CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Scenic Mountain Medical Center **Provider** **vs.**	**Cost Reporting Period Ending:** **December 31, 2012** **Review of:**
WPS Government Health Administrators **Intermediary**	**PRRB Dec. No. 2021-D28** **Dated: August 30, 2021**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. The Center for Medicare (CM) submitted comments requesting that the Administrator reverse the Board's decision. The Medicare Administrative Contractor (MAC) submitted comments requesting that the Administrator review and reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2012 ("FY 2012").

The Board found that the MAC improperly calculated the VDA payment for FY 2012 for the Provider, and that the Provider should receive a VDA payment of $71,827 for FY 2012.

The Board first identified four differences between the MAC and the Provider calculations of the Provider's VDA payment. First, there was a disagreement over the use of the Medicare Cost Report to remove the variable costs to recompute the Medicare Inpatient costs that will be used in the VDA calculation. The Board cited the example in PRM 15-1 § 2810.1(C)(4), which uses the Medicare Inpatient costs from Worksheet D-1, Part II, line 53 of the cost report. The Board found it logical, considering all the complexities of the Medicare cost report, to identify the total inpatient operating costs,

excluding pass-through costs, accordingly. The Board found that removing the variable costs through a Worksheet A-8 adjustment and re-running the cost report, thereby recomputing the Worksheet D-1, Part II, line 53 results, leads to the most accurate Medicare inpatient costs, effectively excluding variable costs.

The Board identified a second disagreement involving the correct Medicare payment amount to be used in the VDA calculation. The parties disagreed whether the hospital specific (HS) payment amount or the IPPS payment amount should be used in the VDA calculation. In addition, the parties did not agree on whether the low volume, hospital readmission, and value-based purchasing payments should be included in the VDA payment calculation. Based on the regulations, the Board found that a Sole Community Hospital's (SCH's) total DRG revenue for inpatient operating costs could include either the amount paid based on the federal rate or the amount paid based on the hospital specific rate (HSR). Therefore, the Board concluded the MAC was correct to use $6,146,887 as the Provider's "total DRG revenue for inpatient operating costs" when calculating the Provider's FY 2012 VDA payment.

Additionally, the Board found that the Provider's claim that the Low Volume Adjustment (LVA) payment should not be included in the VDA calculations is not supported by law. As stated in section 1886(d)(5)(D)(ii) of the Act, an SCH is entitled to "such adjustment to the payment amounts under this subsection . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs . . . ." The VDA provisions are located in subsection section 1886 (d) of the Act. As such, all operating payments authorized by subsection (d) must be taken into account when calculating the VDA payment, including the LVA provisions which are located in subsection (d)(12). Therefore, as a subsection (d) payment, the LVA payment must be considered when calculating the VDA payment. In contrast, the value-based purchasing provisions are located in section 1886(o) and the hospital readmission requirements are located in subsection (q). Accordingly, readmissions and value-based purchasing payments are not authorized under subsection (d), and are not to be included in VDA payments.

The Board also addressed the Provider's assertion that the MAC's VDA payment calculation methodology is flawed. The Provider argued 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 the portion of the payment related to variable costs. The Board determined that, while not agreeing with the methodology, the MAC's methodology was not an improper rule change and was not subject to the Supreme Court's Azar vs. Allina decision.[1] The Board held that the MAC's calculation of the Provider's VDA payment for FY 2012 was incorrect. The Board determined that the MAC's calculation of the Provider's VDA payment was based on "an otherwise new methodology that the Administrator adopted through adjudication." Accordingly, the Board modified the VDA payment to the Provider from $0

SUMMARY OF COMMENTS

[1] *See*, 139 S. Ct. at 1808, 1810.

The MAC submitted comments requesting Administrator reverse the Board's decision with respect to the methodology for calculating Provider's VDA since it is not supported by statute or regulation. The MAC stated that the Administrator has repeatedly advised the Board regarding the proper methodology for performing a VDA calculation. The MAC asserted that it utilized the Administrator's methodology, which has been upheld by the Federal Court of Appeals for the Eighth Circuit; the only circuit court to address this issue. That Court's decision demonstrates that the Administrator's methodology has been weighed, measured and has been found statutorily appropriate. The Board's "fixed cost methodology", is not supported by any authoritative source, requires modifications to existing law to survive a statutory challenge, and those modifications are prospective only and not relevant to the fiscal year at hand.

CM submitted comments requesting that the Administrator reverse the Board's decision and uphold the MAC's determination in regard to the VDA payment calculation in keeping with several court decisions, Administrator decisions, and the language of the rules and regulations. CM disagreed with the Board that the MAC improperly calculated the VDA payment for the Provider for the same reasons set forth in multiple court decisions involving this same issue.

CM also noted that, even if the statute required the VDA calculation methodology to be established through rulemaking, the agency satisfied that obligation by utilizing notice and comment rulemaking to promulgate, revise, and clarify the implementing regulation, and describing in regulation and preamble how the VDA is to be calculated. Specifically, among other things, CMS promulgated a regulation in 1983, which set forth factors to be considered in calculating the VDA. See, e.g., 49 Fed. Reg. 234, 270-271 (Jan. 3, 1984) (Final rule, responding to comments); 48 Fed. Reg. 39,752, 39,781-82 (Sept. 1, 1983) (Interim final rule with comment period); 42 C.F.R. § 405.476(d) (1984). In 1987, CMS proposed and then finalized an amendment to the regulation to establish a ceiling for the VDA, equal to the difference between a hospital's Medicare operating costs and its DRG payments. See 52 Fed. Reg. 33,034, 33,049 (Sept. 1, 1987) (final rule); 52 Fed. Reg. 22,080, 22,090-91 (June 10, 1987) (proposed rule); 42 C.F.R. § 412.92(e)(3) (1987). And, in 2017, CMS issued a notice of proposed rulemaking and then a final rule which explicitly stated (and amended the regulation's text to provide) that a new, proportional VDA calculation methodology would apply solely to cost reporting periods that begin on or after October 1, 2017, whereas the longstanding, then-current VDA calculation methodology (under which the VDA=Fixed Costs-DRG payments) would continue to govern earlier periods such as those at issue here. See, e.g., 82 Fed. Reg. 37,990, 38,179-83, 38,511 (Aug. 14, 2017) (final rule); 82 Fed. Reg. 19,796, 19,933-35 (Apr. 28, 2017) (proposed rule); 42 C.F.R. § 412.92(e)(3) (2018).

CM stated that there is no rule promulgated pursuant to notice and comment rulemaking requires that either the proportional VDA calculation methodology or the Provider's apparent preferred methodology (under which VDA = Total Costs – DRG payments) would govern cost reporting periods that begin before October 1, 2017. Accordingly, even if section 1871 of the Social Security Act required the VDA calculation methodology to be established through notice and comment rulemaking, no rule

promulgated pursuant to those procedures supports the Board's proportional VDA calculation methodology or the Provider's methodology to be applied to the period at issue in this appeal.

CM also noted that, additionally, the Provider asserted that its hospital specific payment should be omitted from its total DRG revenue in the VDA calculation. The Board correctly concluded that a provider's total DRG revenue for inpatient operating costs for purposes of the VDA calculation includes both the amount paid based on the federal rate and the amount paid based on the hospital specific rate and that the MAC's inclusion of the hospital specific payment in the VDA calculation was in accordance with 42 C.F.R. § 412.92(e). Although CM requested that the Administrator affirm that the MAC's calculation was proper, CM agreed with the Board's findings that using a cost report adjustment to remove variable costs, the use of the Hospital Specific Rate (HSR) payment, the inclusion of the Low Volume Adjustment (LVA) payment, and the exclusion of the Hospital Value Based Purchasing (VBP) and Hospital Readmission Reduction Program (HRRP) payment adjustments were all proper methods for calculating the VDA adjustment

BACKGROUND AND DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits.

The Provider, is a non-profit acute care hospital located in Big Spring, Texas. The Provider was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue. The Medicare administrative contractor assigned to the Provider for this appeal is WPS Government Health Administrators ("Medicare Contractor"). In order to compensate it for a decrease in inpatient discharges, the Provider requested a VDA payment for FY 2012. The Medicare Contractor calculated the Provider's FY 2012 VDA payment to be $0.

Section 1886(d)(5)(D)(iii) defines a SCH as any hospital:

> (I) that the Secretary determines is located more than 35 road miles from another hospital,
> (II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A of this subchapter, or (III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(v)(i) of this title as in effect on September 30, 1997.

Section 1886(d)(5)(D)(ii) of the Act authorizes the Secretary to adjust the payment of SCHs that incur a decrease in discharges of more than 5 percent from one cost reporting year to the next, stating:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, …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 core staff and services.

The regulations implementing this statutory adjustment are located at 42 C.F.R. §412.92(e). In particular, subsection (e)(1) specifies the following regarding low volume adjustment:

> The intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances [beyond the hospital's control] a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period.

Once an SCH demonstrates that it has suffered a qualifying decrease in total inpatient discharges, the MAC must determine the appropriate amount, if any, due to the provider as an adjustment. The regulation at 42 C.F.R. §412.92(e)(3) specifies the following regarding the determination of low volume adjustment amount:

> (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 ….
>
> (i) In determining the adjustment amount, the intermediary considers –
>
> (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;
>
> (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
>
> (C) The length of time the hospital has experienced a decrease in utilization.[2]

[2] As reflected in the foregoing regulation and in the notice and comment rulemaking history, even if section 1871 of the Act required the VDA calculation methodology to be established through rulemaking, the agency satisfied that obligation by utilizing notice and comment rulemaking to promulgate, revise, and

In addition to the controlling regulation, CMS also provides interpretive guidelines in the Provider Reimbursement Manual, (PRM 15-1). The Manual is intended to ensure that Medicare reimbursement standards "are uniformly applied nationally without regard to where covered services are furnished."[3] Specifically, §2810.1 provides guidance to assist MACs in the calculation of VDAs for sole community hospitals (SCHs). In this regard, § 2810.1(B) of the PRM states the following regarding the amount of a low volume adjustment:

> B. Amount of Payment Adjustment. Additional payment is made to an eligible SCH for fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
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> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.
>
> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.
>
> In evaluating semi-fixed costs, the MAC considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semi-fixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment. (Emphasis added.)

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clarify the implementing regulation, and describing in regulation and preamble how the VDA is to be calculated. See, e.g., 49 Fed. Reg. 234, 270-271 (Jan. 3, 1984) (Final rule, responding to comments); 48 Fed. Reg. 39,752, 39,781-82 (Sept. 1, 1983) (Interim final rule with comment period); 42 C.F.R. § 405.476(d) (1984). *See* 52 Fed. Reg. 33,034, 33,049 (Sept. 1, 1987) (final rule); 52 Fed. Reg. 22,080, 22,090-91 (June 10, 1987) (proposed rule); 42 C.F.R. § 412.92(e)(3) (1987). And, finally, in 2017, CMS issued a notice of proposed rulemaking and then a final rule which explicitly stated (and amended the regulation's text to provide) the longstanding, then-current VDA calculation methodology (under which the VDA=Fixed Costs-DRG payments) would continue to govern earlier periods such as those at issue here. *See, e.g.*, 82 Fed. Reg. 37,990, 38,179-83, 38,511 (Aug. 14, 2017) (final rule); 82 Fed. Reg. 19,796, 19,933-35 (Apr. 28, 2017) (proposed rule); 42 C.F.R. § 412.92(e)(3) (2018).

[3] *See* CMS Pub. 15-1, Foreword.

In addition, in determining core staffing, § 2810.1(C)(6)(a)[4] states that:

> 6. Core Staff and Services.
> a. For cost reporting periods beginning on or after October 1, 2007, and prior to October 1, 2017, a comparison, by cost center, of full-time equivalent (FTE) employees and salaries in both cost reporting periods must be submitted. The requesting hospital must identify core staff and services in each center and the cost of these staff and services. The request must include justification of the selection of core staff and services including minimum staffing requirements imposed by an external source. The contractor's analysis of core staff is limited to those cost centers (general service, inpatient, ancillary, etc.) where costs are components of Medicare inpatient operating cost.
>
> Core nursing staff is determined by comparing FTE staffing in the Adults and Pediatrics and Intensive Care Unit cost centers to FTE staffing in the prior year and FTE staffing in peer hospitals. Peer hospital information is obtained from data on nursing hours per patient day using the results of the occupational mix survey or the AHA Annual Survey for hospitals of the same size, geographic area (Census Division), and period of time. Acceptable core nursing staff for a year in which a hospital had a volume decline is the lesser of actual staffing in the prior fiscal year or core staff for the prior fiscal year as determined from the occupational mix survey or the AHA Annual Survey data from peer hospitals. When determining core staff hours for other than a full year, the standard hours worked must be multiplied by the actual number of weeks in the cost reporting period. For example, a hospital with a standard work week of 37.5 hours requesting a VDA for a a cost reporting period of January 1, 2008, through June 30, 2008, has a paid hours per year of 975 (26 weeks x 37.5 hours per week).

In the discussion included in the preamble to the August 18, 2006 final rule[5], it was noted:

> The process for determining the amount of the volume decrease adjustment can be found in section 2810.1 of the Provider Reimbursement Manual. Fiscal intermediaries are responsible for establishing whether an SCH or MDH is eligible for a volume decrease adjustment and, if so, the amount of the adjustment. To qualify for this adjustment, the SCH or MDH must demonstrate that: (a) A 5 percent or more decrease of total discharges has occurred; and (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal intermediary has established that the SCH or MDH satisfies these two requirements, it will calculate the adjustment. The adjustment amount is determined by subtracting the second year's DRG payment from the lesser

[4] Rev. 479.
[5] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).

> of: (a) The second year's costs 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.

In the 2018 Final IPPS Rule, CMS changed the method of calculating the VDA, effective for cost reporting periods beginning on or after October 1, 2017. In discussing this change, CMS again explained the method that is at issue in this case:

> As we have noted in Section 2810.1 of the Provider Reimbursement Manual, Part 1 (PRM–1) and in adjudications rendered by the PRRB and the CMS Administrator, under the current methodology, the MAC determines a volume decrease adjustment amount not to exceed a cap calculated as the difference between the lesser of (1) the hospital's current year's Medicare inpatient operating costs or (2) its prior year's Medicare inpatient operating costs multiplied by the appropriate IPPS update factor, and the hospital's total MS–DRG revenue for inpatient operating costs (including outlier payments, DSH payments, and IME payments). In determining the volume decrease adjustment amount, the MAC considers 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; the hospital's fixed costs (including whether any semi-fixed costs are to be considered fixed) other than those costs paid on a reasonable cost basis; and the length of time the hospital has experienced a decrease in utilization.[6]

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[7] and that in those adjudications, the PRRB and the CMS Administrator have recognized that: "(1) The volume decrease adjustment is intended to compensate qualifying SCHs for their fixed costs only, and that variable costs are to be excluded from the adjustment; and (2) an SCH's volume decrease adjustment should be reduced to reflect the compensation of fixed costs that has already been made through MS–DRG payments."[8] CMS explained that it was making the change in how the VDA is calculated because:

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[6] 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).

[7] *Greenwood County Hospital Eureka, Kansas, v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Kansas*, 2006 WL 3050893 (PRRB August 29, 2006); *Unity Healthcare Muscatine, Iowa v. Blue Cross Blue Shield Association/ Wisconsin Physicians Service*, 2014 WL 5450066 (CMS Administrator September 4, 2014); *Lakes Regional Healthcare Spirit Lake, Iowa v. Blue Cross Blue Shield Association/Wisconsin Physicians Service*, 2014 WL 5450078 (CMS Administrator September 4, 2014); *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association*, 2015 WL 5852432 (CMS Administrator, August 5, 2015); *St. Anthony Regional Hospital v. Wisconsin Physicians Service*, 2016 WL 7744992 (CMS Administrator October 3, 2016); and *Trinity Regional Medical Center v. Wisconsin Physician Services*, 2017 WL 2403399 (CMS Administrator February 9, 2017).

[8] 82 Fed. Reg. at 38,180.

> As the above referenced Administrator decisions illustrate and explain, under the current calculation methodology, the MACs calculate the volume decrease adjustment by subtracting the entirety of the hospital's total MS–DRG revenue for inpatient operating costs, including outlier payments and IME and DSH payments in the cost reporting period in which the volume decrease occurred, from fixed costs in the cost reporting period in which the volume decrease occurred, minus any adjustment for excess staff. If the result of that calculation is greater than zero and less than the cap, the hospital receives that amount in a lump sum payment. If the result of that calculation is zero or less than zero, the hospital does not receive a volume decrease payment adjustment.
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> Under the IPPS, MS–DRG payments are not based on an individual hospital's actual costs in a given cost reporting period. However, the main issue raised by the PRRB and individual hospitals is that, under the current calculation methodology, if the hospital's total MS–DRG revenue for treating Medicare beneficiaries for which it incurs inpatient operating costs (consisting of fixed, semi-fixed, and variable costs) exceeds the hospital's fixed costs, the calculation by the MACs results in no volume decrease adjustment for the hospital. In some recent decisions, the PRRB has indicated that it believes it would be more appropriate for the MACs to adjust the hospital's total MS–DRG revenue from Medicare by looking at the ratio of a hospital's fixed costs to its total costs (as determined by the MAC) and applying that ratio as a proxy for the share of the hospital's MS–DRG payments that it assumes are attributable (or allocable) to fixed costs, and then comparing that estimate of the fixed portion of MS–DRG payments to the hospital's fixed costs. In this way, the calculation would compare estimated Medicare revenue for fixed costs to the hospital's fixed costs when determining the volume decrease adjustment.[9]

However, CMS pointed out that despite the change, the previous method was still reasonable and consistent with the statute. CMS stated:

> We continue to believe that our current approach in calculating volume decrease adjustments is reasonable and consistent with the statute. The relevant statutory provisions, at sections 1886(d)(5)(D)(ii) and 1886(d)(5)(G)(iii) of the Act, are silent about and thus delegate to the Secretary the responsibility of determining which costs are to be deemed ''fixed'' and what level of adjustment to IPPS payments may be necessary to ensure that total Medicare payments have fully compensated an SCH or MDH for its ''fixed costs.'' These provisions suggest that the volume decrease adjustment amount should be reduced (or eliminated as the case may be) to the extent that some or all of an SCH's or MDH's fixed costs have already been compensated through other Medicare subsection (d) payments. The Secretary's current approach is also consistent with the

[9] *Id*.

> regulations and the PRM–1. Like the statute, the relevant regulations do not address variable costs, and the regulations and the PRM– 1 (along with the Secretary's preambles to issued rules (48 FR 39781 through 39782 and 55 FR 15156) and adjudications) all make it clear that the volume decrease adjustment is intended to compensate qualifying SCHs and MDHs for their fixed costs, not for their variable costs, and that variable costs are to be excluded from the volume decrease adjustment calculation. Nevertheless, we understand why hospitals might take the view that CMS should make an effort, in some way, to ascertain whether a portion of MS–DRG payments can be allocated or attributed to fixed costs in order to fulfill the statutory mandate to ''fully compensate'' a qualifying SCH for its fixed costs.[10]

CMS revised the regulations at 42 C.F.R. § 412.92(e)(3) to reflect the change in the MAC's calculation of the volume decrease adjustment that would apply prospectively to cost reporting periods beginning on or after October 1, 2017, and to reflect that the language requiring that the volume decrease adjustment amount not exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs would only apply to cost reporting periods beginning before October 1, 2017, but not to subsequent cost reporting periods. While some commenters suggested that the new method should be applied retroactively, CMS noted:

> We also do not agree that we should apply our proposed methodology retroactively. The IPPS is a prospective system and, absent legislation, a judicial decision, or other compelling considerations to the contrary, we generally make changes to IPPS regulations effective prospectively based on the date of discharge or the start of a cost reporting period within a certain Federal fiscal year. We believe following our usual approach and applying the new methodology for cost reporting periods beginning on or after October 1, 2017 would allow for the most equitable application of this methodology among all IPPS providers seeking to qualify for volume decrease adjustments. For these reasons, we are finalizing that our proposed changes to the volume decrease adjustment methodology will apply prospectively for cost reporting periods beginning on or after October 1, 2017.[11]

The Eighth Circuit Court of Appeals upheld the methodology used by CMS, noting:

> The Secretary's interpretation is a reasonable interpretation of the plain language of the statute. The precise language at issue says that the VDA should be given "as may be necessary to fully compensate" a qualified hospital "for the fixed costs it incurs . . . in providing inpatient hospital services." 42 U.S.C. § 1395ww(d)(5)(D)(ii). The Secretary's interpretation

[10] *Id.*
[11] *Id.* at 38,182.

> ensures that the total amount of a hospital's fixed costs in a given cost year are paid out through a combination of DRG payments and the VDA. As the Secretary points out, the prospective nature of DRG payments makes it difficult to determine how best to allocate those payments against the actual fixed costs a hospital incurs. Given the lack of guidance in the statute and the substantial deference we afford to the agency in this case, the Secretary's decision reasonably complied with the mandate to provide full compensation.[12]

The Eighth Circuit found that, just because CMS prospectively adopted a new interpretation, that it was not a sufficient reason to find that the Secretary's prior interpretation was arbitrary or capricious.[13] The Eighth Circuit pointed out that the main argument that the Secretary's prior interpretation was arbitrary and capricious relied on the premise that the PRM's sample calculations conflict with the Secretary's interpretation and that the Secretary is bound by the PRM. As the Eighth Circuit pointed out, though:

> 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 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.[14]

This case centers on the application of the statute and regulation to the proper classification and treatment of costs and the proper calculation of the amount for the low

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[12] *Unity HealthCare v. Azar*, 918 F.3d 571, 577 (8th Cir. 2019).

[13] The Eighth Circuit cited, "An initial agency interpretation is not instantly carved in stone. On the contrary, the agency . . . must consider varying interpretations and the wisdom of its policy on a continuing basis." *Nat'l Cable & Telecommunications Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 981 (2005) (quoting *Chevron*, 467 U.S. at 863–64); *see also LaRouche v. FEC*, 28 F.3d 137, 141 (D.C. Cir. 1994) ("The mere fact that regulations were modified, without more, is simply not enough to demonstrate that the prior regulations were invalid."). The Court also noted, "A statute can have more than one reasonable interpretation, as in this case. *See Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735, 744–45 (1996) (stating that "the question before us is not whether [an agency interpretation] represents the best interpretation of the statute, but whether it represents a reasonable one")."

[14] *Unity* at 578.

volume adjustment. The Administrator's examination of the governing statutes and implementing regulations and guidance clearly recognize three categories of costs, i.e., fixed, semi-fixed and variable. The guidance only considers fixed and semi-fixed costs within the calculation of the volume adjustment but not variable costs.

Regarding the methodology and proper calculation of the Provider's payment adjustment, the Administrator finds that the Board improperly calculated the Provider's adjustment. The VDA calculation methodology used by the Board is in direct contradiction to the statute and CMS' regulations and guidance. The Board found the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$7,956,401[15]
Multiplied by the 2012 IPPS update factor	1.03[16]
2012 Updated Costs (max allowed)	$8,195,093
2012 Medicare Inpatient Operating Costs	$6,580,947[17]
Lower of 2011 Updated Costs or 2012 Costs	$ 6,580,947
Less 2012 IPPS payment (includes low volume payment)	$ 6,502,576[18]
2012 Payment CAP	$ 78,371

Step 2: Calculation of VDA

2012 Updated Costs-fixed portion	$6,031,438[19]
Less 2012 IPPS payment – fixed portion (91.65 percent)	$5,959,611[20]
VDA Payment adjustment amount (subject to CAP)	$ 71,827

[15] Stipulations at ¶ 10.
[16] *Id*.
[17] *Id*.
[18] *Id*. The Board's calculation varies from the Stipulated amount in ¶10 as it excludes $24,536 of non-capital costs related to the low volume payment (LVP) from the IPPS DRG payments. The Board agreed with the use of $6,146,887 as the DRG revenue payment. The Board explained that the payments included as determined by the Medicare Contractor of $6,524,501 should be minus Line 70.93, HVBP payments, of $3,179 and HRR adjustment amount of ($5,790) which are not to be included in the IPPS payments. HVBP payments are included under section 1886(o) of the Social Security Act and HRR adjustment amount is included in section 1886((q). Only the payments that are included in section 1886(d) are included in VDA payments. In addition, the capital amount related to the low volume payment was not excluded by the Medicare Contractor. To calculate the capital amount to be excluded of $24,536 the Board divided the HSR amount of $6,146,887 found on Exhibit C-1, E Part A, Line 49 by the total payment including capital of $6,570,904 on Exhibit C-1, E Part A, Line 59 (the non-capital percentage) times the low volume payment of $380,225 found on Exhibit C-1, Lines 70.96 and 70.97. This amount was determined to be non-capital, leaving the remainder of $24,536 to be excluded
[19] The Inpatient Operating Costs of $6,580,947 times 91.65 percent is $6,031,438. The difference between the $6,031,438 and the number on Stipulations at ¶ 10 of $6,031,449 is immaterial and is due to rounding of the fixed cost percentage.
[20] The $5,979,611 is calculated by multiplying $6,502,576 (the FY 2012 SCH payments) by 0.9165 (the fixed cost percentage determined by the Medicare Contractor).

Since the payment adjustment amount of $71,827 is less than the CAP of $78,371, the Board determined that the Provider's VDA payment for FY 2012 should be $71,827.

The Administrator affirms the Board on its holding regarding the MAC's use of Worksheet A-8 adjustments to remove variable costs from the cost report in order to determine the Medicare fixed Inpatient Operating costs to be used in the VDA calculation. The Administrator also agrees with the Board's legal findings with respect to the appropriate IPPS/SCH payments to be included for the calculation. However, the Administrator disagrees with the Board's VDA methodology. The Administrator finds that the correct payment adjustment, which follows the controlling statute, regulations and is also reflected in Greenwood and Unity, cited supra, is as follows:

Calculation of the VDA

Provider's FY 2012 operating costs	$ 6,580,947[21]
Provider's fixed costs	$ 6,031,449[22]
Provider's DRG payments	$ 6,502,576[23]
VDA Payment Amount	$ 0[24]

Thus, the Provider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG payment. In this case, the DRG payment is more than the fixed costs. Therefore, the Provider is not eligible for a VDA Payment.

The Administrator reverses the Board's decision on the calculation of the VDA using a proportional method. Even if the statute required the VDA calculation methodology to be established through rulemaking, the agency satisfied that obligation by utilizing notice and comment rulemaking to promulgate, revise, and clarify the implementing regulation, and describing in regulation and preamble how the VDA is to be calculated. In addition, there is no rule promulgated pursuant to notice and comment rulemaking requires that either the proportional VDA calculation methodology would govern cost reporting periods that begin before October 1, 2017. Accordingly, even if section 1871 of the Act required the VDA calculation methodology to be established through notice and comment rulemaking, no rule promulgated pursuant to those procedures supports the proportional VDA calculation methodology (or the Provider's preferred methodology) to be applied to the period at issue in this appeal. The Administrator finds that Allina is not

[21] Stipulations at ¶10.

[22] *Id*. *See* n. 19, The Inpatient Operating Costs of $6,580,947 times 91.65 percent is $6,031,438. The difference between the $6,031,438 and the number in Stipulations at ¶ 10 of $6,031,449 is immaterial and is due to rounding of the fixed cost percentage from .9165501 to .9165.

[23] *Id*. The Administrator agrees with the Board's finding that only those payments included in section 1886(d) of the Social Security Act are to be included in VDA payments. Relevant to this case, that includes the low volume payment made pursuant to section 1886(d) minus any non-capital related costs. The amount reflects the total amount used by the Board after removing non-capital costs from the low volume payment in the IPPS DRG payments.

[24] When the Fixed Costs are less than the total DRG payments, there is no VDA payment.

invoked as the MAC's payment calculation methodology is the result of the application of the statutory language and the properly promulgated regulation.

Accordingly, the Administrator finds that the MAC properly determined that the Provider had been fully compensated for its fixed costs and denied the Provider's additional payment request for FY 2012.

DECISION

The decision of the Board regarding the calculation is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: October 8, 2021

/s/
Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services