

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

2023-D2

PROVIDER -
Galesburg Cottage Hospital

RECORD HEARING DATE –
February 3, 2022

Provider No.
14-0040

Cost Reporting Period Ended –
04/30/2016

vs.

MEDICARE CONTRACTOR –
WPS Government Administrators

CASE NO.
20-0420

CONTENTS

ISSUE STATEMENT.....	2
DECISION.....	2
INTRODUCTION	2
STATEMENT OF FACTS AND RELEVANT LAW	2
DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW	5
DECISION.....	15

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment (“VDA”) owed to Galesburg Cottage Hospital (“Galesburg” or the “Provider”) for the significant decrease in inpatient discharges that occurred in its cost reporting period ending April 30, 2016 (“FY 2016”).¹

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 Galesburg’s VDA payment for FY 2016, and that Galesburg should receive an additional VDA payment of \$984,707 for a total VDA payment in the amount of \$1,651,194 for FY 2016.

INTRODUCTION

Galesburg is a Medicare Dependent Hospital (“MDH”) located in Galesburg, Illinois.² The Medicare contractor³ assigned to Galesburg for this appeal is Wisconsin Physicians Service Government Health Administrators (“Medicare Contractor”). Galesburg requested a VDA adjustment,⁴ and the Medicare Contractor approved a VDA payment in the amount of \$666,487 via letter dated June 11, 2019.⁵ Galesburg timely appealed the Medicare Contractor’s final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on February 3, 2022. Galesburg was represented by Ronald Rybar of The Rybar Group, Inc. 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 MDHs if, due to circumstances beyond their control, they incur a decrease in their total number of inpatient discharges of more than 5 percent from one cost reporting year to the next.⁶ VDA payments are intended “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.”⁷

¹ Provider’s Consolidated Final Position Paper (hereinafter “Provider’s FPP”) at 2 (Nov. 4, 2021); Medicare Contractor’s Consolidated Final Position Paper (hereinafter “Medicare Contractor’s FPP”) at 4 (Dec. 2, 2021).

² Stipulations (hereinafter “Stip.”) 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 Stip. at ¶ 5.

⁵ Exhibit (hereinafter “Ex.”) C-1 at 1; Stip. at ¶ 7.

⁶ 42 U.S.C. § 1395ww(d)(5)(G)(iii).

⁷ *Id.*

The implementing regulations are located at 42 C.F.R. § 412.108(d) (2015). When promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals (“SCHs”).⁸

The regulation at 42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates that it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.108(d)(3) states, in pertinent part:

(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

(C) The length of time the hospital has experienced a decrease in utilization.⁹

Significantly, § 412.108(d)(3) makes clear that, when calculating a VDA payment, the Medicare Contactor must take into account multiple factors including but not limited to “the individual hospital's needs and circumstances.”

As CMS noted in the preamble to the final rule published on August 18, 2006,¹⁰ the Provider Reimbursement Manual, CMS Pub. 15-1 (“PRM 15-1”), § 2810.1 (Rev. 371) provides further guidance related to VDAs. Specifically, § 2810.1(B) (Rev. 371) states, in pertinent part:

Additional payment is made to an eligible [MDH] for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference

⁸ 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

⁹ (Emphasis added.) *See also* 42 U.S.C. § 1395ww(d)(5)(G)(iii).

¹⁰ 71 Fed. Reg. at 48056.

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.¹¹

The chart below depicts how the Medicare Contractor and Galesburg each calculated the FY 2016 VDA payment.

	Medicare Contractor calculation using fixed costs ¹²	Provider/PRM calculation using total costs ¹³
a) Prior Year Medicare Inpatient Operating Costs		\$10,555,219
b) IPPS update factor		1.024
c) Prior year Updated Operating Costs (a x b)		\$10,808,544
d) FY 2016/Current Year Operating Costs		\$ 9,746,224
e) Lower of c or d		\$ 9,746,224
f) DRG/MDH payment		\$ 7,613,216
g) Cap (e-f)		\$ 2,133,008
h) FY 2016 Inpatient Operating Costs	\$ 9,746,224 ¹⁴	\$ 9,746,224
i) Fixed Cost percent		1.000 ¹⁵
j) FY 2016 Fixed Costs (h x i)	\$ 8,525,284 ¹⁶	\$ 9,746,224
k) Total DRG/MDH Payments ¹⁷	\$ 7,858,797 ¹⁸	\$ 7,613,216
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	\$ 666,487	
m) VDA Payment Amount (The Provider's VDA is based on the amount by which line j exceeds line k.)		\$ 2,133,008 (666,487) ¹⁹ \$ 1,466,521

The parties to this appeal dispute the application of the statute and regulations used to calculate the VDA payment.²⁰

¹¹ (Emphasis added.)

¹² Stip. at ¶ 12.

¹³ *Id.* at ¶ 9.

¹⁴ *Id.* at ¶ 12; Ex. C-1 at 7.

¹⁵ Galesburg does not remove variable costs from the VDA calculation. Galesburg states that variable costs are not removed in any of the examples in PRM 2810.1 nor in the Federal Register published in 2008. Provider's FPP at 6.

¹⁶ Stip. at ¶ 12, Ex. C-1 at 7.

¹⁷ There is a dispute as to the proper payment calculation. Galesburg is using Worksheet E, Part A, Line 47 while Medicare Contractor is using Worksheet E, Part A, Line 49 (which includes the hospital specific portion of the payment paid to MDHs).

¹⁸ Stip. at ¶ 12; Ex. C-1 at 7.

¹⁹ VDA payment received on June 11, 2019.

²⁰ Stip. at ¶ 14.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that, “the additional [VDA] payment is to compensate for fixed and semi-fixed costs only, not variable costs. . . . The provider believes any potential volume decrease adjustment should ensure it is fully reimbursed for all costs, including variable costs.”²¹

The Medicare Contractor removed variable costs through Worksheet A-8 adjustments on Galesburg’s cost report. As specific instructions to determine the fixed/semi-fixed costs are not included in the statute, regulations, or Provider Reimbursement Manual, the Medicare Contractor used the cost report as a method of calculating fixed/semi-fixed costs, and argues that this is “provides the most accurate determination of Medicare inpatient fixed and semi-fixed costs.”²² The Medicare Contractor notes that “CMS has long considered a provider’s Medicare cost report the most accurate and efficient way of reporting, calculating, and determining Medicare costs,”²³ and argues that this “was the methodology utilized in the *Greenwood, Unity*, and *Lakes* cases . . . [and] if CMS disagreed with the MAC’s methodology, the Administrator would not have affirmed the *Unity* and *Lakes* calculations.”²⁴

Galesburg argues that the Medicare Contractor’s calculation of the VDA was incorrect because the Medicare Contractor “departed from CMS’s manual instructions and step-by-step guide and added an unauthorized and monumental extra step.”²⁵ According to Galesburg, “[n]owhere in the Federal Register does it say to subtract variable costs from the [p]rovider’s costs.”²⁶ The Board notes that the Final Rule published on September 1, 1983 (“FFY 1984 IPPS Final Rule”)²⁷ states that “[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.”²⁸

Galesburg contends that the Medicare Contractor’s approach “does not fully compensate the Provider for its fixed costs.”²⁹ Galesburg also maintains that its current VDA calculation is in accordance with PRM 15-1 § 2810.1,³⁰ and that this was the methodology in effect during the cost reporting periods under appeal.

Finally, Galesburg 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, Galesburg maintains, would ensure an accurate matching of revenue with expenses, “because DRG revenue compensates a hospital for all its expenses in treating inpatients - both fixed *and* variable costs.”³¹

²¹ Medicare Contractor’s FPP at 8.

²² *Id.* at 19.

²³ *Id.* at 12.

²⁴ *Id.* at 15 (referencing *Unity Healthcare v. Blue Cross Blue Shield Ass’n*, Adm’r Dec. 2014-D15 (Sept. 4, 2014) and *Lakes Reg’l Healthcare v. Blue Cross Blue Shield Ass’n*, Adm’r Dec. 2014-D16 (Sept. 4, 2014)).

²⁵ Provider’s FPP at 7.

²⁶ *Id.* at 6.

²⁷ 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983).

²⁸ (Emphasis added.)

²⁹ Provider’s FPP at 11.

³⁰ *Id.* at 3.

³¹ *Id.* at 9.

Galesburg also references the fact that CMS essentially adopted a methodology which compares fixed inpatient costs to fixed MS-DRG revenue, and clarified these calculations to reflect that the same ratio is used for costs and payments when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.³²

The Board identified two basic differences between the Medicare Contractor's and Galesburg's calculations of the VDA payment. The first difference is that Galesburg included the DRG payments on Worksheet E, Part A, Line 47 as the DRG revenue and the Medicare Contractor included Worksheet E, Part A, Line 49, which includes Line 47 plus a percentage of the Hospital Specific Rate ("HSR") payment (on Line 48), as the DRG revenue.³³

The Board reviewed the VDA regulations at 42 C.F.R. § 412.108(d). These regulations require the VDA to be calculated using:

[T]he hospital's *total DRG revenue for inpatient operating costs* based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106).³⁴

The Board also reviewed the MDH payment methodology in 42 C.F.R. § 412.108(c) to determine what payments should be included in the hospital's "total DRG revenue for inpatient operating costs."³⁵ Pursuant to 42 C.F.R. § 412.108(c), MDHs are paid for inpatient operating costs based on the sum of the "Federal payment rate applicable to the hospital" and "75 percent of the amount that the Federal rate...is exceeded by the hospital specific rate."³⁶ Based on these regulations, the Board finds that an MDH'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.

The second issue relates to whether variable costs are to be removed from the VDA calculation. The Medicare Contractor removed variable costs from the Medicare inpatient operating costs, whereas Galesburg asserts that variable costs are not to be removed from the Medicare Inpatient operating costs. Galesburg states that they are entitled to a VDA calculated in accordance with the methodology in PRM 15-1 § 2810.1 that was also formalized in the IPPS final rules for 2007 and 2009.³⁷ The Medicare Contractor states that it is clear per the statute, regulations, and PRM instructions, that viable costs are to be removed from the VDA calculation.³⁸ Galesburg requests that if the Board finds that

³² *Id.*

³³ Stip. ¶ 12 has the IPPS payment as adding Lines 49 plus 50. However, it is clear from a review of Ex. C-1 at 7 that the Medicare Contractor only included the IPPS payments from Line 49 in the VDA calculation.

³⁴ (Emphasis added.)

³⁵ 42 C.F.R. § 412.108(d).

³⁶ 42 C.F.R. § 412.108(c) references various sections including § 412.79, the section that the Medicare Contractor used to calculate Galesburg'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."

³⁷ Provider's FPP at 6.

³⁸ *Id.*

variable costs are to be included in the VDA payment calculation, then the VDA payment be computed under the Boards methodology.³⁹

In recent Board decisions addressing VDA payments,⁴⁰ the Board has disagreed with the methodology used by various Medicare contractors (including the one involved in this appeal) to calculate VDA payments because the methodology used 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 hospital's VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

Referring to the methodology adopted by the Board in previous decisions, Galesburg implies that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, then there should also be a corresponding decrease to the DRG payment for variable costs. Galesburg states its "DRG payments would have been multiplied by the percentage of fixed program costs to all program costs to calculate the DRG payments attributable to fixed costs."⁴¹ Galesburg also references the fact that CMS essentially adopted this approach when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.⁴²

The Administrator has overturned these Board decisions, stating:

[T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . .

In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider.⁴³

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."⁴⁴

³⁹ *Id.*

⁴⁰ *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).

⁴¹ Provider's FPP at 9.

⁴² *Id.*

⁴³ *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).

⁴⁴ *Unity Healthcare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).

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

e. Nonprecedential Nature of the Administrator's Review Decision.—Decisions by the Administrator *are not precedents* for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy [*sic*] having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.⁴⁵

While the statutes and regulations for VDAs for SCHs and MDHs are identical, the Board finds that the applicable statutes and regulations only provide a framework by which to calculate a VDA payment.⁴⁶ 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*.⁴⁷ In this regard, the Board further notes that §§ 412.92(e)(3) and 412.108(d)(3) make clear that the VDA payment determination is subject to review through the Board's appeal process.⁴⁸ 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.

⁴⁵ (Bold and italics emphasis added).

⁴⁶ 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, e.g.,* for SCHs, 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).

⁴⁷ *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).

⁴⁸ 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 IP*") where the Supreme Court ruled on the scope of Medicare policy issuances that are subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) by making clear that "the government's 2014 announcement of the 2012 Medicare fractions [to be used in DSH calculations for FY 2012 where the Agency] 'le[t] the public know [the agency's] current adjudicatory approach' to a critical question involved in calculating payments for thousands of hospitals nationwide" was a "statement of policy that establishes or changes a substantive legal standard" as that phrase is used in 42 U.S.C. § 1395hh(a)(2) and, thus, was subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2). (Citations omitted.)

Significantly, *subsequent to the time period at issue in this appeal*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,⁴⁹ CMS prospectively changed the methodology for calculating the VDA to one that is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated 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.⁵⁰ 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."⁵¹

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 Galesburg's VDA methodology for FY 2016 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 Galesburg's VDA payment by comparing its FY 2016 fixed costs to its FY 2016 *total* DRG payments. However, neither the language nor the examples⁵² in PRM 15-1 compare only 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 Rule⁵³ and the FFY 2009 IPPS Final Rule⁵⁴ 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 Galesburg's VDA using the methodology laid out by CMS in PRM 15-1 or by the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Galesburg's FY 2016 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions best described as follows: the "hospital's VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"⁵⁵ The Board suspects that the

⁴⁹ 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

⁵⁰ This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).

⁵¹ 82 Fed. Reg. at 38180.

⁵² PRM 15-1 § 2810.1(C)-(D).

⁵³ 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

⁵⁴ 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

⁵⁵ *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm'r Dec. 2014-D16 at 8 (Sept. 4, 2014); *Unity*

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.⁵⁶

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

In the case of a Medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to *fully compensate the hospital for the fixed costs it incurs* in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.⁵⁷

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.”⁵⁸ 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.

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).

⁵⁶ 82 Fed. Reg. at 38179-38183.

⁵⁷ (Emphasis added.)

⁵⁸ 48 Fed. Reg. 39752, 39781-39782 (Sept. 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.*⁵⁹

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule, both of which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the Administrator decisions stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."⁶⁰

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."⁶¹ 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 solely for the fixed costs of the Medicare services actually rendered when the hospital, in fact, incurred both fixed and variable costs for those services.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an MDH for all the fixed costs associated with the qualifying volume decrease. This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 412.108(d)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.⁶² Clearly, when a hospital experiences a decrease

⁵⁹ (Emphasis added.)

⁶⁰ *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.

⁶¹ 42 U.S.C. § 1395ww(d)(5)(G)(iii).

⁶² The Board recognizes that 42 C.F.R. § 412.108(d)(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.

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 for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, to ensure full compensation of 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)(G)(iii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes 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. Thus, 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.

Galesburg also argues that “[w]hen the [Medicare Contractor] changed the VDA calculation without following the legal notice and comment period, they unlawfully changed regulations.”⁶³ Galesburg also argues that “[t]he VDA calculation was not lawfully altered until the August 17, 2017 Federal Register was issued.”⁶⁴ Galesburg contends that “[t]he methodology in effect during the four years under appeal was the one described in section 2810.1 of the PRM, as formally adopted and modified in the IPPS rulemakings for FYs 2007 and 2009”⁶⁵ and also contends that CMS and/or the Medicare Contractor improperly departed from this methodology. However, the Board notes that the examples in PRM 15-1 § 2810.1 relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

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

⁶³ Provider's FPP at 11-12.

⁶⁴ *Id.* at 12.

⁶⁵ *Id.*

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 Ct y. Hosp. v. BlueCross BlueShield Ass’n*, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of “not to exceed,” rather than “equal to,” when describing the formula. *We conclude that the Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation.*⁶⁶

Accordingly, what Galesburg 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.”⁶⁷ The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.⁶⁸ This is a different situation than the one addressed by the U.S. Supreme Court in *Allina*, where a new substantive reimbursement policy was announced on the CMS website and was applied nationwide to all hospitals at one time.⁶⁹ Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as explained in 42 C.F.R. § 412.108(d)(3).⁷⁰ 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 PRM guidance regarding the calculation of VDAs.⁷¹ Accordingly, the Board rejects Galesburg’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)(G)(iii) 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.⁷² Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for the Medicare services *actually* furnished. The Board concludes that, in order to both ensure the hospital is fully compensated for its fixed costs *and* be consistent

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

⁶⁷ Moreover, the fact that any particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.

⁶⁸ *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).

⁶⁹ 139 S. Ct. at 1808, 1810.

⁷⁰ 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.”

⁷¹ *See, e.g., Unity Healthcare v. Blue Cross Blue Shield Ass’n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg’ Med. Ctr. v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Further, the application of the PRM definitions of the terms “variable” and “semi-fixed” costs to a specific 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.

⁷² 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).

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 parties incorrectly stipulated that Galesburg’s fixed costs (which includes semi-fixed costs) were 94.61 percent of Galesburg’s total Medicare costs for FY 2016 based on the quotient of Rows H and E.⁷³ The Board notes that for FY 2009, 2013 and 2014, the Fixed cost percentage was correctly calculated, by dividing Current Year Fixed Program operating costs (Row H) by Current Year program operating costs (Row E). However, for 2016 the fixed cost percentage was clearly based on some undisclosed formula. As a result, consistent with prior Board decisions, and Galesburg’s calculation for 2009, 2013 and 2014, the Board will use the quotient of Row H divided by Row E to calculate the fixed portion of the FY 2016 IPPS payment in the computation of Galesburg VDA payment. The quotient of Rows H and E equals 87.47 percent.⁷⁴

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

Step 1: Calculation of the Cap

2015 Medicare Inpatient Operating Costs	\$ 10,555,219 ⁷⁵
Multiplied by the 2014 IPPS update factor	1.024 ⁷⁶
2015 Updated Costs (max allowed)	\$ 10,808,544
2016 Medicare Inpatient Operating Costs	\$ 9,746,224 ⁷⁷
Lower of 2015 Updated Costs or 2016 Costs	\$ 9,746,224
Less 2016 IPPS payment	\$ 7,858,797 ⁷⁸
2016 Payment Cap	\$ 1,887,427

Step 2: Calculation of the VDA

2016 Medicare Inpatient Fixed Operating Costs	\$ 8,525,284 ⁷⁹
Less Excess Staffing	\$ 0
2016 Medicare Inpatient Fixed Costs less Excess Staff	\$ 8,525,284
Less 2016 IPPS payment – fixed portion (87.47%) ⁸⁰	\$ 6,874,090
Payment adjustment amount (subject to cap)	\$ 1,651,194

Since the payment adjustment amount of \$1,651,194 is less than the cap of \$1,887,427, the Board concludes that Galesburg’s VDA payment for FY 2016 should be \$1,651,194. The Medicare

⁷³ Stip. at ¶ 13.

⁷⁴ *Id.* Current Year Fixed Program Operating Costs (Row H) 8,525,284 / Current Year Program Operating Costs (Row E) 9,746,224 = Fixed Cost Ratio (Row I) 0.8747

⁷⁵ Stip. at ¶ 13.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.* (7,858,797 * .8747 = 6,874,090). The difference is due to rounding the fixed cost percentage.

Contractor already made a VDA payment of \$666,487 for FY 2016. Thus, an additional payment of \$984,707 should be made to Galesburg for FY 2016.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Galesburg's VDA payment for FY 2016 and that Galesburg should receive an additional VDA payment of \$984,707 for a total VDA payment in the amount of \$1,651,194 for FY 2016.

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FOR THE BOARD:

10/21/2022

X Clayton J. Nix

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Chair
Signed by: PIV