PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D37

PROVIDER-
Eastern New Mexico Medical Center

Provider No. –
32-0006

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –
December 3, 2020

Cost Reporting Period Ended –
05/31/2008

CASE NO. –
14-0643

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ISSUE STATEMENT

Whether the Provider is entitled to a volume decrease adjustment ("VDA") payment for a sole community hospital ("SCH").[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that, while the Medicare Contractor improperly calculated the VDA payment for Fiscal Year ("FY") 2008 for Eastern New Mexico Medical Center ("Eastern" or "Provider"), Eastern should still not receive a VDA payment for FY 2008.

INTRODUCTION

Eastern is a non-profit acute care hospital located in Roswell, New Mexico. Eastern was designated as a SCH during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Eastern for this appeal is WPS Government Health Administrators ("Medicare Contractor"). In order to compensate it for a decrease in inpatient discharges, Eastern requested a VDA payment of $4,311,118 for FY 2008.[4] The Medicare Contractor calculated Provider's FY 2008 VDA payment to be $0.[5] Eastern timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The parties requested, and the Board approved, a record hearing on December 3, 2020. Eastern was represented by Ronald K. 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 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.[6] VDA payments are intended to compensate a hospital for the fixed costs it incurs providing inpatient hospital services during the period covered by the VDA, including the reasonable cost of maintaining

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[1] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 2.
[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 ¶ 4.
[5] Stip. at ¶ 6.
[6] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

necessary core staff and services.[7] The implementing regulations, located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that Eastern experienced a decrease in discharges greater than 5 percent from FY 2007 to FY 2008 due to circumstances beyond Eastern's control and that, as a result, Eastern was eligible to have a VDA calculation performed for FY 2008.[8] Eastern requested a VDA payment in the amount of $4,311,118 for FY 2008.[9] However, when the Medicare Contractor made the FY 2008 VDA calculation, it determined that Eastern was not entitled to a VDA payment because it had already been fully compensated for its fixed/semi-fixed costs.[10]

42 C.F.R. § 412.92(e) (2008) directs how the Medicare Contractor must adjudicate the VDA once an SCH demonstrates it experienced a qualifying decrease in total inpatient discharges. In pertinent part, § 412.92(e)(3) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[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. . . .

In the preamble to the final rule published on August 18, 2006,[12] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), which provides further guidance related to VDAs and states, in relevant part:

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

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[7] *Id.*
[8] Stip. at ¶ 4.
[9] *Id.* at ¶ 4.
[10] *Id.* at ¶ 9.
[11] (Emphasis added.)
[12] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary *directly*[13] with utilization such as food and laundry costs.

The chart below depicts how the Medicare Contractor and the Provider each calculated the VDA payment.

	Medicare Contractor calculation using fixed costs[14]	Provider/PRM calculation using total costs[15]
a) Prior Year Medicare Inpatient Operating Costs	$22,551,305[16]	$22,551,305
b) IPPS update factor	1.033[17]	1.033
c) Prior year Updated Operating Costs (a x b)	$23,295,498	$23,295,498
d) FY 2008 Operating Costs	$22,896,730	$22,896,730
e) Lower of c or d	$22,896,730	$22,896,730
f) DRG/MDH payment	$18,611,625	$18,611,625
g) CAP (d-f)	$ 4,285,105	$ 4,285,105
h) FY 2008 Inpatient Operating Costs	$22,896,730	$22,896,730
i) Fixed Cost percent	77.54	1.00[18]
j) FY 2008 Fixed Costs (h x i)	$17,754,056[19]	$22,896,730
k) Total DRG/SCH Payments	$18,611,625	$18,611,625
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ (857,569)	
m) VDA Payment Amount (The Provider's VDA is based on the amount line j exceeds line k.)		$4,285,105

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

Eastern asserts that not all of its variable costs should be removed from total costs to compute the VDA based on the policies set forth in the Federal Register and subregulatory guidance.[21] The

[13] (Emphasis added.)
[14] Stip. at ¶¶ 9, 11.
[15] *Id.* at ¶ 7.
[16] *Id*. at ¶ 11.
[17] *Id*.
[18] Provider's Final Position Paper (hereinafter, "Provider's FPP") at 2. Eastern asserts that PRM § 2810.1 and the Federal Register do not mention the removal of variable costs. As a result, the Fixed Cost Percentage is reported at 1.00.
[19] $22,896,730 multiplied by 0.7754 equals 17,754,124. The immaterial difference between $17,754,124 and $17,754,056 is due to the rounding of the fixed cost percentage.
[20] Stip. at ¶ 12.
[21] Provider's FPP at 2-3.

Medicare Contractor asserts that Eastern has misinterpreted the Federal Register.[22] In support of its position, the Medicare Contractor cites to the decision of the U.S. Court of Appeals for the Eighth Circuit in *Unity HealthCare v. Azar* ("*Unity HealthCare*").[23]

Eastern argues that the Medicare Contractor's removal of variable costs through a Worksheet A-8 adjustment, included on the Medicare cost report, is not supported by the recent CMS Administrative decisions, and the regulations do not show a removal of variable costs. They claim removing items deemed variable in this manner distorts the true costs applicable to Medicare patients. It results in a double allocation of variable costs because it allocates costs previously determined as fixed to the designated variable costs.[24]

The Medicare Contractor contends that specific instructions to determine the fixed/semi-fixed costs are not included in the statues, regulations or Provider Reimbursement Manual.[25] Therefore, the Medicare Contractor used the cost report to develop an allegedly accurate method of calculating fixed/semi-fixed costs. The Medicare Contractor notes that the Medicare Inpatient Operating cost used in the VDA calculation is a calculated figure on the Medicare cost report.[26] The Medicare Contractor argues that the best way to compute the fixed cost is to remove the variable cost from the cost report, recalculate the cost report, and the number on Worksheet D-1, Part II, line 53 would include the exact amount of Medicare Inpatient fixed/semi-fixed operating costs.[27] The Medicare Contractor also asserts that the Administrator agreed with this approach and, further, that this approach was found not to be arbitrary or capricious in the *Unity* decision.[28] The Board agrees with the Medicare Contractor's arguments and finds that removing variable cost from the cost report is the best method on which to compute the fixed/semi-fixed costs.

Eastern argues that the Medicare Contractor's calculation of the VDA was incorrect because this methodology guarantees that a SCH will never receive full compensation.[29] According to Eastern, the Medicare Contractor made unsubstantiated adjustments to remove variable costs. Eastern asserts that all costs should be treated as fixed for payment calculation purposes.[30]

Eastern contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[31] Eastern 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. They state that nowhere in the August 19, 2008 Federal Register[32] does it say to subtract variable costs from the Provider's costs.[33] Earlier, in the Federal Register, it states: "The process for determining the amount of the volume decrease adjustment can be found in

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[22] *See generally* Medicare Contractor's FPP at 14.
[23] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct. 523 (2019).
[24] Provider's FPP at 5.
[25] *See* Medicare Contractor's FPP at 8-10.
[26] *Id.* at 9.
[27] *Id*. at 9-10.
[28] *Id.*
[29] Provider's FPP at 3.
[30] *Id*.
[31] *Id.* at 6.
[32] Exhibit (hereinafter "Ex.") P-5.
[33] Provider's FPP at 2.

Section 2810.1 of the Provider Reimbursement Manual." [34] Eastern notes that none of the examples in PRM 15-1 § 2810.1 show variable costs being removed from the VDA calculation.[35]

The Board notes that the statute[36], regulations[37] and PRM[38] manual all state that a provider is ***only*** to be paid for fixed costs related to a qualifying reduction in volumes. The Board also notes the example calculations found in the PRM 15-1 § 2810.1 relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare*:

> 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 "[t]he 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 "[n]ot 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 "[t]hat the examples are intended to demonstrate* ***how to calculate the adjustment limit*** as opposed to determining which costs should be included in the adjustment." See *Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n*, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than *579 "equal to," when describing the formula. *We conclude that the Secretary's interpretation was* ***not*** *arbitrary or capricious and was consistent with the regulation.*[39]

Based on the above, the Board finds that variable costs are to be removed from the VDA calculation.

Eastern 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, Eastern maintains, would assure an accurate matching of revenue

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[34] *Id.*
[35] *Id.*
[36] 42 U.S.C. § 1395ww(d)(5)(D)(ii)
[37] 42 C.F.R. § 412.92(e)(3)(i)(B)
[38] PRM 15-1 § 2810.1B
[39] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).

with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. Eastern 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.[40]

In its recent decisions,[41] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because that methodology compares fixed costs to *total* DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

The Administrator has overturned these Board decisions, stating:

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . . In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. . . . The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable 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 . . . .[42]

Recently, the Eighth Circuit upheld the Administrator's methodology in *Unity HealthCare*, stating the "[S]ecretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[43]

At the outset, the Board notes that 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

[40] Provider's FPP at 4-5.
[41] *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).
[42] *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).
[43] *Unity HealthCare* at 579.

> 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.[44]

Moreover, the Board notes that Eastern is not located in the Eighth Circuit and, thus, the *Unity HealthCare* 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 ***through the rulemaking process***. In the preamble to the FFY 2018 IPPS Final Rule,[45] 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.[46] 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 "[r]emove 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."[47]

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 Eastern's VDA methodology for FY 2008 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 Eastern's VDA payment by comparing its FY 2008 fixed costs to its total FY 2008 DRG payments. However, neither the language nor the examples[48] in PRM 15-1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[49] and the FFY 2009 IPPS Final Rule[50] 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

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[44] (Bold and italics emphasis added.)
[45] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[46] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e).
[47] 82 Fed. Reg. at 38180.
[48] PRM 15-1 § 2810.1(C)-(D).
[49] 71 Fed. Reg. at 48056.
[50] 73 Fed. Reg. at 48631.

> 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 Eastern's VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Eastern's FY 2008 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[51] 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.[52]

The statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) intends for a VDA payment to fully compensate the hospital for its fixed cost:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary *to fully compensate the hospital for the fixed costs it incurs* in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.[53]

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."[54] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 (rev. 356) compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

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[51] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D16 at 8 (Sep. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D15 at 8 (Sep. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Feb. 9, 2017).
[52] 82 Fed. Reg. at 38179-38183.
[53] (Emphasis added.)
[54] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

> C. Requesting Additional Payments.—
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> ****
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> 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*. . . .
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> 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.
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> 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***.[55]

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."[56] Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully

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[55] (Emphasis added.)
[56] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.

disagrees that the Administrator's methodology complies with the statutory mandate to "[f]ully compensate the hospital for the fixed costs it incurs."[57]

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 "[**a]ll** 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 "[t]he 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. § 412.02(e)(3)(i)(A) that the Medicare contractor "[c]onsiders . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[58] 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 adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

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[57] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

[58] The Board recognizes that 42 C.F.R. § 412.92(e)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

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.[59] 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. Thus, the Board concludes that, in order to ensure the hospital is fully compensated for its fixed costs and be consistent with the PRM 15-1 assumption that "[t]he 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.

Finally, the Board recognizes that there is an additional issue to be addressed as part of the VDA involving the termination of Eastern's SCH status effective June 20, 2007. The Board made a Request for Information to both parties on August 11, 2021 asking them to address "[t]he extent to which, if any, the termination of the Provider's SCH status (including the facts and circumstances surrounding that termination) may affect the Provider's qualification for and/or calculation of the VDA for FY 2008." Both parties replied, stating their cases for full-year or partial-year calculation of the VDA, respectively.

Eastern's response argues for a full-year calculation of the VDA. In support of its position, it cites 42 U.S.C. § 1395ww(d)(5)(D)(ii), which states:

> 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.[60]

Eastern focuses its argument on the statement that the Secretary "shall provide for such adjustment" (interpreting "shall" as a command) and the interpretation that the phrase "in the period" refers to the "cost reporting period" in which the hospital realized a decrease of more than 5 percent in its total inpatient cases as compared to the previous cost reporting period.[61] Eastern also argues that "[n]ot only does the regulation contain no reference to prorating VDA payments, the preamble is also tellingly silent."[62] Eastern further focuses on the following excerpt from PRM 15-1 § 2810.1(A) (2008):

> **A. Criteria for Determining Eligibility for Additional Payments**. – In addition to being approved as an SCH for at least a part of the

[59] 48 Fed. Reg. at 39782.
[60] (Emphasis added.)
[61] Provider's Supplemental Final Position Paper (hereinafter, "Provider's SFPP") at 2 (Sept. 8, 2021).
[62] *Id.* at 4.

> cost reporting period in question, the basic criteria for approval of additional payment for SCHs involve two issues, i.e., circumstances beyond the hospital's control and decrease in discharges.

Eastern maintains that this manual guidance indicates that a provider may receive a VDA payment when it qualifies as an SCH for a part of the cost reporting period. The Board notes that this manual provision does not say that the provider will be paid a payment based on calculations for the full year; but rather it only states that the provider would be eligible for a VDA payment. In addition, the Board notes that 42 U.S.C. § 1395ww(d)(5)(D)(ii) could have, in the place of the word "period", included "cost reporting period," which was used earlier in the statute, and which would have clearly indicated the VDA is to be calculated based on the cost reporting period. Instead, the statute included the word "period" which could be interpreted to mean the time period in which a hospital maintained SCH status. As a result, the statute and the manual guidance can be reasonably interpreted such that a pro-rated payment would be made in these cases, as both are silent on the issue of the calculation itself, as Eastern notes in its Supplemental Final Position Paper. Eastern's final argument is that any calculation including proration would require notice and comment rulemaking, which has not occurred, as no proration calculation is mentioned in the regulations.

In response to the Board's Request for Information ("RFI"), the Medicare Contractor provided, on August 24, 2021, a letter dated August 5, 2008 from the CMS Division of Financial Management & Fee-for-Service Operations, Region VI in which the Regional Office terminated Eastern's SCH status, due to the fact its circumstances had changed when a new hospital, Roswell Regional, was opened less than one mile from Eastern. The Medicare Contractor also provided a second letter, dated August 7, 2008, which the Medicare Contractor sent to Eastern, informing the hospital that CMS had agreed with their recommendation to terminate SCH status, again effective June 20, 2007. The Medicare Contractor maintains that:

> The regulation suggests that the Provider could receive potential payment adjustments for discharges occurring while the Provider retained SCH classification. As the VDA is a payment adjustment afforded to SCHs, where SCH status is terminated, the VDA should be based on the number of discharges that occurred during the Provider's SCH classification. As the VDA is based upon a Provider's cost reporting period, the VDA should be determined, considering the number of discharges that occurred during the portion of the cost reporting under SCH classification.[63]

The Medicare Contractor cites to PRRB Decisions 2018-D51[64] and 2018-D52[65] in which the Board majority determined that the plaintiffs' VDAs "should be prorated based on discharges."[66] In both decisions, the Board stated:

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[63] Medicare Contractor's Supplemental Final Position Paper (hereinafter "Medicare Contractor's SFPP") at 5 (Sept. 7, 2021).
[64] *Rice Mem'l Hosp. v. National Gov. Servs.*, PRRB Dec. 2018-D51 (Sept. 28, 2018).
[65] *St. Mary's Reg'l Hosp. v. National Gov. Servs.*, PRRB Dec. 2018-D52 (Sept. 28, 2018).
[66] PRRB Dec. 2018-D51 at 2; PRRB Dec. 2018-D52 at 2.

> The Board majority reviewed the statute, regulations, and manual to determine if the VDA should be prorated for the period the Provider was a SCH. The regulations at 42 C.F.R. § 412.92(b)(2)(iv) specifically address the effective dates for SCH payments adjustments stating that "[a] hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS' approval of the classification." Paragraph (d) addresses how SCHs are paid and includes three subsections. Section (d)(1) states that a hospital is paid the greater of the federal rate or the hospital specific rate, section (d)(2) addresses the hospital specific rate calculations, and section (d)(3) addresses the VDA. Specifically section (d)(3) states, "(3) Adjustment to payments. A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in the number of discharges, as described in paragraph (e) of this section." The Board majority finds that all the payment methodologies in section (d), which includes the VDA are effective 30 days after the date of CMS' approval of the classification. Had CMS not put the VDA under paragraph (d) then the effective date in C.F.R. § 412.92(b)(2)(iv) would not have clearly applied to calculating the VDA.[67]

While the cases cited relate to hospitals that were certified as SCHs with effective dates during the cost reporting period, the Board sees no difference in a case in which a hospital's certification was terminated during the cost reporting period. The regulations at 42 C.F.R. § 412.92(b)(2)(iv) specifically address the effective dates for SCH payments stating that "[a] hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS' approval of the classification." In section (b)(3) the regulation states "An approved classification as a sole community hospital remains in effect without need for reapproval *unless there is a change in the circumstances under which the classification was approved*."[68] Later in the regulation it states that "CMS will cancel the hospital's classification as a sole community hospital effective with the date that the hospital no longer met the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter." The regulations in (b)(3)(ii) and (iii) explain the circumstances under which a hospital can have its SCH status canceled. The Board finds these regulations are intricately linked together and provide the details related to both acquiring and losing SCH certification as well as the methodology under which the hospital will be paid as an SCH. The Board also notes that the word "period" in the statute cannot mean a cost report period, as Eastern is interpreting it, since a hospital could be approved as a SCH in the middle of a cost report period. Based on 42 C.F.R. § 412.92(b)(2)(iv) the SCH, once certified, would be paid under section (d). The period before

[67] PRRB Dec. 2018-D51 at 5-6; PRRB Dec. 2018-D52 at 5.
[68] (Emphasis added.)

certification would have been paid on some other methodology which is most likely as an acute hospital. The Board does not find that the regulations support a provider losing SCH in the middle of a year and being paid under the SCH calculation (section (d)) for the full year.

In addition, the regulations state that the Board "[s]hall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedures, or practice established by CMS"[69] when the interpretation is reasonable and aligns with the statute and regulation. The Board notes that the instructions for Form CMS-2552-96 at PRM 15-2 § 3630 is consistent with the regulations and reads as follows:

> For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102/103) subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04, and 5-7. (9/30/96) Enter on lines 1 through 5 in column 1 the applicable payment data *for the **period** applicable to SCH status*. Enter on lines 1 through 5 in column 1.01 the payment data *for the **period** in which the provider did not retain SCH status*. The data for lines 1 through 5 must be obtained from the provider's records or the PS&R.[70]

These instructions were followed by Eastern in the preparation of the cost report. On worksheet E Part A, they subscripted column 1 for the period of time the hospital had SCH status and column 1.01 for the period of time they did not retain SCH status.[71]

The Board also notes that, as payments are determined to be effective based upon a discharge as of a specific date in the regulations, which include the VDA, a proration of the VDA is not a change in the regulation, and therefore, any argument that this "change" was not accomplished via notice and comment rulemaking is moot.

In the present case, Eastern's SCH status only covered the portion of the cost report from June 1, 2007 to June 19, 2007 (19 days representing 4 percent of the fiscal year) because, effective June 20, 2007, CMS terminated Eastern's Medicare participation status as an SCH[72] and became

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[69] 42 C.F.R. § 405.1867.
[70] (Emphasis added.)
[71] Ex. C-1 at 14.
[72] As an "Item 1" attachment MAC Response to Board RFI (Aug. 24, 2021), the Medicare Contractor included a copy of the CMS Regional Office letter dated August 8, 2008 to the Medicare Contractor in response to Eastern's request for termination of its SCH status. This CMS letter states the following, in pertinent part:

> We have reviewed the documentation that WPS states was sent to this Regional Office (RO) on August 3, 2007 and subsequently then emailed on August 1, 2008 . . . requesting a status on the inquiry. In accordance with 42 CFR 412.92(b)(3), an approved classification as an SCH remains in effect without need for reapproval unless there is a change in the scircumstances under which it was approved. A new hospital, Roswell Regional Hosptial, has opened less than a mile from [Eastern].
> Central Office informed us that termination of a SCH status effective 30 days after notification fromt eh hospital that its' [*sic*] status has changed. . . .
> Please notify the hospital that we have terminated status. Since the RO never received the original request which was date stamped by WPS as having been sent on August 3, 2007, the hosptial's

designated a Medicare Rural Referral Center.[73] The Board finds that any VDA payment to be calculated must be *only* for the period in which Eastern maintained SCH status *since the adjustment relates to and is based on its SCH status and reimbursement as an SCH*.[74] Accordingly, the Board finds any VDA payment to be calculated for Eastern must be *only* for the period in which Eastern maintained SCH status *since the adjustment relates to and is based on its SCH status and reimbursement as an SCH*. The Board's calculations below will account for that situation accordingly.

Noting that 42 C.F.R. § 412.92(b)(2)(iv) clearly indicates payments are "effective with discharges," the Board will make the VDA calculation based upon the Medicare discharges in the SCH period (June 1, 2007 to June 19, 2007) as a percentage of the total Medicare discharges in the cost reporting period. 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 Eastern's fixed costs (which includes semi-fixed costs) were 77.54 percent[75] of the Provider's Medicare costs for FY 2008. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2007 Medicare Inpatient Operating Costs (full-year)	$22,551,305[76]
Multiplied by the 2008 IPPS Update factor	1.033[77]
2008 Updated Costs (max allowed for full-year)	$23,295,498
2008 Medicare Inpatient Operating Costs (full-year)	$22,896,730
SCH status pro-ration	0.0504[78]

status as a sole community hospital has been termination effective 30 days from the date of the letter that [Eastern] wrote, which would have been 06/20/2007.

[73] Provider's SFPP at 3.

[74] Here, Eastern became aware that it no longer qualified for an SCH based on the fact that another hospital was opening less than one mile from it on May 3, 2007. Medicare Contractor's SFFP at 3; MAC Response to Board RFI at Item 1 (Aug. 24, 2021). Pursuant to 42 C.F.R. § 412.92(b)(2)(iii), Eastern was required to give CMS notice of this change *within 90 days*. Accordingly, Eastern gave the required notice (*albeit* 2 days late) on August 3, 2007 and, as a result, CMS terminated Eastern's SCH status 30 days after the August 3, 2007 notice consistent with § 412.92(b)(2)(iii). Medicare Contractor's Response to Board RFI at Item 1 (Aug. 24, 2021). Through this regulatory process, Eastern had the benefit of 4 months transition from event that caused its loss of SCH status, and only the last 19 days of the transition fell within the fiscal year at issue. Finally, the Board notes that these facts differ from those in the cases at *supra* notes 64 and 65 where the impacted provider applied for (and was ultimately granted) designation as an SCH while suffering a qualifying decrease in discharges for the same FY and the Board's application of a partial year in the instant case is consistent with the intent and purpose of the regulation.

[75] Stip. at ¶ 11.

[76] *Id.*

[77] *Id.*

[78] Medicare Inpatient Operating costs are not separately identified on Worksheet D-1, Part II, Line 53 between when the hospital had or did not have SCH status. As a result, for the VDA calculation the Board will prorate the Medicare expenses based on the number of discharges for which Eastern had SCH status. Eastern maintained SCH status for 19 days of the cost reporting year. Per the Medicare Contractor's SFPP at 6, Eastern had 129 Medicare discharges in that period and a total of 2,558 Medicare discharges in the cost reporting year. This results in a percentage of 5.0430023 percent, rounded to 5.04 percent for calculation purposes. The Board further notes that, if Eastern's figures, as

Lower of 2007 updated costs or 2008 actual (SCH period)	$ 1,153,995
Less: 2008 IPPS payment (SCH period)	$ 1,522,163[79]
2008 Payment Cap	**$(-368,168)**

Step 2: Calculation of VDA

2008 Medicare Inpatient Fixed Operating Costs (SCH period)	$ 894,808[80]
Less: 2008 IPPS payment – fixed SCH period portion)	$ 1,180,285[81]
Payment adjustment amount (subject to cap)	**$(-285,477)**

Since the fixed portion of the 2008 IPPS payment for the SCH period exceeds the fixed portion of the inpatient operating costs for the same period, the Board concludes that Eastern should not receive a VDA payment for the 2008 fiscal year.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that, while the Medicare Contractor improperly calculated Eastern's VDA payment for FY 2008, Eastern should still not receive a VDA payment for FY 2008.

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FOR THE BOARD:

9/28/2022

X Clayton J. Nix

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Board Chair
Signed by: PIV

provided in the Provider's SFPP, were used, this percentage would be 5.348014 percent (136 Medicare SCH discharges divided by a total of 2,543 Medicare discharges). However, the end result of the VDA calculation would be the same. We have used the Medicare Contractor's figures, as the Medicare SCH discharges can be verified to the Provider Statistical & Reimbursement Report ("PS&R"), while Eastern's numbers are narrative only, with no support.

[79] Ex. C-1 at 14. (DRG payments for SCH period from cost report Worksheet E Part A line 6.)

[80] Inpatient Fixed Operating Costs for the SCH period are calculated using the Inpatient Operating Costs as calculated in the cap calculation ($1,153,995) multiplied by the stipulated fixed cost percentage (77.54 percent), per the Stip. at ¶ 11.

[81] The fixed portion of the 2008 IPPS payment related to the SCH period is calculated using the IPPS payment as calculated in the cap calculation ($1,522,163) multiplied by the stipulated fixed cost percentage (77.54 percent), per the Stip. at ¶ 11.