**PROVIDER REIMBURSEMENT REVIEW BOARD**
**DECISION**

On the Record

2021-D41

**PROVIDER-**
Massena Memorial Hospital

**Provider No.:** 33-0223

**vs.**

**MEDICARE CONTRACTOR –**
National Government Services, Inc.

**RECORD HEARING DATE –**
February 1, 2021

**Cost Reporting Period Ended** –
12/31/2013

**CASE NO. –** 17-0980

**INDEX**


| | Page No. |
|---|---|
| **Issue Statement……..** | **2** |
| **Decision……..** | **2** |
| **Introduction……...** | **2** |
| **Statement of Facts and Relevant Law…..…….** | **3** |
| **Discussion, Findings of Facts, and Conclusions of Law……** | **5** |
| **Decision…….....** | **15** |

## ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the Revised Volume Decrease Adjustment ("VDA") owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2013 ("FY 2013"), and whether the Medicare Contractor properly reopened the Original VDA approval.[1]

## DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly reopened the Original VDA approval but improperly recalculated the VDA payment for FY 2013 for Massena Memorial Hospital ("Massena" or "Provider"), and that Massena should receive an additional VDA payment for FY 2012 in the amount of $716,366, resulting in a total FY 2013 VDA of $1,608,103.

## INTRODUCTION

Massena is a non-profit acute care hospital located in Massena, New York and was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Massena for this appeal is National Government Services, Inc. ("Medicare Contractor"). In order to compensate it for a decrease in inpatient discharges, Massena requested an original VDA payment of $1,750,274 for FY 2013.[4] On October 23, 2015 the Medicare Contractor originally calculated Massena's FY 2013 VDA payment to be $1,818,093.[5] On January 29, 2016, the Medicare Contractor notified Massena that it was reopening the original VDA approval based on direction from the Center for Medicare and Medicaid Services ("CMS").[6] By letter dated October 11, 2016, the Medicare Contractor issued the Revised VDA Approval in the amount of $891,737.[7] Massena timely appealed the Medicare Contractor's revised VDA approval and met all jurisdictional requirements for a hearing before the Board.

The parties requested, and the Board approved, a record hearing on February 1, 2021. Massena was represented by William H. Stiles, Esq. of Verrill Dana, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

---

[1] Second Revised Stipulations of the Parties at ¶18 ("Revised Stipulations").
[2] *Id.* 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 P-2.
[5] Exhibit P-3.
[6] Revised Stipulations at ¶ 12.
[7] *Id.* at ¶ 13.

**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 the total number of inpatient cases of more than 5 percent from one cost reporting year to the next.[8] VDA payments are designed to fully compensate a hospital for the fixed costs that it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.[9] The implementing regulations, located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that Massena experienced a decrease in total discharges greater than 5 percent from FY 2012 to FY 2013 due to circumstances beyond Massena's control and that, as a result, Massena was eligible to have a VDA calculation performed for FY 2013.[10] Massena requested a VDA payment in the amount of $1,750,274 for FY 2013.[11] The Medicare Contractor initially agreed with the Provider and determined that Massena was entitled to a VDA payment of $1,818,093.[12] The Medicare Contractor later reopened and revised the VDA calculation to $891,737 after removing variable costs, based on direction from CMS.[13]

42 C.F.R. § 412.92(e) (2013) directs how the Medicare Contractor must calculate the VDA once an SCH demonstrates it experienced 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*[14] 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— . . .
>
> (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. . . .

[8] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[9] *Id.*
[10] Revised Stipulations at ¶ 10.
[11] Medicare Contactor's Final Position Paper at 6 (hereinafter "Medicare Contractor's FPP").
[12] *Id.*
[13] *Id.* at 6-7.
[14] (Emphasis added.)

In the preamble to the final rule published on August 18, 2006,[15] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), which provides further guidance related to VDAs and states in relevant part:

> B. Additional payment is made . . . for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
>
> 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*[16] with utilization such as food and laundry costs.

The chart below depicts how the Medicare Contractor and Massena each calculated the VDA payment leading to this appeal.

| | Medicare Contractor calculation using fixed costs[17] | Provider/PRM calculation using total costs[18] |
|---|---|---|
| a) Prior Year Medicare Inpatient Operating Costs | $8,286,484 | $8,321,250 |
| b) IPPS update factor | 1.018 | 1.018 |
| c) Prior Year Updated Operating Costs (a x b) | $8,435,641 | $8,471,033 |
| d) FY 2013 Operating Costs | $8,018,977 | $8,029,993 |
| e) Lower of c or d | $8,018,977 | $8,029,993 |
| f) DRG/SCH Payment | $6,200,884 | $6,279,719 |
| g) CAP (d-f) | $1,818,093 | $1,750,274 |
| | | |
| | | |
| h) FY 2013 Inpatient Operating Costs | $8,018,997 | $8,029,993 |
| i) Fixed Cost Percent | 88.45 | 1.00 |
| j) FY 2013 Fixed Costs (h x i) | $7,092,621 | $8,029,993 |
| k) Total DRG/SCH Payments | $6,200,884 | $6,279,719 |
| l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k) | $ 891,737 | |
| m) VDA Payment Amount (The Providers VDA is based on the amount by which line j exceeds line k.) | | $1,750,274 |

[15] 71 Fed. Reg. 47869, 48056 (Aug. 18, 2006).
[16] (Emphasis added.)
[17] Exhibit P-5 at 5.
[18] Exhibit P-2 at 20.

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**

Massena states that following the Medicare Contractor's review of Massena's VDA Request, and any supplemental responses, the Medicare Contractor determined that Massena's VDA Request satisfied the applicable statute, regulation and CMS program instructions. Accordingly, it originally approved Massena's VDA Request and issued its Original VDA Approval in the amount of $1,818,093.[20]

Massena argues that the Medicare Contractor's methodology for determining the Original VDA Approval was consistent with the approach that it had utilized (and reported to CMS) for over twenty-five years. In addition, the Medicare Contractor's approach was consistent with the plain language of the applicable statute, regulation, and CMS program instructions. Accordingly, Massena did not appeal the Original VDA Approval pursuant to 42 U.S.C § 1395oo.[21]

By letter dated January 29, 2016, the Medicare Contractor notified Massena that it was revising the original VDA.[22] Massena objected to the reopening, and by letter dated October 11, 2016, the Medicare Contractor issued the Revised VDA Approval.[23]

According to Massena, the workpapers attached to the Medicare Contractor's Revised VDA Approval demonstrate that the Medicare Contractor applied a new methodology that was inconsistent with plain language of the applicable statute, regulation, and CMS program instructions.[24]

The Medicare Contractor states that it was directed by CMS to revise Massena's original VDA approval to remove variable costs.[25] Massena argues that the reopening did not comply with the regulations at 42 C.F.R. § 405.1885(c), and should therefore be deemed invalid, and the revised VDA calculation deemed "void."[26]

The Medicare Contractor argues that it has the authority to 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

[19] Stipulations at ¶ 17.
[20] Provider's Final Position Paper at 3 (hereinafter "Provider's FPP").
[21] *Id.*
[22] *Id.*
[23] *Id.* at 4.
[24] *Id.*
[25] Exhibit C-3.
[26] Provider's FPP at 11.

> 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 . . . . [27]

The Medicare Contractor engaged in discussions with CMS regarding the inclusion of variable expenses in its Revised 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 Revised VDA Determination calculation. The Medicare Contractor notified Massena of this review and recalculation of the Revised VDA payment determination in its January 29, 2016, letter to Massena.[28]

The Medicare Contractor asserts that it was bound to revise the VDA payment to remove the variable expenses, in accordance with the plain language of 42 U.S.C. § 1395ww(d)(5)(D)(ii) and 42 C.F.R. § 412.92(e). Further, it argues that it was authorized to make the revision to the Revised VDA payment under its own discretion in accordance with 42 C.F.R. § 405.1885(a).[29]

The Medicare Contractor issued its original VDA approval on October 23, 2015.[30] The Medicare Contractor's subsequent Notice of Reopening was dated January 29, 2016,[31] in compliance with 42 C.F.R. § 405.1885(b)(1), which states:

> An 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 subject to the reopening.

The Board finds that, because 42 C.F.R. § 405.1885(a) gives the Medicare Contractor the authority to reopen a determination, and the Notice of Intent to Reopen was issued within 3 years from the prior determination, the Medicare Contractor properly reopened Massena's original VDA approval.

Massena claims that CMS' Revised VDA approval methodology runs afoul of the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA")[32] and the Medicare statute at 42 U.S.C. § 1395hh(a).[33] Massena 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, Massena argues that "although CMS may be entitled to revise its interpretation of the VDA

---

[27] Medicare Contractor's FPP at 8-9.
[28] *Id.* at 9.
[29] *Id.*
[30] Revised Stipulations at ¶ 11.
[31] *Id.* at ¶ 12.
[32] 5 U.S.C. Ch. 5.
[33] Provider's FPP at 17-19, 23-24.
[34] *Id.* at 18.

statute, such a drastic departure from its previous interpretation amounts to a substantive rule triggering the requirements of notice and comment rulemaking."[35] Massena states that, even 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*")[36] makes clear that the revisions violate the notice and comment rulemaking requirements at 42 U.S.C. § 1395hh(a).[37] 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, Massena 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[,]" and that CMS and/or the Medicare Contractor improperly departed from this methodology.[38] However, the Board notes that these examples relate to the cap and not the actual VDA calculation, as the U.S. Circuit Court for the Eighth Circuit ("Eighth Circuit") recently confirmed in *Unity HealthCare v. Azar*:

> The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B) of the Manual, where the examples are located, contains "the process for determining the amount of the volume decrease adjustment." See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006). However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, *the Board found "that the examples are intended to demonstrate* ***how to calculate the adjustment limit*** as opposed to determining which costs should be included in the adjustment." See *Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n*, No. 2006-D43, 2006 WL 3050893, 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*

[35] *Id.* at 24.
[36] 139 S. Ct. 1804 (2020).
[37] Provider's FPP at 25-27.
[38] *Id.* at 9.

> *Secretary's interpretation was **not** arbitrary or capricious and was consistent with the regulation.*[39]

Accordingly, what Massena 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."[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 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 than 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 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 Massena's APA and *Allina* arguments.

Massena also argues that the Medicare Contractor's revised calculation of the VDA was incorrect because the methodology used guarantees that a hospital will never receive full compensation for fixed costs.[45] According to Massena, the Medicare Contractor's Revised VDA improperly treated fixed (and semi-fixed) costs as variable costs, and confused inpatient and outpatient expenses.[46]

---

[39] 918 F.3d 571, 578-79 (8th Cir. 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."
[44] *See, e.g., Unity Healthcare v. Blue Cross Blue Shield As'n,* PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA,* PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Similarly, the Provider fails to give any examples or support to its position that CMS and/or the Medicare Contractor are substantively changing policy as it relates to determining which costs are "treated" as variable versus semi-fixed in accordance with PRM 15-1 § 2810.1. *See, e.g.,* Provider's Final Position Paper at 26. 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 36.
[46] *Id*. at 11, 38-40.

Massena contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[47] Massena 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, Massena maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Massena also references the fact that CMS recently acknowledged that total MS-DRG payments include a component designed to reimburse variable costs when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[48]

The Board notes that there is a difference in the FY 2013 Inpatient Operating Costs used by the parties in calculating the VDA payment. The Medicare Contractor calculated an adjusted amount of Inpatient Operating Costs to account for variable costs on the cost report.[49] Massena argues that the Medicare Contractor's VDA calculation methodology violates the statutes, regulations, and Provider Reimbursement Manual instructions.[50] However, the Board notes that the parties have agreed, in the Second Revised Stipulations, to the prior and current year Inpatient Operating Costs of $8,286,484 and $8,018,977, respectively. The fixed cost percentage was also stipulated at 88.45 percent.[51]

In its recent decisions,[52] the Board has disagreed with the methodology used by various Medicare contractors (including the Medicare Contractor in this appeal) to calculate VDA payments because that methodology compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

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

[47] *Id.* at 28.
[48] *Id.* at 29-30, 35-36.
[49] *See* Medicare Contractor's FPP at 13.
[50] Provider's FPP at 16-17.
[51] Revised Stipulations at ¶ 21.
[52] *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).

> 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 . . . .[53]

Recently, the Eighth Circuit upheld the Administrator's methodology in *Unity*, stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[54]

At the outset, the Board notes that the CMS 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.[55]

Moreover, the Board notes that Massena 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 the FFY 2018 IPPS Final Rule,[56] CMS prospectively changed the methodology for calculating the VDA to one which is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated portion of the DRG payment that is related to fixed costs, to the hospital's fixed costs, when determining the amount of the VDA payment.[57] The preamble to the FFY 2018 IPPS Final Rule makes this change effective for cost reporting periods beginning on or after October 1, 2017, explaining that it will "remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could

---

[53] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).
[54] *Unity HealthCare v. Azar,* 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).
[55] (Bold and italics emphasis added.)
[56] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[57] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).

ever be less than fully compensated for fixed costs as a result of the application of the adjustment."[58]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As explained below, the Board finds that the Medicare Contractor's calculation of Massena's VDA methodology for FY 2013 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 Massena's VDA payment by comparing its FY 2013 fixed costs to its total FY 2013 DRG payments. However, neither the language nor the examples[59] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[60] and the FFY 2009 IPPS Final Rule[61] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> [T]he adjustment amount is determined by subtracting the second year's MS-DRG payment from the lessor 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 Massena'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 Massena's FY 2013 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[.]"[62] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the methodology explained in the FFY 2007 and 2009 IPPS Final Rules/PRM and the statute. Notably, in applying this new methodology through adjudication, CMS did not

---

[58] 82 Fed. Reg. at 38180.
[59] PRM 15-1 § 2810.1(C)-(D).
[60] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[61] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).
[62] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D16 at 8 (Sep. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D15 at 8 (Sep. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Feb. 9, 2017).

otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[63]

The statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) is intended to fully compensate the hospital for its fixed costs:

> 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.[64]

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."[65] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 (Rev. 356) 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.

[63] 82 Fed. Reg. at 38179-38183.
[64] (Emphasis added.)
[65] 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***.[66]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule, which both 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."[67] 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."[68]

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)(2)(a) 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

---

[66] (Emphasis added.)
[67] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[68] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

determining the payment amount.[69] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

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

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)(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, it is clear that the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[70] 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 ensure the hospital is fully compensated for its fixed costs and 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 percentages as a proxy. In this case the Medicare Contractor determined that Massena's fixed costs (which includes semi-fixed costs) were 88.45 percent[71] of Massena's Medicare costs for FY 2013. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

---

[69] 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.

[70] 48 Fed. Reg. at 39782.

[71] Revised Stipulations at ¶ 21.

Step 1: Calculation of the CAP

| | |
|---|---|
| 2012 Medicare Inpatient Operating Costs | $8,286,484[72] |
| Multiplied by the 2013 IPPS update factor | 1.018[73] |
| 2012 Updated Costs (max allowed) | $8,435,641 |
| 2013 Medicare Inpatient Operating Costs | $8,018,977[74] |
| Lower of 2012 Updated Costs or 2013 Costs | $8,018,977 |
| Less 2013 IPPS payment | $6,200,884[75] |
| 2013 Payment CAP | **$1,818,093** |

Step 2: Calculation of VDA

| | |
|---|---|
| 2013 Medicare Inpatient Fixed Operating Costs | $7,092,785[76] |
| Less Excess Staffing | |
| Less 2013 IPPS payment – fixed portion ( 88.45 percent) | $5,484,682[77] |
| Payment adjustment amount (subject to CAP) | **$1,608,103** |

Since the payment adjustment amount of $1,608,103 is less than the Cap of $1,818,093, the Board concludes that Massena's total VDA payment for FY 2013 should be $1,608,103. Since Massena was already awarded a VDA Payment for FY 2013 in the amount of $891,737,[78] Massena is due an additional VDA payment for FY 2013 in the amount of $716,366.

## DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Massena's VDA payment for FY 2013, and that Massena should receive an additional VDA payment for FY 2013 in the amount of $716,366, resulting in a total FY 2013 VDA of $1,608,103.

[72] Exhibit P-5 at 5.
[73] *Id*.
[74] Revised Stipulations at ¶ 21.
[75] *Id*.
[76] Exhibit P-5 at 5. The current year operating costs is computed at $7,092,621 and slightly off from the $7,092,785. The difference is immaterial and is related to the rounding of the fixed cost percentage from 88.4479552 to 88.44 percent.
[77] The $5,484,682 is calculated by multiplying 6,200,884 (the FY 2013 SCH payments; *see* Stipulations at ¶ 21) by 0.8845 (the fixed cost percentage determined by the Medicare Contractor).
[78] Providers FPP at 4; Revised Stipulations at ¶ 13.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

9/24/2021

X Clayton J. Nix

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