CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Olympic Medical Center	**Cost Reporting Period Ending:**
	December 31, 2012
Provider	
vs.	
Noridian Healthcare Solutions, LLC	**Review of: PRRB Dec. No. 2020-D11**
Medicare Contractor	**Dated: July 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 Medicare Administrative Contractor (MAC) submitted comments, requesting that the Administrator reverse the Board's decision and uphold the decision and methodology utilized by the MAC. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Medicare Administrative Contractor (MAC), correctly determined the amount of the volume decrease adjustment (VDA) in accordance with the regulations and Program instructions per 42 C.F.R. § 412.92(e)(3), and the Provider Reimbursement Manual (PRM), CMS Pub. 15-1 at § 2810.1.

The Board held that the MAC improperly calculated the Provider's VDA payment for FY 2012, and found that the Provider should receive a VDA payment in the amount of $2,500,062.

The Board stated that the Provider experienced a decrease in discharges greater than 5 percent from FY 2011 to FY 2012 due to circumstances beyond its control, and as a result,

was eligible to have a VDA calculation performed. The Provider originally requested a VDA payment of $2,929,138. The MAC denied this request on April 12, 2016 because the Provider's DRG revenue exceeded its fixed and semi fixed Medicare costs. The Provider requested that the MAC reconsider this denial. The Provider stated that the MAC did not respond to this request for reconsideration.

The MAC alleged that a VDA payment is intended to reimburse a qualifying hospital for its fixed costs only, and therefore, the removal of variable costs from the VDA calculation is required. The Provider argued that the MAC's calculation was wrong because the MAC improperly changed the Medicare rules by calculating the Provider's VDA payment based on a comparison of the Provider's fixed costs to its total DRG payment. The Board stated that after examining both parties' calculations, it found that the payment amount is different because of differences in the use of fixed costs rather than total costs in calculating the VDA, and the fixed cost percentage.

The Board noted that the issue of how to calculate a VDA payment is not new, and that in recent decisions, it has disagreed with the methodology used by MACs because it compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. The Board stated that in these cases, it has recalculated the hospital's VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor) and comparing this fixed DRG payment to the hospital's fixed operating costs, so there is an "apples-to-apples" comparison. While the Board noted that these decisions have been overturned by the Administrator and, more recently, the Eighth Circuit Court of Appeals, the Board stated that Administrator decisions are not binding precedent.[1]

The Board stated that in the preamble to 2018 IPPS Final Rule, CMS prospectively changed the methodology for calculating the VDA.[2] The Board noted that the new methodology is very similar to the methodology it uses, and requires Medicare contractors to compare the estimated portion of the DRG payment that is 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 Board noted that 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."[3]

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

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[1] The Board cited to PRM 15-1 § 2927.C.6.e as support. The Board also noted that, in this case, the Provider is not located in the Eighth Circuit.
[2] 82 Fed. Reg. 37,990, 38,179-83 (Aug. 14, 2017).
[3] *Id.* at 38,180.

as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of that PRM 15-1 policy in the relevant Final Rules. While the Medicare Contractor determined the VDA payment by comparing the Provider's fixed costs to its DRG payments, the Board noted, neither the language nor the examples in PRM 15-1[4] compare a hospital's fixed costs to its DRG payments when calculating a hospital's VDA payment. The Board argued that similar to the instructions in PRM 15-1, the preambles to both the FFY 2007 IPPS Final Rule[5] and the FFY 2009 IPPS Final Rule[6] reduce a hospital's cost only by excess staffing (not variable costs) when computing the VDA. These preambles state:

> The adjustment amount is determined by subtracting the second year's MS-DRG payment from the lessor of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

The Board claimed that it is clear from the preambles to these Final Rules that the only adjustment to the hospital's cost is for excess staffing. Therefore, the Board found, the MAC did not calculate the VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preamble to the FFY 2007/2009 IPPS Final Rules, but rather, calculated it based on an otherwise new methodology that the Administrator adopted through adjudication in her decisions described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]" The Board averred that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the methodology explained in the FFY 2007/2009 Final Rules/PRM and the statute. The Board stated that, in applying this new methodology through adjudication, CMS did not otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[7]

The Board argued that the statute at 42 U.S.C. § 1395ww(d)(5)(D)(ii) is clear that the VDA payment is to fully compensate the hospital for its fixed cost, and that in the final rule published on September 1, 1983, the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period . . . . An adjustment will not be made for truly variable costs, such as food and laundry services."[8]

However, the Board claimed, the VDA payment methodology explained in the 2007/2009 Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's total DRG payments and states in pertinent part:

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[4] PRM 15-1 § 2810.1(C), (D).
[5] 71 Fed. Reg. at 48,056.
[6] 73 Fed. Reg. at 48,631.
[7] 82 Fed. Reg. at 38,179-83.
[8] 48 Fed. Reg. 39,752, 39,781-82 (Sept. 1, 1983)

> C. Requesting Additional Payments.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding pass-through costs, exceeds DRG payments, including outlier payments. No adjustment is allowed if DRG payments exceeded program inpatient operating cost. . . .
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> D. Determination on Requests.—. . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost and FY 1987 DRG payments.
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> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so the adjustment is the difference between FY 1987 cost adjusted by the update factor and FY 1988 DRG payments.

The Board stated that this would appear to conflict with the statute and the 1983 Final Rule which limit the VDA to fixed costs, and that it believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the Administrator decisions stating that the "VDA is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling."[9] The Board noted that it is this new methodology that the Eighth Circuit found reasonably complied with the mandate to provide full compensation.[10] However, the Board noted, as the Provider is not located in the Eighth Circuit, it is not mandated to follow the Eighth Circuit's decision on this issue.

Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board stated that it disagrees that the Administrator's methodology complies with the

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[9] The Board cited to the Administrator's decisions in *St. Anthony Regional Hospital,* PRRB Dec. No. 2016-D16; and *Trinity Regional Medical Center,* PRRB Dec. No. 2017-D1.
[10] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019).

statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[11] The Board noted that under the Administrator's methodology, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment only for the fixed costs of the services actually furnished to Medicare patients. However, the statute at 42 U.S.C.§ 1395ww(a)(4) makes it clear that DRG payments includes payment for both fixed and variable costs of the services rendered because it defines operating costs of inpatient services as "all routine operating costs . . . and includes the costs of all services for which payment may be made[.]" The Board stated that the Administrator simply cannot ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments solely for the fixed cost of the services actually rendered when the hospital in fact incurred both fixed and variable costs for those services.

The Board argued that it must conclude that the purpose of the VDA payment is to compensate the hospital for the fixed costs associated with the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost". The Board noted that when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing services to its actual patient load.

The Board found that critical to the proper application of the statute, regulation and Manual provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished actual services in the current year are not part of the volume decrease, and (2) the DRG payment made to the hospital for services furnished to the Medicare patients in the current year is payment for both the fixed and variable costs of the actual services furnished to those patients. Therefore, the Board argued, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its actual Medicare patient load in the current year as well as its full fixed costs in that year.

The Board noted that the Administrator's methodology clearly does not do this, 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. The Board stated that it could find no basis in 42 U.S.C. § 1395ww(d)(5)(D)(ii) 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. The Board thus concluded that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

[11] 42 U.S.C. § 1395ww(d)(5)(D)(ii).

Finally, the Board recognized that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(G)(iii) do not fully address how to remove variable costs when calculating a VDA adjustment, it is clear that the VDA payment is not intended to fully compensate the hospital for its variable costs.[12] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board found that the DRG payment is intended to pay for both variable and fixed costs for Medicare services actually furnished. The Board concluded that, in order to ensure the hospital is fully compensated for its fixed costs and consistent with the PRM 15-1 assumption that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to the portion of the hospital's DRG payment attributable to fixed costs.

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 Provider's fixed/variable cost percentages as a proxy. The Board noted that the Provider disputes the fixed cost percentage calculated by the MAC. While the parties did not disagree with the costs identified as variable, the Provider believed the MAC should use the total costs from Worksheet A, Column 3, Line 200 of the Medicare cost report to determine its fixed cost percentage. The MAC disagreed, believing that Capital, RHC, and HHA costs should be excluded when calculating the Provider's fixed cost percentage.

The Board noted that it disagreed with the Provider that total costs from Worksheet A, Column 3, Line 200 of the Medicare cost report (which included the Provider's Capital, RHC, and HHA costs) should be used to determine its fixed cost percentage. The Board pointed out that the fixed cost percentage is used to estimate the Provider's fixed operating cost and the fixed portion of the Provider's DRG payment. However Capital, RHC and HHA costs are not part of a hospital's operating cost and are not paid as part of Medicare's DRG payment. The Board found nothing in CMS regulations or manuals to support the assertion that total cost must be the amount from Worksheet A, Column 3, Line 200 of the Medicare cost report. Finally, the Board noted, it disagreed with the Provider's statement that the example in the 2018 Final Rule clarified that a hospital's total cost should include the cost of the entire business entity. Based on this, the Board concluded that the MAC's methodology, which excluded Capital, RHC and HHA costs from the Provider's fixed cost percentage resulted in a reasonable proxy to calculate the fixed portion of the Provider's operating costs and DRG payments.

In this case the MAC determined that the Provider's fixed costs (which includes semi-fixed costs) were 85.75 percent[13] of the Provider's Medicare costs for FY 2012. Applying the rationale described above, the Board found the VDA in this case should be calculated as follows:

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[12] 48 Fed. Reg. at 39,782.

[13] *See* Exhibit P-5 (identifying variable cost of $13,677,963 and total cost of $96,001,291 for a variable cost percentage of 14.25 percent and a fixed cost percentage of 85.75 percent). *See also* Medicare Contractor's Final Position Paper at 9.

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$22,820,141[14]
Multiplied by the 2012 IPPS update factor	1.019[15]
2011 Updated Costs (max allowed)	$23,253,724
2012 Medicare Inpatient Operating Costs	$22,040,907[16]
Lower of 2010 Updated Costs or 2012 Costs	$22,040,907
Less 2012 IPPS payment	$19,125,383[17]
2012 Payment CAP	$2,915,524

Step 2: Calculation of VDA

2012 Medicare Inpatient Operating Costs – Fixed	$18,900,078[18]
Less 2012 IPPS payment – fixed portion (81.67 percent)	$16,400,016[19]
Payment adjustment amount (subject to CAP)	$2,500,062

Since the payment adjustment amount of $2,500,062 is less than the CAP of $2,915,524, the Board determined that MAC improperly calculated the Provider's VDA for FY 2012 and that the Provider should receive a VDA payment for FY 2012 in the amount of $2,500,062.

SUMMARY OF COMMENTS

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 the Board's holding specifically disregarded multiple decisions by the Administrator, as well as the recent Eighth Circuit decision in *Unity*, and questioned the legality and propriety of the *Unity* decision as part of its rationale for disregarding that case. The MAC also argued that the Board's decision relies on the 2018 IPPS Final Rule, which is prospective only, and thus, does not apply. The MAC stated that the Administrator has overturned several Board decisions on this issue, and that the Administrator's methodology, which was upheld in *Unity*, equates a provider's VDA to the difference between its fixed and semi-fixed costs and its DRG payment (subject to the ceiling). Contrary to this, the Board's methodology compared the estimated portion of the DRG payment related to fixed costs to the hospital's fixed costs to generate a "fixed cost percentage" of the DRG payment. The MAC noted that the Board's decision requires a "fixed cost percentage", despite the fact that the Board lacked the actuarial data to determine the split between fixed and variable costs related to

[14] Exhibit I-4 (FY 2011 Program Operating Costs Worksheet D-1, Part II, Line 53).
[15] *Id.* (FY 2012 IPPS update factor). *See also* 76 Fed. Reg. 51476, 51797 (Aug. 18, 2011).
[16] Exhibit I-4 (FY 2012 Program Operating Cost Worksheet D-1, Part II, Line 53).
[17] *Id.* (FY 2012 DRG Payments)
[18] *Id.* (FY 2012 Fixed costs were calculated by multiplying 22,040,907 by 85.75 percent).
[19] The $16,400,016 is calculated by multiplying $19,125,383 (the FY 2012 DRG payments) by 85.75 percent (the fixed cost percentage).

a DRG payment. The Board also utilized the MAC's fixed/variable cost percentages as a proxy, a methodology which compounded the Board's improper fixed cost percentage methodology, and is not supported by any source.

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 an acute care hospital located in Port Angeles, Washington, and was designated as a Sole Community Hospital (SCH) during the fiscal year at issue. 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 a SCH. The main statutory provisions governing SCHs are located in § 1886(d)(5)(D)(iii) of the Social Security Act (Act). A SCH is defined as any hospital:

> (I) that the Secretary determines is located more than 35 road miles from another hospital,
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> (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
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> (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 to 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, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it

> incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

The regulations implementing this statutory adjustment are located at 42 C.F.R. § 412.92(e) (2010). 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 –
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> (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;
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> (B)The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
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> (C)The length of time the hospital has experienced a decrease in utilization.

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".[20] Specifically, § 2810.1 provides guidance to assist MACs in the calculation of VDAs for sole community hospitals (SCHs). In this regard, § 2810.1(B) states the following regarding the amount of a low volume adjustment:

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

> B. Amount of Payment Adjustment. Additional payment is made to an eligible SCH for **fixed costs** it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, **not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.**
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> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.
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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[21], 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**

[21] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).

> **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.[22]

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[23] 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."[24] CMS explained that it was making the change in how the VDA is calculated because:

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[22] 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).

[23] *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).

[24] 82 Fed. Reg. at 38,180.

> As the above referenced Administrator decisions illustrate and explain, under the current calculation methodology, the MACs calculate the volume decrease adjustment by subtracting the entirety of the hospital's total MS–DRG revenue for inpatient operating costs, including outlier payments and IME and DSH payments in the cost reporting period in which the volume decrease occurred, from fixed costs in the cost reporting period in which the volume decrease occurred, minus any adjustment for excess staff. If the result of that calculation is greater than zero and less than the cap, the hospital receives that amount in a lump sum payment. If the result of that calculation is zero or less than zero, the hospital does not receive a volume decrease payment adjustment.
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> Under the IPPS, MS–DRG payments are not based on an individual hospital's actual costs in a given cost reporting period. However, the main issue raised by the PRRB and individual hospitals is that, under the current calculation methodology, if the hospital's total MS–DRG revenue for treating Medicare beneficiaries for which it incurs inpatient operating costs (consisting of fixed, semi-fixed, and variable costs) exceeds the hospital's fixed costs, the calculation by the MACs results in no volume decrease adjustment for the hospital. In some recent decisions, the PRRB has indicated that it believes it would be more appropriate for the MACs to adjust the hospital's total MS–DRG revenue from Medicare by looking at the ratio of a hospital's fixed costs to its total costs (as determined by the MAC) and applying that ratio as a proxy for the share of the hospital's MS–DRG payments that it assumes are attributable (or allocable) to fixed costs, and then comparing that estimate of the fixed portion of MS–DRG payments to the hospital's fixed costs. In this way, the calculation would compare estimated Medicare revenue for fixed costs to the hospital's fixed costs when determining the volume decrease adjustment.[25]

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

[25] *Id.*

> 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–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.[26]

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.[27]

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

[26] *Id.*
[27] *Id.* at 38,182.

> 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.[28]

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.[29] 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

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

[29] 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")."

> interpretation was not arbitrary or capricious and was consistent with the regulation.[30]

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 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, § 1886(d)(5)(D)(ii) of the Act and 42 C.F.R. § 412.92(e), 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 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 85.75 percent[31] of the Provider's Medicare costs for FY 2011. Thus, the Board found the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$22,820,141[32]
Multiplied by the 2012 IPPS update factor	1.019[33]
2011 Updated Costs (max allowed)	$23,253,724
2012 Medicare Inpatient Operating Costs	$22,040,907[34]
Lower of 2010 Updated Costs or 2012 Costs	$22,040,907

[30] *Unity* at 578.
[31] *See* Exhibit P-5 (identifying variable cost of $13,677,963 and total cost of $96,001,291 for a variable cost percentage of 14.25 percent and a fixed cost percentage of 85.75 percent). *See also* Medicare Contractor's Final Position Paper at 9.
[32] Exhibit I-4 (FY 2011 Program Operating Costs Worksheet D-1, Part II, Line 53).
[33] *Id.* (FY 2012 IPPS update factor). *See also* 76 Fed. Reg. 51476, 51797 (Aug. 18, 2011).
[34] Exhibit I-4 (FY 2012 Program Operating Cost Worksheet D-1, Part II, Line 53).

Less 2012 IPPS payment	$19,125,383[35]
2012 Payment CAP	$2,915,524

Step 2: Calculation of VDA

2012 Medicare Inpatient Operating Costs – Fixed	$18,900,078[36]
Less 2012 IPPS payment – fixed portion (81.67 percent)	$16,400,016[37]
Payment adjustment amount (subject to CAP)	$2,500,062

Since the payment adjustment amount of $2,500,062 is less than the CAP of $2,915,524, the Board determined that MAC improperly calculated the Provider's VDA for FY 2012 and that the Provider should receive a VDA payment for FY 2012 in the amount of $2,500,062.

The Administrator finds that the correct payment adjustment, which follows the controlling statute, regulations and is also reflected in *Greenwood* and *Unity*, cited *supra*, is as follows:

Calculation of the VDA

Provider's FY 2012 total operating costs	$22,040,907[38]
Provider's FY 2012 fixed costs	$18,900,078[39]
Provider's 2012 DRG payments	$19,125,383[40]
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.

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.

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[35] *Id.* (FY 2012 DRG Payments)
[36] *Id.* (FY 2012 Fixed costs were calculated by multiplying 22,040,907 by 85.75 percent).
[37] The $16,400,016 is calculated by multiplying $19,125,383 (the FY 2012 DRG payments) by 85.75 percent (the fixed cost percentage).
[38] Exhibit I-4 (FY 2012 Program Operating Cost Worksheet D-1, Part II, Line 53).
[39] FY 2012 Fixed costs were calculated by multiplying 22,040,907 by .8575.
[40] Worksheet E Part A lines 49+50+70.97.

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: September 29, 2020

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