

CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:

Freemont Area Medical Center

Provider

vs.

WPS Government Health Administrators

Medicare Contractor

Claim for:

**Cost Reporting Period Ending:
June 30, 2015**

Review of:

PRRB Dec. No. 2021-D33

Dated: September 14, 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 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 Fremont Area Medical Center (“Fremont” or the “Provider”) for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2015 (“FY 2015”).

The Board found that the Medicare Contractor improperly calculated the VDA payment for FY 2015 for Fremont, and that Fremont should receive a VDA payment in the amount of \$1,968,023 for FY 2015.

The Board identified two basic differences in the Medicare Contractor’s and Fremont’s calculation of Fremont’s VDA payment that relates to the FY 2015 Inpatient Operating Costs. First, the Board identified that 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 example in PRM 15-1 § 2810.1(C)(4) uses the Medicare Inpatient costs from Worksheet D-1, Part II, Line 53 of the cost report. Therefore, 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 second difference the Board identified was that Fremont in lieu of the HSP included the DRG payment in the VDA calculation. The Board reviewed the VDA regulations at 42 C.F.R. § 412.108(d), which incorporates the methodology found at 42 C.F.R. § 412.92(e). These regulations require the VDA to be calculated using “the hospital's *total DRG revenue for inpatient operating costs* based on DRG-adjusted prospective payment rates for inpatient operating costs (*including* outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106....)” The Board also reviewed the SCH payment methodology in 42 C.F.R. § 412.92(d) to determine what payments should be included in the hospital's “total DRG revenue for inpatient operating costs.” 42 C.F.R. § 412.92(d) provides that SCHs are paid for inpatient operating costs based whichever’ is the greatest between the “Federal payment or the hospital specific payment.³⁶ As previously noted, when promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for SCHs. Based on these regulations the Board finds that an MDH’s total DRG revenue for inpatient operating costs includes both the amount paid based on the federal rate and the amount paid based on the hospital specific rate. Therefore, the Board concludes the HSR amount of \$11,409,089 should be used when calculating Fremont FY 2015 VDA payment.

On a third matter of disagreement, in recent Board decisions addressing VDA payments, the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because that methodology compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals’ VDA payments by estimating the fixed portion of the hospital’s DRG payments (based on the hospital’s fixed cost percentage as determined by the Medicare contractor), and comparing this fixed portion of the DRG payment to the hospital’s fixed operating costs, so there is an apples-to-apples comparison. Explaining its rationale for this approach, the Board applied the same methodology in this case in finding that the Provider was entitled to a VDA payment

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) 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 the Board correctly concluded that a MDH's total DRG revenue for inpatient operating costs could include either the amount paid based on the federal rate or the combined amount paid based on the federal rate and the HSR and that the MAC was correct to use the combined federal rate/HSR payment of \$11,409,089 as Fremont's "total DRG revenue for inpatient operating costs" when calculating Fremont's FY 2015 VDA payment.

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 an acute care hospital located in Fremont, Nebraska, and is designated as a Medicare Dependent Hospital ("MDH") during FY 2015, the fiscal year at issue. The Medicare contractor assigned to Fremont for this appeal is Wisconsin Physician Services - Government

Health Administrators (“Medicare Contractor”). Fremont requested a VDA payment of \$4,605,489 for FY 2015 to compensate it for a decrease in inpatient discharges during FY 2015. The Medicare Contractor calculated Fremont’s FY 2015 VDA payment to be \$0.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the IPPS. The IPPS provides Medicare payment for hospital inpatient operating and capital related costs at predetermined, specific rates for each hospital discharge. The IPPS also allows special treatment for facilities that qualify as an MDH. The main statutory provisions governing MDHs are located in § 1886(d)(5)(G) of the Social Security Act (Act). An MDH is defined as any hospital:

- (I) located in a rural area,
- (II) that has no more than 100 beds,
- (III) that is not classified as a sole community hospital under subparagraph (D), and
- (IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987, or two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, were attributable to inpatients entitled to benefits under part A.

Section 1886(d)(5)(G) of the Act authorizes the Secretary of DHHS to adjust the payment to MDHs 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 Medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment ... as 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.

The regulations implementing this statutory adjustment are located at 42 C.F.R. § 412.108(d) (2011)¹. In particular, subsection (d)(2) specifies the following regarding low volume adjustment for MDHs:

To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary’s Notice of Amount of Program Reimbursement and it must -

- (i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and
- (ii) Show that the decrease is due to circumstances beyond the hospital’s control.

¹ The regulation at 42 C.F.R. § 412.108(d) was changed in the 2018 Final IPPS Rule. *See* 82 Fed. Reg. 37,990, 38,179-83 (Aug. 14, 2017). The regulation cited in this decision is the language that existed for the cost year at issue.

Once an MDH demonstrates that it has experienced a qualifying decrease in total inpatient discharges, the intermediary must determine the appropriate amount, if any, due to the provider as an adjustment. In this regard, subsection (d)(3) of the controlling regulation specifies the following regarding the determination of the low volume adjustment amount for MDHs:

(3) The intermediary determines a lump sum 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 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 (Emphasis added.)

When CMS promulgated § 412.108(d), CMS made it clear that the low volume adjustment rules for MDHs were identical to those that were already in effect for SCHs:

[T]he Act also provides that a hospital meeting the MDH criteria is entitled to an additional payment adjustment if, due to circumstances beyond its control, its total number of discharges in a cost reporting period has decreased by more than 5 percent compared to the number of discharges in its preceding cover reporting period. Since this adjustment for a 5 percent reduction in discharges is identical to the criteria and adjustment currently provided for SCHs, we are incorporating the same criteria and adjustments into the regulation for MDHs.³

² 42 C.F.R. § 412.108(d)(3) (2011).

³ 55 Fed. Reg. 15,150, 15,155 (Apr. 20, 1999). *See also* 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006). 55 Fed. Reg. 15,150, 15,155 (Apr. 20, 1999). *See also* 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006). 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 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).

In addition to the controlling regulation, CMS also provided interpretive guidelines in the Provider Reimbursement Manual, CMS Pub. No. 15-1 (PRM 15-1). PRM 15-1 is intended to ensure that Medicare reimbursement standards “are uniformly applied nationally without regard to where covered services are furnished”.⁴ While PRM 15-1 does not specifically address MDH low volume adjustments, it does address SCH low volume adjustments at PRM 15-1 § 2810.1. As the criteria for SCH and MDH low volume adjustments are identical, the PRM 15-1 guidance on SCH low volume adjustment is applicable to MDH low volume adjustments. In this regard, § 2810.1(B) 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 semi-fixed costs may not be included in determining the amount of the payment adjustment. (Emphasis added.)

In the discussion included in the preamble to the August 18, 2006 final rule⁵, 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

⁴ See CMS Pub. 15-1, Foreword.

⁵ 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. (Emphasis added.)

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

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).

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:

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.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

⁸ 82 Fed. Reg. at 38,180.

⁹ *Id.*

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 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

Recently, 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

¹⁰ *Id.*

¹¹ *Id.* at 38,182.

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 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

The core dispute in this case centers on the application of the statutes 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 statutes and implementing regulations and guidance clearly recognize three categories of costs, i.e., fixed, semi-fixed and variable. The

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.

guidance only considers fixed and semi-fixed costs within the calculation of the volume adjustment but not variable costs.

The MAC's exclusion of the Provider's variable costs was proper and consistent with the regulation and guidance and intent of the adjustment. The treatment of variable cost within the calculation of the volume decrease adjustment is well established. The plain language of the relevant statute and regulation, Section 1886(d)(5)(G)(iii) and 42 CFR 412.108(d), make it clear that the VDA is intended to compensate qualifying hospitals for their fixed costs, not their variable costs. This position is also supported by past decisions, such as *Greenwood County*, PRRB Dec. No. 2006-D43, where the Board correctly eliminated variable costs from the calculation.

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

2014 Medicare Inpatient Operating Costs	\$14,396,56 ¹⁵
Multiplied by the 2014 IPPS update factor	<u>1.029¹⁶</u>
2014 Updated Costs (max allowed)	\$14,814,068
 2015 Medicare Inpatient Operating Costs	 \$13,795,49 ¹⁷
 Lower of 2014 Updated Costs or 2015 Costs	 \$13,795,496
Less 2015 IPPS/MDH payment	<u>\$11,409,08¹⁸</u>
2015 Payment CAP	\$2,386,407

Step 2: Calculation of VDA

2015 Medicare Inpatient Fixed Operating Costs	\$11,376,874 ¹⁹
Less 2015 IPPS/MDH payment – fixed portion (82.47 percent ²⁰)	<u>\$ 9,408,851²¹</u>
Payment adjustment amount (subject to CAP)	\$ 1,968,023

Since the payment adjustment amount of \$1,968,023 is less than the CAP of \$2,386,407, the Board determined that the Provider's VDA payment for FY 2015 should be \$1,968,023.

¹⁵ Stipulations at ¶ 10.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

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 the VDA

Provider's FY 2015 operating costs	\$13,795,496 ²²
Provider's fixed costs	\$11,376,874 ²³
Provider's DRG payments	<u>\$11,409,089²⁴</u>
VDA Payment Amount	\$ (32,215)²⁵

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.

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 2015.

²² The amount reported in Stipulations at ¶9.

²³ *Id.*

²⁴ Exhibit P-3 at 65, Worksheet E, Part A, Line 49.

²⁵ When the resulting amount is negative, no VDA payment is made to the provider.

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: November 5, 2021

/s/

Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services