CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Cary Medical Center	**Cost Reporting Period Ending: December 31, 2009**
Provider,	
vs.	
National Government Services, Inc.	**Review of: PRRB Dec. No. 2023-D4 Dated: December 21, 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 U.S.C. § 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 Provider is entitled to a Volume Decrease Adjustment (VDA) for cost report period ending December 31, 2009 (FY 2009).

The Board found that the MAC properly reopened the Provider's original VDA approval for FY 2009, however, the Board found that the MAC improperly calculated that the revised VDA payment for the Provider for FY 2009 was $0. Therefore, the Board found that the Provider should receive a VDA payment of $303,115 for FY 2009.

SUMMARY OF COMMENTS

The MAC submitted comments requesting Administrator reverse the Board's decision with respect to the Board's suggested methodology for calculating Provider's VDA, which the MAC states is not supported by statute, regulation or case law. The MAC stated that the Administrator has repeatedly advised the Board regarding the proper methodology for performing a VDA calculation. The MAC asserted that it utilized the Administrator's methodology, which has been upheld by the Eighth Circuit Court of Appeals in *Unity Healthcare v. Azar*, 918 F.3d 571578-79 (8th Cir. 2019); the only circuit court to address this issue. In the *Unity* decision, the Eight Circuit found that the Administrator's methodology (compares a Provider's fixed costs to total Medicare payments and disregards variable costs) has been weighed, measured and found to be statutorily appropriate. The Board's "fixed cost methodology," is not supported by any source, requires modifications to existing law to survive a statutory challenge, and those modifications are prospective only and not relevant to the fiscal year at issue. Finally, the Supreme Court denied a Provider's petition for certiorari in *Unity HealthCare*, 140 S. Ct. 523 (2019).

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

CM also noted 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.[1] 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.[2] 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.[3]

Addressing the Provider's contention that CMS violated 42 U.S.C. § 1395hh(a)(2) and *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019), requiring notice and comment rulemaking, in regulation and preamble how the VDA is to be calculated, CM stated that the agency satisfied that obligation by utilizing notice and comment rulemaking to promulgate, revise, and clarify the implementing regulation.[4] CM also stated that there is no rule promulgated pursuant to notice and comment rulemaking that 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.

CM also noted that MAC has the authority to reopen a determination under the regulations at 42 C.F.R. § 405.1885(a), and that the Board was correct in concluding that the MAC reopening was authorized since its notice of intent to reopen was within 3 years of its original VDA determination. CM stated that in accordance with the Social Security Act at § 1885(d)(5)(D)(ii) and 42 C.F.R. § 412.92(e), the MAC was authorized to revise the Provider's VDA payment to remove variable expenses from the VDA calculation, subject to the limitations of 42 C.F.R. § 405.1885(b)(1).

The Provider submitted comments requesting that the Administrator affirm the Board's decision. The Provider agreed with the Board's decision that the MAC improperly calculated the Provider's VDA

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[1] *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).

[2] *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).

[3] *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).

[4] CM Comments at 2.

payment, for reasons set forth in the Board's final decision. The Provider argued that the MACs reopening was improper. However, the Board did not agree with the Provider's arguments regarding the MAC's authority to reopen a determination.

Finally, the Provider argued that CMS "revised" approval methodology violates the notice and comment rulemaking requirements of the Administrative Procedure Act (APA), the Medicare program at 42 U.S.C. § 1395hh(a), and *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2020) (Allina). Further, the Provider argued that the Provider Reimbursement Review Manual (PRM) at 15-2810.1 details how the MAC is to determine the VDA payment. The Board did not agree with the Provider's arguments relating to the APA, the Medicare Program at 42 U.S.C. § 1395hh(a) or the Provider's arguments regarding the applicability of PRM 15-2810.1 (The Board notes that the examples at PRM 15-2801 relate to the cap and not the actual VDA calculation).[5]

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 Caribou, Maine. The Provider was designated as a Medicare Dependent Hospital (MDH) during the fiscal year at issue.[6] The Medicare administrative contractor[7] assigned to the Provider for this appeal was National Government Services, Inc. ("Medicare Contractor" or "MAC"). On June 29, 2014, the Provider requested an original VDA payment of $351,482 for FY 2009.[8] On October 9, 2015, the MAC calculated the Provider's FY 2009 VDA payment to be $351,482.[9] The MAC notified the Provider on January 15, 2016, that it was reopening the original VDA approval based on direction from the Center for Medicare and Medicaid Services (CMS).[10] By letter dated August 5, 2016, the Medicare Contractor issued a Revised VDA in the amount of $0.[11] As a result of the revised VDA, the Provider was required to repay $351,482.[12]

The Administrator notes the procedural difference in this case varies from other VDA cases, regarding the MAC's reopening of the original VDA adjustment amount. However, the Administrator agrees with the Board's finding that the MAC had the authority to reopen and revise the VDA determination.[13] The Board properly pointed to the MAC's authority under 42 C.F.R. 405.1885(a) to revise a final determination. Additionally, the Board was also correct to find that a MAC's historical method of calculations does not create CMS policy or violate the APA. The Administrator finds that *Allina* is not invoked as the MAC's revised payment calculation methodology is the result of the application of the statutory language and the properly promulgated regulation.

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[5] *Unity HealthCare v. Azar*, 918 F3d 571, 578-79 (8th Cir. 2019); Board Decision at 6.
[6] Stipulations of the Parties (Stipulations) at ¶1.
[7] The term "Medicare Contractor" historically refers to both Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MAC's), as CMS' payment and audit functions under the Medicare program were historically contracted first, to organizations called FIs, and now these functions are contracted with organizations called MAC's.
[8] Stipulations at ¶7; Ex. P-2 at 4.
[9] *Id*. at ¶11.
[10] *Id*. at ¶12.
[11] *Id*. at ¶13.
[12] *Id*. at ¶14.
[13] See Board's Decision at 2, 8-9.

Section 1886(d)(5)(G) of the Social Security Act, (Act), defines an MDH 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. in effect on September 30, 1997.

Section 1886(d)(5)(G) of the Act authorizes the Secretary to adjust the payment for 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).[14] 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 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, subsection (d)(3) of the controlling regulation 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…**
> (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.[15] (Emphasis added.)

[14] 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).
[15] 42 C.F.R. § 412.108(d)(3).

When CMS promulgated 42 C.F.R. § 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:

> [T]he Act also provides that a hospital meeting the MDH criteria is entitled to an additional payment adjustment if, due to circumstances beyond is control, its total number of discharges in a cost reporting period has decreased by more than 5 percent compared to the number of discharges in its preceding cover reporting period. Since this adjustment for a 5 percent reduction in discharges is identical to the criteria and adjustment currently provided for SCHs, we are incorporating the same criteria and adjustments into the regulation for MDHs.[16]

Once an MDH 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 the 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 thehospital'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 reasonablecost 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; . . .[17]

In addition to the controlling regulation, and as CMS noted in the preamble to its 2007 IPPS Final Rule, [18]CMS also provides interpretive guidance in the Provider Reimbursement Manual, (PRM 15-1).[19] The Manual is intended to ensure that Medicare reimbursement standards "are uniformly applied nationally without

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[16] 55 Fed. Reg 15,150, 15,155 (Apr. 20, 1999). *See also* 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006).

[17] As reflected in the foregoing regulation and in the notice and comment rulemaking history, and as noted by CM, 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).

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

[19] Note that the PRM states that an MDH, as defined under 42 CFR 412.108, may also qualify for a VDA in accordance with 42 CFR 412.108(d). The VDA payment amount is determined in accordance with the methodology set forth in 42 CFR 412.92(e)(3), and as described in PRM 15-1 § 2810.1 (A) – (G).

regard to where covered services are furnished." Specifically, §2810.1 provides guidance to assist MACs in the calculation of VDAs for [MDHs]. 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 [MDH] 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 foodand laundry costs.
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> In a hospital setting, however, many costs are neither perfectly fixed nor perfectlyvariable, 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)[20] of the PRM states that:

> 1. General Information. -- The request must include the requesting hospital's name, address, provider number, and date of classification as an SCH.
> 2. Discharge Data. -- The SCH must submit data on the number of discharges in the cost reporting period for which the payment adjustment is being requested and the number of discharges in the cost reporting period immediately preceding the period in question. If either the preceding cost reporting period or the period in which the decline occurred is not 12 months in duration, the hospital must annualize discharges in the short cost reporting period.
> 3. Circumstances. -- The hospital's request must include documentation outlining the circumstances that resulted in the decrease in discharges. This must include a narrative description of the occurrence, date of its onset, and how it affected the number of discharges.
> 4. Cost Data. -- The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding pass-through costs, exceeds DRG payments, including outlier payments. No adjustment is allowed if DRG payments exceeded program inpatient operating cost.
> 5. Semi fixed Costs. -- The request must include a narrative description of those actions

[20] Rev. 479.

> taken by the hospital to reduce semi fixed costs.
> 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…

In the discussion included in the preamble to the August 18, 2006 Final Rule,[21] it was noted:

> The process for determining the amount of the volume decrease adjustment can be found in section 2810.1 of the Provider Reimbursement Manual. Fiscal intermediaries are responsible for establishing whether an SCH or MDH is eligiblefor 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 percentor 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 fixed) other than those costs paid on a reasonable cost basis; and the length of time the hospital has experienced a decrease in utilization.[22]

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[23] and that in those adjudications, the PRRB and the CMS Administrator have

[21] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).
[22] 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).
[23] *Greenwood County Hospital Eureka, Kansas, v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Kansas*, 2006 WL 3050893 (PRRB August 29, 2006); *Unity Healthcare Muscatine, Iowa v. Blue*

recognized that: "(1) The volume decrease adjustment is intended to compensate qualifying MDHs for their fixed costs only, and that variable costs are to be excluded from the adjustment; and (2) an MDH's volume decrease adjustment should be reduced to reflect the compensation of fixed costs that has already been made through MS–DRG payments."[24] CMS explained that it was making the change in how the VDA is calculated because:

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

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

> We continue to believe that our current approach in calculating volume decrease adjustments is reasonable and consistent with the statute. The relevant statutory provisions, at sections 1886(d)(5)(D)(ii) and 1886(d)(5)(G)(iii) of the Act, are silent about and thus delegate to the Secretary the responsibility of determining which costs are to be deemed ''fixed'' and what level of adjustment to IPPS payments may be necessary to ensure that

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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); *See also* CM Comments at 1-2.

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

[25] *Id.*

> 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 effort, make an effort in some way, to ascertain whether a portion of MS–DRG payments can be allocated or attributed to fixed costs in order to fulfill the statutory mandate to ''fully compensate'' a qualifying SCH for its fixed costs.[26]

CMS revised the regulations at 42 C.F.R. § 412.92(e)(3) to reflect the change in the MAC's calculation of the volume decrease adjustment that would apply prospectively to cost reporting periods beginning on or after October 1, 2017, and to reflect that the language requiring that the volume decrease adjustment amount not exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs would only apply to cost reporting periods beginning before October 1, 2017, but not to subsequent cost reporting periods. While some commenters suggested that the new method should be applied retroactively, CMS noted:

> We also do not agree that we should apply our proposed methodology retroactively.The IPPS is a prospective system and, absent legislation, a judicial decision, or other compelling considerations to the contrary, we generally make changes to IPPS regulations effective prospectively based on the date of discharge or the startof a cost reporting period within a certain Federal fiscal year. We believe following our usual approach and applying the new methodology for cost reporting periods beginning on or after October 1, 2017 would allow for the most equitable application of this methodology among all IPPS providers seeking to qualify for volume decrease adjustments. For these reasons, we are finalizing that our proposed changes to the volume decrease adjustment methodology will apply prospectively for cost reporting periods beginning on or after October 1, 2017.[27]

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,

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

> the Secretary's decision reasonably complied with the mandate to provide full compensation.[28]

The Eighth Circuit found that, it was not a sufficient reason to find that the Secretary's prior interpretation was arbitrary or capricious, just because CMS prospectively adopted a new interpretation.[29] The Eighth Circuit pointed out that the main argument that the Secretary's prior interpretation was arbitrary and capricious relied on the premise that the PRM's sample calculations conflict with the Secretary's interpretation and that the Secretary is bound by the PRM. As the Eighth Circuit pointed out:

> 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.[30]

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 VDA. 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.

Regarding the methodology and proper calculation of the Provider's payment adjustment, the Administrator finds that the Board improperly calculated the Provider's adjustment.[31] 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:

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

[29] The Eighth Circuit cited, "An initial agency interpretation is not instantly carved in stone. On the contrary, the agency . . . must consider varying interpretations and the wisdom of its policy on a continuing basis." *Nat'l Cable & Telecommunications Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 981 (2005) (quoting *Chevron*, 467 U.S. at 863–64); *see also LaRouche v. FEC*, 28 F.3d 137, 141 (D.C. Cir. 1994) ("The mere fact that regulations were modified, without more, is simply not enough to demonstrate that the prior regulations were invalid."). The Court also noted, "A statute can have more than one reasonable interpretation, as in this case. *See Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735, 744–45 (1996) (stating that "the question before us is not whether [an agency interpretation] represents the best interpretation of the statute, but whether it represents a reasonable one")."

[30] *Unity* at 578.

[31] The Administrator affirms the portion of the Board's decision that finds that the MAC had the authority to reopen and revise the VDA determination. *See* Board Decision at 6.

Step1: Calculation of the CAP

2008 Medicare Inpatient Operating Costs	$8,844,846[32]
Multiplied by the 2006 IPPS update factor	1.036
2008 Updated Costs (max allowed)	$9,163,260
2009 Medicare Inpatient Operating Costs	$7,306,282[33]
Lower of 2008 Updated Costs or 2009 Costs	$7,306,282
Less 2009 IPPS payment	$6,954,800[34]
2009 Payment CAP	**$351,482**

Step 2: Calculation of VDA

2009 Medicare Inpatient Fixed Operating Costs	$6,300,887[35]
Less 2009 IPPS payment – fixed portion (86.24 percent)[36]	$5,997,772[37]
Payment adjustment amount (subject to CAP)	**$303,115**

Since the payment adjustment amount of $303,115 is less than the CAP of $351,482, the Board determined that Cary's VDA payment for FY 2009 should be $303,115. The revised FY 2009 VDA for the Provider was $0,[38] the Board determined that the Provider was owed an additional payment of $303,115.

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

Calculation of the VDA

FY 2009 I/P Operating Costs	$7,306,282[39]
Provider's Current Year (2009) Operating Fixed Costs	$6,300,887[40]
Less Provider's DRG/MDH payments	$6,954,800
Payment Adjustment Amount (subject to cap)	**$0**

Therefore, the Administrator reverses the Board's decision on the calculation of the VDA using a proportional method. The revised VDA payment of $0 was calculated correctly. Even of the statute

[32] Stipulations at ¶21.
[33] *Id*.
[34] *Id*.
[35] The 2009 Medicare Operating Costs of $7,306,282 x Fixed Cost Percentage of 0.862393119 (the rounded percentage) = $6,300,887.
[36] Stipulation at ¶21. The full number is 0.862393119, rounded to 0.8624. The Board's Decision at note 83 rounded the Fixed Cost Percentage to 0.8554.
[37] Calculation = $6,954,800 x 0.862393119 = $5,997,772.
[38] Provider's FPP at 11; MAC's FPP at 6.
[39] Revised VDA Calculation. Ex. C-7 at 8-9; Ex. P-5 at 5-6.
[40] The $6,300,887 reported on Ex. C-7 at 9 is derived by multiplying the FY 2009 I/P Operating Costs of $7,306,282 by 0.862393119 (the unrounded percentage).

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 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, no rule promulgated pursuant to those procedures supports the proportional VDA calculation methodology to be applied to the period at issue in this appeal.

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: February 3, 2023

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