PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2023-D04

PROVIDER-
Cary Medical Center

Provider No. 20-0031

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.
(J-K)

RECORD HEARING DATE –
February 7, 2022

Cost Reporting Period Ended –
12/31/2009

CASE NO. 17-0931

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ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Cary Medical Center ("Cary" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2009 ("FY 2009") and whether the Medicare Contractor properly reopened the Original VDA approval.[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that, although the Medicare Contractor properly reopened Cary's original VDA approval for FY 2009, it incorrectly calculated the revised VDA payment for FY 2009 as $0. Accordingly, the Board has made a correct calculation and has determined that Cary should receive a VDA payment in the amount of $303,115 for FY 2009.

INTRODUCTION

Cary is an acute care hospital located in Caribou, Maine[2] and was designated as a Medicare Dependent Hospital ("MDH") during FY 2009, the fiscal year at issue.[3] The Medicare contractor[4] assigned to Cary for this appeal is National Government Services, Inc. ("Medicare Contractor"). On June 19, 2014, Cary requested a VDA in the amount of $351,482.[5] On October 9, 2015, the Medicare Contractor approved the Request and issued an amount of $351,482.[6] On January 15, 2016, the Medicare Contractor informed Cary that it was reopening the VDA determination.[7] On August 5, 2016, the Medicare Contractor issued a revised payment amount of $0.[8] As a result of the Medicare Contractor's Revised VDA, Cary was required to repay $351,482.[9] Cary 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 February 7, 2022.[10] Cary was represented by William Stiles, Esq. of Verrill Dana, LLP. The Medicare Contractor was represented by Scott Berends of Federal Specialized Services.[11]

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[1] Provider's Final Position Paper ("Provider's FPP") at 1-3 (Dec. 6, 2021); Medicare Contractor's Final Position Paper ("Contractor's FPP") at 3 (Jan. 12, 2022).
[2] Provider's FPP at 1.
[3] Stipulations of the Parties ("Stipulations") at ¶ 1 (Jan. 19, 2022).
[4] 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.
[5] Stipulations at ¶ 7. *See also* Exhibit ("Ex.") P-2 at 4.
[6] *Id.* at ¶ 11; Ex. P-3.
[7] *Id.* at ¶ 12.
[8] *Id.* at ¶ 13.
[9] *Id.* at ¶ 14.
[10] Board's Notice of Record Hearing and Critical Due Dates – Final (Feb. 7, 2022).
[11] Motion for Hearing on Record (Jan. 19, 2022).

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.[12] 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."[13] The implementing regulations, located at 42 C.F.R. § 412.108(d), reflect these statutory requirements. 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").[14]

It is undisputed that Cary experienced a decrease in discharges greater than 5 percent from FY 2008 to FY 2009 due to circumstances beyond its control.[15] As a result, Cary was eligible to have a VDA calculation performed for FY 2009.[16] The initial VDA determination awarded Cary a VDA payment of $351,482 for FY 2009. On January 15, 2016, the Medicare Contractor notified Cary of its plans to reopen and revise the FY 2009 VDA determination. On August 5, 2016, the Medicare Contractor ultimately issued a revised VDA determination finding that Cary was due a VDA payment of $0.[17] As a result, Cary repaid, in full, to the Medicare Contractor the original VDA payment of $351,482.[18]

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 cases. In particular, § 412.108(d)(3) directs Medicare Contractors to determine the lump sum adjustment via the methodology set forth in § 412.92(e)(3), which states, in pertinent part:

> (3) The [Medicare Contractor] 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).

[12] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[13] *Id.*
[14] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[15] Stipulations at ¶ 10; Provider's FPP at 4-5; Medicare Contractor's FPP at 7.
[16] Stipulations at ¶ 10.
[17] *Id.* at ¶¶ 11, 12, 13.
[18] *Id.* at ¶ 14.

> (i) In determining the adjustment amount, the Intermediary *considers* –
>
> (A) The individual's 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 ….[19]

As CMS noted in the preamble to the final rule published on August 18, 2006,[20] 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 [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.
>
> 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.[21]

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

	Medicare Contractor calculation using fixed costs[22]	Provider/PRM calculation using total costs[23]
a) Prior Year Medicare Inpatient Operating Costs	$8,844,846	$8,844,846
b) IPPS update factor	1.036	1.0338
c) Prior year Updated Operating Costs (a x b)	$9,163,260	$9,143,360
d) FY 2009 Operating Costs	$7,306,282	$7,306,282

[19] (Emphasis added.)
[20] 71 Fed. Reg. at 48056.
[21] (Emphasis added.)
[22] Revised VDA Calculation. Ex. P-5 at 5-6; Ex. C-7 at 8-9.
[23] Ex. C-5 at 4; Ex. P-2 at 7.

e) Lower of c or d	$7,306,282	$7,306,282
f) DRG/MDH payment	$6,954,800	$6,954,800
g) Cap (e-f)	**$351,482**	**$351,482**
h) FY 2009 Inpatient Operating Costs	$7,306,282	
i) Fixed Cost percent	0.862393119	
j) FY 2009 Fixed Costs (h x i)	$6,300,887	
k) Total DRG/MDH Payments	$6,954,800	
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k.)	**$0**	
m) VDA Payment Amount (The Provider's VDA is based on the amount line e exceeds line f.)		**$351,482**

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[24]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Cary contends that the Medicare Contractor correctly determined that Cary's Original VDA request and any supplemental responses "satisfied the applicable statute, regulation, and CMS program instructions."[25] Accordingly, it agrees with the Medicare Contractor initial approval of the Provider's VDA request and issuance of a lump sum payment of $351,482 through the Original VDA Approval.[26] In particular, Cary states that:

> The [Medicare Contractor's] methodology for determining the Original VDA Approval . . . was identical to the approach that it had consistently utilized (and reported to CMS) for over 25 years. In addition, the [Medicare Contractor's] approach complied was consistent with the plain language of the applicable statute, regulation, and CMS program instructions. Accordingly, the Provider did not appeal the Original VDA Approval pursuant to 42 U.S.C § 1395oo.[27]

On January 15, 2016, the Medicare Contractor informed Cary that it was reopening the VDA determination.[28] On August 5, 2016, the Medicare Contractor issued a Revised VDA payment in the amount of $0.[29] As a result of the Medicare Contractor's Revised VDA determination, Cary was required to repay $351,482.[30]

Cary maintains that "[t]he workpapers attached to the [Medicare Contractor's] Revised VDA Approval demonstrate that the [Medicare Contractor] applied a brand-new methodology that

[24] Provider's FPP at 11; Medicare Contractor's FPP at 6.
[25] Provider's FPP at 5.
[26] *Id.* at 4-5.
[27] *Id.* at 5.
[28] Stipulations at ¶ 12.
[29] *Id.* at ¶ 13.
[30] *Id.* at ¶ 14.

was...inconsistent with plain language of the applicable statute, regulation, and CMS program instructions."[31]

Cary claims that CMS' revised VDA approval methodology is "arbitrary and capricious" and violates the "notice and comment rulemaking requirements of the Administrative Procedures Act ("APA") and the Medicare Act."[32] It argues that CMS and/or the Medicare Contractor violated the APA by making a substantive change to the VDA calculation methodology that "produces significant effects on private interests; namely, it substantially reduces the amount of VDA payments due to providers."[33] Further, it argues that, "although CMS may be entitled to revise its interpretation of the VDA statute, such a drastic departure from its previous interpretation amounts to a substantive rule triggering the requirements of notice and comment rulemaking."[34] Cary argues that, "[e]ven if the Revised VDA Approval Methodology does not amount to an improper substantive rule under the APA, the Supreme Court's recent decision in *Azar v. Allina Health Services...* ("*Allina*"),[35] makes clear that the revision violates the Medicare Act's notice and comment rulemaking requirements"[36] at 42 U.S.C. § 1395hh(a). The Board notes that 42 U.S.C. § 1395hh(a) states, in pertinent part, that "[n]o rule, requirement or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1)."[37]

In support of its position, Cary asserts that the examples given at PRM 15-1 § 2810.1 detail exactly how the Medicare Contractor is required to determine the VDA payment,[38] and that CMS and/or the Medicare Contractor improperly departed from this methodology. However, the Board notes that these examples relate to the VDA cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

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

[31] Provider's FPP at 6.
[32] *Id.* at 19.
[33] *Id.* at 28.
[34] *Id.*
[35] 139 S. Ct. 1804 (2020).
[36] Provider's FPP at 28.
[37] Exhibit P-19 at 22.
[38] Provider's FPP at 9-1.

> 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.[39]

Accordingly, what Cary points to as written or published CMS "policy" on how to calculate the VDA payment is 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."[40] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[41] 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.[42] The fact that CMS may have directed the Medicare Contractor to calculate the VDA differently 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. Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as delineated in 42 C.F.R. § 412.108(d)(3).[43] Moreover, the Board has had long-standing disagreements with Medicare contractors (including the Medicare Contractor in this appeal) and the Administrator on their different interpretations and application of the relevant statutes, regulations and Manual guidance regarding the calculation of VDAs.[44] Accordingly, the Board rejects Cary's APA and *Allina* arguments.

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[39] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; emphasis added).

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

[41] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).

[42] 139 S. Ct. at 1808, 1810.

[43] 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."

[44] *See, e.g., Unity Healthcare. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Similarly, Cary 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 28-32. 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

The Medicare Contractor states that CMS directed it to revise Cary's original VDA approval to remove variable costs.[45] Cary argues that this reopening did not comply with 42 C.F.R. § 405.1885(c) as it did not provide "explicit notice that the Original VDA Approval is inconsistent with applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the contractor."[46] Accordingly, Cary argues that the reopening should be deemed void, and that the revised VDA calculation must be vacated.[47]

The Medicare Contractor argues that it has the authority to reopen and revise a final determination under its own discretion pursuant to 42 C.F.R. § 405.1885(a) which states:

> (a) *General*. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), **by the contractor (with respect to contractor determinations)**, **or by the reviewing entity that made the decision**[.][48]

The Medicare Contractor states that it "engaged in discussions with CMS regarding the inclusion of variable expenses in its Final VDA calculation and the need to recalculate the VDA payment amount to remove these costs. Based on these discussions, the [Medicare Contractor] determined that the variable expenses needed to be reviewed and removed from the Final VDA Determination calculation."[49] The Medicare Contractor affirms that it "notified the Provider of this impending review and the recalculation of the Final VDA payment determination in its January 15, 2016 letter to the Provider."[50]

The Medicare Contractor asserts that "it was bound to revise the VDA payments to remove the variable expenses in accordance with the plain language of the relevant statute and regulation, [Social Security Act] § 1886(d)(5)(G)(iii), and 42 C.F.R. § 412.108(d)"[51] and that "it was authorized to make the revision to the Final VDA payment, i.e., a contractor determination, under its own discretion, in accordance with 42 C.F.R. § 405.1885(a)."[52]

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may appeal Medicare contractor VDA determinations to the Board.

[45] Medicare Contractor's FPP at 8-9; Ex. C-6.

[46] Provider's FPP at 15 (quoting 42 C.F.R. § 405.1885(c)(1)(i)).

[47] *Id.* at 16.

[48] (Bold emphasis added.)

[49] Medicare Contractor's FPP at 9.

[50] *Id.*; Stipulations at ¶ 12.

[51] Medicare Contractor's FPP at 9.

[52] *Id*.

The Medicare Contractor issued the original VDA approval on October 9, 2015[53] and the Notice of Reopening was dated January 15, 2016.[54] 42 C.F.R. § 405.1885(b)(1) states "[a]n own motion reopening is timely only if the notice of intent to reopen (as described in § 405.1887) is sent no later than 3 years after the date of the determination or decision that is the subject of the reopening." Further, 42 C.F.R. § 405.1885(b)(4) states:

> If CMS directs a contractor to reopen a matter, reopening is considered an own motion reopening by the contractor. A reopening may result in a revision of any matter at issue in the determination or decision.

Here, it is clear that the Medicare Contractor timely reopened within the 3-year period permitted under 42 C.F.R § 405.1885. Further, the Board finds that Cary has failed to provide sufficient evidence to establish that the reopening was due to "[a] change in legal interpretation or policy ***by CMS*** in a regulation, CMS ruling or other interpretive rules . . . or practice established ***by CMS***"[55] and, thus, prohibited under § 405.1885(c). The facts that CMS directed the Medicare Contractor to reopen and that the Medicare Contractor changed the methodology it used to calculate the VDA payment due to Cary does not establish that ***CMS*** had "[a] change in legal interpretation or policy . . . or practice." Indeed, a simple review of the history of Board decisions involving VDA calculations being overturned by the Administrator supports the Board's finding. Accordingly, the Board finds that the Medicare Contractor had the authority to reopen and revise the VDA determination.

Cary also contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[56] Cary maintains that there are multiple levels of "interpretation" of the relevant regulations (42 C.F.R. §§ 412.92(e) and 412.108(d)) and guidance (PRM 15-1 § 2810.1).[57] Cary believes that the correct interpretation requires a corresponding decrease be made to the portion of DRG payment related to payment of variable costs for any variable costs that are excluded from inpatient operating costs when calculating the VDA.[58] This method, Cary maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs.[59] Cary 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.[60]

The treatment of the FY 2009 Inpatient Operating Costs is the one basic difference between the VDA calculations performed by the Medicare Contractor and Cary. The Medicare Contractor calculated the fixed/semi fixed cost percentage by removing total variable expenses from the total expenses reported on Worksheet A of the cost report and dividing the resulting fixed costs

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[53] Stipulations at ¶ 11.
[54] *Id.* at ¶ 12.
[55] (Emphasis added.)
[56] Provider's FPP at 32-35.
[57] *Id.* at 21.
[58] *Id.* at 33-38.
[59] *Id.* at 34.
[60] *Id.* at 39-42.

by the total Worksheet A expenses.[61] The Medicare Contractor then applied the resultant percentage of fixed/semi fixed costs to the FY 2009 Medicare inpatient operating costs to arrive at the applicable fixed/semi fixed costs for the VDA calculation.[62] Cary argues that, unlike what Cary refers to as the "MAC's Historical VDA Methodology," the Medicare Contractor's Revised VDA calculation methodology violates the applicable statute, regulations, and the PRM instructions.[63]

In recent Board decisions addressing VDA payments,[64] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because that methodology compares fixed costs to total DRG payments. That method only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated a hospital's 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.

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….[65]

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

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[61] Contactor's FPP at 15-16. *See also* the calculations of the variable expense percentage on Ex. C-7 at 10.
[62] *See* Ex. P-5 at 6; Ex. C-7 at 9.
[63] Provider's FPP at 18.
[64] *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).
[65] Ex. C-14 at 8. *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).

> 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.[66]

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."[67] However, the Board notes that Cary is not located in the Eighth Circuit and, thus, the *Unity* decision is not binding precedent in this appeal.

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[68] 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.[69] 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."[70]

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 methodology for the calculation of Cary's VDA for FY 2009 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 Cary's VDA payment by comparing its FY 2009 fixed costs to its total FY 2009 DRG payments. However, neither the language nor the examples[71] 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

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[66] (Bold and italics emphasis added.)
[67] *Unity Healthcare v. Azar*, 918 F.3d 571, 579 (8th Cir.), *cert. denied*, 140 S. Ct. 523 (2019).
[68] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[69] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).
[70] 82 Fed. Reg. at 38180.
[71] PRM 15-1 § 2810.1(C)-(D).

FFY 2009 IPPS Final Rule[72] and the FFY 2009 IPPS Final Rule[73] reduce the hospital's costs *only* by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

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

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

Rather, the Board finds the Medicare Contractor calculated Cary's FY 2009 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions. This methodology is best described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[74] 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.[75]

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.[76]

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[72] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[73] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[74] *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).
[75] 82 Fed. Reg. at 38179-38183.
[76] (Emphasis added.)

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."[77] 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.—. . . .
>
> 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***.[78]

[77] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).
[78] (Emphasis added.)

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."[79]

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."[80] 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 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 of the fixed costs associated with the qualifying volume decrease. This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "the hospital is assumed to have budgeted based on 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.[81] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable costs related to furnishing Medicare services to its *actual* patient load.

Critical to the proper application of the statute, regulation and PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a hospital 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 payments for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year, *as well as* its full fixed costs in that year.

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[79] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[80] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[81] The Board recognizes that 42 C.F.R. § 412.108(d)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs when determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

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

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(G)(iii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is clear that the VDA payment is not intended to fully compensate the hospital for its variable costs.[82] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both the variable and fixed Medicare costs associated with the services *actually* furnished. The Board concludes that, in order to both ensure the hospital is fully compensated for its fixed costs, *and* to be consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentage as a proxy. In this case, the Medicare Contractor determined that Cary's fixed costs (which includes semi-fixed costs) were 86.24 percent[83] of Cary's Medicare costs for FY 2009. 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

2008 Medicare Inpatient Operating Costs	$8,844,846[84]
Multiplied by the 2008 IPPS update factor	1.036 [85]
2008 Updated Costs (max allowed)	$9,163,260
2009 Medicare Inpatient Operating Costs	$7,306.282 [86]
Lower of 2008 Updated Costs or 2009 Costs	$7,306,282
Less 2009 IPPS payment	$6.954,800 [87]
2009 Payment Cap	**$ 351,482**

[82] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).
[83] Stipulations at ¶ 21; Ex. P-5 at 6; Ex. C-7 at 9. The full number is 0.862393119, rounded to 0.8624.
[84] Stipulations at ¶ 21.
[85] *Id.*
[86] *Id.*
[87] *Id.*

Step 2: Calculation of VDA

2009 Medicare Inpatient Fixed Operating Costs	$6,300,887 [88]
Less 2009 IPPS payment – fixed portion (86.24) percent[89])	$5,997,772 [90]
Payment adjustment amount (subject to Cap)	**$ 303,115**

Since the VDA adjustment amount of $303,115 is less than the Cap of $351,482, the Board finds that Cary's VDA payment for FY 2009 should be $303,115. As the Revised FY 2009 VDA for Cary was $0,[91] the Board finds that an additional payment of $303,115 is due to Cary.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that, although the Medicare Contractor properly reopened the original VDA approval for FY 2009, it incorrectly calculated the revised VDA payment for FY 2009 as $0. Accordingly, the Board has made a correct calculation and has determined that Cary should receive a VDA payment in the amount of $303,115 for FY 2009.

Board Members:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

12/21/2022

X Clayton J. Nix

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

[88] 2009 Medicare Inpatient Operating Costs of $7,306,282 x Fixed Cost Percentage of 0.862393119 = $ 6,300,887.
[89] Stipulations at ¶ 21. The full number is 0.862393119, rounded to 0.8624.
[90] Calculation = $6,954,800 x 0.862393119 = $5,997,772.
[91] Provider's FPP at 1.