

## CENTERS FOR MEDICARE AND MEDICAID SERVICES

**In the case of:**

**Scenic Mountain Medical Center**

**Provider**

**vs.**

**WPS Government Health  
Administrators**

**Medicare Contractor**

**Claim for:**

**Cost Reporting Period Ending:  
December 31, 2013**

**Review of:  
PRRB Dec. No. 2021-D29  
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) and the Medicare Administrative Contractor (MAC) submitted comments requesting that the Administrator uphold the MAC's methodology. Accordingly, this case is now before the Administrator for final agency review.

### **ISSUE AND BOARD DECISION**

The issue is whether the MAC properly calculated the Provider's Volume Decrease Adjustment (VDA) payment for the Provider for the cost reporting period ending December 31, 2013 (FY 2013).

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 \$5,555,565 as the Provider's "total DRG revenue for inpatient operating costs" when calculating the Provider's FY 2013 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.<sup>1</sup> The Board held that the MAC's calculation of the Provider's VDA payment for FY 2013 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 to \$225,372.<sup>2</sup>

---

<sup>1</sup> See, 139 S. Ct. at 1808, 1810.

<sup>2</sup> See, Provider Reimbursement Review Board (PRRB) Dec. No. 2021-29 at 16-17.

## SUMMARY OF COMMENTS

The MAC asks that the Administrator reverse the Board's decision with respect to the methodology for calculating Provider's VDA as it is not supported by statute or regulation. The Administrator has repeatedly advised the Board regarding the proper methodology for performing a VDA calculation. The MAC utilized the Administrator's methodology, which has been upheld by the Eighth Circuit; the only circuit court to address this issue. That Court's decision clearly demonstrates that the Administrator's methodology has been weighed, measured and been found statutorily appropriate. The Board's methodology 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.

With respect to the remaining decision, that the MAC's interpretation was not an improper rule change, FSS and the MAC do not challenge that decision.

CM submitted comments requesting that the Administrator reverse the Board's decision (apart from its findings on the removal of the variable costs via a cost report adjustment, the use of the HSR payment, the inclusion of the LVA payment, and the exclusion of hospital VBP and HRRP payment adjustments in the VDA calculation) and affirm that the MAC used the proper methodology to calculate the VDA for the Provider.

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  $VDA = \text{Fixed Costs} - \text{DRG payments}$ ) 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  $VDA = \text{Total Costs} - \text{DRG payments}$ ) 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 designated as an SCH. For the fiscal period in dispute, the Provider experienced a decrease in discharges greater than 5 percent, due to circumstances beyond its control, and as a result, was eligible to have the VDA calculation performed. As such, the Provider requested a VDA payment.<sup>3</sup> The MAC performed a review and removed variable costs from five separate cost centers. As the MAC found that the Provider's DRG/IPPS payments exceeded the fixed and semi-fixed costs the Provider incurred during the period, the Provider did not qualify for a VDA payment.

Section 1886(d)(5)(D)(iii) of the Act, 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.

---

<sup>3</sup> See, Provider's Final Position Paper (FPP) at 4.

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, if the circumstances leading to the decline in discharges were beyond its control. It 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.<sup>4</sup>

---

<sup>4</sup> As reflected in the foregoing regulation and in the notice and comment rulemaking history, and as noted by CM, 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 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

In addition to the controlling regulation, CMS has provided further 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.”<sup>5</sup> Section 2810.1(A)(1) of the PRM defines “circumstances beyond the hospital’s control” as:

1. Circumstances Beyond the Hospital’s Control. – In order for an SCH to qualify for additional payment, the decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects.<sup>6</sup>

Additionally, § 2810.1 provides guidance to assist MACs in the calculation of VDAs for sole community hospitals (SCHs). Specifically, § 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.

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

---

*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).

<sup>5</sup> See CMS Pub. 15-1, Foreword.

<sup>6</sup> See, PRM 15-1, § 2810.1(A)(1).

costs may not be included in determining the amount of the payment adjustment. (Emphasis added.)

The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The intermediary reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

With respect to determining core staffing, § 2810.1(C)(6)(a)<sup>7</sup> 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 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<sup>8</sup>, 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

---

<sup>7</sup> Rev. 479.

<sup>8</sup> 71 *Fed. Reg.*, 47,870, 48,056 (Aug. 18, 2006).

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 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.<sup>9</sup>

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,<sup>10</sup> 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."<sup>11</sup> CMS explained that it was making the change in how the VDA is calculated because:

---

<sup>9</sup> 82 *Fed. Reg.* 37,990, 38,179 (Aug. 14, 2017).

<sup>10</sup> *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).

<sup>11</sup> 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.

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.<sup>12</sup>

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 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

---

<sup>12</sup> *Id.*

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.<sup>13</sup>

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.<sup>14</sup>

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 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.<sup>15</sup>

---

<sup>13</sup> *Id.*

<sup>14</sup> *Id.* at 38,182.

<sup>15</sup> *Unity HealthCare v. Azar*, 918 F.3d 571, 577 (8th Cir. 2019).

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.<sup>16</sup> 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.<sup>17</sup>

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 volume adjustment. The Administrator's examination of the governing statute and implementing regulation 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

2012 Medicare Inpatient Operating Costs

\$6,580,947

---

<sup>16</sup> 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")."

<sup>17</sup> *Unity* at 578.

Multiplied by the 2013 IPPS update factor	<u>1.026</u>
2013 Updated Costs (Max allowed)	\$6,752,052
2013 Medicare Inpatient Operating Costs	\$6,131,005
Lower of 2012 Updated Costs or 2013 Costs	\$6,131,005
Less 2014 IPPS payment	<u>\$5,882,894</u>
2013 Payment Cap	<u>\$248,111</u>

#### Step 2: Calculation of VDA

2013 Medicare Inpatient Costs - Fixed Portion (90.87 percent)	\$5,571,154
Less 2013 IPPS payment – Fixed Portion (90.87 percent)	<u>\$5,345,786</u>
Payment adjustment amount (subject to CAP)_	<u>\$225,372<sup>18</sup></u>

As shown above, the Board determined that, as the payment adjustment amount of \$225,372 is less than the CAP of \$248,111, the Provider's VDA payment for FY 2013 should be \$225,372.

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 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 MAC properly calculated the correct payment adjustment, by following the controlling statute, regulations and various Administrative and Court decisions as reflected in Greenwood and Unity, cited supra, is as follows:

#### Calculation of VDA

2013 Medicare Inpatient Costs - Fixed Portion	\$5,571,158 <sup>19</sup>
Less IPPS/SCH payment	<u>\$5,865,325<sup>20</sup></u>
VDA Payment adjustment amount (subject to CAP)_	<u>\$0<sup>21</sup></u>

<sup>18</sup> *Supra*, n. 1.

<sup>19</sup> The Provider and the Medicare Contractor have stipulated the FY 2013 current year program operating costs in ¶¶ 9 and 10 as \$6,131,005 and in ¶ 6 as \$6,131,032, with both referring to Cost Report Worksheet D-1 line 53 as the source. The 6,131,032 is referring to the Cost Report Worksheet D-1 line 53 at pp 42 (dated 2016). The revised Worksheet D-1 Line 53 (after Worksheet A-8 Adjustments-removal of variable costs-dated 1/17/2017) shows \$5,571,158 which is .9086859 (the fixed portion) of \$6,131,005. As the Board noted, the difference between \$6,131,032 and \$6,131,005, is immaterial.

<sup>20</sup> The payments included by the MAC appear consistent with the Board's legal determination of the types of payments to be included under section 1886(d) of the Social Security Act. However, the MAC's total of IPPS related payments is less than the Board's total amount and therefore the MAC's calculation is to the Provider's benefit. The MAC determined the total payments for inpatient operating costs (\$5,555,565) and included the \$327,328 low volume operating costs payment and excluded a \$17,569 DRG adjustment. (\$5,555,565 + \$327,328 - \$17,569 = \$5,865,325.) *See, e.g.*, C-1 at 33 of 83. It appears the PRRB added in the \$17,569 adjustment. However, in the Board's finding in PRRB Dec. 2021-D28 (FY 2012), the Board took note to remove the capital portion of the low volume payment. In this decision the Board refers to the included \$327,329 as the "operating portion" of the low volume payment.

<sup>21</sup> *See*, MAC's Exhibit C-1 at 32-33 of 83. When the Fixed Costs are less than the total DRG payments, there is no VDA payment.

As shown above, the Administrator finds that the MAC's work papers show that the Provider met the criteria to qualify for a potential payment. However, after removing the variable cost from the five cost centers, the MAC determined that the Provider's total Medicare fixed/semi-fixed inpatient costs are \$5,571,158. As the Medicare fixed/semi-fixed cost of \$5,571,158 is less than the DRG payment of \$5,865,325, the Administrator finds that the Provider has already been paid an amount in excess of its fixed cost. Therefore, since the Provider's Medicare fixed/semi-fixed cost is less than the DRG payment, the Provider does not qualify for a VDA.<sup>22</sup>

Therefore, the Administrator modifies the Board's decision and affirms that the MAC used the proper methodology to calculate the VDA for the Provider. 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 §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 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 2013.

---

<sup>22</sup> The MAC Position Paper at 16 sets forth that for the "Period ending December 31, 2013 - Total Medicare inpatient operating costs were \$6,131,032. Medicare inpatient operating fixed and semi-fixed costs were \$5,571,158. DRG related payments were \$5,865,324."

DECISION

The decision of the Board regarding the calculation of the Provider's VDA 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