CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Brownwood Regional Medical Center	**Cost Reporting Period Ending: September 30, 2012**
Provider	
vs.	
WPS Government Health Administrators	**Review of: PRRB Dec. No. 2021-D8 Dated: February 26, 2021**
Medicare Contractor	

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

ISSUE AND BOARD DECISION

The issue was whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending September 30, 2012 ("FY 2012").

The Board found that the MAC improperly denied the VDA payment for the Provider and that the Provider should receive a VDA payment of $ 930,056.

The Board noted that there is a difference in the FY 2012 Inpatient Operating Costs used by the parties in calculating the VDA payment. The Medicare Contractor adjusted the Inpatient Operating Costs for variable costs via Worksheet A-8 adjustments on the cost report. The Provider argued that the Medicare Contractor's VDA calculation methodology violates the statutes, regulations, and Provider Reimbursement Manual instructions.

In its recent decisions, the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because that methodology compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor), and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

SUMMARY OF COMMENTS

The MAC submitted comments requesting Administrator to reverse the Board's decision. The MAC stated that the Board specifically disregarded 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), even though this is the only case law on the subject, because the Provider is not located in the Eighth Circuit. Finally, the Board noted that subsequent to the period at issue CMS essentially adopted the Board's methodology for calculating a VDA, though that adoption was prospective only. The Board's decision was incorrect with respect to the VDA methodology and mirrors multiple decisions that have been previously overturned by the Administrator. The Board's disregarding of the only case that address this issue was incorrect. Finally, the Board relied on the 2018 IPPS Final Rule despite that rule being prospective only. The MAC asked that the Administrator reverse the Board's decision with respect to the VDA calculation and uphold the determination and methodology utilized by the MAC.

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

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 and finds that the Board's decision should be reversed. The Board's decision on the calculation of the VDA is not supported by the controlling regulations, policies and precedents.

The Provider, is a non-profit acute care hospital located in Brownwood, Texas. The Provider was designated as a Sole Community Hospital ("SCH") during the fiscal year at issue. The Medicare administrative contractor assigned to the Provider for this appeal is Wisconsin Physicians Service Government Health Administrators ("Medicare Contractor").

The Provider requested a VDA payment of $ 1,122,095 for FY 2012 to compensate it for a decrease in inpatient discharges during FY 2012. The Medicare Contractor calculated the Provider's FY 2012 VDA payment to be $0.

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

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

Section 1886(d)(5)(D)(ii) of the Act authorizes the Secretary 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.

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

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

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

> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating

> costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs ….
>
> (i) In determining the adjustment amount, the intermediary considers –
>
> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
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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 provides interpretive guidelines in the Provider Reimbursement Manual, (PRM 15-1). The Manual is intended to ensure that Medicare reimbursement standards "are uniformly applied nationally without regard to where covered services are furnished.[1] Specifically, §2810.1provides 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:

> 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.
>
> 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,

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

> most semi-fixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment. (Emphasis added.)

In the discussion included in the preamble to the August 18, 2006 final rule[2], 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. (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

[2] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).

> than those costs paid on a reasonable cost basis; and the length of time the hospital has experienced a decrease in utilization.[3]

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[4] 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."[5] CMS explained that it was making the change in how the VDA is calculated because:

> As the above referenced Administrator decisions illustrate and explain, under the current calculation methodology, the MACs calculate the volume decrease adjustment by subtracting the entirety of the hospital's total MS–DRG revenue for inpatient operating costs, including outlier payments and IME and DSH payments in the cost reporting period in which the volume decrease occurred, from fixed costs in the cost reporting period in which the volume decrease occurred, minus any adjustment for excess staff. If the result of that calculation is greater than zero and less than the cap, the hospital receives that amount in a lump sum payment. If the result of that calculation is zero or less than zero, the hospital does not receive a volume decrease payment adjustment.
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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

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[3] 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).

[4] *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).

[5] 82 Fed. Reg. at 38,180.

> 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.[6]

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–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.[7]

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

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[6] *Id.*
[7] *Id.*

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.[8]

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.[9]

The Eighth Circuit found that, just because CMS prospectively adopted a new interpretation, that it was not a sufficient reason to find that the Secretary's prior interpretation was arbitrary or capricious.[10] The Eighth Circuit pointed out that the main

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[8] *Id.* at 38,182.

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

[10] 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

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.[11]

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

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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")."

[11] *Unity* at 578.

statute and CMS' regulations and guidance. In this case, the MAC determined that the Provider's fixed costs (which includes semi-fixed costs) were 82.93 percent[12] of the Provider's Medicare costs for the fiscal year at issue.

Applying the rationale described above, the Board found the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$14,884,409[13]
Multiplied by the 2012 IPPS update factor	1.03[14]
2011 Updated Costs (max allowed)	$15,330,941
2012 Medicare Inpatient Operating Costs	$15,667,560[15]
Lower of 2011 Updated Costs or 2012 Costs	$15,330,941
Less 2012 IPPS payment	$14,208,846[16]
2012 Payment CAP	$ 1,122,095

Step 2: Calculation of VDA

2012 Medicare Inpatient Operating Costs – Fixed	$12,713,452[17]
Less 2012 IPPS payment – fixed portion (82.93 percent)	$11,783,396[18]
Payment adjustment amount (subject to CAP)	$ 930,056

Since the payment adjustment amount of $930,056 is less than the CAP of $1,122,095 the Board concluded that Provider's VDA payment for FY 2012 should be $930,056.

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:

[12] Stipulations at ¶ 10.
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.* Stipulations at 6.
[18] The $11,783,396 is calculated by multiplying $14,208,846 (the FY 2012 SCH payments) by 0.8293 (the fixed cost percentage determined by the Medicare Contractor). The immaterial difference between $11,782,935 and $11,783,396 in Stipulations ¶ 10 is due to rounding the fixed cost percentage.

Calculation of the VDA

Provider's FY 2012 updated operating costs	$15,667,560[19]
Provider's fixed costs	$12,713,452[20]
Provider's DRG payments	$14,208,846
VDA Payment Amount	$0[21]

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.

[19] Stipulations at ¶ 6.
[20] Stipulations at ¶¶ 8, 10. The FY 2012 Inpatient Operating Costs multiplied by the Fixed Cost Percentage does not equal the FY 2012 Fixed Costs due to rounding.
[21] *Id.* at ¶ 8. As the Total DRG payments exceed the FY Fixed Costs, the payment would be $0.

DECISION

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

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

Date: April 26, 2021

/s/
Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services