PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2023-D06

PROVIDER-
West Branch Regional Medical Center

Provider No.:
23-0095

vs.

MEDICARE CONTRACTOR –
Wisconsin Physician Services

RECORD HEARING DATE –
February 4, 2021

Cost Reporting Period Ended –
03/31/2011

CASE NO.
15-3152

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ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment owed to West Branch Regional Medical Center ("West Branch" or "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending March 31, 2011.[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 West Branch's VDA payment for FY 2011, and that West Branch is due a VDA payment in the amount of $730,707 for FY 2011.

INTRODUCTION

West Branch is a non-profit acute care hospital located in West Branch, Michigan[2] and was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue.[3] Until July 2012, West Branch's designated Medicare contractor[4] was National Government Services ("NGS") after which Wisconsin Physician Services ("WPS") became its designated Medicare contractor (collectively "Medicare Contractor").[5]

In March 2015, the Medicare Contractor denied West Branch's VDA request for FY 2011.[6] The Medicare Contractor determined that: (1) the decline in discharges were not related to an unusual event beyond the Provider's control; and (2) even it had been beyond their control, no VDA payment should be made because West Branch's inpatient prospective payment system ("IPPS") payments for its operating costs exceeded the allowable inpatient fixed and semi-fixed operating costs.[7] West Branch 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 4, 2021. West Branch was represented by Ronald K. Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Stipulation (Revised) of Facts at ¶ 5 (hereinafter "Stip."); Provider's Final Position Paper (hereinafter "Provider's FPP") at 2; Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3.
[2] Stip. at ¶ 1.
[3] *Id.*
[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[5] Stip. at ¶ 4.
[6] Medicare Contractor's FPP at 6.
[7] Stip. at ¶¶ 3, 6. In the VDA denial letter at Exhibit (hereinafter "Ex.") C-1, it states that the VDA payment was denied because the Medicare Contractor did not believe the 5 percent decrease in discharges was beyond the control of the provider but also because the inpatient prospective payments exceeded the impatient fixed and semi fixed operating costs. The parties have since submitted revised stipulations that state that West Branch has met the criteria in 42 C.F.R. § 412.92(e) and is eligible to receive a volume decrease adjustment.

STATEMENT OF FACTS AND RELEVANT LAW

The Medicare program 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 total inpatient cases of more than 5 percent from one cost reporting year to the next. 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."[8] The implementing regulations, located at 42 C.F.R. § 412.92(e), reflect these statutory requirements.

Notwithstanding the findings in the VDA denial, it is now undisputed that West Branch experienced a decrease in discharges greater than 5 percent from FY 2010 to FY 2011 due to circumstances beyond its control and, as a result, was eligible to have a VDA calculation performed for FY 2011.[9] However, as part of the VDA denial, the Medicare Contractor also performed a VDA calculation and determined that West Branch was not entitled to a VDA payment because West Branch's IPPS payments for its operating costs exceeded the allowable inpatient fixed and semi-fixed operating costs.[10] Thus, what remains at issue in this case is whether West Branch is due a VDA payment, and the parties dispute how that payment should be calculated.

The regulation at 42 C.F.R. § 412.92(e) (2011) 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*[11] 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] Stip. at ¶¶ 2, 3. *See also* Provider's FPP at 2. West Branch had a greater than 5 percent decrease in discharges and the parties have stipulated that the "[p]rovider met the criteria in 42 C.F.R. § 412.92(e) for the fiscal years at issue and is eligible to receive a volume decrease adjustment."
[10] Medicare Contractor's FPP at 6.
[11] (Emphasis added.)

The preamble to the final rule published on August 18, 2006[12] 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:

> 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.[13]

The chart below illustrates how the Medicare Contractor and West Branch each calculated the VDA payment for FY 2011.

	Medicare Contractor calculation using fixed costs	Provider/PRM calculation using total costs[14]
a) Prior Year Medicare Inpatient Operating Costs		$11,767,206
b) IPPS update factor		1.026
c) Prior year Updated Operating Costs (a x b)		$12,073,153
d) FY 2011 Operating Costs		$11,832,050
e) Lower of c or d		$11,832,050
f) DRG/SCH payment		$ 9,193,494
g) CAP (d-f)		$ 2,638,556
h) FY 2011 Inpatient Operating Costs	$12,819,368[15]	$11,832,050
i) Fixed Cost percent		100[16]
j) FY 2011 Fixed Costs (h x i)	$10,285,603[17]	$11,832,050
k) Total DRG/SCH Payments	$11,624,189[18]	$9,193,494

[12] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[13] (Emphasis added.)
[14] Stip. at ¶ 7.
[15] Stip. at ¶ 10. *See also* Medicare Contractor's FPP at 7 (WPS states that they erroneously included capital costs in the inpatient operating costs).
[16] Provider's FPP at 7-8. West Branch asserts that PRM 15-1 § 2810.1 and the Federal Register published on August 19, 2008 make no mention of the removal of variable costs from a provider's operating costs. As a result, the Fixed Cost Percentage is reported at 100.00.
[17] Stip. at ¶ 10. The Medicare Contractor removed the variable costs and re-ran the cost report to recalculate Worksheet D-1, Part II, Line 53.
[18] *Id.* *See also* Medicare Contractor's FPP at 7 (WPS states they erroneously included capital payments in IPPS payments).

l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$ (1,338,586)[19]	
m) VDA Payment Amount (The Provider's VDA is based on the amount by which line j exceeds line k.)		$2,638,556

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

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

West Branch submitted their VDA calculation and did not remove variable costs, stating that the "[d]efinition as to the process of making the payment calculation is principally provided in PRM 15-1 § 2810.1 and subsequently updated in the Federal Register dated August 19, 2008."[21] West Branch asserts that the Federal Register states, "'The adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second year's costs minus any adjustment for excess staff; (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustments for excess staff.'"[22] West Branch claims that nowhere in the August 19, 2008 final rule does it mention the removal of variable costs and that the Federal Register "is very specific in defining the costs as either the costs in the year of the decline minus any adjustments for excess staff, or the previous year's cost multiplied by the PPS update factor minus any adjustments for excess staff."[23] In further support of its argument, West Brach notes that all of the calculation examples found in PRM 15-1 § 2810.1 use "either the hospital's current year "Program Inpatient Operating Cost" or the prior year's "Program Inpatient Operating Cost" increased by the PPS update factor"[24] and further notes that none of the examples remove variable costs from the calculation.[25]

The Medicare Contractor disagrees and argues that the regulations and statute state that the VDA is to be calculated using fixed costs.[26] The Medicare Contractor used a calculation which removed variable costs from the Medicare Inpatient Operating Costs but did not remove the portion of the IPPS DRG payments attributable to variable costs. The Medicare Contractor notes this was the same method utilized in both the *Unity* and *Lakes* calculations that were affirmed by the Iowa District and the Eighth Circuit courts.[27] West Branch asserts this is a flawed methodology since the DRG payment includes both variable and fixed costs.[28] West Branch claims that not removing the variable portions from both the Medicare inpatient operating costs and the DRG

[19] When the calculated payment is negative, the payment to the hospital is $0.
[20] Stip. at ¶ 7.
[21] Provider's FPP at 7 (citing to the FY 2009 IPPS Final Rule, 73 Fed. Reg. 48434, 48630-48635 (Aug. 19, 2008)).
[22] *Id.* (quoting 73 Fed. Reg. at 48631).
[23] *Id.*
[24] *Id.* at 7-8.
[25] *Id* at 8.
[26] Medicare Contractor's FPP at 9.
[27] *Id.*
[28] Provider's FPP at 9.

payments ensures that it will never receive the full compensation of fixed costs mandated by Congress.[29]

In calculating the fixed costs, the Medicare Contractor notes that the Medicare inpatient operating costs, as used in its VDA calculation, is a figure based on the Medicare cost report Worksheet D-1, Part II, Line 53. The Medicare Contractor states that: "CMS has long considered a provider's Medicare cost report the most accurate and efficient way of reporting, calculating, and determining Medicare Costs."[30] As a result, it contends that the cost report is the best method to remove the variable costs from Worksheet D-1, Part II, Line 53.[31] To remove the variable costs, the Medicare Contractor followed a step by step approach, as outlined in their position paper.[32] Basically, to remove the variable costs the Medicare Contractor identified the variable costs and removed them, using Worksheet A-8 adjustments, and then recomputed the cost report to obtain a revised amount on Worksheet D-1, Part II, Line 53 (Medicare inpatient operating cost).

West Branch argues that "[r]emoving variable costs through a [Worksheet] A-8 adjustment is not supported by the recent CMS Administrator decisions."[33] In support of this argument, West Branch quotes the FY 2018 IPPS Final Rule that clarifies CMS's understanding of the current methodology and emphasizes specific statements as shown:

> We have modified the example below to address this inconsistency and **to clarify our intent** by including additional details **to more clearly illustrate how Medicare fixed costs and the fixed MS-DRG revenue are calculated** and used in the calculation, including to reflect that this same ratio, that is, **the hospital's fixed inpatient costs to total inpatient costs**, is applied to total Medicare costs to arrive at fixed Medicare costs, as **under the current methodology**.[34]

The example provided in the FY 2018 IPPS Final Rule calculates the hospital's fixed costs to be 85 percent by dividing the fixed costs ($2,720,000) by its total costs ($3,200,000); ($2,720,000/$3,200,000 = 0.85).[35] West Branch relies on this example for its assertion that this simple calculation, not a calculation using the Medicare cost report, will identify the fixed costs. West Branch notes that the rulemaking later states: "While there may have been inconsistencies in volume decrease adjustment determinations made by some [Medicare Contractors], inconsistent [Medicare Contractor] determinations and PRRB decisions that are subsequently reversed by the Administrator do not establish agency policy nor bind the agency."[36] West

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[29] *Id.*
[30] Medicare Contractor's FPP at 13-14.
[31] *Id.* at 13-14.
[32] *Id.*
[33] Provider's FPP at 12.
[34] 82 Fed. Reg. 38181 (Aug. 14, 2017) (emphasis not in original but rather in the quote included in the Provider's FPP).
[35] *Id*.
[36] Provider's FPP at 12.

Branch states that "[a]ny guidance that may have been given to WPS is superseded by the [FY 2018 IPPS] final rule published by CMS, with the stated intent of clarifying current policy."[37]

In addition to the above, West Branch points to PRRB Dec. No. 2016-D16 (*St. Anthony Reg'l Hosp. v Wisconsin Physicians Serv*. ("*St. Anthony*")) and states that this "is the only case in which the question of how to remove variable costs from the [total Medicare inpatient operating costs] calculation was directly raised."[38] In the *St. Anthony* case, the Medicare Contractor offset the pharmacy and cafeteria revenue against fixed costs.[39] Offsetting the revenue only against the fixed costs resulted in a lower fixed cost percentage and a lower VDA payment. In its *St. Anthony* decision, the Board concluded that it was incorrect to offset the total cafeteria and pharmacy revenue against fixed costs; and this decision was upheld by the Administrator.[40] West Branch refers to this decision as "further evidence that the method utilized [by the Medicare Contractor] in the determination is not accepted CMS policy."[41]

The Board finds that the Medicare regulations do not specify how the variable costs are to be calculated and removed from the VDA calculation. The calculations in the Federal Register, as referenced by West Branch, are more general in nature and would not prohibit the Medicare Contractor from using the cost report to remove variable costs from Medicare inpatient operating costs. In fact, the VDA calculation examples in PRM 15-1 § 2810.1 use the Medicare Inpatient costs from Worksheet D-1, Part II, Line 53 of the cost report. Therefore, the Board finds that removing variable costs through a Worksheet A-8 adjustment, and re-running the cost report to compute the revised Worksheet D-1, Part II, line 53, will result in the most accurate Medicare inpatient fixed costs. However, the Board agrees, as was decided in the *St. Anthony* decision, that certain revenue offsets are related to variable as well as fixed costs and these revenue offsets should be included when re-running the cost report to calculate adjusted fixed costs. Although the Board agrees with the *St. Anthony* decision, the Board notes that West Branch did not identify any necessary revisions to the Medicare Contractor's calculations, as was done in *St. Anthony*.

Another area of disagreement involves the correct payment amount to be used in the VDA calculation. The parties disagree on whether the hospital specific payment or the DRG amount should be used in the calculation of the VDA payment. The parties also do not agree whether the low volume payment should be included in payments.

West Branch has not provided a clear explanation as to why it believes the IPPS payments should include only DRG payments. West Branch, in its position paper, states that 42 C.F.R. § 412.92(e) "provides guidance on determining both the appropriate amount of Medicare Inpatient Cost and the DRG Amount including outliers."[42] The regulation at 42 C.F.R. § 412.92(e)(3) defines a hospital's total DRG revenue as the total of the:

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[37] *Id.*
[38] *Id.* at 12-13.
[39] *St. Anthony Reg'l Hosp. v Wisconsin Physicians Serv.,* PRRB Dec. 2016-D16 at 5.
[40] Ex. P-10.
[41] Provider's FPP at 13.
[42] *Id.* at 15.

> 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).[43]

West Branch appears to interpret this regulation as limiting the total DRG revenue to be used in the VDA calculation, to *only the base DRG payments*, while excluding from the VDA calculation any additional outlier and other DRG adjustment payments made to the hospital.

The Medicare Contractor asserts that West Branch appears to suggest that hospital specific payments are not DRG related payments, stating:

> The federal payment, which the Provider believes is DRG revenue, is calculated by adjusting national per discharge base payment rates (standardized amounts) to account for DRG weights and wage index factors. The hospital specific rate is calculated similarly but instead of utilizing the standardized amounts the rate is calculated using the highest of the hospital's per-discharge rates from base years (1982, 1987, 2002, etc.). The hospital specific payment applies DRG weights and wage index factors to the highest of those base rates. Once the hospital specific payments are determined, an SCH hospital receives the higher of its federal payment amount or the hospital specific payment.[44]

The Board reviewed the VDA regulation at 42 C.F.R. § 412.92(e)(3), which requires 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 and for indirect medical education costs as determined under § 412.105).[45]

The Board also 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." The regulation at 42 C.F.R. § 412.92(d) provides that SCHs are paid for inpatient operating costs based upon whichever is the greatest between the Federal payment or the hospital

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[43] 42 C.F.R. § 412.92(e)(3).
[44] Medicare Contractor's FPP at 10.
[45] 42 C.F.R. § 412.92(e)(3).

specific payment.[46] 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 that the hospital specific amount of $10,877,749 should be used when calculating West Branch's FY 2011 VDA payment.

In its position paper, West Branch states that while there has been much conversation about Low Volume Adjustment ("LVA") payments in recent years, "there is no mention of them in the final rule relating to the changes to the VDP methodology. Had CMS intended these adjustments to be considered when making VDP calculations it stands to reason they would have explicitly stated so in the final rule."[47]

The Medicare Contractor responds that the LVA payments received were "amounts based on a percentage increase to the DRG for each Medicare discharge, which increased the DRG payments for the instant period."[48] It further notes that the PRM 15-1 § 2910.1(D)(2)(a) "includes the operating portion of the LVA payment"[49] in the VDA calculation.

The Board disagrees with West Branch's claim that the LVA payment should not be included in the VDA calculation and finds that it is not supported by law. As stated in 42 U.S.C. § 1395ww(d)(5)(D)(ii), an SCH is entitled to "such adjustment to the payment amounts under this subsection . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs . . . ."[50] Accordingly, all operating payments authorized by subsection (d) must be included when calculating the VDA payment. The provisions authorizing both VDA and LVA payments are in subsection (d) of 42 U.S.C. § 1395ww and, thus, must be considered when calculating the VDA payment.

In addition, West Branch argues that the VDA calculation was unlawfully altered without going through the notice and comment process. In regard to this statement, it refers to the D.C. Circuit's decision in *Allina Health Servs. v. Price* ("*Allina*")[51] which states that "'HHS unlawfully failed to provide for notice and comment.'"[52] West Branch asserts that "[t]he methodology in effect during the [year] under appeal was the one described in section 2810.1 of the PRM, as formally adopted and modified in the IPPS rulemaking for FYs 2007 and 2009."[53] Furthermore, West Branch contends that "the VDA calculation was not lawfully altered until the August 17, 2017

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[46] *See* 42 C.F.R. § 412.92(d) which references various sections including § 412.79, the section that the Medicare Contractor used to calculate West Branch'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."

[47] Provider's FPP at 13.

[48] Medicare Contractor's FPP at 21.

[49] *Id.*

[50] The Board recognizes that this statutory provision includes the following exception: "such adjustment to the payment amounts under this subsection *(other than under paragraph (9)).*" However, the *sole* exception for Paragraph (9) of subsection (d) is not applicable since paragraph (9) addresses payments to Puerto Rico subsection (d) hospitals. (Emphasis added.)

[51] 863 F.3d 937 (D.C. Cir. 2017).

[52] Provider's FPP at 14 (quoting 863 F.3d at 942).

[53] *Id.*

Federal Register was issued. Our position is that the applicable lawful regulations are those that were published in the Federal Register on August 19, 2008."[54]

The Board finds that the statute[55], regulations[56] and PRM[57] all require the VDA calculation to be based on fixed costs. The fact that the Medicare Contractor may have previously calculated the VDAs differently does not automatically mean there is a departure from a Medicare program "policy" adopted by CMS or the Secretary.[58] Further, the Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[59] 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 distinguishable from the *Allina* situation where CMS adopted a new "nationwide" substantive policy.[60] Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as described at 42 C.F.R. § 412.92(e)(3).[61] 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.[62] Accordingly, the Board rejects West Branch's argument that the VDA calculation was unlawfully altered without going through notice and comment.

West Branch concludes that, if the Board rejects their argument to be paid in a manner consistent with their interpretation of PRM 15-1 2810.1 (which the Board has), then it requests that the VDA payment be paid based on the methodology that was adopted by the Board in the *St. Anthony* and *Trinity* decisions.[63] The Board notes that the major difference between the Medicare Contractor's and the Board's calculation method is that the Board removes variable costs from the DRG payments.

In recent decisions, the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because that methodology compared fixed costs to total DRG payments and only resulted in a VDA payment if the fixed costs exceeded the total DRG

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[54] *Id.*
[55] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[56] 42 C.F.R. § 412.92(e)(3).
[57] PRM 15-1 § 2810.1(B).
[58] Moreover, the fact that this particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[59] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[60] 139 S. Ct. at 1808, 1810.
[61] 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."
[62] *See, e.g.*, *Unity Healthcare v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA*, PRRB Dec. No. 2020-D01 (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 FPP at 14. 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.
[63] Provider's FPP at 15.

payment amount.[64] In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of a hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and comparing the fixed portion of the DRG payment to the hospital's fixed operating costs, resulting in an apples-to-apples comparison.[65]

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 . . . .[66]

Recently, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[67]

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

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[64] *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D1 (Dec. 15, 2016), *modified by*, Adm'r Dec. (Feb. 9, 2017); *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2015-D11 (June 9, 2015), *modified by*, Adm'r Dec. (Aug. 5, 2015).

[65] The Board notes that the only major difference between the Medicare Contractor's calculation and the Board's is that the Board removes the calculated payments related to variable costs from the total DRG payments when calculating the VDA payment.

[66] *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).

[67] 918 F.3d 571, 579 (8th Cir. 2019) *cert. denied*, 140 S. Ct. 523 (2019).

> may be generally known and applied by providers, intermediaries, and other interested parties.[68]

Moreover, the Board notes that West Branch 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,[69] CMS changed the methodology for calculating a VDA payment for cost reporting periods beginning on or after October 1, 2017, and the new methodology is one 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.[70] The preamble to the FFY 2018 IPPS Final Rule explains that this methodology 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."[71]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As set forth below, the Board finds that the Medicare Contractor's methodology used to calculate West Branch's VDA payment for FY 2011 was incorrect because it was *not* based on CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preambles to the relevant Final Rules.

The Medicare Contractor determined West Branch's VDA payment by comparing its FY 2011 fixed costs to its total FY 2011 DRG payments. However, neither the language nor the examples[72] in PRM 15-1 § 2810.1 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 § 2810.1, the preambles to both the FFY 2007 IPPS Final Rule[73] and the FFY 2009 IPPS Final Rule[74] 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.

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[68] (Bold and italics emphasis added).
[69] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[70] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).
[71] 82 Fed. Reg. at 38180.
[72] PRM 15-1 § 2810.1(C)-(D).
[73] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[74] 73 Fed. Reg. 48434, 48631 (Aug. 19, 2008).

The preambles to these Final Rules make clear that the only permissible adjustment to a hospital's cost when calculating the VDA is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate West Branch's VDA payment using the methodology laid out by CMS in PRM 15-1 § 2810.1, or by the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds that the Medicare Contractor calculated West Branch's FY 2011 VDA based on an otherwise *new* methodology that the Administrator apparently adopted through adjudication in her decisions. This methodology is best described as, a hospital's "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[75] The Board suspects that the Administrator developed this new methodology, using only fixed costs, because of a seeming conflict between the statute and the methodology explained in the FFY 2007 and 2009 IPPS Final Rules/PRM. 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.[76]

The clear intent of 42 U.S.C. § 1395ww(d)(5)(D)(ii) is 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.

In the Final Rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule"), the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[77] However, the VDA payment methodology (as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1) compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments.—. . . .
>
> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding

[75] *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 (Dec. 15, 2016).
[76] 82 Fed. Reg. at 38179-38183.
[77] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).

> period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
>
> D. Determination on Requests.— . . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
>
> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
>
> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[78]

At first glance, this calculation 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."[79]

Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[80] 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.

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[78] (Emphasis added.)
[79] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[80] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

However, the statute at 42 U.S.C. § 1395ww(a)(4) makes 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 in the provision of 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. 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 "consider[] . . . [t]he individual hospital's needs and circumstances" when determining the VDA payment amount.[81] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable 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 is payment for *both the fixed and variable costs* of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year as well as its full fixed costs in that year.

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs 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 payment, has been fully compensated for its fixed costs and, therefore, the Administrator's methodology is not a reasonable interpretation of the statute.

Finally, the Board also 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 payment, it is clear that the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[82] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG

[81] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) (2011) 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.
[82] 48 Fed. Reg. at 39782.

payments are intended to pay both variable and fixed costs for the Medicare services *actually* furnished. The Board concludes that, in order to ensure the hospital is fully compensated for its fixed costs and 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.

The Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to the DRG payments. Thus, the Board elects to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case, the Medicare Contractor determined that West Branch's fixed costs (which includes semi-fixed costs) were 78.63 percent[83] of its Medicare costs for FY 2011.

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

Step 1: Calculation of the Cap

2010 Medicare Inpatient Operating Costs[84]	$ 11,767,206
Multiplied by the 2011 IPPS update factor[85]	1.026
2010 Updated Costs (max allowed)	$ 12,073,153
2011 Medicare Inpatient Operating Costs[86]	$ 11,832,050
Lower of 2010 Updated Costs or 2011 Costs	$ 11,832,050
Less 2011 IPPS payment[87]	$ 10,902,525
2011 Payment Cap	**$ 929,525**

Step 2: Calculation of the VDA

2011 Medicare Inpatient Fixed Operating Costs[88]	$ 9,303,362
Less Excess Staffing	$ 0
2011 Medicare Inpatient Fixed Costs less Excess Staff	$ 9,303,362

[83] Stip. at ¶ 11, Provider FPP at 6, Table C.
[84] Stip. at ¶ 11.
[85] *Id.*
[86] *Id.*
[87] *See,* Ex. P-3 at 128. Amount reported in Stip. at ¶ 10 reflects ***only*** Worksheet E Part A, Line 8), however Low Volume Payments should also be included in the Total Payment. The Board, therefore, has calculated Total Payment for Inpatient Operating costs as $10,877,749 (Worksheet E, Part A, Line 8) plus Low Volume Adjustment Payment of $24,776 equals $10,902,525. The Low Volume Adjustment Payment was calculated by dividing $10,877,749 (Worksheet E, Part A, Line 8) by $11,624,189 (Total payments including Capital, Worksheet E, Part A, Line 16) times Low Volume Adjustment Payment of $26,476 (Worksheet E, Part A, Line 24.94).
[88] Stip. at ¶ 11 (The cost report was recalculated, after variable costs were removed, and the Total Operating Costs, excluding Capital, were obtained from Worksheet D-1, Part II, line 53 of the recalculated report. This is reflected in the Stip. at ¶ 11.).

Less 2011 IPPS payment – fixed portion (78.63%[89])[90]	$8,572,655
Payment adjustment amount (subject to cap)	**$ 730,707**

Since the payment adjustment amount of $730,707 is less than the cap of $929,525, the Board concludes that West Branch is due a VDA payment in the amount of $730,707 for FY 2011.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated West Branch's VDA payment for FY 2011, and that West Branch is due a total VDA payment in the amount of $730,707 for FY 2011.

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2/17/2023

X Clayton J. Nix

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Board Chair
Signed by: PIV

[89] *See* Ex. P-3 at 136. The cost report was re-run to remove variable costs and the Medicare Inpatient Operating Costs were calculated to be $9,303,362 (*see* Stipulation at ¶ 11). This amount was divided by 2011 Inpatient Operating Costs of $11,832,050 to get a fixed cost percentage of 78.628488 percent which was rounded to 78.63 percent on Stipulations (revised) at ¶ 11.

[90] The $8,572,655 is calculated by multiplying $10,902,525 (the FY 2011 SCH payments) by .7863 (the rounded fixed cost percentage, as reported in the Stip. at ¶ 11).