

CENTERS FOR MEDICARE AND MEDICAID SERVICES

In the case of:

**Sandhills Regional Medical Center
Provider,**

vs.

**WPS Government Health Administrators
Medicare Contractor.**

Claim for:

**Cost Reporting Period Ending:
September 30, 2013**

Review of:

PRRB Dec. No. 2024-D06

Dated: January 26, 2024

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. § 1395oo(f)). The Medicare Administrative Contractor (MAC) submitted comments, requesting that the Administrator reverse the Board’s decision with respect to its methodology for the VDA calculation and uphold the determination and methodology used by the MAC. 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 (apart from findings on the removal of variable costs). Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Medicare Administrative Contractor (MAC), properly calculated the volume decrease adjustment (VDA) owed to the Provider for the significant decrease in inpatient discharges that occurred in its cost reporting period ending September 30, 2013 (FY 2013).¹

The Board held that the MAC improperly calculated the Provider’s VDA payment for FY 2013 and found that the Provider should receive a VDA payment in the amount of \$350,661.

SUMMARY OF COMMENTS

The MAC commented, requesting 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 MAC stated that the Board disregarded multiple decisions by the

¹ The parties stipulated that Sandhills experienced a qualifying decrease in inpatient discharges greater than 5 percent from FY 2012 to FY 2013 due to circumstances beyond its control and was therefore eligible to have a VDA calculation performed for FY 2013. *See* Stipulations at ¶5; Board Decision at 3.

Administrator², the recent Eighth Circuit decision in *Unity HealthCare v. Azar*³, and the recent decision of the D.C. District Court in *Stephens County Hospital v. Becerra*. The MAC stated that the Administrator’s methodology, which was upheld in *Unity*, equates the Provider’s VDA to the difference between its fixed and semi-fixed costs and its DRG payment (subject to the ceiling). That methodology compares fixed costs to total Medicare payments and disregards variable costs. Instead, the Board compared the estimated portion of the DRG payment related to fixed costs to the hospital’s fixed costs to generate a “fixed cost percentage” as explained in *Fairbanks Mem’l Hosp. v. Wisconsin Physician Serv.*,⁴ despite the fact that the Board lacked the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment.⁵ As such, the MAC asked that the Administrator reverse the Board’s decision and find that the MAC utilized the proper methodology, which has been used repeatedly by the Administrator and upheld by the Eighth Circuit.

CM submitted comments, recommending that the Administrator reverse the Board’s decision (apart from its findings on the removal of variable costs), 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 multiple court decisions involving the same issue. CM referenced *Lake Region Healthcare Corp. v. Becerra*,⁶ *Stephens County Hosp. v. Becerra*,⁷ *Unity HealthCare v. Azar*,⁸ *St. Anthony Regional Hospital v. Azar*,⁹ and *Trinity Regional Medical Center v. Azar*.¹⁰ CM further referenced regulatory language in the August 2017 Final Rule¹¹ in support of their position.

BACKGROUND AND DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board’s decision. All comments were received timely and are included in the record and have been considered.

The Provider is a Medicare Dependent Hospital (MDH) located in Hamlet, North Carolina. The Provider timely requested a VDA payment, which was denied by the MAC via letter. The Medicare Contractor denied the Provider’s request for a VDA payment because it concluded that the Provider’s Medicare fixed and semi-fixed operating costs exceeded its allowable Inpatient Prospective Payment System (IPPS) payments, and thus, the Provider

² The MAC cited to the Administrator’s decisions in *St. Anthony Reg’l Hosp. v. Wisconsin Physician Serv.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016); *Trinity Reg’l Med. Ctr. v. Wisconsin Physician Serv.*, PRRB Dec. No. 2017-D21 (Dec. 15, 2016); *Fairbanks Mem’l Hosp. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2015-D11 (June 9, 2015).

³ 918 F.3d 571 (8th Cir. 2019).

⁴ 2015 WL 5852432, at *5, (CMS Admin. Aug. 5, 2015).

⁵ MAC’s Comments at 3.

⁶ No. 20-cv-03452 (JMC), 2022 WL 9936856 (D.D.C. Oct. 17, 2022)

⁷ No. 19-cv-3020 (DLF), 2021 WL 4502068 (D.D.C. Sept. 30, 2021).

⁸ 918 F.3d 571 (8th Cir. 2019).

⁹ 294 F.Supp.3d 768 (N.D. Iowa 2018).

¹⁰ 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).

¹¹ 82 Fed. Reg. 37,990, 38,179-83 (Aug. 14, 2017).

was not eligible for a VDA.¹² The Provider 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 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) (2008).¹³ 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

¹² Ex. C-1 at 1; C-1 at 2.

¹³The 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.

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 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.¹⁴ (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 its 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.¹⁵

Additionally, in the preamble to the August 18, 2006 Final Rule,¹⁶ CMS referenced further guidance with respect to VDAs 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".¹⁷

¹⁴ 42 C.F.R. § 412.108(d)(3) (2008).

¹⁵ 55 Fed. Reg 15,150, 15,155 (Apr. 20, 1999).

¹⁶ See also 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006).

¹⁷ See CMS Pub. 15-1, Foreword.

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.**

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.

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.)

In the discussion included in the preamble to the August 18, 2006 Final Rule,¹⁸ 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**

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

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.¹⁹

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,²⁰ 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.”²¹ 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

¹⁹ 82 Fed. Reg. 37,990, 38,179 (Aug. 14, 2017).

²⁰ *Greenwood County Hospital Eureka, Kansas, v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Kansas*, 2006 WL 3050893, (PRRB Aug. 29, 2006); *Unity Healthcare Muscatine, Iowa v. Blue Cross Blue Shield Association/ Wisconsin Physicians Service*, 2014 WL 5450066, (CMS Admin. Sept. 4, 2014); *Lakes Regional Healthcare Spirit Lake, Iowa v. Blue Cross Blue Shield Association/Wisconsin Physicians Service*, 2014 WL 5450078, (CMS Admin. Sept. 4, 2014); *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association*, 2015 WL 5852432, (CMS Admin., Aug. 5, 2015); *St. Anthony Regional Hospital v. Wisconsin Physicians Service*, 2016 WL 774499,2 (CMS Admin. Oct. 3, 2016); and *Trinity Regional Medical Center v. Wisconsin Physician Services*, 2017 WL 2403399, (CMS Admin. Feb. 9, 2017); *Stephens County Hosp. v. Palmetto GBA*, (CMS Admin. July 25, 2019); *Lake Region Healthcare Corp. v. NGS, Inc.* (CMS Admin. July 31, 2020); *Brownwood Regn. Medical Ctr. v. WPS Government Health Administrators* (CMS Admin. April 26, 2021).

²¹ 82 Fed. Reg. at 38,180.

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.

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.²²

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,

²² *Id.*

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.²³

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

We also do not agree that we should apply our proposed methodology retroactively. The IPPS is a prospective system and, absent legislation, a judicial decision, or other compelling considerations to the contrary, we generally make changes to IPPS regulations effective prospectively based on the date of discharge or the start of a cost reporting period within a certain Federal fiscal year. We believe following our usual approach and applying the new methodology for cost reporting periods beginning on or after October 1, 2017 would allow for the most equitable application of this methodology among all IPPS providers seeking to qualify for volume decrease adjustments. For these reasons, we are finalizing that our proposed changes to the volume decrease adjustment methodology will apply prospectively for cost reporting periods beginning on or after October 1, 2017.²⁴

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.²⁵

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

²³ *Id.*

²⁴ *Id.* at 38,182.

²⁵ *Unity HealthCare v. Azar*, 918 F.3d 571, 577 (8th Cir. 2019).

or capricious.²⁶ The Eighth Circuit pointed out that the main argument that the Secretary's prior interpretation was arbitrary and capricious relied on the premise that the PRM's sample calculations conflict with the Secretary's interpretation and that the Secretary is bound by the PRM. As the Eighth Circuit pointed out, though:

However, the examples are not presented in isolation. The same section of the Manual reiterates that the volume-decrease adjustment is "not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." In a decision interpreting § 2810.1(B) immediately following the Secretary's guidance, the Board found "that the examples are intended to demonstrate how to calculate the adjustment limit as opposed to determining which costs should be included in the adjustment." See *Greenwood Cty. Hosp. v. BlueCross BlueShield Ass'n*, No. 2006-D43, 2006 WL 3050893, at *9 n.19 (P.R.R.B. Aug. 29, 2006). That decision was not reviewed by the Secretary and therefore became a final agency action. The agency's conclusion that the examples are meant to display the ceiling for a VDA, rather than its total amount, is a reasonable interpretation of the regulation's use of "not to exceed," rather than "equal to," when describing the formula. We conclude that the Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation.²⁷

The core dispute in this case centers on the application of the statute 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 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 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. The Board correctly pointed out that the MAC's calculation was comparable to the Board's handling in the past using filed and adjusted program costs on Worksheet D-1 and consistent

²⁶ 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 U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 863-64 (1984)); 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")."

²⁷ *Unity* at 578.

with past decisions was reflected in part of the Board's calculations.

Regarding the methodology and proper calculation of the Provider's payment adjustment, (apart from the Board's proper removal of variable costs), 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 stated that, as it did not have the IPPS actuarial data to determine a split between fixed and variable costs related to a DRG payment, it opted to use the MAC's fixed/variable cost percentages as a proxy. In this case, the MAC determined that the Provider's fixed costs (which includes semi-fixed costs) when rounded were 90.14 percent²⁸ of the Provider's Medicare costs for FY 2013. Applying the rationale described above, the Board found the VDA in this case should be calculated as follows:

Step 1: Calculation of the CAP

FY 2012 Medicare Inpatient Operating Costs	\$8,130,912 ²⁹
Multiplied by the 2013 IPPS update factor	1.018 ³⁰
FY 2012 Updated Costs (max allowed)	<u>\$8,277,268</u>
FY 2013 Medicare Inpatient Operating Costs	\$8,370,738 ³¹
Lower of FY 2012 Updated Costs or FY 2013 Costs	\$8,277,268
Less FY 2013 IPPS payment	<u>\$7,926,607³²</u>
FY 2013 Payment CAP	<u>\$350,661</u>

Step 2: Calculation of VDA

FY 2013 Medicare Inpatient Fixed Operating Costs	\$7,545,474 ³³
Less FY 2013 IPPS payments – fixed portion (90.14 percent)	<u>\$7,145,044</u>
Payment adjustment amount (subject to CAP)	<u>\$400,430</u>

Thus, the Board concluded that as the payment adjustment amount of \$400,430 exceeds the cap of \$350,661, the Provider's VDA payment for FY 2013 should be \$350,661.

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:

²⁸ Stipulations at ¶ 10. (Fixed program operating costs of \$7,545,474 divided by Total Program Operating Costs of \$8,370,738 = 0.901410843, rounded to 0.9014). Calculation necessary due to improper Stipulation at ¶ 11, which calculated the Current Year Fixed Program Operating Costs as a percentage of updated Prior Year Total Program Operating Costs, rather than using current year amounts in both the numerator and denominator. Board Decision at 13 n.67.

²⁹ *Id.*

³⁰ Stipulations at ¶¶ 7 and 11 used 1.026 as the IPPS update factor. However, the update factor for FY 2013 is 1.018. See IPPS Final Rule Table 1A. The Board used the update factor in the Final Rule. Board Decision at 12 n.69.

³¹ Stipulations at ¶ 10

³² *Id.*

³³ *Id.*

Calculation of the VDA³⁴

FY 2013 Medicare Inpatient Operating Costs	\$8,370,738
FY 2013 Fixed Costs (.9014 of total operating costs)	\$7,545,474
Total DRG/MDH Payments	<u>\$7,926,607</u>
VDA Payment Amount	(\$381,133)

Thus, the Provider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG/MDH payment. In this case, the Provider was not entitled to a VDA payment, as its DRG/MDH payments exceeded its fixed costs.

Therefore, the Administrator reverses the Board's decision (apart from the adoption of the MAC's exclusion of variable costs). The MAC properly determined that the Provider's DRG/MDH payments exceeded its calculated fixed operating costs, and as a result, no VDA payment was due.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: March 15, 2024

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

³⁴ Stipulations at ¶ 10; Board Decision at 5, n.16-n.19.