CENTERS FOR MEDICARE AND MEDICAID SERVICES

In the case of:	**Claim for:**
Skiff Medical Center **Provider** **vs.** **Wisconsin Physicians Service** **Medicare Contractor**	**Cost Reporting Period Ending:** **June 30, 2008** **Review of:** **PRRB Dec. No. 2022-D14** **Dated: March 16, 2022**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board).[1] 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) and the Medicare Administrative Contractor (MAC) both submitted comments requesting that the Administrator revise 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 volume decrease adjustment (VDA) owed the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2008 (FY 2008).

In this case, the parties disagree over the use of the Medicare cost report to remove the variable costs to recompute the Medicare Inpatient costs that will be used in the Provider's VDA calculation.[2] The Board found the MAC's methodology acceptable since it resembled the calculations that have been found acceptable in other cases.[3] The Provider argued that the MAC's calculation of the VDA was incorrect because the MAC departed from the instructions and step-by-step guidance in PRM 15-1, and added an unauthorized and monumental extra step. The Provider argued that the *Federal Register* does not subtract variable costs from the Provider's costs. The Board disagreed and noted that the Final Rule published on September 1, 1983 (FFY 1984 IPPS Final Rule) states that "[t]he statute requires that the [VDA] payment adjustment be

[1] The Administrator notes that the term PRRB and Board are used interchangeably to reference the same party, the Provider Reimbursement Review Board.
[2] *See*, Provider Reimbursement Review Board (PRRB) Dec. No. 2022-14 at 5.
[3] *Id*. at 6-7.

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."

The Board identified three basic differences between the MAC's and the Provider's calculation of the VDA payment. The first was related to excess staffing. The MAC deducted $35,234 for excess staffing, whereas the Provider deducted $34,819. The difference in the excess staffing is related to the Provider improperly including the excess staffing for FYE 2007 as opposed to FYE 2008.

The second issue is that the Provider included in the VDA calculation the DRG payments on Line 6 of the cost report whereas, the MAC included the total payments on Line 8, that includes a percentage of the DRG and Hospital Specific Rate (HSR) payment. The Board reviewed the VDA regulations at 42 C.F.R. § 412.108(d). These regulations require the VDA to be calculated using "the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106. . . .)" The Board also reviewed the MDH payment methodology in 42 C.F.R. § 412.108(c) to determine what payments should be included in the hospital's "total DRG revenue for inpatient operating costs." 42 C.F.R. § 412.108(c) provides that MDHs are paid for inpatient operating costs based on whichever is the greatest between the Federal payment or the hospital specific payment. Based on these regulations the Board found that an MDH's total DRG revenue for inpatient operating costs includes both the amount paid based on the federal rate and the amount paid based on the hospital specific rate. Therefore, the Board concluded that the MAC was correct to use $6,447,943 as the Provider' s "total DRG revenue for inpatient operating costs" when calculating the Provider's FY 2008 VDA payment.

The last issue relates to whether variable costs are to be removed from the VDA calculation. The MAC removed variable costs from the Medicare inpatient operating costs. The Provider argued that its VDA calculation methodology was calculated in accordance with the statute, regulations, and PRM instructions, in removing variable costs from the comparison methodology. In recent Board decisions addressing VDA payments, the Board has disagreed with the methodology used by various Medicare contractors (including the one involved in this appeal) to calculate VDA payments because the methodology compared 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.

The Board noted that it was not bound to apply the specific VDA methodology applied by the Administrator in *Unity v. Azar*, and upheld by the Eight Circuit, as they did not create a binding precedent that the Board was obligated to follow. The Board held that the MAC's calculation of the Provider's VDA payment for FY 2008 was incorrect because it was *not* based on CMS' stated policy as delineated in the PRM 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preambles to the relevant Final Rules.[4] The Board further determined that the based on its review of

[4] *Id.* at 10.

the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs." Therefore, the Board determined that the Provider should receive an additional VDA payment in the amount of $406,220, resulting in a total VDA of $832,339 for FY 2008.[5]

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. In this case, 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. Finally, regardless of which methodology is applied, the Provider is not entitled to a VDA payment since the Provider's IPPS payments exceeded the Provider's fixed inpatient operating cost for FY 2008.

CM submitted comments requesting that the Administrator reverse the Board's decision (apart from its findings on the excess staffing amount, the use of the HSR payment, and the removal of the variable costs) and affirm that the MAC used the proper methodology to calculate the VDA for the Provider.

In particular, the Provider argued that the MAC unlawfully changed regulations without following the legal notice and comment period, when they changed the VDA calculation methodology and that the VDA calculation was not lawfully altered until the August 17, 2017 *Federal Register* was issued. Skiff contended that the methodology in effect during the four years under appeal was the one described in section 2810.1 of the PRM and also contended that CMS and/or the MAC improperly departed from this methodology. CM noted, with respect to *Azar v. Allina Health Services* and 42 U.S.C. § 1395hh(a)(2), even if § 1395hh required the VDA calculation methodology to be established through rulemaking, the agency satisfied that obligation by utilizing notice and comment rulemaking to promulgate, revise, and clarify the implementing regulation, and describing in regulation and preamble how the VDA is to be calculated. Specifically, among other things, CMS promulgated a regulation in 1983, which set forth factors to be considered in calculating the VDA. See, e.g., 49 Fed. Reg. 234, 270-271 (Jan. 3, 1984) (Final rule, responding to comments); 48 Fed. Reg. 39,752, 39,781-82 (Sept. 1, 1983) (Interim final rule with comment period); 42 C.F.R. § 405.476(d) (1984). In 1987, CMS proposed and then finalized an amendment to the regulation to establish a ceiling for the VDA, equal to the difference between a hospital's Medicare operating costs and its DRG payments. See 52 Fed. Reg. 33,034, 33,049 (Sept. 1, 1987) (final rule); 52 Fed. Reg. 22,080, 22,090-91 (June 10, 1987) (proposed rule); 42 C.F.R. § 412.92(e)(3) (1987). And, in 2017, CMS issued a notice of proposed rulemaking and then a final rule which explicitly stated (and amended the regulation's text to provide) that a new, proportional VDA calculation methodology would apply solely to cost reporting periods that begin on or after October 1, 2017, whereas the longstanding, then-current VDA calculation methodology (under which the VDA=Fixed Costs-DRG payments) would continue to govern earlier

[5] *Id*. at 14-15.

periods such as those at issue here. See, e.g., 82 Fed. Reg. 37,990, 38,179-83, 38,511 (Aug. 14, 2017) (final rule); 82 Fed. Reg. 19,796, 19,933-35 (Apr. 28, 2017) (proposed rule); 42 C.F.R. § 412.92(e)(3) (2018).

CM stated that no rule promulgated pursuant to notice and comment rulemaking requires that either the proportional VDA calculation methodology or the Provider's apparent preferred methodology (under which VDA = Total Costs – DRG payments) would govern cost reporting periods that begin before October 1, 2017. Accordingly, even if § 1395hh required the VDA calculation methodology to be established through notice and comment rulemaking, no rule promulgated pursuant to those procedures supports the proportional VDA calculation methodology or the Provider's preferred methodology to be applied to the period at issue in this appeal.

CM stated that the Board correctly concluded that $34,819 reflects the excess staffing amount from the prior year, while $35,234 is the current year excess staffing amount and that the excess staffing in the amount of $35,234 is the correct amount to be used in the VDA calculation. In addition, the Board correctly concluded that a MDH's total DRG revenue for inpatient operating costs could include either the amount paid based on the federal rate or the combined amount paid based on the federal rate and the HSR and that the MAC was correct to use the combined federal rate/HSR payment of $6,447,943 as Skiff's "total DRG revenue for inpatient operating costs" when calculating Skiff's FY 2008 VDA payment.

Finally, the Board properly rejected the Provider's argument regarding *Allina* as this case is different from the situation discussed by the Supreme Court in *Allina*, where a new substantive reimbursement policy was announced on the CMS website and was applied nationwide.

BACKGROUND AND DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits.

The Provider is a general acute care hospital located in Newton, Iowa that has been designated by Medicare as a Medicare Dependent Hospital (MDH).[6] For the fiscal period in dispute, the Provider experienced a decrease in discharges greater than 5 percent, due to circumstances beyond its control, and as a result, was eligible to have the VDA calculation performed.[7] On February 5, 2010 the Provider requested an adjustment to its DRG payments under 42 C.F.R. §412.108(d) of the Medicare regulations.[8] The MAC conducted a review and approved a VDA payment in the amount of $426,119.[9] On October 29, 2010, the Provider requested reconsideration.[10] The MAC denied the reconsideration request on January 4, 2011.[11] On February 23, 2011 the Provider appealed the MAC final determination.[12]

[6] *See*, MAC Final Position Paper (FPP) at 5.
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*

Section 1886(d)(5)(G)(iv)[13] of the Act, defines a MDH as:

> The term "Medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any hospital—
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> (I) located in a rural area,
> (II) that has not 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)(iii)[14] of the Act authorizes the Secretary to adjust the payment of MDHs that incur a decrease in discharges of more than 5 percent from one cost reporting year to the next, if the circumstances leading to the decline in discharges were beyond its control, 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 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(d)(1). In particular, subsection (d)(1) states:

> CMS provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, a more than 5 percent decrease in its total inpatient discharges as compared to its immediately preceding cost reporting period….

CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals (SCHs).[15] In determining the adjustment for a qualified MDH, 42 C.F.R. § 412.108(d)(3) instructs:

> (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

[13] 42 U.S.C. §1395ww(d)(5)(G)(iv).
[14] 42 U.S.C. §1395ww(d)(5)(G)(iii).
[15] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under
> § 412.105).
> (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.[16]

In addition to the controlling regulation, CMS has provided further interpretive guidelines in the 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."[17] Section 2810.1(A)(1) of the PRM defines "circumstances beyond the hospital's control" as:

> 1. *Circumstances Beyond the Hospital's Control*. – In order for an SCH to qualify for additional payment, the decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects.[18]

Additionally, § 2810.1 provides guidance to assist MACs in the calculation of VDAs for MDHs. Specifically, § 2810.1(B) of the PRM 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*

[16] As reflected in the foregoing regulation and in the notice and comment rulemaking history, even if section 1871 of the Act required the VDA calculation methodology to be established through rulemaking, the agency satisfied that obligation by utilizing notice and comment rulemaking to promulgate, revise, and clarify the implementing regulation, and describing in regulation and preamble how the VDA is to be calculated. See, e.g., 49 Fed. Reg. 234, 270-271 (Jan. 3, 1984) (Final rule, responding to comments); 48 Fed. Reg. 39,752, 39,781-82 (Sept. 1, 1983) (Interim final rule with comment period); 42 C.F.R. § 405.476(d) (1984). *See* 52 Fed. Reg. 33,034, 33,049 (Sept. 1, 1987) (final rule); 52 Fed. Reg. 22,080, 22,090-91 (June 10, 1987) (proposed rule); 42 C.F.R. § 412.92(e)(3) (1987). And, finally, in 2017, CMS issued a notice of proposed rulemaking and then a final rule which explicitly stated (and amended the regulation's text to provide) the longstanding, then-current VDA calculation methodology (under which the VDA=Fixed Costs-DRG payments) would continue to govern earlier periods such as those at issue here. *See, e.g*., 82 Fed. Reg. 37,990, 38,179-83, 38,511 (Aug. 14, 2017) (final rule); 82 Fed. Reg. 19,796, 19,933-35 (Apr. 28, 2017) (proposed rule); 42 C.F.R. § 412.92(e)(3) (2018).

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

[18] *See*, PRM 15-1, § 2810.1(A)(1).

> *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 semifixed costs may not be included in determining the amount of the payment adjustment. (Emphasis added.)
>
> The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The intermediary reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

With respect to determining core staffing, § 2810.1(C)(6)(a)[19] states that:

> 6. Core Staff and Services.
> a. For cost reporting periods beginning on or after October 1, 2007, and prior to October 1, 2017, a comparison, by cost center, of full-time equivalent (FTE) employees and salaries in both cost reporting periods must be submitted. The requesting hospital must identify core staff and services in each center and the cost of these staff and services. The request must include justification of the selection of core staff and services including minimum staffing requirements imposed by an external source. The contractor's analysis of core staff is limited to those cost centers (general service, inpatient, ancillary, etc.) where costs are components of Medicare inpatient operating cost.
>
> Core nursing staff is determined by comparing FTE staffing in the Adults and Pediatrics and Intensive Care Unit cost centers to FTE staffing in the prior year and FTE staffing in peer hospitals. Peer hospital information is obtained from data on nursing hours per patient day using the results of the occupational mix survey or the

[19] Rev. 479.

> AHA Annual Survey for hospitals of the same size, geographic area (Census Division), and period of time. Acceptable core nursing staff for a year in which a hospital had a volume decline is the lesser of actual staffing in the prior fiscal year or core staff for the prior fiscal year as determined from the occupational mix survey or the AHA Annual Survey data from peer hospitals. When determining core staff hours for other than a full year, the standard hours worked must be multiplied by the actual number of weeks in the cost reporting period. For example, a hospital with a standard work week of 37.5 hours requesting a VDA for a cost reporting period of January 1, 2008, through June 30, 2008, has a paid hours per year of 975 (26 weeks x 37.5 hours per week).

In the discussion included in the preamble to the August 18, 2006 final rule[20], it was noted:

> The process for determining the amount of the volume decrease adjustment can be found in section 2810.1 of the Provider Reimbursement Manual. Fiscal intermediaries are responsible for establishing whether an SCH or MDH is eligible for a volume decrease adjustment and, if so, the amount of the adjustment. To qualify for this adjustment, the SCH or MDH must demonstrate that: (a) A 5 percent or more decrease of total discharges has occurred; and (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal intermediary has established that the SCH or MDH satisfies these two requirements, it will calculate the adjustment. The adjustment amount is determined by subtracting the second year's DRG payment from the lesser of: (a) The second year's costs minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff**.** The SCH or MDH receives the difference in a lump-sum payment.

In the 2018 Final IPPS Rule, CMS changed the method of calculating the VDA, effective for cost reporting periods beginning on or after October 1, 2017. In discussing this change, CMS again explained the method that is at issue in this case:

> 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

[20] 71 *Fed. Reg*., 47,870, 48,056 (Aug. 18, 2006).

> fixed) other than those costs paid on a reasonable cost basis; and the length of time the hospital has experienced a decrease in utilization.[21]

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[22] 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."[23] 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 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

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[21] 82 *Fed. Reg*. 37,990, 38,179 (Aug. 14, 2017).

[22] *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).

[23] 82 *Fed. Reg*. at 38,180.

> calculation would compare estimated Medicare revenue for fixed costs to the hospital's fixed costs when determining the volume decrease adjustment.[24]

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.[25]

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

[24] *Id.*
[25] *Id.*

> 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.[26]

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.[27]

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.[28] 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

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

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

[28] 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")."

> 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.[29]

This case centers on the application of the statute and regulation 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 statute and implementing regulation 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 agrees with the Board's findings regarding the MAC's proper exclusion of variable costs, the MAC's proper determination of the excess staffing dollar amount, the MAC's proper inclusion of the HSR, and the inapplicability of *Allina*.

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:

Step 1: Calculation of the CAP

2007 Medicare Inpatient Operating Costs	$7,310,921
Multiplied by the 2007 IPPS update factor	1.033
2007 Updated Costs (Max allowed)	$7,552,181
2008 Medicare Inpatient Operating Costs	$7,373,937
Lower of 2007 Updated Costs or 2008 Costs	$7,373,937
Less 2008 IPPS payment	$6,447,943
2008 Payment Cap	$925,994

Step 2: Calculation of VDA

2008 Medicare Inpatient Costs - Fixed Operating Costs	$6,909,296
Less Excess Staffing	$35,234
2008 Medicare Inpatient Fixed Operating Costs less Excess Staff	$6,874,062
Less 2008 IPPS payment – Fixed Portion (93.7 percent)	$6,041,723
Payment adjustment amount (subject to CAP)	$832,339[30]

As shown above, the Board determined that, as the payment adjustment amount of $832,339 is less than the CAP of $925,994, the Provider's VDA payment for FY 2008 should be $832,339.

The Administrator disagrees with the Board's VDA methodology. The Administrator finds that the MAC properly calculated the correct payment adjustment, by following the controlling statute,

[29] *Unity* at 578.
[30] *See*, Provider Reimbursement Review Board (PRRB) Dec. No. 2022-14 at 14-15.

regulations and various Administrative and Court decisions as reflected in *Greenwood* and *Unity*, cited *supra*, is as follows:

Step 2: Calculation of VDA

2008 Medicare Inpatient Costs - Fixed Portion	$6,874,062
Less 2008 IPPS payment	$6,447,943
Payment adjustment amount (subject to CAP)	**$426,119**[31]

As shown above, the Administrator finds that the MAC's work papers establish that the Provider met the criteria to qualify for a potential VDA payment. However, these same work papers reveal that the Provider has not been fully compensated for its fixed cost. The result show that the IPPS payments is less than the fixed costs. Therefore, since the IPPS payments are less than the fixed costs, the Provider is eligible for a VDA payment in the amount of $426,119.

Accordingly, the Administrator reverses the Board's decision (apart from its findings on the excess staffing amount, the use of the HSR payment, and the removal of the variable costs) and affirms that the MAC used the proper methodology to calculate the VDA for the Provider. Even if the statute required the VDA calculation methodology to be established through rulemaking, the agency satisfied that obligation by utilizing notice and comment rulemaking to promulgate, revise, and clarify the implementing regulation, and describing in regulation and preamble how the VDA is to be calculated. In addition, there is no rule promulgated pursuant to notice and comment rulemaking requires that either the proportional VDA calculation methodology would govern cost reporting periods that begin before October 1, 2017. Accordingly, even if §1871 of the Act, required the VDA calculation methodology to be established through notice and comment rulemaking, no rule promulgated pursuant to those procedures supports the proportional VDA calculation methodology (or the Provider's preferred methodology) to be applied to the period at issue in this appeal.

[31] *See*, MAC's Exhibit I-2.

DECISION

The decision of the Board regarding the calculation of the Provider's VDA is reversed in accordance with the foregoing opinion.

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

Date: May 13, 2022

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