**CENTERS FOR MEDICARE AND MEDICAID SERVICES**
***Order of the Administrator***

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| **In the case of:** | **Claim for:** |
| **EJ Noble Hospital** | **Cost Reporting Period Ending: December 31, 2011** |
| **Provider** | |
| **vs.** | |
| **National Government Services, Inc.** | **Review of: PRRB Dec. No. 2022-D16 Dated: March 17, 2022** |
| **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) submitted comments, requesting that the Administrator reverse the Board's decision. 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 was whether the Medicare Contractor properly calculated the Revised Volume Decrease Adjustment ("VDA") owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2011 ("FY 2011"), and whether the Medicare Contractor properly reopened the original VDA determination. The Board found that the Medicare Contractor properly reopened the original VDA determination for the Provider for FY 2011.

Concerning the Provider's challenge of the determination of the exclusion of variable costs, the Board reviewed the MAC's calculation. Pursuant to the review, the MAC's Exhibit C-3, variable expenses were identified at the account level, within each of the cost centers on the cost report Worksheet A. The MAC identified $1,999,115 in variable expenses through their analysis. This amount was compared to total expenses per Worksheet A, excluding specific excluded units and outpatient units. This resulted in a variable cost percentage of 10.96 percent and a fixed cost percentage of 89.04 percent. This fixed cost percentage was then used to determine the fixed portion of the Medicare Inpatient Operating Costs for use in the VDA calculation.

The Board found that the Medicare Contractor was correct in removing variable costs from the inpatient operating costs and that the method used to identify and remove these costs was reasonable, based on the operations of the cost report and the data the Provider provided to the MAC, as well as the failure of the Provider to provide any alternative calculation (with support documentation). However, the Board also found that the portion of the DRG payment related to variable costs should have been removed from the total DRG payment. Thus, the Medicare Contractor improperly recalculated the amount of the Provider's VDA payment for FY 2011 to which the Provider was entitled. The Board determined that the Provider should receive a VDA payment for FY 2011 in the amount of $177,121.

## SUMMARY OF COMMENTS

The MAC requests that the Administrator reverse the Board's decision with respect to the methodology for calculating the 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.

CM submitted comments that recommend the Administrator to reverse the Board's decision (apart from its findings on properly reopening the original VDA approval and its findings on the APA and Allina claims) and uphold the MAC's determination. CM stated that the Provider improperly argued that the reopening did not comply with the regulations stated in 42 C.F.R. § 405.1885(c) and, therefore, should be deemed invalid/void as well as the ensuing revised VDA calculation. The provisions of 42 C.F.R. § 405.1885(a) give the MAC 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). Thus, 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.

CM disagrees 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. CM referred the Administrator to the government's brief in *Stephens County Hosp. v. Becerra*, No. 19-cv-3020 (DLF), 2021 WL 4502068 (Sept. 30, 2021) and in *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019), along with the decisions in that case, in *St. Anthony Regional Hospital v. Azar*, 294 F.Supp.3d 768 (N.D. Iowa 2018), and in *Trinity Regional Medical Center v. Azar*, No. 17-3029, 2018 WL 4295290 (N.D. Iowa Sept. 10, 2018) (district court decision), 2018 WL 1558451 (N.D. Iowa Mar. 19, 2018) (magistrate decision), for a comprehensive discussion of their position on the issues presented in this case.

CM also noted that the Provider pointed to *Azar v. Allina Health Svcs*[1] ("*Allina*") in stating that CMS' VDA methodology runs afoul of notice and comment rulemaking requirements of the Administrative Procedures Act ("APA) and that CMS unlawfully changed regulations. CM asserts, with respect to *Allina* and 42 U.S.C. §1395hh(a), 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 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).

CM stated that there is 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 section 1871 of the Social Security Act required the VDA calculation methodology to be established through notice and comment rulemaking, no rule promulgated pursuant to those procedures supports the Board's proportional VDA calculation methodology or the Provider's methodology to be applied to the period at issue in this appeal.

The Provider submitted comments stating that the Board's decision should be affirmed. The Provider stated that the facts of this case differ from the Medicare 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 stated that the CMS Administrator review is unnecessary, however, alternatively, if review must occur, the CMS Administrator should modify the PRRB's decision to restore the original VDA approval of $478,324 for FY 2011. The Provider stated that the CMS Administrator must (as the PRRB did) reject the MAC's revised VDA methodology as it failed to "fully compensate" the Provider as required by the applicable law. If the CMS Administrator declines to reinstate the original VDA approval, it should affirm the PRRB's determination that the Provider is entitled to a VDA payment. The Administrator should affirm the PRRB's determination that the

[1] 139 S. Ct. 1804 (2019).

MAC should reduce DRG payments by the same fixed portion percentage used by the MAC to reduce Inpatient Operating Costs. Again, there is no dispute that MS-DRG payments contain a component designed to reimburse a Provider for its variable costs. Because the MAC's Revised VDA Methodology uses "variable" cost reimbursement in an attempt to satisfy "fixed" cost payments, the Provider has not truly been reimbursed for its fixed costs. It has been shortchanged. In sum, 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 Provider is a non-profit acute care hospital located in Gouverneur, New York and was designated as a sole community hospital ("SCH") during the fiscal year at issue. In order to compensate it for a decrease in inpatient discharges, the Provider requested a VDA payment of $474,917 for FY 2011. On November 21, 2013, the MAC calculated the Provider's FY 2011 VDA payment to be $478,324. Subsequently, on February 5, 2016, the MAC notified the Provider that it was reopening the original VDA determination based on direction from the CMS. By letter dated July 22, 2016, the MAC issued the revised VDA determination to revise the VDA payment to $0 and to recoup the original payment of $478,324.

As a preliminary matter, the Provider argued that the reopening did not comply with the regulations stated in 42 C.F.R. § 405.1885(c) and, therefore, the reopening should be deemed invalid, thereby invalidating the ensuing revised VDA calculation. However, as noted by CM and the Board, the provisions of 42 C.F.R. § 405.1885(a) give the MAC 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). Thus, 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.

With respect to the merits of the dispute, 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 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
> (C) The length of time the hospital has experienced a decrease in utilization.[2]

[2] 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)

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."[3] Specifically, §2810.1provides guidance to assist MACs in the calculation of VDAs for sole community hospitals (SCHs). In this regard, § 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 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.)

In addition, in determining core staffing, § 2810.1(C)(6)(a)[4] states that:

> 6. Core Staff and Services.

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(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).

[3] *See* CMS Pub. 15-1, Foreword.
[4] Rev. 479.

> 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 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 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[5], it was noted:

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

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

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[5] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).

> As we have noted in Section 2810.1 of the Provider Reimbursement Manual, Part 1 (PRM–1) and in adjudications rendered by the PRRB and the CMS Administrator, under the current methodology, the MAC determines a volume decrease adjustment amount not to exceed a cap calculated as the difference between the lesser of (1) the hospital's current year's Medicare inpatient operating costs or (2) its prior year's Medicare inpatient operating costs multiplied by the appropriate IPPS update factor, and the hospital's total MS–DRG revenue for inpatient operating costs (including outlier payments, DSH payments, and IME payments). In determining the volume decrease adjustment amount, the MAC considers the individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies; the hospital's fixed costs (including whether any semi-fixed costs are to be considered fixed) other than those costs paid on a reasonable cost basis; and the length of time the hospital has experienced a decrease in utilization.[6]

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[7] 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."[8] 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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[6] 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).

[7] *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).

[8] 82 Fed. Reg. at 38,180.

> 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.[9]

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.[10]

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

[9] *Id.*
[10] *Id.*

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.[11]

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.[12]

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.[13] 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

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

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

[13] 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")."

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.[14]

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 finds that the Board properly rejected the Provider's challenge to the MAC's reopening of the original VDA determination and properly found that *Allina* is inapplicable. In addition, the Administrator finds that the Board properly determined the variable costs to be removed (challenged by the Provider) and the MAC's methodology for the computation of the fixed costs and, finally, the calculated fixed cost percentage used to determine the fixed Medicare inpatient costs. 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 decrease adjustment but not variable costs.

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

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| 2010 Medicare Inpatient Operating Costs | $2,609,149[15] |
| Multiplied by the 2011 IPPS update factor | 1.0235[16] |
| 2011 Updated Costs (max allowed) | $2,670,464 |

[14] *Unity* at 578.
[15] Stipulations at ¶ 21 and Exhibits P-5 at 5, C-3 at 1.
[16] *Id.*

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| 2011 Medicare Inpatient Operating Costs | $2,955,293[17] |
| Lower of 2010 Updated Costs or 2011 Costs | $2,670,464 |
| Less 2011 IPPS payment | $2,493,343[18] |
| 2011 Payment CAP | $ 177,121 |

Step 2: Calculation of VDA

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| 2011 Medicare Inpatient Costs- fixed portion | $2,631,393[19] |
| Less Excess Staffing | 0[20] |
| Less 2011 IPPS payment – fixed portion (89.04 percent) | $2,220,073[21] |
| Payment adjustment amount (subject to CAP) | $411,320 |

Since the payment adjustment amount of $411,320 is more than the Cap of $177,121, the Board concluded that the Provider's total VDA payment for FY 2011 should be $177,121.

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

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|---|---|
| Provider's FY 2011 operating costs | $2,955,293[22] |
| Provider's fixed costs | $2,631,393[23] |
| Provider's DRG payments | $2,493,343[24] |
| VDA Payment Amount (subject to the cap) | $138,050 |

The Provider's VDA payment is equal to the difference between its fixed and semi-fixed costs and its DRG payment subject to the cap. In this case, after the correction for the use of the FY 2011 fixed costs, instead of the prior year's updated costs, the DRG payment is less than the fixed costs. Therefore, the Provider is eligible for a VDA payment of $138,050.

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[17] *Id.*
[18] *Id*.
[19] The Board found that the current year fixed operating costs is computed by taking the current year operating costs of $2,955,293 x 89.04 percent = $2,631,393. The Board found that the MAC used the incorrect current year operating costs at Exhibit C-3 at 2 to calculate fixed operating costs. The amount of $2,670.464 which is used as the current year operating costs on C-3 page 2 is from the updated 2010 prior year I/P Operating costs set forth at C-3 page 1.
[20] Neither the Medicare Contractor nor the Provider calculated a deduction for excess staffing.
[21] The $2,220,073 is calculated by multiplying $2,493,343 (the FY 2011 SCH payments; see Stipulations at ¶ 21) by 0.8904 (the fixed cost percentage determined by the Medicare Contractor).
[22] See C-3, pages 1-2. (From Worksheet D-1, Pt II, line 53.)
[23] *Id*. The fixed operating costs are multiplied by .8904. The MAC carried the percentage to .890420904.
[24] *Id*. (From Worksheet E Part A, line 49.)

The Administrator reverses the Board's decision on the calculation of the VDA using a proportional method. 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 section 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.

Accordingly, the Administrator finds that the MAC properly determined that the Provider had been fully compensated for its fixed costs and denied the Provider's additional payment request for FY 2011.

## 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: May 13, 2022

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