PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2024-D12

PROVIDER-
Champlain Valley Physicians Hospital

Provider No.: 33-0250

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
September 13, 2023

Cost Reporting Period Ended –
12/31/2011

CASE NO. – 17-1252

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Champlain Valley Physicians Hospital ("Champlain Valley" or the "Provider") for the significant decrease in inpatient discharges that occurred during its fiscal year ending December 31, 2011 ("FY 2011"). [1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated Champlain Valley's VDA payment for FY 2011, and that Champlain Valley should receive a VDA payment in the amount of $1,096,388 for FY 2011.

INTRODUCTION

Champlain Valley is an acute care hospital designated as a Sole Community Hospital ("SCH") located in Plattsburgh, New York.[2] The Medicare contractor [3] assigned to Champlain Valley for this appeal is National Government Services, Inc. ("Medicare Contractor"). On March 3, 2015, Champlain Valley timely requested a VDA payment of $1,306,001 to compensate it for a qualifying decrease in inpatient discharges during FY 2011.[4] On September 15, 2016, the Medicare Contractor issued a determination, finding that the requirements for a VDA "were not met" and denying Champlain Valley's VDA request.[5] Champlain Valley 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 September 13, 2023. Champlain Valley was represented by William H. Stiles, Esq of Verill Dana, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

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

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[1] Stipulations at ¶¶ 14-16; Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3.
[2] Provider's Final Position Paper (hereinafter "Provider's FPP") at 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare Contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Exhibit (hereinafter "Ex.") P-2 at 1. Stipulations at ¶ 7.
[5] Ex. P-3 at 1. Stipulations at ¶ 9.

more than 5 percent from one cost reporting year to the next. VDA payments are designed "to fully compensate the hospital for the fixed costs that it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services."[6] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

While not specifically addressed in the final VDA determination, it is now undisputed that Champlain Valley experienced a decrease in discharges greater than 5 percent from FY 2010 to FY 2011 due to circumstances beyond Champlain Valley's control. As a result, Champlain Valley was eligible to have a VDA calculation performed for FY 2011.[7] In its VDA request, Champlain Valley asserted that a VDA payment should be approved in the amount of $1,306,001 for FY 2011.[8] However, when the Medicare Contractor reviewed the request, it calculated that Champlain Valley was entitled to a VDA payment of $0 after removing a percentage of the costs it deemed variable to leave only fixed/semi-fixed costs in its VDA calculation.[9] Thus, what remains at issue in this case is whether Champlain Valley is due a VDA payment and, in particular, the parties' dispute regarding how that payment should be calculated.[10]

The regulation at 42 C.F.R. § 412.92(e) directs how the Medicare Contractor must determine the VDA once an SCH demonstrates it experienced a qualifying decrease in total inpatient discharges. In pertinent part, § 412.92(e)(3)(2011) 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 for 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).
>
> (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; and

[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[7] Stipulations at ¶ 8.
[8] Ex. P-2.
[9] Stipulations at ¶¶ 9, 15.
[10] *Id.* at ¶ 13.

> (C)The length of time the hospital has experienced a decrease in utilization.[11]

In the preamble to the final rule published on August 18, 2006,[12] CMS referenced the Provider Reimbursement Manual, CMS Pub.15-1 ("PRM 15-1") § 2810.1 (Rev. 371), which provides further guidance related to VDAs and states, in relevant part:

> Additional payment is made . . . for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
>
> 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*[13] with utilization such as food and laundry costs.

The chart below depicts how the Medicare Contractor and Champlain Valley each calculated the VDA payment for FY 2011.

	Medicare Contractor calculation using fixed costs[14]	Provider/PRM calculation using total costs[15]
a) Prior Year Medicare Inpatient Operating Costs	$ 43,516,450[16]	$ 51,438,417
b) IPPS update factor[17]	1.0235	1.019
c) Prior year Updated Operating Costs (a x b)	$ 44,539,087	$ 52,415,747
d) Current Year Program Operating Costs	$ 52,122,827	$ 52,122,827
e) Lower of c or d	$ 44,539,087	$ 52,122,827
f) DRG/SCH payment	$ 50,816,826	$ 50,816,826
g) VDA Payment Cap (e-f)	$ (6,277,739)	$ 1,306,001
h) Current Year Inpatient Operating Costs	$ 52,122,827	$ 52,122,827
i) Fixed Cost percent	83.95%[18]	100.00%[19]

[11] (Emphasis added.) *See also* 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[12] 71 Fed. Reg. at 47870, 48056 (Aug. 18, 2006).
[13] (Emphasis added).
[14] Ex. C-1 at 4.
[15] Ex. P-2 at 0022.
[16] The Board notes that the Medicare Contractor's calculation originally used an incorrect value for the prior year (2010) Medicare Inpatient Operating Costs, as verified by the FY 2010 settled cost report (Ex. P-4) and Stipulations at ¶ 17.
[17] The Board notes that the Medicare Contractor is using the Federal Fiscal Year ("FFY") 2011 update factor while Champlain Valley is using the FFY 2012 update factor. FFY 2011 covers the period from 10/1/2010 to 9/30/2011 and FFY 2012 covers the period from 10/1/2011 to 9/30/2012.
[18] Calculation = $212,251,570/$252,822,262 = 0.839528799, rounded to 0.8395. *See* Ex. C-1 at 10.
[19] Champlain Valley does not remove variable costs from the VDA calculation. *See* Medicare Contractor's FPP at 9.

j) FY 2011 Fixed Costs (h x i)	$ 43,758,614	$ 52,122,827
k) Total DRG Payments	$ 50,816,826	$ 50,816,826
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 0[20]	
m) VDA Payment Amount (The Provider's VDA is based on the amount line d exceeds line f.)		$ 1,306,001

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[21]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that the regulation is "quite clear…that the [VDA] payment adjustment is '… to fully compensate the hospital for the **fixed costs** it incurs in the period in providing inpatient hospital services, including the reasonable costs of maintaining necessary core staff and services.'"[22] Further, the Medicare Contractor cites that the "method of calculating the VDA is outlined in PRM 15-1, Section 2810.1"[23]

The Medicare Contractor contends the intent of the VDA is to compensate qualified hospitals for their fixed/semi-fixed costs only, and not their variable costs.[24] This result, according to the Medicare Contractor, was achieved when it "(A) properly removed additional variable costs from the Provider's Medicare inpatient operating costs to determine the Provider's *fixed* Medicare inpatient operating costs; and (B) properly subtracted *total* MS-DRG revenue from the Provider's *fixed* Medicare inpatient operating costs to determine the payment set forth in the Revised VDA Determination."[25]

In support of its position, the Medicare Contractor cites to the United States Court of Appeals for the Eighth Circuit ("Eighth Circuit") in *Unity Healthcare vs. Azar ("Unity")*[26] and the Administrator's decisions in *Lakes Regional Healthcare v. BCBSA/Wisconsin Physicians Services*,[27] and *Fairbanks Memorial Hospital v. Wisconsin Physician Services*.[28, 29]

The Medicare Contractor calculated a VDA payment of $0, which Champlain Valley argues

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[20] Ex. C-1 (finding that the calculated amount would be negative, the Medicare Contractor determined no (or $0) VDA payment was due).
[21] Stipulations at ¶¶ 13-14.
[22] Medicare Contractor's FPP at 10.
[23] *Id.*
[24] *Id.* at 11.
[25] Stipulations at ¶ 15.
[26] Medicare Contractor's FPP at 11 (citing *Unity Healthcare v. Azar*, 918 F.3d 571 (8th Cir. 2019) *cert. denied*, 140 S. Ct. 523 (2019)).
[27] *Id.* (citing *Lakes Reg'l Healthcare v. BCBSA.,* Adm'r. Dec. 2014-D16 at 8 (Sept. 4, 2014).
[28] *Id.* at 12 (citing *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs*, PRRB Dec. No. 2015-D11 (June 9, 2015), *modified by*, Adm'r Dec. (Aug. 5, 2015).
[29] The Medicare Contractor uses these cases as support for its contention that it correctly removed the provider's variable costs from the VDA calculation. Medicare Contractor's FPP at 16-17.

"was approximately $1,306,001 less than that Provider requested."[30] Champlain Valley states, "the MAC's methodology for determining the VDA Approval was not consistent with its historical VDA Approval Methodology, the approach the MAC had consistently utilized (and reported to CMS) for over 25 years."[31] In addition, Champlain Valley contends that the Medicare Contractor's "approach was not consistent with the plain language of the applicable statute, regulation, and CMS program instruction."[32]

Champlain Valley also claims that the Medicare Contractor's VDA methodology is not only "arbitrary and capricious, but it also runs afoul of the notice and comment rulemaking requirements of the Administrative Procedures Act ("APA") and the Medicare Act."[33]

Champlain Valley argues that CMS and/or the Medicare Contractor violated the APA by making a substantive change in the VDA calculation methodology that "operate[s] to the significant financial detriment of the Provider."[34] Further, Champlain Valley 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."[35] Champlain Valley states that, "[e]ven if the Revised VDA Approval Methodology does not amount to an improper substantive rule under the APA, the Supreme Court's recent decision in *Azar v. Allina Health Services*, . . . , 139 S. Ct. 1804 (2019) ("Allina"), makes clear that the revision violates the Medicare Act's notice and comment rulemaking requirements"[36] which Champlain Valley cited at 42 U.S.C. § 1395hh(a)(2). The provisions of 42 U.S.C. § 1395hh(a)(2) specify, in pertinent part, that "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1)."

In support of its position, Champlain Valley asserts that the examples given at PRM 15-1 § 2810.1 "detail[] exactly how the [Medicare Contractor] is required to determine the VDA payment amount[,]"[37] and that CMS and/or the Medicare Contractor improperly departed from this methodology.[38] However, the Board notes that these examples relate to the VDA cap and not the actual VDA calculation, as the U.S. Circuit Court for the Eighth Circuit ("Eighth Circuit") recently confirmed in *Unity HealthCare v. Azar*:

> The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B)

[30] Provider's FPP at 1.
[31] *Id.* at 4.
[32] *Id.*
[33] *Id.* at 15.
[34] *Id.* at 16.
[35] *Id.* at 23.
[36] *Id.* at 24.
[37] *Id.* at 10.
[38] *Id.* at 15.

> of the Manual, where the examples are located, contains "the process for determining the amount of the volume decrease adjustment." See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006). However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, the Board found "that the examples are intended to demonstrate how to calculate the adjustment limit as opposed to determining which costs should be included in the adjustment." See Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n, No. 2006-D43, 2006 WL 3050893, *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. *The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than "equal to," when describing the formula.* We conclude that **the Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation.**[39]

Accordingly, what Champlain Valley points to as written or published CMS "policy" on how to calculate the VDA payment was not, in fact, such a policy.

Moreover, the fact that the Medicare Contractor, itself, may have previously calculated VDA payments differently does not automatically mean there is a departure from a Medicare program 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 applied nationwide to all hospitals at one time.[42] The fact that CMS may have directed the Medicare Contractor to calculate the VDA in this particular case (or even on a case-by-case basis, as presented to CMS) is not inconsistent with adopting a substantive policy through adjudication, and is different from the Allina situation where CMS posted publicly on its website a "nationwide" adoption of a new substantive policy. Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as delineated at 42 C.F.R. § 412.92(e)(3).[43] Moreover, the Board has had long-standing disagreements with Medicare Contractors and with the Administrator on their different interpretations and the application of the relevant statutes, regulations, and Manual

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[39] 918 F.3d 571, 578-79 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019) (footnotes omitted) (bold and italics 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."

guidance regarding the calculation of VDAs.[44] Accordingly, the Board rejects Champlain Valley's APA, Medicare statute, and Allina arguments.

Champlain Valley also argues that the Medicare Contractor's revised calculation of the VDA was incorrect because the methodology used guarantees that a hospital never receives full compensation for fixed costs.[45] According to Champlain Valley, the Medicare Contractor's revised VDA determination "improperly treats fixed (and semi-fixed) costs as variable costs, and confuses inpatient and outpatient expenses."[46] Champlain Valley contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[47] Champlain Valley 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, Champlain Valley maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed and variable costs. Specifically, Champlain Valley states that "basic logic requires the [Medicare Contractor] (at a minimum) to identify Medicare inpatient *fixed costs* and compare that figure to the total Medicare inpatient payments *received for those fixed costs*. The [Medicare Contractor]'s Revised VDA Approval Methodology fails to satisfy this simple, logical test."[48] Champlain Valley also references the fact that "CMS recently acknowledged that total MS-DRG payments include a component designed to reimburse variable costs"[49] when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[50]

Accordingly, the Board finds that the Medicare Contractor was correct in removing variable costs from the inpatient operating costs and that the method used to identify and remove these costs was reasonable, based on the operations of the cost report and the data Champlain Valley provided to the Medicare Contractor. However, the Board also finds that the comparable portion of the DRG payment related to variable costs should have been removed from the total DRG payment. The statute states that the VDA payment is to be adjusted "as may be necessary to fully compensate the hospital for the *fixed costs* it incurs in the period in providing inpatient hospital services."[51] The regulations state that to determine the payment the intermediary considers "[t]he hospital's fixed (and semi fixed) costs."[52] Further, the PRM states that "[a]dditional payment is made to an eligible [SCH] for the fixed costs it incurs in the period in providing inpatient hospital services."[53]

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[44] *See, e.g.*, *Unity Healthcare v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Similarly, the Provider fails to give any examples or support for its position that CMS and/or the Medicare Contractor are substantively changing policy as it relates to determining which costs are "treated" as variable versus semi-fixed in accordance with PRM 15-1 § 2810.1. See, e.g., Provider's FPP at 27-28. Further, the application of the PRM definitions of these terms to a particular provider's VDA request seems to be the very nature of adjudicatory fact-finding and why providers may appeal Medicare contractor VDA determinations to the Board.

[45] Provider's FPP at 35.

[46] *Id* at 12.

[47] *Id* at 28.

[48] *Id*.

[49] *Id* at 29.

[50] 82 Fed. Reg. 37990, 38180 (Aug. 14, 2017).

[51] 42 U.S.C. § 1395ww(d)(5)(D)(ii) (emphasis added).

[52] 42 C.F.R. § 412.92(e)(3).

[53] PRM 15-1 § 2810.1(B).

In recent Board decisions addressing VDA payments,[54] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because it compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor) and 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. . . .
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> 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 . . . .[55]

Recently, as noted above, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[56]

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

[54] *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).

[55] *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).

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

> 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.[57]

Moreover, noting that Champlain Valley is not located in the Eighth Circuit and the statutes and regulations for VDAs for SCHs and MDHs are identical, the Board finds that these applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[58] 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*.[59] In this regard, the Board further notes that §§ 412.92(e)(3) makes it clear that the VDA payment determination is subject to review through the Board's appeal process.[60] Thus, the Board finds that the Eighth Circuit's *Unity* decision was simply adjudicating a dispute regarding the reasonableness of the Administrator's interpretation of the statute and regulations governing VDAs that the Administrator applied in rendering her decision in *Unity*. As such, the Eighth Circuit's decision in *Unity* 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*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[61] CMS prospectively changed the methodology for calculating the VDA to one which is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated portion of the DRG payment that is related to

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[57] (Bold and italics emphasis added).

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

[59] *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).

[60] 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).

[61] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

fixed costs to the hospital's fixed costs when determining the amount of the VDA payment.[62] 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."[63]

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 Champlain Valley's VDA for FY 2011 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 Champlain Valley's VDA payment by comparing its FY 2011 fixed costs to its total FY 2011 DRG payments. However, neither the language nor the examples[64] 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[65] and the FFY 2009 IPPS Final Rule[66] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> The adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

It is clear from the preambles to these Final Rules that the only adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Champlain Valley'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 Champlain Valley's FY 2011 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[.]"[67] 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

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[62] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).
[63] 82 Fed. Reg. at 38180.
[64] PRM 15-1 § 2810.1(C)-(D).
[65] 71 Fed. Reg. at 48056.
[66] 73 Fed. Reg. at 48631.
[67] *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 (Dec. 15, 2016), *modified by*, Adm'r Dec. (Feb. 9, 2017).

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.[68]

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 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."[69] 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.

[68] 82 Fed. Reg. at 38179-38183.
[69] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

> 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***.[70]

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."

Based on its review of the statute, the regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[71] 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 SCH 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. § 412.92(e)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when

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[70] (Emphasis added).
[71] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

determining the payment amount.[72] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

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

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(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 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)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment, the VDA payment is clearly not intended to fully compensate the hospital for its variable costs. [73] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for Medicare services actually furnished. The Board concludes that, in order to both ensure the hospital is fully compensated for its fixed costs and be consistent with the assumption stated in PRM 15-1 § 2810.1 that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case the Medicare Contractor determined that Champlain Valley's 2011 fixed costs (which includes semi-fixed costs) were 83.95 percent[74] of its Medicare total costs for FY 2011. Applying the rationale described above, the Board finds that the VDA in this case should be calculated as follows:

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[72] 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.

[73] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).

[74] Stipulations at ¶ 17.

Step 1: Calculation of the Cap

2010 Medicare Inpatient Operating Costs	$ 51,438,417[75]
Multiplied by the 2010 IPPS update factor	1.0224[76]
2010 Updated Costs (max allowed)	$ 52,590,638
2011 Medicare Inpatient Operating Costs	$ 52,122,827[77]
Lower of 2010 Updated Costs or 2011 Costs	$ 52,122,827
Less 2011 IPPS payment	$ 50,816,826[78]
2011 Payment Cap	**$ 1,306,001**

Step 2: Calculation of VDA

2011 Medicare Inpatient Fixed Operating Costs	$ 43,757,113[79]
Less 2011 IPPS payment – fixed portion (83.95 percent)	$ 42,660,725[80]
Payment adjustment amount (subject to Cap)	**$ 1,096,388**

Since the payment adjustment amount of $1,096,425 is ***less*** than the Cap of $1,306,001, the Board determines that Champlain Valley's VDA payment for FY 2011 should be $1,096,388.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Champlain Valley's VDA payment for FY 2011, and that Champlain Valley should receive a total VDA payment in the amount of $1,096,388 for FY 2011.

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FOR THE BOARD:

4/24/2024

X Clayton J. Nix

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

[75] *Id*.
[76] The IPPS Update Factor for Federal Fiscal Year (FFY) 2011 is 1.0235 and for FFY 2012 is 1.019. As the Provider's fiscal year has 273 days (1/1/11 to 9/30/11) in FFY 2011 and 92 days (10/1/11 to 12/31/11) in FFY 2012, the proper factor is as follows ((273 x 1.0235) + (92 x 1.019)) / 365 = 1.02236575342, or 1.0224, rounded.
[77] Stipulations at ¶ 17.
[78] *Id*.
[79] *Id*. (Calculation = $52,122,827 x 83.95 percent = 43,757,113, rounded).
[80] The $42,662,725 is calculated by multiplying $50,816,826 (the FY 2011 DRG payments) by 0.8395 (the fixed cost percentage determined by the Medicare Contractor).