PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2023-D13

PROVIDER-
Cheyenne Regional Medical Center

RECORD HEARING DATE –
July 6, 2022

Provider No. –
53-0014

Cost Reporting Period Ended –
06/30/2014

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions

CASE NO. –
17-1542

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the sole community hospital ("SCH") volume decrease adjustment ("VDA") owed to Cheyenne Regional Medical Center ("Cheyenne" or "Provider") for its cost reporting period ending June 30, 2014 ("FY 2014").[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board or PRRB") finds that the Medicare Contractor improperly calculated the VDA payment for FY 2014, and that Cheyenne should receive a VDA payment in the amount of $5,617,590 for FY 2014.

INTRODUCTION

Cheyenne is a SCH located in Cheyenne, Wyoming.[2] The Medicare contractor[3] assigned to Cheyenne for this appeal is Noridian Healthcare Solutions ("Medicare Contractor").

In a letter dated March 22, 2016, Cheyenne requested a VDA payment in the amount of $18,560,468 for FY 2014 because it experienced a qualifying decrease in inpatient discharges during FY 2014.[4] The Medicare Contractor denied Cheyenne's request as it calculated Cheyenne's FY 2014 VDA payment to be $0.[5] Cheyenne timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board. In this appeal, Cheyenne revised its calculation of the FY 2014 VDA payment based on an updated notice of program reimbursement ("NPR") and now contends that it is due a VDA payment of $6,648,035 for FY 2014.[6]

The Board approved a record hearing on July 6, 2022. Cheyenne was represented by Ronald K. Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Wilson C. Leong, 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 subject to certain payment adjustments, one of these payment adjustments is referred to as a VDA payment. A VDA payment is available to a

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[1] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3.
[2] Stipulations of the Parties (hereinafter "Stip.") at ¶ 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare Contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Exhibit (hereinafter "Ex.") C-1 at 25; Ex. P-1.
[5] Medicare Contractor's FPP at 6; Ex. C-2; Ex. P-2 at 48.
[6] Provider's Final Position Paper (hereinafter "Provider's FPP) at 3.

SCH if, due to circumstances beyond its control, it incurs a greater than 5 percent decrease in the total number of inpatient cases from one cost reporting year to the next. 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."[7] The implementing regulations located at 42 C.F.R. § 412.92(e) reflect these statutory requirements.

It is undisputed that Cheyenne experienced a decrease in discharges greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond Cheyenne's control and, as a result, Cheyenne was eligible to have a VDA calculation performed for FY 2014.[8] In March 2016, Cheyenne submitted a request for a VDA payment of $18,560,468 VDA payment for FY 2014.[9] Cheyenne's current calculation of its VDA payment based on an updated NPR is $6,648,035.[10] However, when the Medicare Contractor calculated the FY 2014 VDA, it determined that Cheyenne was not entitled to a VDA payment because it was fully compensated for its fixed/semi-fixed costs.[11]

The regulation at 42 C.F.R. § 412.92(e)(3)(ii)(3) directs how the Medicare Contractor must adjudicate a VDA request 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*[12] 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—
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> . . . .
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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. . . .

In the preamble to the final rule published on August 18, 2006,[13] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 356), which provides further guidance related to VDAs and states in relevant part:

> B. Amount of Payment Adjustment. --- Additional payment is made . . . for the fixed costs it incurs in the period in providing

[7] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[8] Stip. at ¶ 3.
[9] Ex. P-1; Ex. C-1 at 25.
[10] Provider's FPP at 3; Stip. at ¶ 7.
[11] Medicare Contractor's FPP at 4; Ex. C-2; Ex. P-2 at 48; Stip. at ¶¶ 6, 10.
[12] (Emphasis added.)
[13] 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> 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*[14] with utilization such as food and laundry costs.

The chart below depicts how the Medicare Contractor and Cheyenne each calculated the VDA payment in the Stipulations.

	Medicare Contractor calculation using fixed costs[15]	Provider/PRM calculation using total costs[16]
a) Prior Year Medicare Inpatient Operating Costs	$53,007,219	$53,007,219
b) IPPS update factor	1.0173	1.026
c) Prior year Updated Operating Costs (a x b)	$53,924,244	$54,385,407
d) FY 2014 Operating Costs	$52,702.291[17]	$52,702,291
e) Lower of c or d	$52,702.291	$52,702,291
f) DRG/SCH payment	$46,054,256	$46,054,256
g) CAP (e-f)	$6,648,035	$6,648,035
h) FY 2014 Inpatient Operating Costs	$52,702,291	$
i) Fixed Cost percent	84.50%[18]	
j) FY 2014 Fixed Costs (h x i)	$44,533,436	$
k) Total DRG/SCH Payments	$46,054,256[19]	$
l) VDA Payment Amount (The Medicare Contractor's VDA is based on the amount line j exceeds line k)	$ 0[20]	
m) VDA Payment Amount (The Provider's VDA is based on the amount line d exceeds line f.)		$6,648,035

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[21]

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[14] (Emphasis added).
[15] Stip. at ¶ 10.
[16] *Id*. at ¶ 7.
[17] Ex. C-6 (Medicare Inpatient Operating Costs on the FY 2014 Medicare Cost Report Worksheet D-1, Line 53 - before any removal of variable costs).
[18] Ex. C-7; Stip. at ¶ 10 (percentage of current year fixed program costs to current year total program costs).
[19] Ex. C-6; Stip. at ¶ 10.
[20] Ex. C-2; Ex. C-6 at 2 (finding that the calculated amount would be negative, the Medicare Contractor determined no (or $0) VDA payment is due).
[21] Stip. at ¶¶ 7, 10, 11.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor interprets the regulation at 42 C.F.R. § 412.92(e)(3)(i) and the program instructions at PRM Section 2810.1(B) to mean that variable costs cannot be included in the VDA. The Medicare Contractor notes that in the Board's August 29, 2006 decision in *Greenwood County Hospital v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Kansas*, PRRB Decision 2006-D43, the VDA calculation was "limited to fixed and semi-fixed costs."[22] The Medicare Contractor states that their policy of only removing fixed and semi fixed costs from the Inpatient Medicare operating costs is supported by the CMS Administrator decisions that modified PRRB Dec. Nos. 2014-D15, 2014-D16, 2015-D11.[23]

According to the Medicare Contractor, Cheyenne relies on PRRB Dec. Nos. 2016-D16 (hereinafter "*St. Anthony*"[24]) and 2017-D1 (hereinafter "*Trinity*"[25]) to support the premise that variable costs should be removed from the Medicare Inpatient operating costs as well as the variable portion of payments being removed from the DRG revenue in the VDA calculation. The Medicare Contractor notes that "both of these PRRB decisions were reviewed and modified by the CMS Administrator"[26] to remove the variable costs from the Medicare inpatient operating costs, consistent with the Medicare Contractor's calculation.[27]

Cheyenne contends that "it is entitled to a VDA payment adjustment calculated in accordance with the methodology in [§] 2810.1 of the PRM (as formalized in the IPPS final rules for FYs 2007 and 2009)."[28] Chenyenne claims that the methodology used by the Medicare Contractor, "is contrary to the statute and the regulation."[29] Cheyenne states that the "[d]efinition as to the process of making the [VDA] payment calculation is principally provided in PRM [§] 2810.1 and subsequently updated in the Federal Register dated August 19, 2008."[30] Cheyenne contends that "there is no mention in this section [of the Federal Regiester] of removing variable costs. The Federal Register is very specific in defining the costs as either the costs in the year of the decline minus any adjustment for excess staff, or the previous year's cost multiplied by the PPS update factor minus any adjustment for excess staff."[31]

Additionally, Cheyenne notes that, "[i]n PRM [§] 2810.1 there are several examples of VDA calculations, each one uses either the hospital's current year 'Program Inpatient Operating Cost' or the prior year's 'Program Inpatient Operating Cost' increased by the PPS update factor. . .

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[22] Medicare Contractor's FPP at 7.
[23] *Id*. at 8.
[24] Medicare Contractor's FPP at 9; *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).
[25] *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).
[26] Medicare Contractor's FPP at 9.
[27] *Id*.
[28] Provider's FPP at 6.
[29] *Id.*
[30] *Id.*
[31] *Id*.

none of the examples show variable costs being removed from the calculation."[32] Cheyenne contends that "[r]emoving variable costs from the calculation would make the cap defined in the Regulations, in PRM [§] 2810.1 and the calculation in the Federal Register unnecessary as the cap would never be reached."[33] Cheyenne continues that "it has been understood by CMS since the beginning that variable costs will be the first costs covered by DRG revenue, not fixed costs as the Medicare Contractor's calculation suggests."[34] Cheyenne contends that the Medicare Contractor "departed from CMS's manual instructions and step-by-step guide and added an unauthorized and monumental extra step: Although the Manual specifically instructs that the 'inpatient operating costs' should be used in calculating the adjustment amount, [the Medicare Contractor] took the Provider's inpatient operating costs and removed all variable costs."[35]

Cheyenne maintains that the VDA payment calculation should be reversed because the methodology used by the Medicare Contractor is "inherently flawed. This method guarantees that a [SCH] will never receive the full compensation mandated by Congress because its fixed cost will always be reduced by reimbursement attributable to both fixed and variable costs."[36] Cheyenne avers that "Congress has directly spoken to the precise question at issue by mandating full compensation of a [SCH's] fixed costs."[37] Cheyenne contends that the Medicare Contractor's calculation is flawed because DRG revenue, which includes reimbursement for both variable and fixed costs, is subtracted from Medicare inpatient operating costs that exclude variable costs. Cheyenne maintains that the Medicare Contractor does this so that "a hospital does not receive a windfall through payment of the VDA."[38] Cheyenne further claims:

> [T]he [Medicare Contractor's] logic is that a hospital has already been reimbursed for its fixed costs through receipt of DRG revenue; hence, that revenue must be deducted from the hospital's total fixed costs in order to determine the remaining amount of fixed costs to be reimbursed through the VDA. If a hospital's fixed costs were not reduced in this fashion, so the logic goes, then the hospital could receive a VDA that, when taken together with already received DRG revenue, might result in reimbursement that exceeds total costs.[39]

Cheyenne argues that "[a]ny concern regarding a windfall of this kind, however, is unwarranted. The governing regulations already address this issue through the use of the 'not to exceed' payment cap. The cap is determined by deducting DRG revenue from a hospital's total inpatient operating costs and is an amount that the VDA cannot exceed."[40] Cheyenne contends that, under the Medicare Contractor's methodology, which subtracts variable costs from the Medicare inpatient operating costs and does not subtract reimbursement for variable costs from the total

[32] *Id.* at 6-7.
[33] *Id.* at 7.
[34] *Id.*
[35] *Id.*
[36] *Id*. at 8.
[37] *Id.* at 9.
[38] *Id.*
[39] *Id*.
[40] *Id.*

DRG revenue, understates the VDA payment.[41] Cheyenne concludes that "the calculation used by the [Medicare Contractor] does not fully compensate it for its fixed costs and is inconsistent with what the Final Rule establishes as the CMS method for calculating a VDA."[42]

Cheyenne notes that the Board methodology in its *Trinity* and *St. Anthony* decisions was later adopted by CMS in the FY 2018 IPPS Final Rule and "shows that the Provider was not fully compensated for its fixed costs."[43] In response, the Medicare Contractor asserts that these changes are not relevant because "the changes adopted by CMS in the FY 2018 IPPS final rule do not apply to the Provider's [fiscal year end ("FYE") June 30, 2014] which is the subject of this appeal case."[44] In its final position paper, Cheyenne requests the Board to calculate its VDA payment in accordance with the methodology it used in the *St. Anthony* and *Trinity* decisions, if the Board finds that variable costs are to be excluded from the VDA calculation.[45]

The Board finds that the Parties' only disagreement, vis-à-vis the calculation of the VDA payment, is whether variable costs are to be removed from total inpatient operating costs when calculating the VDA payment. The Medicare Contractor removed variable costs from the Medicare inpatient operating costs – Cheyenne did not. Cheyenne states that its VDA must be "calculated in accordance with the methodology in [§] 2810.1 of the PRM (as formalized in the IPPS final rules for 2007 and 2009)."[46] Per Cheyenne, "[n]owhere in the Federal Register does it say to subtract variable costs from the Provider's costs."[47]

In recent decisions,[48] 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 can only result in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated each hospital's VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare Contractor), and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs. This results in 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

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[41] *Id*.
[42] *Id*. at 11.
[43] *Id.* at 9.
[44] Medicare Contractor's FPP at 9.
[45] Provider's FPP at 12.
[46] *Id.* at 6.
[47] *Id*.
[48] *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).

> 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 . . . .[49]

Recently, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in Unity HealthCare v. Azar ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[50]

At the outset, the Board notes that Cheyenne is not located in the Eighth Circuit, and that the 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.[51]

Significantly, *subsequent to the time period at issue*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[52] 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, to determine the VDA payment amount.[53] 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."[54]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As set forth below, the Board finds that the Medicare Contractor's

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[49] *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).
[50] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019) *cert. denied*, 140 S. Ct. 523 (2019).
[51] (Bold and italics emphasis added).
[52] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).
[53] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).
[54] 82 Fed. Reg. at 38180.

calculation of Cheyenne's VDA methodology for FY 2014 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 Cheyenne's VDA payment by comparing its FY 2014 fixed costs to its total FY 2014 DRG payments. However, neither the language nor the examples[55] in PRM 15-1 § 2810.1 compare only the hospital's fixed costs to its total DRG payments when calculating a hospital's VDA payment. Similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[56] and the FFY 2009 IPPS Final Rule[57] 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 adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Cheyenne's VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preambles to the FFY 2007 and FFY 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Cheyenne's FY 2014 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions described as follows: a hospital's "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[58] The Board suspects that the Administrator developed this new methodology 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.[59]

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

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a

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[55] PRM 15-1 § 2810.1(C)-(D).
[56] 71 Fed. Reg. at 48056.
[57] 73 Fed. Reg. at 48631.
[58] *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 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Feb. 9, 2017).
[59] 82 Fed. Reg. at 38179-38183.

> decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) *as may be necessary to fully compensate the hospital for the fixed costs* it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.[60]

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

> C. Requesting Additional Payments.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*.
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> D. Determination on Requests.— The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.

[60] (Emphasis added.)
[61] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).

> 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***.[62]

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 . . . ."[63]

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 . . . ."[64]

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 costs of the Medicare services actually provided 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) 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.[65] 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.

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[62] (Emphasis added).
[63] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[64] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[65] 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.

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)(D)(ii) that allows the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG payment is payment for both fixed and variable costs - and deem the entire DRG payment as payment solely for fixed costs. The Board concludes that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

Cheyenne also argues that the only change to the payment calculation that followed the requirements of notice and a comment period is the final rule published in August, 2017. Cheyenne argues that after "the publication of the Federal Register in 2008 some [Medicare Contractors] began to change their methodology attempting to circumvent the notice-and-comment requirements of the Medicare statute by adopting a new methodology by way of adjudication."[66] Since the change did not go through a notice and comment period, Cheyenne maintains the Medicare Contractor "is supposed to calculate the VDA based on published regulations and guidance, not decide on their own to make a change to the program."[67] As a result, Cheyenne contends that "[t]he methodology in effect during the year under appeal was the one described in [§] 2810.1 of the PRM."[68] However, the Board notes that the examples in PRM 15-1 § 2810.1 relate to the cap and not the actual VDA calculation, as the Eighth Circuit recently confirmed in *Unity HealthCare v. Azar*:

> The hospitals' main argument to the contrary relies on the premise that the Manual's sample calculations unambiguously conflict with the Secretary's interpretation and that the Secretary is bound by the Manual as incorporated via later regulations. The hospitals point out that the Secretary has previously stated that [PRM 15-1] § 2810.1(B) of the Manual, where the examples are located, contains "the process for determining the amount of the volume decrease adjustment." See 71 Fed. Reg. 47,870, 48,056 (Aug. 19, 2006).
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> 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

[66] Provider's FPP at 11.
[67] *Id.*
[68] Provider's FPP at 12.

> 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 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.*[69]

Accordingly, what Cheyenne 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."[70] The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted through case-by-case adjudication.[71] 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.[72] Indeed, the Board notes that VDA calculations, by their very nature, are provider specific and subject to appeal, as explained in 42 C.F.R. § 412.108(d)(3).[73] Moreover, the Board has had long standing disagreements with Medicare contractors and the Administrator on their differing interpretations and application of the relevant statutes, regulations and PRM guidance regarding the calculation of VDAs.[74] Accordingly, the Board rejects Cheyenne's argument regarding lack of notice or comment opportunity.

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[69] 918 F.3d 571, 578-79 (8th Cir. 2019) (footnotes omitted; bold and italics emphasis added).

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

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

[72] 139 S. Ct. at 1808, 1810.

[73] 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."

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

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.[75] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for the Medicare services *actually* furnished. The Board concludes that, in order to ensure the hospital is fully compensated for its fixed costs, and consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

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 Cheyenne's fixed costs (which includes semi-fixed costs) were 84.50 percent[76] of Cheyenne's Medicare total inpatient operating costs for FY 2014. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step 1: Calculation of the Cap

2013 Medicare Inpatient Operating Costs	$53,007,219[77]
Multiplied by the 2014 IPPS update factor	1.0173[78]
2013 Updated Costs (max allowed)	$53,924,244
2014 Medicare Inpatient Operating Costs	$52,702,291[79]
Lower of 2013 Updated Costs or 2014 Costs	$52,702,291
Less 2014 IPPS payment	$46,054,256[80]
2014 Payment CAP	**$ 6,648,035**

Step 2: Calculation of VDA

2014 Medicare Inpatient Fixed Operating Costs	$44,533,436[81]
Less 2014 IPPS payment – fixed portion (84.50 percent)	$38,915,846[82]
Payment adjustment amount (subject to cap)	**$ 5,617,590**

Since the payment adjustment amount of $5,617,590 is less than the CAP of $6,648,035, the Board finds that Cheyenne is due a VDA payment of $5,617,590 for FY 2014.

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[75] 48 Fed. Reg. at 39782.
[76] Stip. at ¶ 10.
[77] *Id*. at ¶ 11.
[78] *Id*.
[79] *Id*.
[80] *Id*.
[81] *Id.*
[82] The fixed portion of the DRG payment of $38,915,846 is calculated by multiplying $46,054,256 (the FY 2014 SCH IPPS payments) by 0.845 (the fixed cost percentage as determined by the Medicare Contractor).

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Cheyenne's VDA payment for FY 2014, and that Cheyenne should receive a VDA payment in the amount of $5,617,590 for FY 2014.

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4/12/2023

X Clayton J. Nix

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