

**PROVIDER REIMBURSEMENT REVIEW BOARD  
DECISION  
On the Record**

2021-D43

**PROVIDER-**  
St. Peter's Hospital

**Provider No.:** 27-0003

**vs.**

**MEDICARE CONTRACTOR –**  
Noridian Healthcare Solutions

**RECORD HEARING DATE –**  
April 12, 2021

**Cost Reporting Period Ended –**  
5/31/2014

**CASE NO. –** 17-0592

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## **ISSUE STATEMENT**

Whether the Medicare Contractor properly calculated the volume decrease adjustment owed to St. Peter's Hospital ("St. Peter's" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending May 31, 2014 ("FY 2014").<sup>1</sup>

## **DECISION**

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated the VDA payment for FY 2014 for St. Peter's, and that St. Peter's should receive a VDA payment in the amount of \$1,384,784 for FY 2014.

## **INTRODUCTION**

St. Peter's is a Sole Community Hospital ("SCH") located in Helena, Montana.<sup>2</sup> St. Peter's was designated as an SCH during the fiscal year at issue.<sup>3</sup> The Medicare contractor<sup>4</sup> assigned to St. Peter's for this appeal is Noridian Healthcare Solutions ("Medicare Contractor").<sup>5</sup> On January 7, 2016, St. Peter's filed a timely request for VDA payment in the amount of \$3,323,114 for the cost reporting period ending May 31, 2014.<sup>6</sup> The Medicare Contractor denied the request on July 29, 2016 because it concluded that St. Peter's inpatient prospective payment system ("IPPS") payments for its operating costs exceeded its allowable inpatient fixed and semi-fixed operating costs.<sup>7</sup> St. Peter's filed a Request for Reconsideration on September 26, 2016, which the MAC denied on March 14, 2017.<sup>8</sup> On December 6, 2016, St. Peter's timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on April 12, 2021. St. Peter's was represented by Ronald K. Rybar of The Rybar Group, Inc. Noridian Solutions, Inc. was represented by Scott Berends, Esq. of Federal Specialized Services.

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<sup>1</sup>Provider's Final Position Paper ("Provider's FPP") at 2; Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 3, 5.

<sup>2</sup> Stipulations at ¶ 1.

<sup>3</sup> *Id.*

<sup>4</sup> 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.

<sup>5</sup> Stipulations at ¶ 3.

<sup>6</sup> *Id.* at ¶ 4.

<sup>7</sup> *Id.* at ¶ 5; Exhibit P-2.

<sup>8</sup> Stipulations at ¶ 6.

## **STATEMENT OF FACTS AND RELEVANT LAW**

The Medicare program pays certain hospitals a predetermined, standardized amount per discharge under the 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 more than 5 percent from one cost reporting year to the next. VDA payments are designed to compensate a hospital for the fixed costs it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.<sup>9</sup> The implementing regulations, located at 42 C.F.R. § 412.92(e), reflect these statutory requirements.

It is undisputed that St. Peter’s experienced a decrease in discharges greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond its control, and that, as a result, St. Peter’s was eligible to have a VDA calculation performed for FY 2014.<sup>10</sup> However, when the Medicare Contractor made the FY 2014 VDA calculation, it determined that St. Peter’s’ DRG payment exceeded its fixed program operating costs by \$573,538.<sup>11</sup> Therefore, the Medicare Contractor concluded that St. Peter’s did not qualify for a VDA payment for FY 2014.<sup>12</sup>

The regulation at 42 C.F.R. § 412.92(e) (2014) directs how the Medicare Contractor must determine the VDA once an SCH demonstrates it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.92(e)(3) states, in pertinent part:

(3) The intermediary determines a lump sum adjustment amount *not to exceed*<sup>13</sup> 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. . . .

The preamble to the final rule published on August 18, 2006<sup>14</sup> references the Provider Reimbursement Manual, Pub. No. 15-1 (“PRM 15-1”) § 2810.1 (Rev. 371), which offers further guidance related to VDAs. This manual provision states, in relevant part:

<sup>9</sup> 42 U.S.C. § 1395ww(d)(5)(D)(ii).

<sup>10</sup> Stipulations at ¶ 4. *See also* Provider’s FPP at 2.

<sup>11</sup> Stipulations at ¶¶ 5, 11.

<sup>12</sup> *Id.*

<sup>13</sup> (Emphasis added.)

<sup>14</sup> 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

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* with utilization such as food and laundry costs.<sup>15</sup>

The chart below depicts how the Medicare Contractor and St. Peter's each calculated the VDA payment.

	Medicare Contractor calculation using fixed costs <sup>16</sup>	Provider/PRM calculation using total costs <sup>17</sup>
a) Prior Year Medicare Inpatient Operating Costs	\$18,147,012	\$18,147,012
b) IPPS update factor	1.0171	1.127 <sup>18</sup>
c) Prior year Updated Operating Costs (a x b)	\$18,457,326	\$20,499,337
d) FY 2014 Operating Costs	\$19,629,005	\$19,629,005
e) Lower of c or d	\$18,457,326	\$18,457,326 <sup>19</sup>
f) DRG/SCH payment	\$17,072,542	\$17,072,542
g) CAP (e-f)	\$ 1,384,784	\$ 1,384,784
h) FY 2014 Inpatient Operating Costs	\$18,457,326	\$19,629,005
i) Fixed Cost percent	0.8939	1.00 <sup>20</sup>
j) FY 2014 Fixed Costs (h x i)	\$16,499,004	\$19,629,005
k) Total DRG/SCH Payments	\$17,072,542	\$16,804,725
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	\$ (573,538)	
m) VDA Payment Amount (The Provider's VDA is based on the amount by which line j exceeds line k.)		\$ 2,824,280

<sup>15</sup> (Emphasis added).

<sup>16</sup> Stipulations at ¶ 11.

<sup>17</sup> *Id.* at ¶ 8.

<sup>18</sup> *Id.* at ¶ 8 (this includes a PPS Update Factor of 1.026 and an anomaly adjustment to increase the Medicare Utilization by 1.101 percent).

<sup>19</sup> *Id.* at ¶ 11.

<sup>20</sup> Provider's FPP at 4. St. Peter's states that "[n]owhere in the Federal Register [dated August 19, 2008 at 48630-35] does it say to subtract variable costs from the Provider's costs." *Id.* As a result, the fixed cost is stated as 100 percent.

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.<sup>21</sup>

### **DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW**

The Medicare Contractor disagrees with St. Peter's assertion that the Federal Register does not specifically state that variable costs should be removed from total costs to compute the VDA.<sup>22</sup> In support of its position, the Medicare Contractor cites to the decision of the U.S. Court of Appeals for the U.S. Court of Appeals for the Eighth Circuit ("Eighth Circuit"), *Unity Healthcare, St. Anthony Regional Hospital and Lakes Regional Healthcare vs. Alex M Azar, II, Secretary, U.S. Department of Health and Human Services*.<sup>23</sup>

St. Peter's argues that the Medicare Contractor's calculation of 89.4 percent<sup>24</sup> of fixed costs was in error, but does not provide an alternative calculation. Instead, on Table 3<sup>25</sup> of their final position paper, St. Peter's submitted a chart of alternative fixed cost percentage calculations ranging from 89.4 percent to 98.74 percent.<sup>26</sup>

In addition, St. Peter's argues that CMS improperly changed its methodology for calculating VDA payments without going through notice-and-comment rulemaking.<sup>27</sup> St. Peter's states that, since the publication of the Federal Register in 2008, some of the Medicare contractors began to change the methodology for computing the VDA payments. It contends that the VDA calculation was not lawfully altered until the August 19, 2017 Federal Register was issued. St. Peter's references the *Allina v. Burwell* (D.C. Cir. Case No. 16-5255) ruling where the Department of Health and Human Services failed to go through a notice and comment period when changing a policy that had a major impact on payments.<sup>28</sup>

St. Peter's also contends that the Medicare Contractor's approach does not fully compensate St. Peter's for its fixed and semi-fixed inpatient operating costs.<sup>29</sup> St. Peter's maintains that the most appropriate methodology to calculate the VDA payment can be found in 42 C.F.R. § 412.92 and PRM 15-1 § 2810.1.

St. Peter's, in essence, favors applying the methodology adopted by the Board, and argues 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, St. Peter's maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. St. Peter's also references the

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<sup>21</sup> Provider's FPP at 4-9; Medicare Contractor's FPP at 8-12.

<sup>22</sup> Medicare Contractor's FPP at 9.

<sup>23</sup> *Id.* at 10-12.

<sup>24</sup> Exhibit C-7 at 2 (1 - 0.105969903 = 0.8940301 or 89.4% rounded).

<sup>25</sup> Provider's FPP at 6.

<sup>26</sup> See Exhibit P-5 for variable costs.

<sup>27</sup> Provider's FPP at 9.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* at 6-9.

fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.<sup>30</sup>

The Board identified three basic differences between the Medicare Contractor's and St. Peter's calculations of St. Peter's VDA payment. First, St. Peter's does not agree with the Medicare Contractor's calculation of the fixed cost percentage. St. Peter's has offered five alternative calculations, including the Medicare Contractor's calculation of the fixed cost percentage. Although the Board does not find any one of these calculations to be completely theoretically accurate,<sup>31</sup> the Board finds the Medicare Contractor's methodology (the Provider's Option 1 calculation) to be the most accurate.<sup>32</sup>

The second difference is that St. Peter's included the DRG payment in the VDA calculation in lieu of the Hospital Specific Payment ("HSP"). The Board notes that the VDA regulations at 42 C.F.R. § 412.92(e) require the VDA to be calculated using "the hospital's *total DRG revenue for inpatient operating costs* based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106. . . .)"<sup>33</sup>

The Board reviewed the SCH payment methodology in 42 C.F.R. § 412.92(d) to determine what payments should be included in the hospital's "total DRG revenue for inpatient operating costs." 42 C.F.R. § 412.92(d) provides that SCHs are paid for inpatient operating costs based on the greater of the Federal payment rate or the hospital specific rate.<sup>34</sup> Based on these regulations, the Board finds that an SCH's total DRG revenue for inpatient operating costs includes both the amount paid based on the federal rate and the amount paid based on the hospital specific rate. Therefore, the Board concludes the HSP amount of \$17,072,542 should be used when calculating St. Peter's FY 2014 VDA payment.

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<sup>30</sup> *Id.* at 5-7.

<sup>31</sup> The calculation is not considered to be sufficiently accurate since the variable costs identified by the Medicare Contractor included General Service Cost Centers (cost report lines above 5 to 18) that would be allocated down to non-reimbursable costs (cost report lines below line 118) and the HHA (line 101), Hospice (line 116), Home Dialysis (94) and Ambulance (line 95). *See* Provider's FPP at 10, Table 5; *see also* Exhibits C-6 & C-7. The Board finds that the most accurate method to calculate the fixed cost percentage is to remove variable costs from the cost report and recompute D-1, Part II, line 53 of the cost report.

<sup>32</sup> The Board rejects Options 2 to 5 since the Medicare Contractor only analyzed variable costs for cost report lines above 118 and did not include lines 119 and below in their analysis of variable costs. For the same reason, the Board rejects Option 2 since the HHA, Hospice, Home Dialysis and Ambulance cost centers were not included in the cost report lines reviewed by the Medicare Contractor. *Id.* In essence, if cost centers that were not reviewed for variable costs are included in the VDA calculation, the calculation of the fixed cost percentage will be improperly deflated.

<sup>33</sup> (Emphasis added.)

<sup>34</sup> *See* 42 C.F.R. § 412.92(d), which references various sections, including § 412.79, the section that the Medicare Contractor used to calculate St. Peter's hospital specific rate payment. 42 C.F.R. § 412.79 provides for the determination of the hospital specific rate stating in subsection (e) "[t]he applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge."

Third, St. Peter's maintains that they qualify for a VDA payment because the calculations in this case produced an anomalous result, as described in PRM § 2810.1(D)(2).<sup>35</sup> Because St. Peter's Medicare discharges increased 3.6 percent while its total discharges decreased by 5.9 percent, St. Peter's has adjusted its FY 2013 inpatient operating costs in the VDA calculation to reflect the FY 2014 utilization when calculating its VDA payment.<sup>36</sup>

The Board finds that the facts in this case do not meet the example in PRM § 2810.1(D)(2) of a situation that may produce an anomalous result. The Medicare contractor has been granted discretion to request a review by CMS in those circumstances where "the procedures in . . . [PRM section 2810.1(D)(2)], when applied to a specific adjustment request, generate an anomalous result." The PRM gives a single example of what might produce an anomalous result: "when the decrease in Medicare discharges is significantly *less* than the decrease in total discharges."<sup>37</sup> Here, St. Peter's Medicare discharges actually *increased* when compared to FY 2013, such that St. Peter's does not meet the plain language of the only example in any controlling authority (*i.e.*, guidance in case law, in regulations, in Federal Register pronouncements, or PRM 15-1 provisions) that may produce an anomalous result, for purposes of qualifying for a VDA payment.<sup>38</sup>

With regard to what methodology should be utilized in calculating St. Peter's VDA payment, this issue is not new to the Board. In recent Board decisions addressing VDA payments,<sup>39</sup> the Board has disagreed with the methodology used by various Medicare contractors (including the one involved 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

<sup>35</sup> Provider's FPP at 2-3.

<sup>36</sup> Exhibit P-1 at 18; *see also* Stipulations at ¶ 8.

<sup>37</sup> (Emphasis added.)

<sup>38</sup> While the Board understands that a change in utilization could result in a different allocation of costs to the Medicare Program, the Board declines to overturn the Medicare Contractor's judgment related to an anomalous result, in part, because of the limited information in the record (*e.g.*, limited information on the reason for the 11.9 percent increase in Medicare days (*see* Exhibit P-1 at 18). Similarly, the Board notes that the record does not include copies of the cost report worksheets and that the limited record raises concerns about the basis for the unusual 3.9 percent increase in St. Peter's total costs (*Id.* at 25) even though its total volume decreased by 5.9 percent (*see id.* at 18).

<sup>39</sup> *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).

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 . . . .<sup>40</sup>

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.”<sup>41</sup>

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

e. Nonprecedential Nature of the Administrator's Review Decision.—Decisions by the Administrator *are not precedents* for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy [*sic*] having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.<sup>42</sup>

Moreover, the Board notes that St. Peter’s is not located in the Eighth Circuit and, thus, the *Unity* decision is not binding precedent in this appeal. The Board further finds that 42 U.S.C. § 1395ww(d)(5)(D)(ii) and 42 C.F.R. § 412.92(d)(3) only provide a framework by which to calculate a VDA payment,<sup>43</sup> and the Board is not bound to apply the *specific* VDA calculation

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<sup>40</sup> *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).

<sup>41</sup> *Unity Healthcare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

<sup>42</sup> (Bold and italics emphasis added).

<sup>43</sup> With regard to 42 U.S.C. § 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 purposes.”), *aff’d*, *Unity HealthCare v. Azar*, 918 F. 3d 571 (8<sup>th</sup> Cir. 2019) With regard to 42 C.F.R. § 412.92(e)(3), *see, e.g., id.* at 772, 780 (adopting the Magistrate’s report which found that “[t]he regulations promulgated by the Secretary in effect during the relevant time period did not provide a specific formula for calculating the VDA payment[,]” and “[i]nstead, the regulation directed that the following factors be considered in determining the VDA payment amount. . . .”). The Board’s plain reading of the regulation is confirmed by the Agency’s discussion of this regulation in the preamble to rulemakings. *See, e.g.,* 52 Fed. Reg.

methodology that the Administrator applied in *Unity* and which the Eighth Circuit upheld.<sup>44</sup> In this regard, the Board further notes that 42 C.F.R. § 412.92(d)(3) makes it clear that the VDA payment determination is subject to review through the Board appeals process.<sup>45</sup> 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* and, as such, the Eighth Circuit's decision in *Unity* did not create a binding precedent that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to the FFY 2018 IPPS Final Rule,<sup>46</sup> 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.<sup>47</sup> 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."<sup>48</sup>

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 St. Peter's' VDA methodology for FY 2014 was incorrect because it was *not* based on CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preambles to the relevant Final Rules.

The Medicare Contractor determined St. Peter's' VDA payment by comparing its FY 2014 fixed costs to its total FY 2014 DRG payments. However, neither the language nor the examples<sup>49</sup> in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a

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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).

<sup>44</sup> 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).

<sup>45</sup> 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 "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.)

<sup>46</sup> 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

<sup>47</sup> This amount continues to be subject to the caps specified in 42 C.F.R. § 412.92(e).

<sup>48</sup> 82 Fed. Reg. at 38180.

<sup>49</sup> PRM 15-1 § 2810.1(C)-(D).

hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule<sup>50</sup> and the FFY 2014 IPPS Final Rule<sup>51</sup> reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

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

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 St. Peter'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 that the Medicare Contractor calculated St. Peter's' FY 2014 VDA based on an otherwise *new* methodology that the Administrator apparently adopted through adjudication in her decisions, which 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[.]"<sup>52</sup> 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.<sup>53</sup>

The intent of 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 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.

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<sup>50</sup> 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

<sup>51</sup> 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

<sup>52</sup> *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014); *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm'r Dec. 2017-D1 at 12 (Feb. 9, 2017).

<sup>53</sup> 82 Fed. Reg. at 38179-38183.

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.”<sup>54</sup> 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.*<sup>55</sup>

<sup>54</sup> 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

<sup>55</sup> (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.”<sup>56</sup>

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.”<sup>57</sup> Under 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 rationale necessarily assumes that the entire DRG payment is payment *only for the fixed costs* of the services actually furnished to Medicare patients.

However, 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 the 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 determining the payment amount.<sup>58</sup> 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 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.

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<sup>56</sup> *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.

<sup>57</sup> 42 U.S.C. § 1395ww(d)(5)(D)(ii).

<sup>58</sup> The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) (2014) 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.

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, the Administrator's methodology is not a reasonable interpretation of the statute.

St. Peter's further argues that “[w]hen the MAC changed the [VDA] calculation without following the legal notice and comment period, they unlawfully changed regulations. The [VDA] calculation was not lawfully altered until the August 17, 2017 Federal Register was issued.”<sup>59</sup> St. Peter's contends that “the process of making the payment calculation is principally provided in PRM 2810.1 and subsequently updated in the Federal Register dated August 19, 2008 pages 48630-35.”<sup>60</sup> However, the Board notes that the examples in PRM 15-1 § 2810.1 relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B) of the Manual, where the examples are located, contains “the process for determining the amount of the volume decrease 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

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<sup>59</sup> Provider's FPP at 9.

<sup>60</sup> *Id.* at 4

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.*<sup>61</sup>

Accordingly, what St. Peter's 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."<sup>62</sup> The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.<sup>63</sup> 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.<sup>64</sup> 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).<sup>65</sup> 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.<sup>66</sup> Accordingly, the Board rejects St. Peter's argument regarding lack of notice or comment opportunity.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(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.<sup>67</sup> 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 both that the hospital is

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<sup>61</sup> 918 F.3d 571, 578-79 (8<sup>th</sup> Cir. 2019) (footnotes omitted; bold and italics emphasis added).

<sup>62</sup> Moreover, the fact that any particular Medicare contractor historically calculated VDAs in a particular manner does not make that calculation CMS policy.

<sup>63</sup> See, e.g., *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).

<sup>64</sup> 139 S. Ct. at 1808, 1810.

<sup>65</sup> 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."

<sup>66</sup> 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). Further, the application of the PRM definitions of the terms "variable" and "semi-fixed" costs to a particular provider's VDA request seems to be the very nature of adjudicatory fact-finding and why providers may appeal Medicare contractor VDA determinations to the Board.

<sup>67</sup> 48 Fed. Reg. at 39782.

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 percentages as a proxy. In this case, the Medicare Contractor determined that St. Peter’s fixed costs (which includes semi-fixed costs) were 89.39 percent<sup>68</sup> of St. Peter’s Medicare costs for FY 2014. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the CAP

2013 Medicare Inpatient Operating Costs	\$18,147,012 <sup>69</sup>
Multiplied by the 2013 IPPS update factor	<u>1.0171<sup>70</sup></u>
2013 Updated Costs (max allowed)	\$18,457,326
2014 Medicare Inpatient Operating Costs	\$19,629,005 <sup>71</sup>
Lower of 2013 Updated Costs or 2014 Costs	\$18,457,326
Less 2014 IPPS payment	<u>\$17,072,542<sup>72</sup></u>
2014 Payment CAP	<b>\$ 1,384,784</b>

Step 2: Calculation of VDA

2014 Medicare Inpatient Fixed Operating Costs	\$17,546,368 <sup>73</sup>
Excess Staffing	<u>\$ 306,848<sup>74</sup></u>
2014 Medicare Inpatient Fixed Operating Costs Less Excess Staff	\$17,239,520
Less 2014 IPPS payment – fixed portion (89.39 percent)	<u>\$15,261,146<sup>75</sup></u>
Payment adjustment amount (subject to CAP)	<b>\$ 1,978,374</b>

<sup>68</sup> Stipulations at ¶ 12. Amount per Exhibit C-2 at 2 is 89.40 percent (1 - 0.105969903 = 89.40 percent rounded). Pass variance as immaterial.

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> Calculated by multiplying 2014 Medicare Inpatient Operating Costs of \$19,629,005 by the Fixed cost percentage of 89.39 percent.

<sup>74</sup> Exhibit C-2 at 2. The New Program Operating Costs with excess staffing removed was calculated by the Medicare Contractor to be \$19,322,157. The 2014 Medicare Inpatient Operating Costs of \$19,629,005 minus \$19,322,157 equals the excess staffing amount of \$306,848.

<sup>75</sup> Calculation = 17,072,542 \* 0.8939000156 = 15,261,145.560132, rounded to \$15,261,146.

Since the payment adjustment amount of \$1,978,374 is greater than the Cap of \$1,384,784, the Board determines that St. Peter's' VDA payment for FY 2014 is limited to the Cap amount and is \$1,384,784.

**DECISION**

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated the VDA payment for FY 2014 for St. Peter's, and that St. Peter's should receive a VDA payment in the amount of \$1,384,784 for FY 2014.

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FOR THE BOARD:

9/30/2021

**X** Clayton J. Nix

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Signed by: PIV