PROVIDER REIMBURSEMENT REVIEW BOARD

DECISION

On the Record

2023-D10

PROVIDER-
St. James Healthcare

Provider No.
27-0017

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions, Inc.

RECORD HEARING DATE –
April 4, 2022

Cost Reporting Period Ended –
12/31/2015

CASE NO.
21-0061

CONTENTS

ISSUE STATEMENT

Whether the Provider has proven that it is entitled to a Sole Community Hospital Volume Decrease Adjustment ("VDA") for the fiscal year ending December 31, 2015 ("FY 2015").[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("PRRB" or "Board") finds that the Medicare Contractor improperly calculated the Provider's VDA payment for FY 2015 and that the Provider is due a VDA payment in the amount of $1,968,660 for FY 2015.

INTRODUCTION

St. James Healthcare (the "Provider" or "St. James") is a sole community hospital ("SCH") located in Butte, Montana.[2] The Medicare contractor[3] assigned to St. James for this appeal is Noridian Healthcare Solutions ("Medicare Contractor").

On August 15, 2018, St. James requested a VDA payment of $4,744,196 for FY 2015 to compensate it for a decrease in inpatient discharges during FY 2015.[4] On May 5, 2020, the Medicare Contractor determined that St. James was not entitled to a VDA payment because St. James' "inpatient prospective payment system ("IPPS") payments for its operating costs exceeded [its] allowable inpatient fixed and semi-fixed operating costs."[5] St. James 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 4, 2022. St. James was represented by Richard S. Reid of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the Inpatient Prospective Payment System ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments. One of these payment adjustments is referred to as a VDA payment, and it is available to SCHs if, due to circumstances beyond their control, they incur a decrease in total inpatient cases of more than 5 percent from one cost reporting year to the next.[6] VDA payments are intended "to fully

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[1] *See* Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 4.
[2] Stipulations (hereinafter "Stip.") at ¶ 1.
[3] CMS's payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs"), but these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Exhibit (hereinafter "Ex.") P-3.
[5] Stip. at ¶ 6. *See also* Ex. C-2 (copy of the May 5, 2020 determination).
[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services."[7] The implementing regulations located at 42 C.F.R. §412.92(e) reflect these statutory requirements.

It is undisputed that St. James experienced a decrease in inpatient discharges greater than 5 percent from FY 2014 to FY 2015 due to circumstances beyond its control.[8] As a result, St. James is eligible to have a VDA calculation performed for its FY 2015.[9] St. James requested a VDA payment in the amount of $4,744,196 for FY 2015.[10] However, when the Medicare Contractor calculated the FY 2015 VDA, it removed the variable costs from the "latest finalized 2015 Medicare inpatient costs"[11] and concluded that St. James was not entitled to a VDA payment for FY 2015.[12]

The regulation at 42 C.F.R. § 412.92(e) directs how the Medicare Contractor must resolve a VDA request once an SCH demonstrates it suffered a qualifying decrease in total inpatient discharges. In pertinent part, § 412.92(e)(3) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[13] 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 . . . .
>
> (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;
>
> (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. . . .[14]

Significantly, 42 C.F.R. § 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."

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[7] *Id.*
[8] Stip. at ¶ 5.
[9] *Id*. at ¶ 3.
[10] Ex. P-3 at 100.
[11] Medicare Contractor's FPP at 7.
[12] Ex. C-2.
[13] (Emphasis added.)
[14] (Emphasis added.) *See also* 42 U.S.C. § 1395ww(d)(5)(D)(ii).

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

> Additional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
>
> 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.[16]

The chart below depicts how the Medicare Contractor and St. James each calculated the FY 2015 VDA payment:

	Medicare Contractor (calculation using fixed costs)[17]	Provider (calculation using total costs)[18]
a) Prior Year Medicare Inpatient Operating Costs	$ 21,179,555	$ 21,179,55
b) IPPS Update Factor	1.018	1.018
c) Prior Year Updated Operating Costs (a x b)	$ 21,560,787	$ 21,560,787
d) Current year program operating costs	$18,512,480	$ 18,512,480
e) Lower of c or d	$18,512,480	$ 18,512,480
f) DRG/SCH Payment	$16,235,256	$ 16,235,256
g) CAP (e - f)	$2,277,224	$ 2,277,224
h) Current year program operating costs	$18,512,480	
i) Percentage of current year fixed program cost to current year total program costs	86.45%	
j) FY 2015 Fixed Costs (h x i)	$16,004,039	
k) Total DRG/SCH Payments	$16,235,256	
l) VDA Payment Amount (Medicare Contractor's VDA is the amount line j exceeds k)	**$(231,217)**	
m) VDA Payment Amount (the Provider's VDA is based on the amount line e exceeds line f)		**$ 2,277,224**

[15] 71 Fed. Reg. 47870, 48056.
[16] (Emphasis added.)
[17] Stip. at ¶10.
[18] *Id.* at ¶ 7.

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[19]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor and St. James disagree on the methodology used to calculate the VDA payment.[20]

The Medicare Contractor interprets the regulation at 42 C.F.R. § 412.92(e)(3)(i) and program instructions found at PRM 15-1 § 2810.1(B) to mean that the VDA is made only for fixed and semi-fixed costs and that variable costs cannot be included.[21] The Medicare Contractor argues the Board has found that a VDA payment "is limited to fixed and semi-fixed costs" and, in support, cites to the 2006 Board decision in *Greenwood County Hospital vs. Blue Cross Blue Shield Association / Blue Cross Blue Shield of Kansas*, PRRB Decision 2006-D43.[22]

The methodology used by St. James and the Medicare Contractor to calculate the VDA are different notwithstanding the fact that both parties begin with the FY 2015 Medicare inpatient operating cost of $18,512,480 as their starting point.[23] The Medicare Contractor argues that variable costs cannot be included in the VDA payment and that several Administrator decisions support this methodology to calculate the VDA payment:

> The CMS Administrator has reviewed several cases (2014-D15, 2014-D16, 2015-D11) concerning the proper calculation of the volume decrease adjustment recently. These decisions clearly establish the CMS policy for performing these calculations. It is the contractor's understanding that under the calculation outlined in the Administrator Review of 2015D-11, that the SCH VDA would be the same as the one calculated by the contractor.[24]

St. James counters that the Medicare Contractor's calculation of the VDA was wrong because it "departed from CMS's established policy and did not use the policy set forth in section 2810.1 of the PRM and summarized in Federal Register rulemaking."[25] St. James asserts that this policy does not mention the removal of variable costs and, despite its earlier reference to fixed and semi-fixed costs, "none of the examples show variable costs being removed from the calculation."[26]

Moreover, St. James contends that "[r]emoving variable costs from the calculation would make the cap defined in the Regulations, in PRM [15-1 §] 2810.1 and the calculation in the Federal

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[19] *Id.* at ¶ 12.
[20] *Id.*
[21] Medicare Contractor's FPP at 6.
[22] *Id.* at 7 (stating: "The Board, however, finds that the Intermediary correctly chose not to consider within its calculation those costs which the Provider, by its own election, labeled as variable. The Board finds that 42 CFR 412.96(e) and PRM 2810.1 explicitly dictate that the adjustment is limited to fixed and semi-fixed costs.").
[23] *Id.*
[24] *Id.* at 8.
[25] Provider's Final Position Paper (hereinafter "Provider's FPP") at 6.
[26] *Id.* at 7.

Register unnecessary, as the cap would never be reached."[27] By removing variable costs, the Medicare Contractor "recalculated its inpatient operating costs as if [St. James] did not have to provide any food, any drugs, any medical supplies, or any laundry services to its inpatients."[28] In doing so, St. James argues, it was not fully compensated for all of its fixed costs.[29]

St. James also claims the Medicare Contractor unlawfully changed the VDA payment calculation without going through notice-and-comment rulemaking, as required by the Medicare Statute and the Administrative Procedure Act.[30] St. James finds this significant because a Medicare Contractor cannot alter its VDA calculation since "CMS is required to provide notice and a comment period" to change a rule.[31] St. James' position is that "the applicable lawful regulations are those that were published in the Federal Register on August 19, 2008."[32]

In recent decisions, the Board has consistently disagreed with the methodology used by various Medicare contractors (including the one involved in this appeal) 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.[33] 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 then comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so that there is an apples-to-apples comparison.

The Administrator has overturned these Board decisions, stating:

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue.… In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or 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. . . .[34]

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[27] *Id.*
[28] *Id.* at 6.
[29] *Id.* at 8.
[30] *Id.* at 12.
[31] *Id.* at 11-12 (citing the decision in *Allina v. Burwell* (D.C. Court of Appeals Case No. 16-5255)).
[32] *Id.*at 12.
[33] *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).
[34] *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).

In the *Unity HealthCare* case, the Eighth Circuit Court of Appeals recently upheld the methodology espoused by the Administrator, finding that the "interpretation was not arbitrary or capricious and was consistent with the regulation."[35] Initially, the Board notes that St. James is not located in the Eighth Circuit, and 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.[36]

Further, the Board finds that the applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[37] 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*.[38] The Board notes that § 412.92(e)(3)(iii) makes clear that the VDA payment determination is subject to review through the Board's appeal process.[39] Thus, the Board must conclude that the Eighth Circuit's *Unity* decision adjudicated a dispute regarding the reasonableness of the Administrator's interpretation and application of the VDA statute and regulations 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.

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

[36] (Emphasis added.)

[37] Regarding 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, e.g.*, 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987) (stating for SCHs: "We 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).

[38] *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).

[39] 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.)

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,[40] CMS prospectively changed the methodology for calculating VDA payments to one which is very similar to the methodology used by the Board. Under the Administrator's 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.[41] 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."[42]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As explained in detail below, the Board finds that the Medicare Contractor's calculation of St. James' VDA for FY 2015 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 St. James' VDA payment by comparing its *fixed* FY 2015 costs to its *total* FY 2015 DRG payments. However, neither the language nor the examples 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 and the FFY 2009 IPPS Final Rule reduce the hospital's cost only by excess staffing (not variable costs) when calculating 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 is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate St. James' VDA using the methodology laid out by CMS in PRM 15-1 or by the Secretary in the preambles to the FFY 2007 and FFY 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated St. James' FY 2015 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions. This calculation is best described as the hospital's "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment … subject to the

[40] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[41] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).
[42] 82 Fed. Reg. at 38180.

ceiling[.]"[43] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the statute and the methodology explained in the PRM, and endorsed in the FFY 2007 and 2009 IPPS Final Rules. Notably, in applying this new methodology through adjudication, CMS did not otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[44]

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

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

In the final rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule"), the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[45] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

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

[43] *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).
[44] 82 Fed. Reg. at 38179-38183.
[45] 48 Fed. Reg. at 39781-39782 (Sept. 1, 1983) (emphasis added).

> *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***.[46]

At first blush, this would appear to conflict with the statute and the FYY 1984 IPPS Final Rule, both of which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing 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."[47] 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."[48]

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 for the fixed costs of the Medicare services actually provided because the hospital, in fact, incurred *both* fixed and variable costs for those services.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an SCH for all the fixed costs associated with the qualifying volume decrease. This is in keeping with the assumption stated in PRM 15-1 § 2810.1D that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with

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[46] (Emphasis added.)
[47] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[48] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

the directive in 42 C.F.R. § 412.92(e)(3)(i)(A) that the Medicare contractor "considers … [t]he individual hospital's needs and circumstances" when determining the payment amount.[49] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce the variable costs associated with the volume loss, but the hospital will always have some variable costs related to furnishing Medicare services to its *actual* patient load.

Critical to the proper application of the statute, regulation and PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which the provider furnished *actual* services in the current year are not part of the volume decrease; and (2) the DRG payments made to the hospital for services furnished to Medicare patients in the current year is payment for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year as well as its full fixed costs in that year.

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

St. James also argues that, "[w]hen the [Medicare Contractor] changed the VDA calculation without following the legal notice and comment period, they unlawfully changed regulations."[50] St. James continues, stating, "[t]he VDA calculation was not lawfully altered until the August 17, 2017 Federal Register was issued."[51] St. James contends that "[t]he methodology in effect during the three 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"[52] 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*:

> 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

[49] The Board recognizes that 42 C.F.R. § § 412.92(e)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.
[50] Provider's FPP at 12.
[51] *Id.*
[52] *Id*.

> 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 theexamples 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 wasconsistent with the regulation*.[53]

Accordingly, what St. James 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."[54] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[55] This is a different situation than the one addressed by the U.S. 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.[56] Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as explained in 42 C.F.R. § 412.108(d)(3).[57] Moreover, the Board has long standing disagreements with Medicare contractors and the Administrator on their different interpretations and applications of the relevant statutes, regulations and PRM guidance regarding the calculation of VDAs.[58] Accordingly, the Board rejects St. James' argument regarding lack of notice or comment opportunity.

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[53] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[54] Moreover, the fact that any particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[55] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[56] 139 S. Ct. at 1808, 1810.
[57] 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."
[58] *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.

The Board reviewed the VDA regulations at 42 C.F.R. § 412.92(e). These regulations require the VDA to be calculated using

> [T]he 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 . . . .)[59]

To determine which payments should be included in the hospital's "total DRG revenue for inpatient operating costs," the Board reviewed 42 C.F.R. § 412.92(d), which provides that SCHs are paid for inpatient operating costs based on:

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

Further, 42 C.F.R. § 412.78(a) states, "[i]f the 2006 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under § 412.64 or the hospital-specific rates for either FY 1982 under § 412.73, FY 1987 under § 412.75 or FY 1996 under § 412.77, this 2006 rate will be used in the payment formula set forth in § 412.92(d)(1)." Thus, it is clear that the hospital-specific rate and related payments "will be used," per § 412.78(a), so that "SCHs are paid for inpatient operating costs," per § 412.92(d). Based on these regulations, the Board finds that an SCH's total DRG *revenues* for inpatient operating costs for FY 2015 includes both the amount paid for the DRGs and any potential additional amount paid based on the hospital-specific rate.

Finally, the Board recognizes that PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment. However, the VDA payment is clearly ***not intended*** to fully compensate the hospital for its variable costs.[60] 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 consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on

[59] 42 C.F.R. § 412.92(e)(3) (emphasis added.)
[60] 48 Fed. Reg. at 39782.

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 independently determine the split between fixed/variable costs related to each DRG payment, the Board therefore opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case, the Medicare Contractor determined that St. James' fixed costs (which includes semi-fixed costs) were 86.45 percent[61] of St. James' Medicare costs for FY 2015. This fixed cost ratio will be used in the Board's VDA calculation.

Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2014 Medicare Inpatient Operating Costs	$ 21,179,555[62]
Multiplied by the 2014 IPPS Update Factor	1.018[63]
2014 Updated Costs (max allowed)	$21,560,787
2015 Medicare Inpatient Operating Costs	$18,512,480[64]
Lower of 2014 Updated Costs or 2015 Costs	$ 18,512,480
Less 2015 IPPS Payment	$ 16,235,256[65]
2015 Payment Cap	**$ 2,277,224**

Step 2: Calculation of VDA

2015 Medicare Inpatient Fixed Operating Costs	$16,004,039[66]
Less 2015 IPPS Payment – fixed portion (86.45 percent[67])	$14,035,379[68]
Payment adjustment amount (subject to cap)	**$ 1,968,660**

Since the payment adjustment amount of $1,968,660 is less than the cap of $2,277,224 the Board determines that St. James should receive a VDA payment of $1,968,660 for FY 2015.

[61] Stip. at ¶ 11.
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] 2015 fixed IPPS payment is calculated – total IPPS payment x fixed percentage = fixed IPPS payment ($16,235,256 X 86.45 percent =$14,035,378.81).

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated St. James' VDA payment for FY 2015, and that St. James is due a VDA payment of $1,968,660 for FY 2015.

Board Members Participating:

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For the Board:

3/17/2023

X Clayton J. Nix

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