CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Halifax Regional Medical Center	**Cost Reporting Period Ending:**
	September 30, 2012
Provider	
vs.	
	Review of:
Palmetto GBA	**PRRB Dec. No. 2020-D2**
Medicare Contractor	**Dated: January 31, 2020**

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 U.S.C. § 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 and uphold the Medicare Administrative Contractor (MAC)[1] determination. The MAC submitted comments, requesting that the Administrator reverse the Board's decision and uphold the decision and methodology utilized by the MAC. The Provider submitted comments, requesting that the Board's decision be affirmed. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The sole disputed issue in this appeal is the methodology used to calculate the Volume Decrease Adjustment ("VDA") payment.

[1] Formerly known as Fiscal Intermediaries (FIs), CMS's payment and audit functions under the Medicare program are now contracted to organizations known as Medicare Administrative Contractors (MACs). However, the term "intermediary" is still used in various statutes and regulations, and is interchangeable with the terms "Medicare Administrative Contractor" or "Medicare Contractor".

The Board held that the Medicare Contractor improperly calculated Halifax Regional Medical Center's ("Halifax" or "Provider") VDA payment for Fiscal Year ("FY") 2012, and that Halifax should receive a VDA payment for FY 2012 in the amount of $1,594,735.

The Board stated that the issue of how to calculate a VDA payment is not new to the Board. In recent decisions, the Board has disagreed with the methodology used by multiple Medicare contractors to calculate VDA payments because it compares fixed costs to total diagnosis-related group ("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 DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

The Board notes that the Administrator has overturned the Board's decisions stating that the Board attempted to remove the portion of the DRG payments the Board attributed to variable costs from the IPPS/DRG revenue and in doing so, the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount and that the VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization, hence the means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider.

The Board also notes that recently, the Eighth Circuit Court of Appeals ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation." According to the Board, Administrator decisions are not binding precedent and further states that the Provider is not located in the Eighth Circuit and that, *subsequent to the time period at issue*, CMS essentially adopted the Board's methodology for calculating VDA payments. As noted in the preamble to 2018 IPPS Final Rule, CMS prospectively changed the methodology for calculating a VDA. Significantly, the new methodology is very similar to the methodology used by the Board, requiring Medicare contractors to compare the estimated portion of the DRG payment, related to fixed costs to the hospital's fixed costs, when determining the amount of the VDA payment (this amount continues to be subject to the cap specified in 42 C.F.R. § 412.92(e)(3)). The preamble to the 2018 IPPS Final Rule makes this change effective for cost reporting periods beginning on or after October 1, 2017, explaining that it will "remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment."

The Board found that the Medicare Contractor's calculation of Halifax's VDA methodology for FY 2012 was not correct because it was *not* based on CMS' stated

policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of that PRM 15-1 policy in the relevant Final Rules.

The Board states that since the Board does not have the IPPS actuarial data to determine a split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentages as a proxy. In this case the Medicare Contractor determined that Halifax's fixed costs (which include semi-fixed costs) were 83.09 percent of the Provider's Medicare costs for FY 2012. Therefore, the Board found that the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$23,874,073
Multiplied by the 2012 IPPS update factor	1.019
2011 Updated Costs (max allowed)	$24,327,680
2012 Medicare Inpatient Operating Costs	$23,229,866
Lower of 2011 Updated Costs or 2012 Costs	$23,229,866
Less 2012 IPPS payment	$21,310,841
2012 Payment CAP	$ 1,919,025

Step 2: Calculation of VDA

2012 Medicare Inpatient Operating Costs – Fixed	$19,301,912
Less 2012 IPPS payment – fixed portion (83.09 percent)	$17,707,177
Payment adjustment amount (subject to CAP)	$ 1,594,735

Since the payment adjustment amount of $1,594,735 is less than the CAP of $1,919,025, the Board determines that Halifax should receive a VDA for FY 2012 in the amount of $1,594,735.

SUMMARY OF COMMENTS

CM submitted comments, recommending that the Administrator reverse the Board's decision and uphold the MAC's determination. CM stated that, it disagreed with the Board that the MAC improperly calculated the VDA payment for the Provider. CM noted that it disagreed with the Board for the same reasons set forth in multiple court decisions involving this same issue. CM referred the Administrator to the government's brief in *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019), along with the decisions in *St. Anthony Regional Hospital v. Azar*, 294 F.Supp.3d 768 (N.D. Iowa 2018), and in *Trinity Regional Medical Center v. Azar*, No. 17-3029, 2018 WL 4295290 (N.D. Iowa Sept. 10, 2018) (district court decision), 2018 WL 1558451 (N.D. Iowa Mar. 19, 2018)

(magistrate decision), for a comprehensive discussion of CM's position on the issues presented in this case.

In further support of their position, CM also referred the Administrator to the August 2017 final rule, in particular the language at 82 Fed. Reg. 37,990, 38,179-83 (Aug. 14, 2017).

CM also referred the Administrator to the following series of adjudications, in which the PRRB and the CMS Administrator have upheld their current approach to calculating the VDA: *Greenwood County Hospital Eureka, Kansas, v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Kansas*, 2006 WL 3050893 (PRRB Aug. 29, 2006); *Unity Healthcare Muscatine, Iowa v. Blue Cross Blue Shield Association/Wisconsin Physicians Service*, 2014 WL 5450066 (CMS Administrator Sept. 4, 2014); *Lakes Regional Healthcare Spirit Lake, Iowa v. Blue Cross Blue Shield Association/Wisconsin Physicians Service*, 2014 WL 5450078 (CMS Administrator Sept. 4, 2014); *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association*, 2015 WL 5852432 (CMS Administrator, Aug. 5, 2015); *St. Anthony Regional Hospital v. Wisconsin Physicians Service*, 2016 WL 7744992 (CMS Administrator Oct. 3, 2016); and *Trinity Regional Medical Center v. Wisconsin Physician Services*, 2017 WL 2403399 (CMS Administrator Feb. 9, 2017). Therefore, CM recommend that the Administrator reverse the Board's decision and uphold the MAC's determination.

The MAC submitted comments stating that it disagreed with the Board's finding that it had improperly calculated the VDA payment for the Provider. The MAC noted that the Administrator has consistently overturned similar Board VDA decisions in *St. Anthony Reg'l Hosp. v. Wisconsin Physician Serv.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physician Serv.*, PRRB Dec. No. 2017-D21 (Dec. 15, 2016); and *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2015-D11 (June 9, 2015). In each instance in which the Board's decision was overturned, the Administrator stated:

> The Board attempted to remove the portion of the DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. … ***In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount.*** … The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider…. (Emphasis added.)

According to the MAC, the Board specifically disregarded those multiple decisions by the Administrator on the ground that those decisions "are not binding precedent; as explained by PRM 15-1 § 2927.C.6.e." The Board also disregarded the recent Eighth

Circuit decision in *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019) ("*Unity*") on the ground that the Provider is not located in the Eighth Circuit.

The MAC stated that the Administrator's methodology, which was upheld in *Unity*, equates the Provider's VDA to the difference between its fixed and semi-fixed costs and its DRG payment (subject to the ceiling). That methodology compares fixed costs to total Medicare payments and disregards variable costs. It does so because the VDA is intended to compensate qualifying hospitals for their fixed costs, not their variable costs.

Though the Board's decision requires a "fixed cost percentage" the Board lacked the actuarial data to determine the split between fixed and variable costs related to a DRG payment. This missing information (which should have been provided by the Provider if it wished to utilize the fixed cost percentage methodology) should have been fatal to the Board's methodology (and is not required for the Administrator's). Notwithstanding this deficiency, the Board generated another workaround that is not supported by statute or regulation – it utilized the MAC's fixed/variable cost percentages as a proxy. Once again, this methodology, which compounded the Board's improper fixed cost percentage methodology, is not supported by any source and the Board's decision should be overturned.

The Administrator's decisions and methodology, the methodology that the MAC adhered to, has been upheld as complying with the applicable Medicare statutes. However, the Board concocted an estimated fixed cost portion of the DRG payment and compared that amount to the Provider's fixed costs. That methodology, according to the Administrator does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. Further, the Board quotes from *Unity*, which stated the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."

The MAC's methodology, which adhered to previous Administrator decisions, has been adjudicated by the Eighth Circuit in *Unity* as "consistent with the regulation." However, it is the Board's methodology that does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. Therefore, the MAC requests that the Administrator reverse the Board and uphold the MAC's determination of the Provider's VDA for the FY at issue.

The Provider submitted comments, stating that the Board was correct to reverse the MAC's determination. The Provider stated that in this matter, the Board properly focused on the law and the agency's statutory obligation to "fully compensate the hospital for the fixed costs it incurs." 42 U.S.C. § 1395ww(d)(5)(D)(ii). The Board recognized the nature of DRG payments and its implications for properly calculating the VDA by stating that "the Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(G)(iii) allowing the Secretary to ignore 42 U.S.C. § 1395ww (a)(4) – which is clear that the DRG payment is payment for fixed and variable costs – and deem the full DRG payment as payment solely for fixed costs."

In the words of the Board, it is an "unequivocal fact" that "the DRG payment made to the SCH for services furnished to the Medicare patients in the current year is payment for both the fixed and variable costs of the services furnished to those patients." Any methodology that does not recognize and account for this, unlawfully shifts certain of the PPS DRG payments made to a hospital for variable costs to cover the remaining fixed costs of the hospital, depriving VDA eligible hospitals of the full benefit of PPS DRG payments provided for by the Medicare statute and undermining the purpose of the VDA and the PPS system itself.

The Provider states that the Provider Reimbursement Manual is the Secretary's primary source of sub-regulatory guidance on Medicare costs and payments directed to providers. At all times relevant to this matter, the guidance in the PRM provided detailed examples as to how to calculate the VDA for hypothetical "Hospital C" and "Hospital D." These examples are directly on point. If one inputs into those examples the data for the hospital in the instant matter, one arrives at the required VDA payment for the Provider, which is higher than the figure the Board arrives at using an alternative methodology.

The Provider points to the Federal Register, and states that the Secretary repeatedly endorsed the PRM's VDA methodology, stating that "the adjustment amount [VDA] 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 [hospital] receives the difference in a lump-sum payment".

The Provider states that the Medicare Act provides that "[n]o rule, or other statement of policy … that establishes or changes a substantive legal standard governing … the payment for services … shall take effect unless it is promulgated by the Secretary by regulation." 42 U.S.C. § 1395hh(a)(2). The agency may not simply change its mind on how to determine the VDA without following an appropriate process for making that change. Recently, the United States Supreme Court ruled that the Medicare Act requires notice and comment rulemaking when an agency changes a substantive legal standard governing the payment for services. *Azar v. Allina Health Servs.*, 139 S.Ct. 1804, 204 L.Ed.2d 139 (2019). Here, the agency adopted regulations and promulgated guidance in the PRM as to how to apply the VDA statute. The agency repeatedly endorsed the methodology in the Federal Register. The agency is not free to simply abandon that methodology without formal notice and comment rulemaking, which has not been done here.

Similarly, the Provider argues that the agency's regulations require a computation of the "difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs." 42 C.F.R. § 412.108(d)(3). An agency's authority to interpret its own regulations is not unbounded. That interpretation must be "reasonable," reflect the agency's "authoritative" or "official position," implicate the agency's substantive expertise, and reflect the agency's "fair and considered judgment." *Kisor v. Wilkie*, 139 S.Ct. 2400, 204 L.Ed.2d 841 (2019). An agency's "new

interpretation" should not create "unfair surprise to regulated parties," which "may occur when an agency substitutes one view of a rule for another." *Id*.

The Provider argues that the Board recognized that in this matter the MAC did not follow "CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of that PRM 15-1 policy in the relevant Final Rules." Board Decision at 7. Instead, the MAC used "an otherwise *new* methodology" that had not been adopted by proper rulemaking, even though CMS "did not otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule." Board Decision at 8.

According to the Provider, the Board properly found that the VDA statute requires a like-to-like comparison, not the type of comparison that the MAC engaged in or that the Administrator has adopted in certain other VDA appeals. As the Board noted, the Administrator in those decisions wrongly assumed "that the entire DRG payment is payment *only for the fixed costs* of the services actually furnished to Medicare patients." Board Decision at 10 (emphasis original). Starting from this fundamentally flawed perspective, the Administrator reached an equally flawed conclusion, wrongly adopting an apples-to-oranges comparison that failed to compensate VDA eligible hospitals properly and fully. That methodology "clearly does not" account for the nature of DRG payments "as it takes the portion of the DRG payment intended for variable costs and impermissibly mischaracterizes it as payment for the hospital's fixed costs." Board Decision at 10. The Board rightly found that this "is not a reasonable interpretation of the statute." Board Decision at 10.

The Provider states that the methodology used by the Board in its decision, and prospectively adopted by the agency, uses a like-to-like comparison by applying the fixed-to-variable cost ratio to DRG revenue. As the agency has stated, "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. 82 Fed. Reg. 37,990, 38,180 (Aug. 14, 2017).

BACKGROUND AND DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments were received timely and are included in the record and have been considered.

In this case, the Provider, is a non-profit acute care hospital located in Roanoke Rapids, North Carolina. Halifax was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue. The MAC assigned to Halifax for this appeal is Palmetto GBA ("MAC" or "Medicare Contractor"). Halifax requested a VDA payment of $1,592,791 to compensate it for a decrease in inpatient discharges during FY 2012.

Under the Medicare program, a SCH is defined at § 1886(d)(5)(D)(iii) 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 1395i–4(i)(1) of this title as in effect on September 30, 1997.

Section 1886(d)(5)(D)(ii) of the Act authorizes the Secretary of DHHS 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.[2]

The statute does not define the relevant term "fixed costs," or the explain how the agency is to "fully compensate" the hospital for those fixed costs. In 1983, the agency promulgated a rule to implement this provision.[3]. In the preamble to the rule, the agency explained that "fixed costs" are "those over which management has no control", such as "rent, interest, and depreciation." Id. at 39,781. The preamble stated that the agency would, "on a case by case basis," consider semifixed costs "as fixed" costs, at least "[f]or a short period of time" following a sudden decrease in patient volume outside the hospital's control. [4]The agency anticipated, however, that "a cost-effective hospital would take some action to reduce unnecessary expenses" over time, and that "if a hospital did not take such action," the agency "would not include such costs in determining the amount of the adjustment." *Ibid.* Thus, the implementing regulation provided that the volume-decrease adjustment would be based on "[t]he hospital's fixed

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[2] 55 FR 35990 (Sept. 4, 1990; 55 FR 15150, 15152 (April 20, 1990 ("In addition to the changes in qualifying criteria and payment methodology, the new section 1886 (d)(5)(D) of the Act deleted the sunset date on the 5 percent volume decline adjustment, thus allowing SCHs to receive the adjustment indefinitely. (The sunset provision was in section 1886(d)(5)(C)(ii) of the Act. Section 6003(c)(1) of Public Law 101-239 amended that provision and redesignated it as section 1886(d)(5)(D) of the Act.) We are amending § 412.92 (e) and (f) to reflect this change."

[3] 48 Fed. Reg. 39,752, 39,828 (Sept. 1, 1983).

[4] 48 Fed. Reg. at 39,782.

(and semifixed) costs," as well as "[t]he length of time the hospital has experienced a decrease in utilization."[5]

In 1987, the agency proposed to "clarify the regulations." 52 Fed. Reg. 22,080, 22,091 (June 10, 1987). The agency explained that some sole community hospitals that had received DRG payments in excess of their inpatient operating costs had been requesting a volume decrease adjustment on top of those DRG payments, notwithstanding that the hospitals had made "a profit under the prospective payment system" even when faced with "a decline in occupancy." *Ibid.* The agency stated that hospitals are "not entitled to receive a payment adjustment" in those circumstances. *Ibid.* Paying a volume-decrease adjustment in those circumstances would mean that Medicare is "shar[ing] in the costs attributable to non-Medicare beneficiaries," which the agency concluded was "clearly inappropriate." *Ibid* Accordingly, the agency revised its regulations "to make it clear that any adjustment amounts granted to [sole community hospitals] for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and [the] total payments made under the prospective payment system." [6]The substance of the regulations remained largely unchanged over the next 30 years and while the regulations established a ceiling that the volume-decrease adjustment may not exceed, they did not prescribe a formula for calculating the amount of the adjustment.

During the time relevant to this case, the regulations directed the Medicare contractor responsible for processing requests for volume-decrease adjustments to "determine[] a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG [payments] for inpatient operating costs." 42 C.F.R. 412.92(e)(3) (2016). The regulations further directed the contractor to "consider[]," in determining the lump sum amount: "[t]he 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"; "[t]he hospital's fixed (and semifixed) costs, other than those costs paid on a reasonable cost basis under [other provisions]"; and "[t]he length of time the hospital has experienced a decrease in utilization." 42 C.F.R. 412.92(e)(3)(i) (2016).

Thus for the period at issue the regulations implementing this statutory adjustment, located at 42 C.F.R. § 412.92(e), provided at subsection (e)(1) 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

[5] *Id.* at 39,828.

[6] 52 Fed. Reg. 33,034, 33,049 (Sept. 1, 1987); see 42 C.F.R. 412.92(e)(3) (1988) (providing that the agency will "determine[] a lump sum [volume-decrease] adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue based on DRG-adjusted prospective payment rates")

> 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.

In addition to the controlling regulation, CMS also provides 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.[7] Specifically, § 2810.1 provides guidance to assist MACs in the calculation of VDAs for sole community hospitals (SCHs) and, thus the PRM pronouncements are evidence of CMS' practice. In this regard, § 2810.1(B)[8] evidences 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.**

[7] *See*, CMS Pub. 15-1, Forward.

[8] Transmittal No. 356 (March 1990) Transmittal No 356 changes provided that the final determination at sections 2810.1 and 2810.2 on a request for a volume payment adjustment is made by the intermediary.

> 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.
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> 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.
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> 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 rule[9], 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 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:

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[9] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).

> 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.[10]

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[11] 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."[12] 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

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[10] 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).

[11] *Greenwood County Hospital Eureka, Kansas, v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Kansas*, (PRRB Dec. No. 2006-D43) 2006 WL 3050893 (PRRB August 29, 2006); *Unity Healthcare Muscatine, Iowa v. Blue Cross Blue Shield Association/ Wisconsin Physicians Service*, (PRRB Dec. No. 2014-D15) 2014 WL 5450066 (CMS Administrator September 4, 2014); *Lakes Regional Healthcare Spirit Lake, Iowa v. Blue Cross Blue Shield Association/Wisconsin Physicians Service*, PRRB Dec. No. 2014-D16) 2014 WL 5450078 (CMS Administrator September 4, 2014); *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association*,(PRRB Dec. No. 2015-D11) 2015 WL 5852432 (CMS Administrator, August 5, 2015); *St. Anthony Regional Hospital v. Wisconsin Physicians Service*, (PRRNB Dec. No. 2016-D16) 2016 WL 7744992 (CMS Administrator October 3, 2016); and *Trinity Regional Medical Center v. Wisconsin Physician Services*, ((PRRB Dec. No. 2017-D1) 2017 WL 2403399 (CMS Administrator February 9, 2017).

[12] 82 Fed. Reg. at 38,180.

> 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.[13]

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 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–

[13] *Id.*

> 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.[14]

CMS revised the regulations at 42 C.F.R. § 412.92(e)(3) to reflect a 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.[15]

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 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.[16]

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[14] *Id.*
[15] *Id.* at 38,182.
[16] *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, was not a sufficient reason to find that the Secretary's prior interpretation was arbitrary or capricious.[17] 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.[18]

The core dispute in this case centers on the application of the statute to the proper classification and treatment of costs and the proper calculation of the amount for the low volume decrease adjustment. The Administrator's examination shows that the governing statute and implementing regulations and guidance recognize three categories of costs, i.e., fixed, semi-fixed and variable and that only fixed and semi-fixed costs are recognized 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

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[17] 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")."

[18] *Unity* at 578.

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 Board stated that, as it did not have the IPPS actuarial data to determine a split between fixed and variable costs related to a DRG payment, it opted to use the MAC's fixed/variable cost percentages as a proxy. In this case the MAC determined that the Provider's fixed costs (which includes semi-fixed costs) were 83.09 percent[19] of the Provider's Medicare costs for FY 2012. Thus, the Board found the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$23,874,073[20]
Multiplied by the 2012 IPPS update factor	1.019[21]
2011 Updated Costs (max allowed)	$24,327,680
2012 Medicare Inpatient Operating Costs	$23,229,866[22]
Lower of 2011 Updated Costs or 2012 Costs	$23,229,866
Less 2012 IPPS payment	$21,310,841[23]
2012 Payment CAP	$ 1,919,025

Step 2: Calculation of VDA

2012 Medicare Inpatient Operating Costs – Fixed	$19,301,912[24]
Less 2012 IPPS payment – fixed portion (83.09 percent)	$17,707,177[25]
Payment adjustment amount (subject to CAP)	$ 1,594,735

Since the payment adjustment amount of $1,594,735 is less than the CAP of $1,919,025, the Board determined that Halifax should receive a VDA for FY 2012 in the amount of $1,594,735.

[19] Exhibit C-2 and Exhibit P-1 at 32.
[20] Exhibit C-2 (listing $23,874,073 as the FY 2011 Program Operating Costs Worksheet D-1, Part II, Line 53).
[21] Exhibit P-1 at 12. *See also* 76 Fed. Reg. 51475, 51797 (Aug. 18, 2011).
[22] Exhibit C-2 (listing $23,229,866 as the FY 2012 Program Operating Cost Worksheet D-1, Part II, Line 53).
[23] *Id.* (listing $21,310,841 as the FY 2012 DRG/SCH Payments Worksheet E, Part A, Line 49).
[24] *Id. (listing $19,301,912 as the FY 2012 Fixed costs).*
[25] The $17,707,177 is calculated by multiplying $21,310,841 the FY 2012 IPPS payments (Worksheet E, Part A, Line 49) by 0.8309 (the fixed cost percentage).

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 total operating costs	$23,229,866
Fixed Cost percentage	83.09
Provider's fixed costs	$19,301,912
Provider's DRG payments	$21,310,841
VDA Payment Amount	$0

Thus, the Provider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG payment. In this case, as the DRG payment exceeded the fixed costs, the VDA payment amount would be $0. In finding so, the MAC took into account: 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 (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and the length of time the hospital has experienced a decrease in utilization.

In contrast, the Provider's primary reading of the regulation would produce the anomalous result that would be contrary to the statutory design of the prospective payment system. The Provider's initial proposed interpretation, in which the volume-decrease adjustment would have equaled the amount by which its total Medicare operating costs exceeded its DRG payments, would fully compensated petitioner for its *fixed* costs and provide a dollar-for-dollar reimbursement of its *variable* costs.

Finally the Provider contends that CMS' policy is contrary to section 1886(d)(5)(D)(ii) of the Act as CMS did not publish the methodology applied in this case, which the Provider claims, is required by *Azar v. Allina Health Service.*, 139 S. Ct. 1804 (2019) (*Allina*). Even assuming, *arguendo*, section 1871 of the Social Security Act required the VDA calculation methodology to be established through rulemaking, the agency promulgated, revised, and clarified the implementing regulation, and describing in regulation and preamble how the VDA is to be calculated pursuant to notice and comment rulemaking as noted above. Consistent with the rulemaking, the VDA adjustment in this case, took into account: 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 (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and the length of time the hospital has experienced a decrease in utilization. The Secretary's interpretation of the relevant statute and regulation is consistent with the text, as the formula adopted by the Secretary ensures that any VDA adjustment will not exceed the difference between the hospital Medicare inpatient operating costs and the hospital total DRG revenue for inpatient operating costs, while conforming to the regulatory text to consider the individual characteristics of each hospital alongside the fixed and non-fixed costs.

While the Provider may contend that the agency's implementation of section 1886(d)(5)(D)(ii) should be rejected, no notice and comment rulemaking supports either the Board's version that requires a proportional VDA calculation methodology or the Provider's primary methodology (under which VDA is to equal "Total Costs – DRG payments") for cost reporting periods that begin before October 1, 2017. Accordingly, even if section 1886(d)(5)(D)(ii) of the Act required the VDA calculation methodology to be specifically established through notice and comment rulemaking, no rule promulgated pursuant to those procedures specifically supports the proportional VDA calculation methodology or the Provider's preferred methodology to be applied to the period at issue in this appeal.

Therefore, the Administrator reverses the Board's decision. The MAC properly determined that the Provider's DRG payments exceeded its calculated fixed operating costs, and as a result, no VDA payment was due. Thus, the MAC was correct to deny the Provider's VDA request.

DECISION

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

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

Date: MAR 13, 2020

/s/
Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services