CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Heartland Regional Medical Center (AKA Marion General Hospital/ Marion Memorial)	**Cost Reporting Period Ending:**
Provider	**April 30, 2011**
vs.	
WPS Government Health Administrators	**Review of: PRRB Dec. No. 2022-D4**
Medicare Contractor	**Dated: January 12, 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). 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. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Marion Memorial Hospital[1] ("Marion" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending April 30, 2011 ("FY 2011").

The Board found that the Medicare Contractor improperly calculated the Provider's VDA payment for FY 2011 and that Marion should receive a VDA payment in the amount of $222,702 for FY 2011.

[1] *See* Board Decision, footnote 3, stating "that when the appeal was filed, it was filed as Marion General Hospital. The underlying documents, such as the VDA request and determination all state Marion General. At some point, it appears that the hospital name changed to Heartland Regional Medical Center. However, as the appeal was filed as Marion Memorial, and it was Marion Memorial in the year under dispute, the Board will refer to the hospital as Marion Memorial in this decision."

SUMMARY OF COMMENTS

The MAC asks 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 MAC pointed out that 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 requesting that the Administrator reverse the Board's decision (apart from its findings on the removal of the variable costs via a cost report adjustment) and affirm that the MAC used the proper methodology to calculate the VDA for the Provider.

CM stated that it disagreed with the Board that the MAC improperly calculated the VDA payment for the Provider for the same reasons set forth in the Department of Health and Human Service's Eighth Circuit Brief in *Unity HealthCare v. Azar*[2], two briefs in *Stephens County Hosp. v. Becerra*[3], *and* opening brief in *Lake Region Healthcare Corporation v. Becerra*[4] on the same issue. CM further referenced the August 2017 Final Rule[5] in support of their position, and additionally cited to other decisions in which the Administrator upheld the current approach to calculating the VDA.[6]

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. *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

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[2] 918 F.3d 571, 579 (8th Cir. 2019).
[3] No. 19-cv-3020 (DLF), 2021 WL 4502068 (Sept. 30, 2021).
[4] No. 20-3452 (KBJ) (D.D.C.).
[5] 82 Fed. Reg. 37,990, 38,179-83 (Aug. 14, 2017).
[6] CM cited to the Administrator's decisions in *Greenwood County Hospital* , PRRB Dec. No. 2006-D43; *Unity Healthcare*, PRRB Dec. No. 2014-D15; *Lakes Regional Healthcare,* PRRB Dec. No. 2014-D16; *Fairbanks Memorial Hospital, PRRB Dec. No.* 2015-D11; *St. Anthony Regional Hospital,* PRRB Dec. No. 2016-D16; and *Trinity Regional Medical Center*, PRRB Dec. No. 2017-D1.

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.

CM also noted that while the Provider disagreed with the MAC's methodology of computing the variable costs, the Board used the MAC's calculation of fixed/semi fixed costs, indicating that that the Board agreed that an A-8 worksheet adjustment leads to an accurate calculation of Medicare inpatient costs, excluding variable costs.

BACKGROUND AND DISCUSSION

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

In this case, the Provider, located in Marion, Illinois, was designated as a Medicare Dependent Hospital ("MDH") during the fiscal year at issue. The MAC assigned to Marion for this appeal is Wisconsin Physicians Service. The Provider requested a VDA in the amount of $282,858 on February 9, 2015. On January 19, 2016, the MAC issued a denial of the VDA because it concluded that Marion's inpatient prospective payment system ("IPPS") payments had exceeded Marion's allowable inpatient fixed and semi-fixed costs. Marion filed a Request for Reconsideration on March 17, 2016. The Medicare Contractor denied the Request for Reconsideration on May 9, 2016. The Board received Marion's appeal request on June 24, 2016. Marion timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the IPPS. The IPPS provides Medicare payment for hospital inpatient operating

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

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

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

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

The regulations implementing this statutory adjustment are located at 42 C.F.R. § 412.108(d) (2011)[7]. 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

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

> (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…**
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> (i) In determining the adjustment amount, the intermediary considers—
> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
> (C) The length of time the hospital has experienced a decrease in utilization.[8] (Emphasis added.)

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

> [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

[8] 42 C.F.R. § 412.108(d)(3) (2011). 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).

> 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.[9]

In addition to the controlling regulation, CMS also provided interpretive guidelines in the Provider Reimbursement Manual, CMS Pub. No. 15-1 (PRM 15-1). PRM 15-1 is intended to ensure that Medicare reimbursement standards "are uniformly applied nationally without regard to where covered services are furnished".[10] While PRM 15-1 does not specifically address MDH low volume adjustments, it does address SCH low volume adjustments at PRM 15-1 § 2810.1. As the criteria for SCH and MDH low volume adjustments are identical, the PRM 15-1 guidance on SCH low volume adjustment is applicable to MDH low volume adjustments. In this regard, § 2810.1(B) states the following regarding the amount of a low volume adjustment:

> B. Amount of Payment Adjustment. Additional payment is made to an eligible SCH for **fixed costs** it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, **not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.**
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> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.
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> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.
>
> In evaluating semi-fixed costs, the MAC considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, 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 semi-fixed costs may not be included in determining the amount of the payment adjustment. (Emphasis added.)

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[9] 55 Fed. Reg 15,150, 15,155 (Apr. 20, 1999). *See also* 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006).
[10] *See* CMS Pub. 15-1, Foreword.

In the discussion included in the preamble to the August 18, 2006 final rule[11], it was noted:

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

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

> As we have noted in Section 2810.1 of the Provider Reimbursement Manual, Part 1 (PRM–1) and in adjudications rendered by the PRRB and the CMS Administrator, under the current methodology, the MAC determines a volume decrease adjustment amount not to exceed a cap calculated as the difference between the lesser of (1) the hospital's current year's Medicare inpatient operating costs or (2) its prior year's Medicare inpatient operating costs multiplied by the appropriate IPPS update factor, and the hospital's total MS–DRG revenue for inpatient operating costs (including outlier payments, DSH payments, and IME payments). In determining the volume decrease adjustment amount, the MAC considers the individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies; the hospital's fixed costs (including whether any semi-fixed costs are to be considered fixed) other than those costs paid on a reasonable cost basis; and the length of time the hospital has experienced a decrease in utilization.[12]

[11] 71 Fed. Reg., 47,870, 48,056 (Aug. 18, 2006).
[12] 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[13] 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."[14] 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

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[13] *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).

[14] 82 Fed. Reg. at 38,180.

> 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.[15]

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.[16]

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:

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[15] *Id.*
[16] *Id.*

> 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.[17]

Recently, the Eighth Circuit Court of Appeals upheld the methodology used by CMS, noting:

> The Secretary's interpretation is a reasonable interpretation of the plain language of the statute. The precise language at issue says that the VDA should be given "as may be necessary to fully compensate" a qualified hospital "for the fixed costs it incurs . . . in providing inpatient hospital services." 42 U.S.C. § 1395ww(d)(5)(D)(ii). The Secretary's interpretation ensures that the total amount of a hospital's fixed costs in a given cost year are paid out through a combination of DRG payments and the VDA. As the Secretary points out, the prospective nature of DRG payments makes it difficult to determine how best to allocate those payments against the actual fixed costs a hospital incurs. Given the lack of guidance in the statute and the substantial deference we afford to the agency in this case, the Secretary's decision reasonably complied with the mandate to provide full compensation.[18]

The Eighth Circuit found that just because CMS prospectively adopted a new interpretation, that was not a sufficient reason to find that the Secretary's prior interpretation was arbitrary or capricious.[19] The Eighth Circuit pointed out that the main

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

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

[19] 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

argument that the Secretary's prior interpretation was arbitrary and capricious relied on the premise that the PRM's sample calculations conflict with the Secretary's interpretation and that the Secretary is bound by the PRM. As the Eighth Circuit pointed out, though:

> However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, the Board found "that the examples are intended to demonstrate how to calculate the adjustment limit as opposed to determining which costs should be included in the adjustment." *See Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n*, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than "equal to," when describing the formula. We conclude that the Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation.[20]

The core dispute in this case centers on the application of the statutes to the proper classification and treatment of costs and the proper calculation of the amount for the low volume adjustment. The Administrator's examination of the governing statutes and implementing regulations and guidance clearly recognize three categories of costs, i.e., fixed, semi-fixed and variable. The guidance only considers fixed and semi-fixed costs within the calculation of the volume adjustment but not variable costs.

The MAC's exclusion of the Provider's variable costs was proper and consistent with the regulation and guidance and intent of the adjustment. The treatment of variable cost within the calculation of the volume decrease adjustment is well established. The plain language of the relevant statute and regulation, Section 1886(d)(5)(G)(iii) and 42 CFR 412.108(d), make it clear that the VDA is intended to compensate qualifying hospitals for their fixed costs, not their variable costs. This position is also supported by past decisions, such as *Greenwood County*, PRRB Dec. No. 2006-D43, where the Board correctly eliminated variable costs from the calculation.

Regarding the methodology and proper calculation of the Provider's payment adjustment, the Administrator finds that the Board improperly calculated the Provider's adjustment. The VDA calculation methodology used by the Board is in direct contradiction to the

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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")."

[20] *Unity* at 578.

statute and CMS' regulations and guidance. The Board found the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2010 Medicare Inpatient Operating Costs	$22,253,384[21]
Multiplied by the 2010 IPPS update factor	1.021[22]
2010 Updated Costs (max allowed)	$22,720,705
2011 Medicare Inpatient Operating Costs	$17,920,042[23]
Lower of 2010 Updated Costs or 2011 Costs	$17,920,042
Less 2011 IPPS payment	$17,637,184[24]
2011 Payment CAP	$ 282,858

Step 2: Calculation of VDA

2011 Medicare Inpatient Fixed Operating Costs	$14,108,971[25]
Less 2011 IPPS payment – fixed portion (78.73 percent[26])	$13,886,269[27]
Payment adjustment amount (subject to CAP)	$ 222,702

Since the payment adjustment amount of $222,702 is less than the Cap of $282,858, the Board determined that the Provider's VDA payment for FY 2011 should be $222,702.

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

Provider's FY 2011 operating costs	$17,920,042[28]
Provider's fixed costs	$14,108,971[29]
Provider's DRG payments	$17,637,184[30]

[21] Stipulations at ¶ 10.
[22] *Id*.
[23] *Id*.
[24] *Id*.
[25] *Id*.
[26] *Id*. (Calculation = Line H/Line E = 14,108,971/17,920,042 = 0.78732913, rounded to 0.7873).
[27] *Id*. (Calculation = 17,637,184*0.78732913 = $13,886,268.73, rounded to $13,886,269).
[28] The amount reported in Stipulations at ¶9.
[29] *Id*.
[30] Exhibit P-2 at 36, Worksheet E, Part A, Line 49.

VDA Payment Amount $(3,528,213)[31]

Thus, the Provider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG payment. In this case, the DRG payment is more than the fixed costs. Therefore, the Provider is not eligible for a VDA Payment.

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.

[31] When the resulting amount is negative, no VDA payment is made to the provider.

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: March 11, 2022

/s/

Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services