. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2007 Medicare Inpatient Operating Costs	$7,310,921[81]
Multiplied by the 2007 IPPS update factor	1.033[82]
2007 Updated Costs (max allowed)	$7,552,181

[75] *See, e.g., Unity Healthcare v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg' Med. Ctr. v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Further, the application of the PRM definitions of the terms "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.
[76] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).
[77] Stipulations at ¶ 6.
[78] *Id.* at ¶ 9.
[79] Exhibit C-1 at 12, Step 8.
[80] Stipulations at ¶ 10.
[81] *Id.*.
[82] *Id*.

2008 Medicare Inpatient Operating Costs	$7,373,937[83]
Lower of 2007 Updated Costs or 2008 Costs	$7,373,937
Less 2008 IPPS payment	$6,447,943[84]
2008 Payment Cap	**$ 925,994**

Step 2: Calculation of VDA

2008 Medicare Inpatient Fixed Operating Costs	$6,909,296[85]
Less Excess Staffing	$ 35,234[86]
2008 Medicare Inpatient Fixed Op. Costs less Excess Staff	$6,874,062
Less 2008 IPPS payment – fixed portion (93.7 percent[87])	$6,041,723[88]
Payment adjustment amount (subject to cap)	**$ 832,339**

Since the payment adjustment amount of $832,339 is less than the cap of $925,994, the Board determines that Skiff's VDA payment for FY 2008 should be $832,339. Since Skiff was already awarded a VDA payment of $426,119, Skiff is due an additional VDA payment for 2008 in the amount of $406,220.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Skiff's FY 2008 VDA payment, and that Skiff should receive an additional VDA payment in the amount of $406,220, resulting in a total VDA of $832,339 for FY 2008.

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3/16/2022

X Clayton J. Nix

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Chair
Signed by: PIV

[83] *Id*.
[84] *Id*.
[85] *Id*.
[86] *See infra* n.77-79 and accompanying text.
[87] Stipulations at ¶ 10.
[88] Calculation = $6,447,943 * 0.937 = $6,041,722.59, rounded to $6,041,723.