CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Chenango Memorial Hospital	**Cost Reporting Period Ending: December 31, 2012**
Provider	
vs.	**Review of: PRRB Dec. No. 2022-D13 Dated: March 3, 2022**
National Government Services, Inc.	
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 U.S.C. § 1395oo (f)). The Medicare Administrative Contractor (MAC) submitted comments, requesting that the Administrator reverse the Board's decision with respect to the methodology used for calculating the Provider's volume decrease adjustment (VDA). The Center for Medicare (CM) submitted comments, requesting that the Administrator reverse the Board's decision methodology to calculate the VDA for the Provider. The Provider submitted comments requesting that the Administrator affirm the Board's Decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether the MAC properly calculated the VDA owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2012.

The Board found that the MAC properly reopened the Provider's 2012 VDA approval but improperly calculated the Provider's VDA payment and that the Provider should receive an additional VDA payment for FY 2012 of $225,125, for a total VDA payment amount of $1,718,775 for FY 2012.

SUMMARY OF COMMENTS

The MAC requested that the Administrator reverse the Board's decision with respect to the methodology for calculating Provider's VDA as it is not supported by statute or regulation. The Administrator has repeatedly advised the Board regarding the proper methodology for performing

a VDA calculation. The MAC utilized the Administrator's methodology, which has been upheld by the Eighth Circuit; the only circuit court to address this issue. That Court's decision clearly demonstrates that the Administrator's methodology has been weighed, measured and been found statutorily appropriate. The Board's methodology requires modifications to existing law to survive a statutory challenge, and those modifications are prospective only and not relevant to the fiscal year at hand. The MAC did, however, agree that no VDA payment is warranted regardless of the methodology applied.

CM submitted comments, stating that it disagreed with the Board that the MAC improperly calculated the VDA payment for the Provider for the same reasons set forth in the Department of Health and Human Service's Eighth Circuit Brief in *Unity HealthCare v. Azar*[1], two briefs in *Stephens County Hosp. v. Becerra*[1], *and* opening brief in *Lake Region Healthcare Corporation v. Becerra*[23] on the same issue. CM further referenced the August 2017 Final Rule,[4] in support of their position, and additionally cited to other decisions in which the Administrator upheld the current approach to calculating the VDA.[4] CM also explained while the Provider pointed to *Azar v. Allina Health Svcs*[5] ("*Allina*") in stating that CMS' VDA methodology is contrary to the notice and comment rulemaking requirements of the Administrative Procedures Act ("APA) and that CMS unlawfully changed regulations, CMS met that obligation.

CM noted that, while the Provider disagreed with the MAC's methodology of computing the variable costs, the Board determined that the MAC's methodology resembled the calculations that were found acceptable in *Unity, Lake Regional* and *Fairbanks* court case and the Board therefore found the MAC's calculation acceptable. The MAC originally calculated the VDA payment to the Provider to be $2,352,605 and subsequently notified the Provider that the original VDA approval was being reopened based on directions from the Centers for Medicare and Medicaid Services (CMS). The MAC later issued the revised VDA payment in the amount of $1,493,650. The Board found that the MAC properly reopened the original VDA approval, but improperly recalculated the VDA payment for the Provider.

The Provider submitted comments stating that the facts of this case differ from the Medicare Volume Decrease Adjustment ("VDA") cases the CMS Administrator has previously addressed. Here, the MAC reopened an otherwise final VDA determination to apply a brand-new methodology. In all previous cases decided by the CMS Administrator, the MAC application of the new methodology occurred during the original VDA determination. The Provider noted that

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[1] 918 F.3d 571, 579 (8th Cir. 2019), *cert. denied*, 140 S. Ct 523 (2019); No. 19-cv-3020 (DLF), 2021 WL 4502068 (Sept. 30, 2021).

[2] No. 20-3452 (KBJ) (D.D.C.).

[3] Fed. Reg. 37,990, 38,179-83 (Aug. 14, 2017).

[4] CM cited to the Administrator's decisions in *Greenwood County Hospital* , PRRB Dec. No. 2006D43; *Unity Healthcare,* PRRB Dec. No. 2014-D15; *Lakes Regional Healthcare,* PRRB Dec. No. 2014-D16; *Fairbanks Memorial Hospital, PRRB Dec. No.* 2015-D11; *St. Anthony Regional Hospital,* PRRB Dec. No. 2016-D16; and *Trinity Regional Medical Center,* PRRB Dec. No. 2017-D1.

[5] 139 S. Ct. 1804 (2019).

CMS has revised the regulation governing VDA payments to reach the *exact same result* as the PRRB's decision. Because the regulation has been revised, there are only a limited number of similar cases possible. The CMS Administrator should not waste its limited resources reviewing an issue that can no longer arise, especially because CMS has tacitly agreed that the MAC's Revised VDA Approval Methodology did not "fully compensate" the Provider, and therefore should no longer be used. This is particularly true when, as here, the MAC reopened an otherwise final determination to apply a new methodology that did not even exist at the time the final determination was made.

For these reasons, the Provider contended that the CMS Administrator should affirm the PRRB Decision. If the CMS Administrator declines to reinstate the Original VDA Approval, it should affirm the PRRB's determination that the MAC should reduce DRG payments by the same fixed portion percentage used by the MAC to reduce Inpatient Operating Costs. However, the Provider disagrees with the PRRB's inclusion of Low Volume Adjustment ("LVA") payments totaling $576,179, as neither the plain language of the statute nor regulation supports inclusion of LVA payments. Indeed, the applicable regulation specifies "DRG revenue for inpatient costs" and only adds outlier payments, DSH payments and indirect IME costs. 42 C.F.R. § 412.108(d)(3). The LVA amounts were correctly excluded from DRG revenue by the MAC in both the Original VDA Approval and Revised VDA Approval. Accordingly, the Provider is entitled to VDA payment of $2,294,934. The Provider respectfully requests that the CMS Administrator affirm the PRRB's Decision. If the CMS Administrator modifies the PRRB's Decision, such modifications should be limited to reinstating the MAC's Original VDA Approval and rejecting the MAC's Revised VDA Approval.

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 Norwich, New York, and was designated as a Medicare Dependent Hospital (MDH) during the fiscal year at issue. The Provider initially requested a VDA payment for FY 2012 in the amount of $2,614,006 on May 5, 2014.[6] On August 21, 2015, the MAC issued a VDA in the amount of $2,352,605.[7] The MAC reopened its VDA determination on January 15, 2016,[8] and on August 30, 2016, the MAC issued a revised VDA payment of $1,493,650.[9] As a result of the MAC's revised VDA, the Provider was required to repay $858,955.[10] Provider timely appealed the MAC's final decision, and met the jurisdictional requirements for a Board hearing.

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[6] Stipulations at ¶7, Ex. P-2.
[7] Stipulations at ¶11, Ex. P-3.
[8] Stipulations at ¶12.
[9] *Id*. at ¶13.
[10] *Id*. at ¶14.

As an initial matter, the provisions of 42 C.F.R. § 405.1885(a) give the Medicare Contractor the authority to reopen a determination. The MAC asserted that it was obliged to revise the VDA payment to remove the variable expenses, in accordance with the plain language of the relevant statute and regulation and that it was authorized to make the revision to the interim VDA payment under its own discretion, subject to the limitations of 42 C.F.R. § 405.1885(b)(1). The Board correctly concluded that the MAC had the authority to reopen the VDA determination, since the notice of intent to reopen was within 3 years of the original VDA determination

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

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

Section 1886(d)(5)(G) of the Act authorizes the Secretary of DHHS to adjust the payment to MDHs that incur a decrease in discharges of more than 5 percent from one cost reporting year to the next, stating:

> In the case of a Medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment … as be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

The regulations implementing this statutory adjustment are located at 42 C.F.R. § 412.108(d)(1)-(3) (2012)[11]. In particular, subsection (d)(2) specifies the following regarding low volume adjustment for MDHs:

> To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request no later than 180

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

> days after the date on the intermediary's Notice of Amount of Program Reimbursement and it must -
>
> (i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and
>
> (ii) Show that the decrease is due to circumstances beyond the hospital's control.

Once an MDH demonstrates that it has experienced a qualifying decrease in total inpatient discharges, the intermediary must determine the appropriate amount, if any, due to the provider as an adjustment. In this regard, 42 C.F.R. § 412.108(d)(3) specifies the following regarding the determination of the low volume adjustment amount for MDHs:

> (3) The intermediary determines a lump sum adjustment amount not exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs…
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> (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.[12]

When CMS promulgated § 412.108(d), CMS made it clear that the low volume adjustment rules for MDHs were identical to those that were already in effect for SCHs.[13]

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".[14] While PRM 15-1 does not specifically address MDH low volume adjustments, it does address SCH low volume adjustments at PRM 15-1 § 2810.1. As the criteria for SCH and MDH low volume adjustments are identical, the PRM 15-1 guidance on SCH low volume adjustment is applicable to MDH low volume adjustments. In this regard, § 2810.1(B) states the following regarding the amount of a low volume adjustment:

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[12] 42 C.F.R. § 412.108(d)(3) (2011).
[13] 55 Fed. Reg 15,150, 15,155 (Apr. 20, 1999). *See also* 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006).
[14] *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 semifixed 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,[15] 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).

[15] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).

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 semifixed 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.[16]

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[17] 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."[18] 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

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[16] 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).

[17] *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).

[18] 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).

> 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.[19]

However, CMS pointed out that despite the change, the previous method was still reasonable and consistent with the statute:

> 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

[19] *Id.*

> 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.[20]

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.[21]

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.[22]

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[20] *Id.*

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

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

The Eighth Circuit found that just because CMS prospectively adopted a new interpretation, that was not a sufficient reason to find that the Secretary's prior interpretation was arbitrary or capricious.[23] 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.[24]

The core dispute in this case centers on 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 Administrator finds that 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

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[23] 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")."

[24] *Unity* at 578.

language of the relevant statute and regulation, Section 1886(d)(5)(G)(iii) and 42 CFR 412.108(d), make it clear that the VDA is intended to compensate qualifying hospitals for their fixed costs, not their variable costs. This position is also supported by past decisions, such as *Greenwood County*, PRRB Dec. No. 2006-D43, where the Board correctly eliminated variable costs from the calculation.

Regarding the methodology and proper calculation of the Provider's payment adjustment, the Administrator finds that the Board improperly calculated the Provider's adjustment. The VDA calculation methodology used by the Board is in direct contradiction to the statute and CMS' regulations and guidance. The Board found the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2011 Medicare Inpatient Operating Costs	$9,178,020[25]
Multiplied by the 2012 IPPS update factor	1.019[26]
2011 Updated Costs (max allowed)	$9,352,402
2012 Medicare Inpatient Operating Costs	$8,580,334[27]
Lower of 2011 Updated Costs or 2012 Costs	$8,580,334
Less 2012 IPPS payment (includes LVA)	$6,625,182[28]
2012 Payment CAP	$1,955,152

Step 2: Calculation of VDA

2012 Medicare Inpatient Fixed Operating Costs	$7,542,972[29]
Less 2012 IPPS payment – fixed portion (87.91 percent)	$5,824,197[30]
Payment adjustment amount (subject to CAP)	$1,718,775

Since the payment adjustment amount of $1,718,775, is less than the payment cap of 1,955,152, the Board found that the Provider's VDA payment for FY 2012 should be $1,718,775. As the revised FY 2012 VDA for Chenango was $1,493,650,[31] and an additional VDA payment of $225,125 should be made to the Provider.

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[25] Second Revised Stipulations ¶21; Ex. P-5, C-3.

[26] Second Revised Stipulations ¶21.

[27] *Id*.

[28] 2012 IPPS Payment = $6,049,003 (Medicare DRG Payment per Second Revised Stipulations ¶21) + $399,123 + $177,056 (Low Volume Adjustments from Worksheet E Part A Lines 70.96 and 70.97) = $6,625,182.

[29] *Id.*

[30] The $5,824,197, is calculated by multiplying the $6,625,182, (the 2012 IPPS Payment), by the Fixed Cost percentage of 88.14 percent).

[31] Provider's FPP at 4.

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	
2012 Medicare Inpatient Operating Costs	$9,178,020[32]
2012 Fixed Operating Costs, allowable amount after adjustments	$7,542,653[33]
Total DRG/MDH Payments	$6,049,003[34]
VDA Payment Amount	**$1,493,650**

Thus, the Provider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG/MDH payment. In this case, the MAC's revised calculation of the Provider's VDA showed the Provider should receive a payment of $1,493,650. Consequently, the MAC properly revised the original payment of $2,352,605 to $1,493,650.[35] However, while the methodology used by the MAC was proper, adopting the Board's finding on the LV payment, means the VDA payment is further adjusted to $917,471.

Finally, as CM noted, while the Provider pointed to *Azar v. Allina Health Svcs*[36] ("*Allina*") in stating that CMS' VDA methodology is contrary to the notice and comment rulemaking requirements of the Administrative Procedures Act ("APA) and that CMS unlawfully changed regulations, CMS met that obligation. With respect to *Allina* and section 1871 of the Act, CM correctly pointed out that even if the statute required the VDA calculation methodology to be established through rulemaking, the agency satisfied that obligation by utilizing notice and comment rulemaking to promulgate, revise, and clarify the implementing regulation, and describing in regulation and preamble how the VDA is to be calculated. Specifically, among other things, CMS promulgated a regulation in 1983, which set forth factors to be considered in calculating the VDA. *See, e.g.*, 49 Fed. Reg. 234, 270-271 (Jan. 3, 1984) (Final rule, responding to comments); 48 Fed. Reg. 39,752, 39,781-82 (Sept. 1, 1983) (Interim final rule with comment period); 42 C.F.R. § 405.476(d) (1984). In 1987, CMS proposed and then finalized an amendment

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[32] Second Revised Stipulations at ¶21.

[33] *Id*. (FY 2012 allowable amount from Worksheet D-1, Line 53 of the Settled Cost Report after adjustments. MAC FPP C-2, C-3 (per PRM 15-1, § 2810.1) MAC FPP, C-5.); MAC's FPP, Ex.C-3, at 8. The Administrator finds that the MAC properly excluded variable costs from total operating costs. *See* Second Revised Stipulations at ¶19.

[34] *Id*. (FY 2012 MDH Payment from Worksheet E, Part A, Line 49); MAC's FPP, Exhibit C-3 at 4.

[35] MAC's FPP, Exhibit C-3 at 8. Were the Board's calculation of the FY 2012 IPPS payments of $6,625,182 to be adopted, the payment would be further reduced. This FFY 2012 IPPS payment has not been fully brief by both sides at this time. The Administrator will not disturb the MAC's calculation made pursuant to the reopening under the limited circumstance of this case.

[36] 139 S. Ct. 1804 (2019).

to the regulation to establish a ceiling for the VDA, equal to the difference between a hospital's Medicare operating costs and its DRG payments. *See* 52 Fed. Reg. 33,034, 33,049 (Sept. 1, 1987) (final rule); 52 Fed. Reg. 22,080, 22,090-91 (June 10, 1987) (proposed rule); 42 C.F.R. § 412.92(e)(3) (1987). And, in 2017, CMS issued a notice of proposed rulemaking and then a final rule which explicitly stated (and amended the regulation's text to provide) that a new, proportional VDA calculation methodology would apply solely to cost reporting periods that begin on or after October 1, 2017, whereas the longstanding, then-current VDA calculation methodology (under which the VDA=Fixed Costs-DRG payments) would continue to govern earlier periods such as those at issue here. *See, e.g.*, 82 Fed. Reg. 37,990, 38,179-83, 38,511 (Aug. 14, 2017) (final rule); 82 Fed. Reg. 19,796, 19,933-35 (Apr. 28, 2017) (proposed rule); 42 C.F.R. § 412.92(e)(3) (2018).

There is no rule promulgated pursuant to notice and comment rulemaking that requires that the proportional VDA calculation methodology would govern cost reporting periods that begin before October 1, 2017. Accordingly, even if section 1871 of the Act required the VDA calculation methodology to be established through notice and comment rulemaking beyond that already undertaken by CMS, no rule promulgated pursuant to those procedures supports the Board's or the Provider's proportional VDA calculation methodology to be applied to the period at issue in this appeal.

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: April 22, 2022

/s/
Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services