PROVIDER REIMBURSEMENT REVIEW BOARD DECISION
On the Record

2025-D10

PROVIDER-
Stephens Memorial Hospital

Provider No.: 20-0032

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
March 12, 2024

Cost Reporting Period Ended –
09/30/2008

CASE NO. – 17-0904

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor[1] 1) properly reopened the original volume decrease adjustment ("VDA") approval, and 2) properly calculated the revised VDA payment owed to Stephens Memorial Hospital ("Stephens" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending September 30, 2008 ("FY 2008").[2]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly reopened the Original VDA approval for Fiscal Year ("FY") 2008, but improperly calculated the VDA payment for FY 2008 for Stephens, and that Stephens should receive an additional payment of $866,082 for FY 2008, resulting in a total FY 2008 VDA payment of $1,143,962.

INTRODUCTION

Stephens is an acute care hospital located in Norway, Maine.[3] Stephens was designated as a Medicare Dependent Hospital ("MDH") during the time period at issue.[4] The Medicare contractor assigned to Stephens for this appeal is National Government Services, Inc. (the "Medicare Contractor").

On March 28, 2014, Stephens filed a timely request for a VDA payment of $1,217,950 for FY 2008 to compensate it for a decrease in inpatient discharges during FY 2008.[5] On September 25, 2014, the Medicare Contractor requested additional information to continue its review.[6] On October 9, 2015, the Medicare Contractor approved Stephen's VDA payment request for $1,217,950 (the "Original VDA Approval").[7] On January 22, 2016, the Medicare Contractor notified Stephens that the Medicare Contractor had been directed by CMS to revise the determination.[8] Stephens objected to the reopening, but nonetheless provided the information requested.[9] On August 5, 2016, the Medicare Contractor issued a revised VDA payment of $277,880 (the "Revised VDA Approval"), requiring Stephens to refund $940,070 of the original VDA payment.[10] Stephens timely appealed

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[1] 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 relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs as appropriate and relevant.
[2] *See* Provider's Final Position Paper ("FPP") at 3. Stephens' Fiscal Year runs October 1 through September 30, *i.e.*, corresponds with the Federal Fiscal Year ("FFY").
[3] *Id* at 1.
[4] *Id*.
[5] Provider's FPP at 1; *see also* Exhibit (hereinafter, "Ex.") P-2 at 0256 and 0275 (Provider's VDA Request).
[6] Ex. P-6 (MAC's Original Supplemental Request).
[7] Ex. C-1 at 1.
[8] Ex. P-4 (MAC's Reopening Notice)
[9] Provider's FPP at 6. *See also* Ex. P-9 (Response to Reopening).
[10] Provider's FPP at 1; *see also* Ex. P-5 (Revised VDA Approval).

the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on March 12, 2024. Stephens 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 such payment adjustment is a VDA payment, which is available to an MDH if, due to circumstances beyond its control, it incurs a decrease of more than 5 percent in the total number of inpatient discharges from one cost reporting year to the next.[11] VDA payments are designed 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."[12]

Regulations direct how a Medicare contractor must determine the VDA payment once an MDH demonstrates that it experienced a qualifying decrease in total inpatient cases. Specifically, 42 C.F.R. § 412.108(d)(3) states, in pertinent part:

> (d) Additional payments to hospitals experiencing a significant volume decrease.
>
> * * *
>
> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under §412.106 and for indirect medical education costs as determined under §412.105).
>
> (i) In determining the adjustment amount, the intermediary considers -

[11] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[12] *Id*.

> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
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> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
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> (C)The length of time the hospital has experienced a decrease in utilization. [13]

The parties do not dispute that Stephens was eligible to have a VDA calculation performed for FY 2008.[14] Stephens requested a VDA payment in the amount of $1,217,950 for FY 2008, and the Medicare Contractor approved that amount in October, 2015.[15] However, when the Medicare Contractor revised its calculation of the FY 2008 VDA payment in August 2016, it determined that Stephens was entitled to a VDA payment of $277,880 after removing a percentage of costs identified as variable in the Medicare Contractor's analysis.[16] In this appeal, the parties dispute "the correct amount of [Stephens'] VDA payment under the applicable laws, regulations and program instructions."[17]

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

	Medicare Contractor's calculation[18]	Provider's calculation[19]
a) Prior Year Medicare Inpatient Operating Costs	$ 7,921,682	$ 7,921,682
b) IPPS update factor	1.0330	1.0330
c) Prior year Updated Operating Costs (a × b)	$ 8,183,098	$ 8,183,098
d) Current Year Operating Costs	$ 8,271,555	$ 8,271,555
e) Lower of c or d	$ 8,183,098	$ 8,183,098
f) DRG/MDH payment	$ 6,965,148	$ 6,965,148
g) Cap (e - f)	$ 1,217,950	$ 1,217,950

[13] Unless otherwise noted, the Board is referring to the version of 42 C.F.R. § 412.108 effective October 1, 2006, to September 30, 2010, the version in effect during the fiscal year in question (*i.e.*, FY 2008). *See also* 42 U.S.C. § 1395ww(d)(5)(G)(iii), stating that the Secretary shall provide for adjustments to payment amounts to compensate hospitals experiencing a specified decrease in inpatient cases.
[14] *See* Stipulations at ¶¶ 10, 16. Stephens experienced a decrease in discharges greater than five percent (5%) from FY 2007 to FY 2008 due to circumstances beyond Stephens' control.
[15] Stipulations at ¶¶ 7, 11. Ex. P-2.
[16] *Id.* at ¶ 13; *see also*, Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 16.
[17] Stipulations at ¶ 17.
[18] Stipulations at ¶ 13. Ex. C-6 at 8.
[19] Stipulations at ¶ 11. Ex. P-2.

h) Current Year Inpatient Operating Costs	$ 8,271,555	
i) Fixed Cost percent	87.57%[20]	
j) FY 2008 Fixed Costs (h × i)	$ 7,243,028	
k) Total DRG Payments	$ 6,965,148	
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 277,880	
m) VDA Payment Amount (The Provider's VDA is based on the amount line e exceeds line f, also identified as the Cap amount)		$ 1,217,950

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

I. First, Stephens contends that the Medicare Contractor's reopening "failed to satisfy the specific requirements set forth in 42 C.F.R. § 405.1885(c), and therefore the reopening (and any subsequent action taken by the [Medicare Contractor]) is void."[21]

Stephens argues that the Medicare Contractor "improperly reopened the Provider's Original VDA Approval."[22] First, Stephens argues that the Medicare Contractor has failed to produce "explicit notice" from CMS directing the reopening. Stephens bases its argument on 42 C.F.R. § 405.1885(c), which provides that jurisdiction for reopening rests with the Medicare contractor that made the determination, based on *explicit directive from CMS* to reopen or not reopen.[23] CMS may direct a reopening within three (3) years of the date of determination by providing explicit direction to the Medicare contractor.[24]

Stephens contends that the Medicare Contractor "has failed to demonstrate that CMS has provided the required '*explicit notice*' that the Original VDA Approval 'is inconsistent with the applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the contractor' as required by the applicable regulation."[25]

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[20] Ex. C-6 at 8. Calculation: ((total expenses $38,645,449 less variable cost $4,805,373)/total expenses 38,645,449) = 0.8756548798, rounded up to 0.8757.

[21] Provider's FPP at 13.

[22] Provider FPP at 14. *See* Ex. P-4 (MAC's Reopening Notice). This reopening notice is also provided as the Medicare Contractor's Ex. C-1 at 8.

[23] 42 C.F.R. § 405.1885(c) (Oct. 1, 2014 – Sept. 30, 2020) (emphasis added). The Board finds that this Oct. 1, 2014 version is applicable, as it was the rule in place at the time of the reopening (*i.e.*, Jan. 22, 2016). However, to assuage any doubts, the immediately prior version of the regulation, in place effective Jan. 1, 2014 through Sept. 30, 2014, differs only in that it uses the term "intermediary" instead of "contractor." As referenced in (c)(1), the time limits specified in paragraph (b) (*i.e.*, three (3) years from the date of determination) are not at issue in this case as the reopening occurred within one (1) year of the Original VDA Approval.

[24] 42 C.F.R. § 405.1885(c)(1); *see also* 42 C.F.R. § 405.1885(b)(2).

[25] Provider's FPP at 15 – 16 (emphasis added), *citing* 42 C.F.R. § 405.1885(c)(1)(i).

In its argument, Stephens emphasizes the *writing* requirement found in guidance. The Provider Reimbursement Manual ("PRM") states, in pertinent part:

> A determination and a decision will be reopened and corrected by [a Medicare contractor] if within 3 years of the date of the intermediary's notice of amount of program reimbursement […], [CMS] notifies the [Medicare contractor] *in writing* that such determination or such decision is inconsistent with the applicable law, regulations, or general instructions issued by [CMS].[26]

Stephens refers to the language of the reopening notice indicating that a revised determination "is being made based on *direction* from the Centers for Medicare and Medicaid Services (CMS)" and that the Medicare Contractor has "been *directed* to review and recalculate the VDA to remove all variable expenses."[27] Stephens maintains that the mandatory reopening must fail without an explicit *written notice* from CMS to the Medicare Contractor.[28] Stephens, therefore, asks that the Board 1) find the reopening to be void, 2) vacate the Revised VDA Approval, and 3) reinstate the Original VDA Approval.[29]

The Medicare Contractor did not respond to this argument. However, Stephens has anticipated the Medicare Contractor's defense and proffers:

> To the extent that the [Medicare Contractor] suggests that this was a discretionary reopening, such an argument must be rejected. First, the plain language of the reopening notices clearly contradicts such an argument. Second, the structure of the applicable regulation and PRM clearly state that the [Medicare Contractor] "determines" the amount of the VDA payment using its discretion while balancing three considerations. Since the [Medicare Contractor] had already properly exercised that discretion–and reported its determination to CMS–the Revised VDA Approval represents a new interpretation of the applicable criteria to which deference must not attach. […] The Original VDA Approval was consistent with the [Medicare Contractor's] Historical VDA Approval Methodology. Therefore, there was no 'new and material evidence,' or a 'clear and obvious error.'[30]

However, Stephens overlooks the fact that the provisions of 42 C.F.R. § 405.1885(a) give a Medicare contractor the authority to reopen a determination "with respect to specific findings on matters at issue in a determination."[31] Such a reopening may be through a Medicare contractor's own motion and, if CMS directs a Medicare contractor to reopen a matter, that reopening is

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[26] Provider's FPP at 15 – 16, *citing* Provider Reimbursement Manual ("PRM") § 2931.1(C) (emphasis added).
[27] Ex. P-4 (emphasis added).
[28] Provider's FPP at 16.
[29] *Id.* at 16.
[30] Provider's FPP at 15, note 9.
[31] 42 C.F.R. § 405.1885(a)(1).

considered a Medicare contractor's own motion.[32] Such was the case in *Maine Medical Center v. Burwell*, 841 F.3d 10, 20 (1st Cir. 2016). The Board finds persuasive the following observations of the Court in *Maine Medical Center*:

> The record indicates that CMS instructed the intermediary to reopen the cost reports, but did not issue a written directive to that effect. Rather, the instruction appears to have taken place orally and informally. The Hospitals' argument is that, under 42 C.F.R. § 405.1885(b)(1), a written directive from CMS was a condition precedent to reopening. We find this wooden reading of the regulation insupportable: it would nullify an intermediary's power to reopen if CMS advises it to reopen only in a casual conversation, and that dilution of the intermediary's power would serve no useful purpose. Indeed, it would pay obeisance to formalism for formalism's sake.[33]

Stephens relies on PRM § 2931.2, which is related to an intermediary reopening an otherwise final determination *at the request of the provider*, in its attempt to show that the Medicare Contractor failed to provide "new and material evidence" or a "clear and obvious error."[34] Stephens argues that written notice is well founded only "if it identifies the 'applicable law' (as CMS understood [it] at the time)."[35] However, as explained above, written notice is not a condition precedent to reopening, and even if it were, the Board believes Stephens is misreading 42 C.F.R. § 405.1885(c)(1)(i) to include a *requirement* that the Secretary or the Medicare contractor give the provider notice of *which* law, regulation, ruling, etc. it finds the prior decision to be inconsistent.

The Board finds that 42 C.F.R. § 405.1885(a) gives the Medicare Contractor the authority to reopen a determination. The Medicare Contractor's reopening was compliant with 42 C.F.R. § 405.1885(b)(1), which states, in pertinent part:

> An own motion reopening is timely only if the notice of intent to reopen (as described in § 405.1887) is mailed no later than 3 years

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[32] 42 C.F.R. § 405.1885(a)(2), (4).

[33] *Maine Medical Center v. Burwell,* 841 F.3d 10, 20 (1st Cir. 2016) (confirming that CMS may force a Medicare contractor to reopen its determination).

[34] PRM § 2931.2, reproduced below, is immediately followed by instructions as to when a provider may file an amended cost report.

> Reopening Final Determination.--Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions. Information submitted in support of an amended cost report or the audit findings on a previously unaudited cost report could provide new and material evidence on which to base a reopening.

[35] Provider's FPP at 16.

> after the date of the determination or decision that is the subject of the reopening.[36]

The elapsed time between the Original VDA Approval on October 9, 2015, and the Revised VDA Approval on August 5, 2016, was just shy of *ten (10) months*. Accordingly, the Board finds that the Medicare Contractor had the authority to reopen and revise the Original VDA Approval.

II. Second, Stephens argues that "when issuing the Original VDA Approval, the [Medicare Contractor] correctly applied the applicable statute, regulation, and program guidance, therefore, the Original VDA Approval must be reinstated."[37]

Stephens expresses a preference for the manner in which the MAC originally calculated the VDA, stating that it exactly follows the statute, regulation, and PRM instructions.[38] Stephens says CMS recently adopted a new interpretation and is attempting to retroactively apply it.[39] The Board finds that this second argument is substantively a summation of Stephens' other arguments; thus, the Board will not separately address Stephens' second argument.

III. Third, Stephens contends "the Revised VDA Approval Methodology represents a new substantive interpretation that the [Medicare Contractor] seeks to apply retroactively to a prior decision without observing the proper process. Therefore, the Original VDA Approval must be reinstated."[40]

Stephens claims that (1) "the Revised VDA Approval Methodology represents a departure from longstanding policy unsupported by a reasoned explanation, and is therefore "arbitrary and capricious" under the Administrative Procedures Act"; (2) "the Revised VDA Approval Methodology represents an improper interpretation of an interpretation of an interpretation that is not entitled to deference"; (3) the Medicare Contractor's "application of the Revised VDA Approval Methodology represents a substantive change that should have been subject to notice and comment rulemaking under the Administrative Procedures Act" ("APA");[41] and (4) the Medicare Contractor's "application of the Revised VDA Approval Methodology represents a change to a substantive legal standard that should have undergone notice and comment rulemaking under the Medicare Act."[42]

Stephens claims that CMS' revised VDA approval methodology runs afoul of the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA") and the Medicare program at 42 U.S.C. § 1395hh(a).[43] Stephens argues that CMS (through the Medicare Contractor) violated the APA by making a substantive change in the VDA calculation methodology that "produces significant effects on private interests; . . . [and] substantially

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[36] 42 C.F.R. § 405.1885(b)(1). This version of the regulation was in effect August 21, 2008 to December 31, 2013.
[37] Provider's FPP at 13.
[38] *Id.* at 16-17.
[39] *Id.* at 17.
[40] *Id.* at 13-14.
[41] *Id.* at 20, 21, and 27. The Administrative Procedure Act ("APA") is found at 5 U.S.C. § 551 et seq.
[42] *Id.* at 29.
[43] *Id.*

reduces the amount of VDA payments due to providers."[44] Further, they argue that, even though 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."[45] Stephens states that, "[e]ven if the revised VDA Approval Methodology does not amount to an improper substantive rule under the APA, the Supreme Court's recent decision in *Azar v. Allina Health Services* ("*Allina*")[46] makes clear that the revision violates the Medicare Act's notice and comment rulemaking requirements"[47] at 42 U.S.C. § 1395hh(a) which, the Board notes, specifies, 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)."[48]

In support of its position, Stephens asserts that the examples given at PRM 15-2810.1 detail exactly how the Medicare Contractor is required to determine the VDA payment, and that CMS (through the Medicare Contractor) improperly departed from this methodology.[49] However, the Board notes that these examples relate to the adjustment limit (*i.e.*, the cap or ceiling) and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

> The hospitals' main argument to the contrary [of the Secretary's formula] 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 *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

[44] *Id.* at 28.
[45] *Id.*
[46] 139 S. Ct. 1804 (2020).
[47] Provider's FPP at 29.
[48] 42 U.S.C. § 1395hh(a)(2) (effective Dec. 8, 2003).
[49] Provider's FPP at 31.

> 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.*[50]

Accordingly, what Stephens points to as written or published CMS "policy" on how to calculate the VDA payment was not, in fact, such a policy. Moreover, the fact that the Medicare Contractor may have previously calculated VDAs differently does not automatically mean there is a departure from a Medicare program "policy." The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[51] This is different than the situation discussed by the Supreme Court in *Allina*, where a new substantive reimbursement policy was announced on the CMS website and was applied nationwide to all hospitals at one time.[52] The fact that CMS may have directed the Medicare Contractor to calculate the VDA differently *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 than the *Allina* situation where CMS posted publicly on its website a "nationwide" adoption of 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. § 412.108 (d)(3).[53] In addition, 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.[54] Accordingly, the Board rejects the Provider's APA and *Allina* arguments.

IV. Fourth and Fifth, Stephens argues "the Revised VDA Approval relies upon a new substantive interpretation that violates the plain language of the statute, and therefore the Board must reject this interpretation."[55] That is, Stephens contends the Revised VDA Approval Methodology (1) does not "fully compensate" the provider as required by the applicable statute, (2) that the Medicare Contractor's (and CMS's) "apples-to-oranges" (*i.e.*, fixed costs to total payments) comparison is improper,[56] and (3) that "CMS cannot justify the methodology used by the [Medicare Contractor] in the Revised VDA Approval, and CMS [thus] has correctly abandoned it."[57] And finally, Stephens contends

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[50] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).
[51] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).
[52] 139 S. Ct. at 1808, 1810.
[53] 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."
[54] *See, e.g.*, *Unity Healthcare v. Blue Cross Blue Shield Association*, PRRB Dec. No. 2014-D15 (July 10, 2014); *Halifax Regional Medical Center v. Palmetto GBA*, PRRB Dec. No. 2020-D1 (Jan. 31, 2020). Similarly, the Provider fails to give any examples or support to its position that CMS and/or the Medicare Contractor are substantively changing policy as it relates to determining which costs are "treated" as variable versus semi-fixed in accordance with PRM 15-1 § 2810.1. *See, e.g.*, Provider's Final Position Paper at 21. 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.
[55] Provider's FPP at 14.
[56] *Id.* at 35-39.
[57] *Id.* at 39.

the Revised VDA Approval "improperly treated fixed (and semi-fixed) costs as variable costs (and confused inpatient and outpatient costs)," and therefore the Board must modify the Revised VDA Approval.[58]

The Medicare Contractor responds to Stephens' fourth and fifth arguments together, so the Board will address these in conjunction, as well. The Medicare Contractor disagrees with the Provider's assertion that the Federal Register does not specifically state that variable costs should be removed from *total* costs to compute the VDA. The Medicare Contractor asserts that it has correctly interpreted the Federal Register and that the calculation is consistent with PRM-1 §2810.1B, which distinguishes fixed, semi-fixed, and variable costs.[59] In support of its position, the Medicare Contractor cites Administrator Decisions for *Lakes Regional Healthcare v. BCBSA*, PRRB Dec. No. 2014-D16 (July 10, 2014) and *Unity Healthcare v. BCBSA*, PRRB Dec. No. 2014-D15 (July 10, 2014), in which the CMS Administrator affirmed this methodology in its decisions dated September 4, 2014 in both cases. The Medicare Contractor also references the Administrator's Decision in *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association,* Adm'r. Dec. 2015-D11, (Aug. 5, 2015).[60]

The Medicare Contractor contends that the intent of the VDA is to compensate qualified hospitals for their fixed/semi-fixed costs only, and not their variable costs.[61] In order to eliminate these costs, the Medicare Contractor used Stephens' submitted "analysis identifying what they believed to be the fixed, semi-fixed and variable costs (Provider noted the variable costs identified were per MAC's list sent with the MAC's request)" compared to total expenses on worksheet A of Stephens' cost report.[62] The Administrator agreed with this approach in the *Unity* and *Lakes Regional* decisions.[63]

Stephens argues the Medicare Contractor's calculation is inherently flawed, arguing the Medicare Contractor's methodology "current approach guarantee[s] that VDA payment would not 'fully compensate the hospital for the fixed costs it incurs in the period….' [64] Stephens' argument continues, noting that the Medicare Contractor's methodology ignores the fact that certain hospital functions are required to keep a hospital open and operating such as laundry and dietary, and are essential for operations, even when the inpatient census declines. [65,66]

The Board identified one basic difference in the Medicare Contractor's and Stephens' calculation of the Provider's VDA payment. Whether the FY 2008 DRG payments are multiplied by the fixed cost percentage being applied to the current year inpatient operating costs differs between

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[58] *Id.* at 42-45.
[59] Medicare Contractor's FPP at 10-11.
[60] *Id.* at 12.
[61] *Id.* at 11.
[62] *Id.* at 15-16.
[63] *Id.* at 12.
[64] Provider's FPP at 42.
[65] *Id.* at 43-44.
[66] Here, the Board notes that the Final Rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule") states that "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the *fixed* costs it incurs in the period . . . . An adjustment will ***not*** be made for truly *variable* costs, such as food and laundry services." (Bold and italics emphasis added.)

the parties. Stephens argues that the Medicare Contractor's VDA calculation "treated *all* MS-DRG payments received by the Provider as a payment for its fixed costs only – even though the [Medicare Contractor] knew that a portion of the MS-DRG payments actually represented reimbursement for *variable* costs."[67]

Historically,[68] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because it 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.

Referring to the methodology adopted by the Board in previous decisions, Stephens implies 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. Stephens demonstrates that DRG payments should have been multiplied by the percentage of fixed program costs to all program costs (87.57%) to calculate the DRG payments attributable to fixed costs.[69] Stephens 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.[70]

Until 2025, the Administrator routinely overturned Board decisions using the methodology described above for cases involving reporting periods prior to October 1, 2017,[71] stating:

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . .
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> 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 . . . .[72]

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[67] Provider's FPP at 34.
[68] *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Serv.*, 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).
[69] Provider's FPP at 39.
[70] *Id.* at 40; discussed *infra*.
[71] *See infra.*
[72] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r. Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).

Additionally, in 2019, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[73] Here, it is important to note that Administrator decisions are not binding precedent upon the Board. PRM 15-1 § 2927.C.6.e explains:

> 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.[74]

Noting that Stephens is not in the Eighth Circuit and that the statutes and regulations for VDAs for SCHs and MDHs are identical, the Board finds that the applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[75] As a result, the Board is not bound to apply the specific VDA calculation methodology that the Administrator applied (and the Eighth Circuit upheld) in *Unity*.[76] In this regard, the Board further notes that §§ 412.92(e)(3) and 412.108(d)(3) make clear that the VDA payment determination is subject to review through the Board's appeal process.[77] Thus, the Board finds that the Eighth Circuit's *Unity* decision was

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

[74] (Bold and italics emphasis added).

[75] With regard to SCHs, 42 U.S.C. § 1395ww(d)(5)(D)(ii), see, e.g., *St. Anthony Reg'l Hosp. v. Azar*, 294 F. Sup. 3d 768, 779 (N.D. Iowa 2018) (stating that § 1395ww(d)(5)(D)(ii) contains a gap as it directs that "the Secretary shall provide for such . . . payment . . . as may be necessary" and that "[t]he Secretary has filled that gap in a manner that I find to be reasonable in light of the statutory framework and purpose."), aff.d, *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019). With regard to SCHs, 42 C.F.R. § 412.92(e)(3), see, e.g., *id.* at 772, 781 (adopting the Magistrate's report which found that '"[t]he regulations promulgated by the Secretary in effect during the relevant time period did not provide a specific formula for calculating the VDA payment[,]'" and '"[i]nstead, the regulation directed that the following factors be considered in determining the VDA payment amount...'"). The Board's plain reading of the regulation is confirmed by the Agency's discussion of this regulation in the preamble to rulemakings. See, for SCHs, e.g., 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987) (stating that "[w]e determine on a case-by-case basis whether an adjustment will be granted and the amount of that adjustment." (emphasis added)); 48 Fed. Reg. 39752, 39781-82 (Sept. 1, 1983).

[76] *See, e.g.*, *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1107-08 (D.C. Cir. 2014) (discussing regulatory interpretations adopted through adjudication versus through rulemaking).

[77] Moreover, the Board notes that, subsequent to the Eighth Circuit's decision in *Unity*, the U.S. Supreme Court issued its decision in *Azar v. Allina Health Servs*, 139 S. Ct. 1804, 1810, (2019) ("*Allina II*") where the Supreme Court ruled on the scope of Medicare policy issuances that are subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) by making clear that "the government's 2014 announcement of the 2012 Medicare fractions [to be used in DSH calculations for FY 2012 where the Agency] 'le[t] the public know [the agency's] current adjudicatory approach' to a critical question involved in calculating payments for thousands of hospitals nationwide" was a "statement of policy that establishes or changes a substantive legal standard" as that phrase is used in 42 U.S.C.

simply adjudicating a dispute regarding the reasonableness of the Administrator's interpretation of the statute and regulations governing VDAs that the Administrator applied in rendering her decision in *Unity*. As such, the Eighth Circuit's decision in *Unity* did not create a binding precedent as to the specific VDA calculation methodology that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue*, as mentioned above, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[78] CMS prospectively changed the methodology for calculating the VDA to one which is very similar to the methodology used by the Board. Under the FFY 2018 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.[79] 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."[80]

Of further significance, most recently, following the D.C. Circuit's holding in *Lake Region Healthcare Corp. v. Becerra*, 113 F.4th 1002, 1009 (D.C. Cir. 2024),[81] the Administrator has declined review of similar Board decisions, signaling acquiescence to the Board's long-standing methodology for cost reporting periods before October 1, 2017.[82]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. Accordingly, as set forth below, the Board finds that the Medicare Contractor's calculation of Stephens' 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 Stephens' VDA payment by comparing its FY 2008 fixed costs to its total FY 2008 DRG payments. However, neither the language nor the examples[83] 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[84] and the FFY 2009 IPPS Final Rule[85] reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

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§ 1395hh(a)(2) and, thus, was subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) (citations omitted).

[78] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

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

[80] 82 Fed. Reg. at 38180.

[81] Not to be confused with *Lakes Regional*, referenced *supra*.

[82] *See, e.g., Tennova Healthcare – Volunteer Martin v. WPS Government Health Administrators*, PRRB Dec. 2025-D06 (Dec. 17, 2024), Administrator declined review (Jan. 8, 2025).

[83] PRM 15-1 § 2810.1(C)-(D).

[84] 71 Fed. Reg. at 47870, 48056. (Aug. 18, 2006).

[85] 73 Fed. Reg. at 48434, 48631. (Aug. 19, 2008).

> The 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 adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Stephens' 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.

The Board finds, instead, that the Medicare Contractor calculated Stephens' 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[.]"[86] 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.[87]

The statute at 42 U.S.C. § 1395ww(d)(5)(G)(iii) (2008) is clear that the VDA payment is to fully compensate the hospital for its fixed cost:

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

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."[88] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a

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

[87] 82 Fed. Reg. at 38179-38183.

[88] 48 Fed. Reg. at 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

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***.[89]

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."[90]

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

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."[91]

Using the Administrator's rationale, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment ***only*** *for the* ***fixed*** *costs* of the services actually furnished to Medicare patients. However, the statute at 42 U.S.C. § 1395ww(a)(4) makes it clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines operating costs of inpatient services as "**all** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]" The Administrator cannot simply ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as 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 MDH for all the fixed costs associated with the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 405.108(d)(3)(i)(A) that the Medicare contractor "considers . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[92] 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 and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(G)(iii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes 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. Thus, the Board agrees with the U.S. Court of Appeals for the D.C. Circuit

[91] 42 U.S.C. § 1395ww(d)(5)(G)(iii).

[92] The Board recognizes that 42 C.F.R. § 405.108(d)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

that "the fixed-total method used by [the Administrator] [does] not 'fully compensate' [a hospital] for its 'fixed costs[.]'"[93]

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(G)(iii) do not fully address how to remove variable costs when calculating a VDA adjustment, the VDA payment is clearly not intended to fully compensate the hospital for its variable costs. [94] 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 both ensure the hospital is fully compensated for its fixed costs and be consistent with the assumption stated in PRM 15-1 § 2810.1 that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case, the Medicare Contractor determined that Stephens' fixed costs (which includes semi-fixed costs) were 87.57 percent[95] 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	$ 7,921,682[96]
Multiplied by the 2008 IPPS update factor	1.0330[97]
2007 Updated Costs (max allowed)	$ 8,183,098
2008 Medicare Inpatient Operating Costs	**$** 8,271,555[98]
Lower of 2007 Updated Costs or 2008 Costs	$ 8,183,098
Less 2008 IPPS payment	$ 6,965,148[99]
2008 Payment Cap	**$ 1,217,950**

Step 2: Calculation of VDA

2008 Medicare Inpatient Fixed Operating Costs	$ 7,243,028[100]
Less 2008 IPPS payment – fixed portion (87.57 percent)	$ 6,099,066[101]
Payment adjustment amount (subject to Cap)	**$ 1,143,962**

[93] *See Lake Region Healthcare Corp. v. Becerra*, 113 F.4th 1002, 1009 (D.C. Cir. 2024).
[94] 48 Fed. Reg. at 39752, 39782 (Sept. 1, 1983).
[95] Stipulations at ¶ 21; See Ex. C-6 at 8. (Calculated as 0.875654893, rounded to 0.8757).
[96] *Id*.
[97] *Id*.
[98] *Id*.
[99] *Id*.
[100] Fixed Operating Costs calculated as follows: Total Medicare Inpatient Operating Costs (8,271,555) multiplied by the fixed cost percentage (0.875654893) = 7,243,028.
[101] The $6,099,066 fixed portion of payment is calculated by multiplying $6,965,148 (the FY 2008 DRG payments) by 0.875654893 (the fixed cost percentage determined by the Medicare Contractor).

Since the payment adjustment amount of $1,143,962 is ***less*** than the Cap of $1,217,950, the Board determines that Stephens' VDA payment for FY 2008 should be $1,143,962. A VDA payment in the amount of $277,880 was issued by the Medicare Contractor on August 5, 2016[102]; therefore, Stephens should receive an additional payment for its VDA in the amount of $866,082 for FY 2008.

DECISION AND ORDER

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly reopened the Original VDA approval for FY 2008, but improperly calculated the VDA payment for FY 2008 for Stephens, and that Stephens should receive an additional payment of $866,082 for FY 2008 resulting in a total FY 2008 VDA payment of $1,143,962.

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FOR THE BOARD:

3/11/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

[102] Provider FPP Ex. P-5. See also, Stipulations at ¶ 13.