PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

On the Record

2022-D16

PROVIDER-
EJ Noble Hospital

Provider No. 33-0177

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
February 8, 2021

Cost Reporting Period Ended –
12/31/2011

CASE NO. 17-0848

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the Revised Volume Decrease Adjustment ("VDA") owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2011 ("FY 2011"), and whether the Medicare Contractor properly reopened the original VDA determination.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that:

1. The Medicare Contractor properly reopened the original VDA determination for EJ Noble Hospital ("EJ Noble" or "Provider") for FY 2011;

2. The Medicare Contractor improperly recalculated EJ Noble's VDA payment for FY 2011; and

3. EJ Noble should receive a VDA payment for FY 2011 in the amount of $177,121.

INTRODUCTION

EJ Noble is a non-profit acute care hospital located in Gouverneur, New York and was designated as a sole community hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to EJ Noble for this appeal is National Government Services, Inc. ("Medicare Contractor"). In order to compensate it for a decrease in inpatient discharges, EJ Noble requested a VDA payment of $474,917 for FY 2011.[4] On November 21, 2013 the Medicare Contractor calculated EJ Noble's FY 2011 VDA payment to be $478,324.[5] Subsequently, on February 5, 2016, the Medicare Contractor notified EJ Noble that it was reopening the original VDA determination based on direction from the Centers for Medicare and Medicaid Services ("CMS").[6] By letter dated July 22, 2016, the Medicare Contractor issued the revised VDA determination to revise the VDA payment to $0 and to recoup the original payment of $478,324.[7] EJ Noble timely appealed the Medicare Contractor's revised VDA determination and met all jurisdictional requirements for a hearing before the Board.

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[1] Second Revised Stipulations of the Parties (hereinafter "Stipulations") at ¶ 18.
[2] *Id.* at ¶ 1; Provider's Final Position Paper (hereinafter "Provider's FPP") at 1. Subsequent to the Applicable Fiscal Year, EJ Noble Hospital was dissolved and Gouverneur Hospital, which is located in the same location as the former EJ Noble Hospital, bought the assets of EJ Noble Hospital. *Id.* at n.1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Exhibit P-2 at 2.
[5] Exhibit P-3 at 1.
[6] Stipulations at ¶ 12.
[7] *Id.* at ¶¶ 13, 14.

The parties requested, and the Board approved, a record hearing on February 8, 2021. EJ Noble was represented by William H. Stiles, Esq. of Verrill Dana, LLP. 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 which is available to SCHs if, due to circumstances beyond their control, they incur a decrease in the total number of inpatient cases of more than 5 percent from one cost reporting year to the next.[8] VDA payments are designed to fully compensate a hospital for the fixed costs that it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.[9] The implementing regulations, located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that EJ Noble experienced a decrease in total discharges greater than 5 percent from FY 2010 to FY 2011 due to circumstances beyond its control and that, as a result, EJ Noble was eligible to have a VDA calculation performed for FY 2011.[10] EJ Noble requested a VDA payment in the amount of $474,917 for FY 2011.[11] The Medicare Contractor initially agreed with EJ Noble and determined that EJ Noble was entitled to a VDA payment of $478,324.[12] However, based on direction from CMS, the Medicare Contractor later reopened that determination and, after removing variable costs, revised the VDA calculation to $0.[13]

42 C.F.R. § 412.92(e) (2011) directs how the Medicare Contractor must calculate the VDA once an SCH demonstrates it experienced a qualifying decrease in total inpatient discharges. In pertinent part, § 412.92(e)(3) states:

> (3) The intermediary determines a lump sum adjustment amount *not to exceed*[14] the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs . . . .
>
> (i) In determining the adjustment amount, the Intermediary considers— . . .
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter. . . .

[8] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[9] *Id.*
[10] Stipulations at ¶¶ 10, 16.
[11] Medicare Contactor's Final Position Paper at 6 (hereinafter "Medicare Contractor's FPP").
[12] *Id.*
[13] *Id.* at 6-7.
[14] (Emphasis added.)

In the preamble to the final rule published on August 18, 2006,[15] CMS referenced Provider Reimbursement Manual, CMS Pub. 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, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary *directly*[16] with utilization such as food and laundry costs.

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

	Medicare Contractor calculation using fixed costs[17]	Provider/PRM calculation using total costs[18]
a) Prior Year Medicare Inpatient Operating Costs	$2,609,149	$3,004,718
b) IPPS update factor	1.0235	1.022366
c) Prior Year Updated Operating Costs (a x b)	$2,670,464	$3,071,922
d) FY 2011 Operating Costs	$2,955,293	$3,372,705
e) Lower of c or d	$2,670,464	$3,071,922
f) DRG/SCH Payment	$2,493,343	$2,597,005
g) CAP (d-f)	$ 177,121	$ 474,917
h) FY 2011 Inpatient Operating Costs	$2,670,464	$3,071,922
i) Fixed Cost Percent	89.04	1.00
j) FY 2011 Fixed Costs (h x i)	$2,377,837	$3,071,922
k) Total DRG/SCH Payments	$2,493,343	$2,597,005
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount by which line j exceeds line k)	$ 0	
m) VDA Payment Amount (The Providers VDA is based on the amount by which line j exceeds line k.)		$ 474,917

[15] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).
[16] (Emphasis added.)
[17] Exhibit P-5 at 5-6.
[18] Exhibit P-2 at 13.

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[19]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

EJ Noble states that the Medicare Contractor, after review of EJ Noble's VDA request, and any supplemental responses, decided that it satisfied the applicable statute, regulation and CMS program instructions. Accordingly, the Medicare Contractor originally approved EJ Noble's VDA request and issued the original VDA determination in the amount of $478,324.[20]

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

By letter dated February 5, 2016, the Medicare Contractor notified EJ Noble that it was revising the original VDA determination.[22] EJ Noble objected to the reopening. Notwithstanding, by letter dated July 22, 2016, the Medicare Contractor issued the revised VDA determination.[23]

According to EJ Noble, the workpapers attached to the Medicare Contractor's revised VDA determination demonstrate that the Medicare Contractor applied a new methodology that was inconsistent with the plain language of the applicable statute, regulations, and CMS program instructions.[24]

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

The Medicare Contractor argues that it has the authority to revise a final determination under its own discretion,[27] pursuant to 42 C.F.R. § 405.1885(a),which states:

> (a) *General.* (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings

[19] Stipulations at ¶ 17.
[20] Provider's FPP at 3.
[21] *Id.*
[22] *Id.*
[23] *Id.* at 4.
[24] *Id.*
[25] Exhibit C-7.
[26] Provider's FPP at 11.
[27] Medicare Contractor's FPP at 8-9.

> on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision . . . .

The Medicare Contractor was directed by CMS to reopen and recalculate the VDA payment amount to remove all variable expenses from a VDA calculation.[28] The Medicare Contractor notified EJ Noble of this review and recalculation of the VDA payment in its July 22, 2016, letter to EJ Noble.[29]

The Medicare Contractor asserts that it was bound to revise the VDA payment to remove the variable expenses, in accordance with the plain language of 42 U.S.C. § 1395ww(d)(5)(D)(ii) and 42 C.F.R. § 412.92(e).[30] Further, it argues that it was authorized to reopen and revise the original VDA determination under its own discretion pursuant to 42 C.F.R. § 405.1885(a).[31]

The Medicare Contractor issued its original VDA determination on November 21, 2013.[32] The Medicare Contractor's subsequent Notice of Reopening was dated February 5, 2016,[33] in compliance with 42 C.F.R. § 405.1885(b)(1), which states:

> An own motion reopening is timely only if the notice of intent to reopen (as described in § 405.1887) is sent no later than 3 years after the date of the determination or decision that is subject to the reopening.

The Board finds that 42 C.F.R. § 405.1885(a) gives the Medicare Contractor the authority to reopen a determination, and that the Notice of Intent to Reopen was issued within 3 years from the prior determination.[34] The Board, therefore, concludes that the Medicare Contractor had the authority to reopen EJ Noble's original VDA determinaiton.

EJ Noble also claims that VDA methodology used in the revised VDA determination runs afoul of the notice and comment rulemaking requirements of the Administrative Procedure Act

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[28] *Id.* at 7.
[29] *Id.* at 9. *See also* Exhibit C-7.
[30] Medicare Contractor's FPP at 9.
[31] *Id.*
[32] Stipulations at ¶ 11.
[33] *Id.* at ¶ 12.
[34] The notice of reopening dated February 5, 2016 (copy at Exhbiit P-4) suggests that this was a CMS-directed reopening permissible under 42 C.F.R. § 405.1885(c)(1) for the stated purpose: "review and recalculate the VDA to remove all variable expenses." Regardless, the Medicare Contractor had discretion to reopen on its own authority and the record demonstrates that the stated purpose for the reopening was not otherwise prohibited by § 405.1885(c)(2) since variable costs per CMS policy at 42 C.F.R. § 412.92(e)(3)(i)(B) and PRM 15-1 § 2810.1(B) are not to be included in the VDA calculation. *See infra* notes 54-55 and accompanying text. Moreover, the reopening did not involve any general change in CMS policy regarding the VDA calculation as discussed *infra* in the context of the Eight Circuit's decision in *Unity HealthCare v. Azar,* 918 F.3d 571 (8th Cir. 2019).

("APA")[35] and the Medicare statute at 42 U.S.C. § 1395hh(a).[36] EJ Noble argues that CMS and/or the Medicare Contractor violated the APA by making a substantive change in the VDA calculation methodology that "operate[s] to the significant financial detriment of the Provider."[37] Further, EJ Noble argues that "although CMS may be entitled to revise its interpretation of the VDA statute, such a drastic departure from its previous interpretation amounts to a substantive rule triggering the requirements of notice and comment rulemaking."[38] EJ Noble states that, even if the VDA methodology used in the revised VDA determination does not amount to an improper substantive rule under the APA, the Supreme Court's recent decision in *Azar v. Allina Health Services* ("*Allina*")[39] makes clear that the revisions violate the notice and comment rulemaking requirements at 42 U.S.C. § 1395hh(a).[40] The provisions of 42 U.S.C. § 1395hh(a)(2) specify, in pertinent part, that "[n]o rule, requirement or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1)."

In support of its position, EJ Noble asserts that the examples given at PRM 15-1 2810.1 "detail[] exactly how the [Medicare Contractor] is required to determine the VDA payment amount[,]" and that CMS and/or the Medicare Contractor improperly departed from this methodology.[41] However, the Board notes that these examples relate to the VDA cap and not the actual VDA calculation, as the U.S. Circuit Court for the Eighth Circuit ("Eighth Circuit") recently confirmed in *Unity HealthCare v. Azar*:

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

[35] 5 U.S.C. Ch. 5.
[36] Provider's FPP at 17-19, 23-24.
[37] *Id.* at 18.
[38] *Id.* at 24.
[39] 139 S. Ct. 1804 (2019).
[40] Provider's FPP at 25-27.
[41] *Id.* at 9.

> *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than "equal to," when describing the formula. *We conclude that the Secretary's interpretation was **not** arbitrary or capricious and was consistent with the regulation*.[42]

Accordingly, what EJ Noble contends was written or published CMS "policy" on how to calculate the VDA payment was not, in fact, such a policy.

Moreover, the fact that the Medicare Contractor, itself, may have *previously* calculated VDA payments differently does not automatically mean there is a departure from a Medicare program "policy" (*i.e.*, the policy of CMS or the Secretary)[43] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[44] This is different than the situation discussed by the Supreme Court in *Allina*, where a new substantive reimbursement policy was announced on the CMS website and applied nationwide to all hospitals at one time.[45] The fact that CMS may have directed the Medicare Contractor to calculate the VDA here in this particular case (or even on a case-by-case basis, as presented to CMS) is not inconsistent with adopting a substantive policy through adjudication, and is different from the *Allina* situation where CMS posted publicly on its website a "nationwide" adoption of a new substantive policy. Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as delineated at 42 C.F.R. § 412.92(e)(3).[46] 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.[47] Accordingly, the Board rejects EJ Noble's APA, Medicare statute, and *Allina* arguments.

EJ Noble also argues that the Medicare Contractor's revised calculation of the VDA was incorrect because the methodology used guaranteed that a hospital never receives full compensation for fixed costs.[48] According to EJ Noble, the Medicare Contractor's revised VDA

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[42] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[43] Moreover, the fact that this particular Medicare contractor historically calculated VDAs in a particular manner does not make that CMS policy.
[44] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius,* 718 F.3d 914 (D.C. Cir. 2013).
[45] 139 S. Ct. at 1808, 1810.
[46] 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."
[47] *See, e.g., Unity Healthcare v. Blue Cross Blue Shield As'n,* PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Reg'l Med. Ctr. v. Palmetto GBA,* PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Similarly, EJ Noble fails to give any examples or support to its position that CMS and/or the Medicare Contractor are substantively changing policy as it relates to determining which costs are "treated" as variable versus semi-fixed in accordance with PRM 15-1 § 2810.1. *See, e.g.,* Provider's Final Position Paper at 26. Further, the application of the PRM definitions of these terms to a particular provider's VDA request seems to be the very nature of adjudicatory fact-finding and why providers may appeal Medicare contractor VDA determinations to the Board.
[48] Provider's FPP at 36.

determination improperly treated certain fixed (and semi-fixed) costs as variable costs, and confused inpatient and outpatient expenses.[49]

EJ Noble contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs.[50] EJ Noble 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, EJ Noble maintains, would assure an accurate matching of revenue with expenses, because the DRG payment is intended to cover both fixed *and* variable costs. EJ Noble also suggests that CMS recently acknowledged that total DRG payments include a component designed to reimburse variable costs when it prospectively changed the final rule for calculating VDA payments, starting in FFY 2018.[51]

EJ Noble states that "[t]he statute does not specifically define the methodology for determining the exact amount of the required adjustment. However, its use of broad language requires inclusiveness, rather than exclusiveness."[52] EJ Noble's argument continues by pointing out that "[t]he Medicare Act itself does not define 'fixed costs.'"[53] While EJ Noble focuses on the "broad language" requiring inclusiveness, this argument ignores that the final rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule") clearly states "[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*[.]"[54] Not only does this regulation state that the VDA payment is to compensate for "fixed costs," but it also clarifies that variable costs should not be factored into the calculation. Moreover, this supports the Medicre Contractor's reopening of the original VDA calculation (which EJ Noble asserts must be based on "clear and obvious error") because the costs used in the original VDA calculation clearly included variable costs in error.[55]

The Board notes that the main difference between the Medicare Contractor's and EJ Noble's VDA calculations is that the Medicare Contractor removed variable costs from the inpatient operating costs and EJ Noble did not remove *any* variable costs. However, as noted above, variable costs must be removed. As a secondary argument, EJ Noble disagrees with the *extent* of the Medicare Contractor's removal of variable costs and contends that the Medicare Contractor improperly removed fixed costs as variable costs from such accounts as laundry, dietary. catering and supply costs.[56] While EJ Noble recognizes that the general ledger accounts specified by the Medicare Contractor as containing variable costs "may 'vary somewhat' with inpatient utilization," it suggests that it was the Medicare Contractor's responsibility to "demonstrate[] that they vary 'directly' with inpatient utilization."[57] EJ Noble further asserts that when the Medicare Contractor's process to identify variable costs improperly used trial balances that were

[49] *Id*. at 11, 38-40.
[50] *Id*. at 28.
[51] *Id*. at pp. 29-30, 35-36.
[52] *Id*. at 5.
[53] *Id*.
[54] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).
[55] Provider's FPP at 13 n.8.
[56] *Id*. at 39-40.
[57] *Id*.

for *total* hospital costs and that, as a result, the identified variable costs were too high since they included both inpateint and outpatient expenses (*i.e.*, total inpatient operating costs should be reduced only by inpatient variable costs in order to identify fixed inpatient operating costs).[58] Signficantly, EJ Noble has not presentated any evidence or information to quantify these contentions.

The Board finds that EJ Noble's contentions are flawed and that the Medicare Contractor's process was proper. In a Medicare cost report, actual Medicare cost is a calculated amount based upon a cost center or department's ratio of costs to charges which is applied to the applicable Medicare charges (inpatient or outpatient) to determine Medicare cost. A single ratio of cost to charges is applied to inpatient or outpatient charges. There are not separate ratios for inpatient and outpatient. The purpose of the Medicare Contractor's calculations is to determine the percentage of fixed costs as compared to total costs for the full hospital. This is done by identifying variable costs and excluding them from total costs, to arrive at fixed costs only. Then, using the cost report's calculation of total inpatient costs (which includes both fixed and variable costs), the Medicare Contractor can apply the calculated fixed cost percentage to determine the portion of total inpatient costs which are fixed. This is used in the VDA calculation to determine the fixed costs for which the provider must be reimbursed, in accordance with the FFY 1984 IPPS Final Rule's statement that "An adjustment will not be made for truly variable costs." If EJ Noble had concerns that certain costs should not have been considered as variable or that a different calculation should have been made to arrive at fixed costs for inpatient services after allocation, then it should have provided support or sample calculations for such an alternate calculation. As noted above, it has not done so.

Per review of the Medicare Contractor's Exhibit C-3, variable expenses were identified at the account level, within each of the cost centers on the cost report Worksheet A.[59] The Medicare Contractor identified $1,999,115 in variable expenses through their analysis. This amount was compared to total expenses per Worksheet A, excluding specific excluded units and outpatient units. This resulted in a variable cost percentage of 10.96 percent and a fixed cost percentage of 89.04 percent.[60] This fixed cost percentage was then used to determine the fixed portion of the Medicare Inpatient Operating Costs for use in the VDA calculation. EJ Noble argues that the Medicare Contractor "used...outpatient expenses to reduce total Medicare Inpatient costs."[61] This is incorrect. The Medicare Contractor is not subtracting these costs from the Medicare inpatient costs, but instead is determining fixed and variable cost percentages of the hospital's total costs which are then applied to the Medicare inpatient costs to arrive at fixed Medicare inpatient costs. As the cost report does not change the "type" of cost through its allocation, it is reasonable for the Medicare Contractor to presume that the total percentage of total costs which is fixed will still remain the same percentage after the costs have been determined for just the Medicare payor and the related inpatient services.

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[58] *Id.* at 40.
[59] The Provider recognizes that, as part of this review, the Medicare Contrctor reviewed the trial balances of specified general ledger accounts that contained expenses alleged to be variable for purposes of identifying and quantifying variable costs. Provider's FPP at 38.
[60] Exhibit C-3 at 5.
[61] Provider's FPP at 40.

Accordingly, the Board finds that the Medicare Contractor was correct in removing variable costs from the inpatient operating costs and that the method used to identify and remove these costs was reasonable, based on the operations of the cost report and the data EJ Noble provided to the Medicare Contractor, as well as the failure of EJ Noble to provide any alternative calculation (with support documentation). However, the Board also finds that the portion of the DRG payment related to variable costs should have been removed from the total DRG payment. The statue states the VDA payment is to be adjusted "as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services."[62] The regulations state that to determine the payment the intermediary considers "[t]he hospital's fixed (semi fixed) costs."[63] And the PRM states "[a]dditional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services."[64]

In its recent decisions,[65] the Board has disagreed with the methodology used by various Medicare contractors (including the Medicare Contractor in this appeal) to calculate VDA payments because that methodology compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospital's VDA payment 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 that 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 . . . .[66]

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[62] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[63] 42 C.F.R. § 412.92(e)(3)(i)(B).
[64] PRM 15-1 2810.1(B).
[65] *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).
[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).

Recently, the Eighth Circuit upheld the Administrator's methodology in *Unity*, stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[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 may be generally known and applied by providers, intermediaries, and other interested parties.[68]

Moreover, the Board notes that EJ Noble 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 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.[70] The preamble to the FFY 2018 IPPS Final Rule makes this change effective for cost reporting periods beginning on or after October 1, 2017, explaining that it will "remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment."[71]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As explained below, the Board finds that the Medicare Contractor's calculation of EJ Noble's VDA methodology 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.

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

The Medicare Contractor determined EJ Noble'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 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[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.

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

Rather, the Board finds the Medicare Contractor calculated EJ Noble's FY 2011 VDA based on an otherwise *new* methodology that the Administrator apparently adopted through adjudication in her decisions best described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[75] 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.[76]

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

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary **to**

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[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).
[75] *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).
[76] 82 Fed. Reg. at 38179-38183.

> **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.[77]

As stated earlier, in the FFY 1984 IPPS Final Rule, the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[78] However, the VDA payment methodology (as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 (Rev. 356)) compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and states in pertinent part:

> C. Requesting Additional Payments.—. . . .
>
> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
>
> D. Determination on Requests.— . . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost.* Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
>
> 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***.[79]

[77] (Emphasis added.)
[78] 48 Fed. Reg. 39752, 39781-39782 (Sept. 1, 1983) (emphasis added).
[79] (Emphasis added.)

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule, which both limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology, through adjudication in the Administrator decisions, stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[80] 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."[81]

Using the Administrator's rationale, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment ***only*** *for the* ***fixed*** *costs* of the services actually furnished to Medicare patients. However, the statute at 42 U.S.C. § 1395ww(a)(4) makes it clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines operating costs of inpatient services as "***all*** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]"[82] 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*. This is in keeping with the assumption stated in PRM 15-1 § 2810.1(D)(2)(a) that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 412.92(e)(3)(i)(A) that the Medicare contractor "consider[] . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[83] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable costs related to furnishing Medicare services to its *actual* patient load.

Critical to the proper application of the statute, regulation and PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished *actual* services in the current year are not part of the volume decrease, and (2) the DRG payments made to the hospital for services furnished to Medicare patients in the current year are payments for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year as well as its full fixed costs in that year.

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[80] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[81] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[82] (Emphasis added.)
[83] 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 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. Accordingly, the Board concludes that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(D)(ii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is clear that the VDA payment is *not* intended to fully compensate the hospital for its variable costs.[84] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for Medicare services *actually* furnished. The Board concludes that, in order to ensure the hospital is fully compensated for its fixed costs and be consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board elects to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case the Medicare Contractor determined that EJ Noble's fixed costs (which includes semi-fixed costs) were 89.04 percent of EJ Noble's Medicare costs for FY 2011.[85] 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	$2,609,149[86]
Multiplied by the 2011 IPPS update factor	1.0235[87]
2010 Updated Costs (max allowed)	$2,670,464
2011 Medicare Inpatient Operating Costs	$2,955,293[88]
Lower of 2010 Updated Costs or 2011 Costs	$2,670,464
Less 2011 IPPS payment	$2,493,343[89]
2011 Payment CAP	**$ 177,121**

[84] 48 Fed. Reg. at 39782.
[85] Stipulations at ¶ 21.
[86] *Id.*; Exhibits P-5 at 5, C-3 at 1.
[87] *Id.*
[88] *Id.*
[89] *Id.*

Step 2: Calculation of VDA

2011 Medicare Inpatient Fixed Operating Costs	$2,631,393[90]
Less Excess Staffing	$ 0[91]
Less 2011 IPPS payment – fixed portion (89.04 percent)	$2,220,073[92]
Payment adjustment amount (subject to cap)	**$ 411,320**

Since the payment adjustment amount of $411,320 is greater than the Cap of $177,121, the Board concludes that EJ Noble's total VDA payment for FY 2011 should be $177,121.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that:

1. The Medicare Contractor properly reopened EJ Noble's original VDA determination for FY 2011;

2. The Medicare Contractor improperly recalculated EJ Noble's VDA payment for FY 2011 ; and

3. EJ Noble should receive a VDA payment for FY 2011 in the amount of $177,121.

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FOR THE BOARD:

3/17/2022

X Clayton J. Nix

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

[90] The current year fixed operating costs is computed by taking the current year operating costs of $2,955,293 x 89.04 percent = $2,631,393. The Medicare Contractor used the incorrect current year operating costs at Exhibit C-3 at 2 to calculate fixed operating costs.
[91] Neither the Medicare Contractor nor EJ Noble calculated a deduction for excess staffing.
[92] The $2,220,073 is calculated by multiplying $2,493,343 (the FY 2011 SCH payments; *see* Stipulations at ¶ 21) by 0.8904 (the fixed cost percentage determined by the Medicare Contractor).