CENTERS FOR MEDICARE AND MEDICAID SERVICES

In the case of:	**Claim for:**
Champlain Valley Physicians Hospital **Provider** **vs.** **National Government Services, Inc.** **Medicare Contractor**	**Cost Reporting Period Ending:** **December 31, 2013** **Review of:** **PRRB Dec. No. 2024-D13** **Dated: April 24, 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).[1] The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. The Center for Medicare (CM) and the Medicare Administrative Contractor (MAC) both submitted comments requesting that the Administrator reverses the Board's decision (apart from the removal of variable costs) and affirm that the MAC used the proper methodology to calculate the VDA for the Provider. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether the MAC, properly calculated the volume decrease adjustment (VDA) owed the Champlain Valley Physicians Hospital (Provider) for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2013 (FY 2013).

The Board held that the MAC's calculation of the Provider's VDA payment for FY 2013[2] was incorrect because it was *not* based on CMS' stated policy as delineated in the Provider Reimbursement Manual (PRM) 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preamble to the 2018 Final IPPS Rule.[3]

In making this determination, the Board concluded that the MAC's calculation of the Provider's VDA payment was based on "an otherwise *new* methodology that the Administrator adopted

[1] The Administrator notes that the term PRRB and Board are used interchangeably to reference the same party, the Provider Reimbursement Review Board.
[2] *See*, Provider Reimbursement Review Board (PRRB) Dec. No. 2024-D13 at 2.
[3] *Id.*, at 11 -13. *See also,* 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

through adjudication."[4] The Board rejected the Provider's argument that CMS' VDA calculation methodology violated the notice and comment rulemaking requirements of the Administrative Procedure Act (APA). The Board determined that CMS' methodology was not an improper rule change and was not subject to the Supreme Court's *Alina* decision.[5]

The Board concluded that the MAC was correct in removing variable costs from the inpatient operating costs, however, the comparable portion of the DRG payment related to variable costs should have been removed from the total DRG payment. Based on this determination the Board recalculated the Provider's VDA payment by estimating the fixed portion of the Provider's DRG payment and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs.[6]

Finally, the Board determined that it was not bound by the Eight Circuit decision in *Unity Healthcare v. Azar*, 918 f.3d 571 (8th Cir. 2019).[7] The Board held that the *Unity* decision was "simply adjudicating a dispute regarding the reasonableness of the Administrator's interpretation of the statute and regulations governing VDAs that the Administrator applied in rendering her decision in Unity."[8] As such, the decision in *Unity* "did not create a binding precedent as to the specific VDA calculation methodology that the Board was obligated to follow."[9] Accordingly, the Board determined that the Provider should receive a VDA payment to in the amount of $3,000,364 for FY 2013.[10]

SUMMARY OF COMMENTS

The MAC submitted comments requesting that the Administrator reverse the Board's decision with respect to the VDA calculation and uphold the determination and methodology utilized by the MAC. The MAC noted that the Board disregarded multiple decisions by the Administrator on the ground that those decisions "are not binding precedent as explained by PRM 15-1 § 2927(c)(6)(e)."[11] In addition, the Board decision disregarded the Eighth Circuit decision in *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019),[12] because the Provider is not located in the Eighth Circuit. The Board also disregarded and failed to note the D.C. District Court decision in *Stephens County Hospital v. Becerra*, which affirmed the Administrator's decision overturning a decision substantially similar to the present decision.[13] The MAC contends that the Board's VDA methodology requires modification to existing law and those modifications are prospective only and not relevant to the fiscal period in dispute.

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[4] *Id.*
[5] *Id.*, at 7 - 8. *See also*, 139 S. Ct. at 1808, 1810.
[6] *Id.*, at 14.
[7] *Id.* at 9.
[8] *Id.*
[9] *Id.*
[10] *Id.*, at 15.
[11] *See*, MAC's comments at 1.
[12] *Id.* The Administrator notes that the Eighth Circuit decision in *Unity HealthCare v. Azar*, is the only appellate caselaw on the subject.
[13] *See*, MAC's comment at 2. *See also*, 2021 WL 4502068 (D.D.C. Sept. 30, 2021).

CM submitted comments requesting that the Administrator reverse the Board's decision (apart from its finding on the removal of the variable costs and its finding on the unlawful change in regulations/*Allina* claim) and affirm that the MAC used the proper methodology to calculate the Provider's VDA payment.[14] CM agreed with the Board determined that CMS' methodology was not an improper rule change and was not subject to the Supreme Court's *Alina* decision. In addition, CM agreed with the Board's conclusion on the use of the cost report to remove variable costs.

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 an acute care hospital located in Plattsburgh, New York. The Provider was designated as a Sole Community Hospital ("SCH") during FY 2013. For the fiscal period in dispute, the Provider experienced a decrease in discharges greater than 5 percent, due to circumstances beyond its control, and as a result, was eligible to have the VDA calculation performed.[15] By letter dated October 6, 2015, the Provider timely requested a VDA payment. On October 14, 2016, the MAC denied the request because the Provider's total Medicare fixed, and semi-fixed costs were less than the Provider's total Medicare PPS payments.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the inpatient prospective payment system (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 SCH.

Section 1886(d)(5)(D)(iii) of the Act, defines a SCH as any hospital:

> (I) that the Secretary determines is located more than 35 road miles from another hospital,
> (II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A of this subchapter, or
> (III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(v)(i) of this title as in effect on September 30, 1997.

Section 1886(d)(5)(D)(ii) of the Act authorizes the Secretary to adjust the payment of SCHs that incur a decrease in discharges of more than 5 percent from one cost reporting year to the next, if the circumstances leading to the decline in discharges were beyond its control, stating:

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[14] *See*, CM comments at 4.
[15] *See*, Stipulations at ¶ 1.

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

The regulations implementing this statutory adjustment are located at 42 C.F.R. § 412.92(e). In particular, subsection (e)(1) specifies the following regarding low volume adjustment:

> (1)For cost reporting periods beginning on or after October 1, 1983, the intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period….[16]

In determining the adjustment for a SCH, 42 C.F.R. § 412.92(e)(3) instructs:

> (3)The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under §412.106 and for indirect medical education costs as determined under §412.105).
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> (i) In determining the adjustment amount, the intermediary considers—
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> (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.

In addition to the controlling regulation, CMS has provided further interpretive guidelines in the PRM 15-1. The Manual is intended to ensure that Medicare reimbursement standards "are uniformly applied nationally without regard to where covered services are furnished."[17]

Section 2810.1(A)(1) of the PRM defines "circumstances beyond the hospital's control" as:

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[16] *See*, 42 C.F.R. §412.92(e)(2013).
[17] *See* CMS Pub. 15-1, Foreword.

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

Additionally, § 2810.1 provides guidance to assist MACs in the calculation of VDAs for MDHs. Specifically, § 2810.1(B) of the PRM states the following regarding the amount of a low volume adjustment:

> B. Amount of Payment Adjustment. Additional payment is made to an eligible SCH for *fixed costs* it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, *not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.*
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> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.
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> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semi-fixed. Semi-fixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semi-fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.
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> In evaluating semi-fixed costs, the MAC considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semi-fixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment. (Emphasis added.)
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> The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The intermediary reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

In the discussion included in the preamble to the August 18, 2006, final rule[19], it was noted:

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[18] *See*, PRM 15-1, § 2810.1(A)(1).
[19] 71 *Fed. Reg*., 47,870, 48,056 (Aug. 18, 2006).

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

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

> As we have noted in Section 2810.1 of the Provider Reimbursement Manual, Part 1 (PRM–1) and in adjudications rendered by the PRRB and the CMS Administrator, under the current methodology, the MAC determines a volume decrease adjustment amount not to exceed a cap calculated as the difference between the lesser of (1) the hospital's current year's Medicare inpatient operating costs or (2) its prior year's Medicare inpatient operating costs multiplied by the appropriate IPPS update factor, and the hospital's total MS–DRG revenue for inpatient operating costs (including outlier payments, DSH payments, and IME payments). In determining the volume decrease adjustment amount, the MAC considers the individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies; the hospital's fixed costs (including whether any semi-fixed costs are to be considered fixed) other than those costs paid on a reasonable cost basis; and the length of time the hospital has experienced a decrease in utilization.[20]

CMS noted that the VDA has been the subject of a series of adjudications, rendered by the PRRB and the CMS Administrator,[21] and that in those adjudications, the PRRB and the CMS Administrator have recognized that: "(1) The volume decrease adjustment is intended to

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[20] 82 *Fed. Reg*. 37,990, 38,179 (Aug. 14, 2017).

[21] *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 Reginal Medical Center v. Wisconsin Physician Services*, 2017 WL 2403399 (CMS Administrator February 9, 2017); *Stephens County Hospital v. Becerra*, 2021 WL 4502068 (D.D.C. Sept. 30, 2021) and *Lake Region Healthcare Corp. v. Becerra*, Civ. No. 20-CV-3452 (D.D.C. Oct. 17, 2022)

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."[22] CMS explained that it was making the change in how the VDA is calculated because:

> As the above referenced Administrator decisions illustrate and explain, under the current calculation methodology, the MACs calculate the volume decrease adjustment by subtracting the entirety of the hospital's total MS–DRG revenue for inpatient operating costs, including outlier payments and IME and DSH payments in the cost reporting period in which the volume decrease occurred, from fixed costs in the cost reporting period in which the volume decrease occurred, minus any adjustment for excess staff. If the result of that calculation is greater than zero and less than the cap, the hospital receives that amount in a lump sum payment. If the result of that calculation is zero or less than zero, the hospital does not receive a volume decrease payment adjustment.
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> Under the IPPS, MS–DRG payments are not based on an individual hospital's actual costs in a given cost reporting period. However, the main issue raised by the PRRB and individual hospitals is that, under the current calculation methodology, if the hospital's total MS–DRG revenue for treating Medicare beneficiaries for which it incurs inpatient operating costs (consisting of fixed, semi-fixed, and variable costs) exceeds the hospital's fixed costs, the calculation by the MACs results in no volume decrease adjustment for the hospital. In some recent decisions, the PRRB has indicated that it believes it would be more appropriate for the MACs to adjust the hospital's total MS–DRG revenue from Medicare by looking at the ratio of a hospital's fixed costs to its total costs (as determined by the MAC) and applying that ratio as a proxy for the share of the hospital's MS–DRG payments that it assumes are attributable (or allocable) to fixed costs, and then comparing that estimate of the fixed portion of MS–DRG payments to the hospital's fixed costs. In this way, the calculation would compare estimated Medicare revenue for fixed costs to the hospital's fixed costs when determining the volume decrease adjustment.[23]

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

[22] 82 *Fed. Reg*. at 38,180.
[23] *Id.*

> 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.[24]

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.[25]

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

[24] *Id.*
[25] *Id.* at 38,182.

> 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.[26]

The Eighth Circuit found that, just because CMS prospectively adopted a new interpretation, that it was not a sufficient reason to find that the Secretary's prior interpretation was arbitrary or capricious.[27] 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.[28]

This case centers on the application of the statute and regulation to the proper classification and treatment of costs and the proper calculation of the amount for the low volume adjustment.[29] The Administrator's examination of the governing statute and implementing regulation and guidance clearly recognize three categories of costs, i.e., fixed, semi-fixed and variable. The guidance only considers fixed and semi-fixed costs within the calculation of the volume adjustment but not variable costs.

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

[27] 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")."

[28] *Unity* at 578.

[29] *See*, Stipulations at ¶ 14.

Regarding the methodology and proper calculation of the Provider's payment adjustment, the Administrator finds that the Board improperly calculated the Provider's adjustment.[30] The VDA calculation methodology used by the Board is in direct contradiction to the statute and CMS' regulations and guidance. The Board found the VDA in this case should be calculated as follows:

Step 1: Calculation of the CAP

2012 Medicare Inpatient Operating Costs	$50,537,312
Multiplied by the 2010 IPPS update factor	1.018[31]
2012 Updated Costs (Max allowed)	$51,446,984
2013 Medicare Inpatient Operating Costs	$51,636,729
Lower of 2012 Updated Costs or 2013 Costs	$51,446,984
Less 2013 IPPS payment	$48,091,206
2013 Payment Cap	**$3,355,788**

Step 2: Calculation of VDA

2013 Medicare Inpatient Costs - Fixed Operating Costs	$43,697,066
Less 2013 IPPS payment – Fixed Portion (84.624 percent)	$40,696,702
Payment adjustment amount (subject to CAP)	**$3,000,364**[32]

As shown above, the Board determined that, as the payment adjustment amount of $3,000,364 is less than the CAP of $3,355,788, the Provider's VDA payment for FY 2011 should be $3,000,364.

After reviewing the statute, regulations, CMS policy and the Eight Circuit decision in *Unity HealthCare v. Azar*, 918 F.3d 571, 577 (8th Cir. 2019), the Administrator, affirms the Board on its holding regarding the MAC's adjustments to remove variable costs from the cost report in order to determine the Medicare fixed Inpatient Operating costs to be used in the VDA calculation. However, the Administrator disagrees with the Board's VDA methodology. The Administrator finds that the MAC properly calculated the correct payment adjustment, by following the controlling statute, regulations and various Administrative and Court decisions as reflected in *Greenwood* and *Unity*, cited *supra*, is as follows:

Step 2: Calculation of VDA

2013 Medicare Inpatient Costs - Fixed Portion	$43,696,986
Less 2013 IPPS payment	$48,091,206
Payment adjustment amount (subject to CAP)	0[33]

[30] *See*, Provider Reimbursement Review Board (PRRB) Dec. No. 2024-D13 at 15.
[31] While the Board and the MAC used the same update factor, the Board prorated the update factor between the two Federal years. However, this action did not impact the final determined updated factor of 1.018.
[32] *Id.*
[33] *See*, Provider's Exhibit P-3 at 4. MAC Exhibit C-1.

As shown above, the Administrator finds that the Provider's DRG payment is more than the Provider's fixed costs. Therefore, the Provider is not eligible for a VDA payment.

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

In sum, 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 2013.

DECISION

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

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

Date: June 14, 2024

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