CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of: **Mayo Clinic Health System Fairmont** **Provider,** **vs.** **National Government Services, Inc.** **Medicare Contractor.**	**Claim for:** **Cost Reporting Period Ending: December 31, 2014** **Review of:** **PRRB Dec. No. 2024-D21** **Dated: June 28, 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 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 certain specified finding. The Medicare Administrative Contractor (MAC) submitted comments, requesting that the Administrator reverse the Board's decision with respect to the methodology for calculating the Provider's Volume Decrease Adjustment (VDA) as it is not supported by statute or regulation. The Provider submitted comments requesting that the Board decision be affirmed. 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 determined the sole community hospital's (SCH) volume decrease adjustment (VDA) granted for the cost reporting period ending December 31, 2014, (FY 2014).

The Board held that the MAC improperly calculated the Provider's VDA payment for FY 2014, and that the Provider should receive a VDA payment in the amount of $1,461,110.

SUMMARY OF COMMENTS

The MAC submitted comments requesting that Administrator reverse the Board's decision with respect to its suggested methodology for calculating the Provider's VDA, which the MAC states is not supported by statute, regulation or case law. The MAC stated that the Administrator has repeatedly advised the Board regarding the proper methodology for performing a VDA calculation. The MAC asserted that it utilized the Administrator's methodology, which has been upheld by the Eighth Circuit Court of Appeals in *Unity Healthcare v. Azar*, 918 F.3d 571, 578-79 (8th Cir. 2019);

the only circuit court to address this issue. In the *Unity* decision, the Eighth Circuit found that the Administrator's methodology (compares a Provider's fixed costs to total Medicare payments and disregards variable costs) has been weighed, measured and found to be statutorily appropriate. The Board's "fixed cost methodology," is not supported by any source, requires modifications to existing law to survive a statutory challenge, and those modifications are prospective only and not relevant to the fiscal year at issue. Additionally, the Supreme Court denied a Provider's petition for certiorari in *Unity HealthCare*, 140 S. Ct. 523 (2019). Moreover, the MAC argued that the PRRB failed to note *Stephens County Hospital v. Becerra*, 2021 WL 4502068, (D.D.C. Sept. 30, 2021), which affirmed the Administrator's decision to overturn the PRRB's decision in a substantially similar case.

The Provider submitted comments requesting that the Administrator affirm the Board's decision. The Provider agreed with the Board's decision that the MAC improperly calculated the Provider's VDA payment, for reasons set forth in the Board's final decision. The Provider argued that under *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244, 2263 (2024), CMS' interpretation of the VDA statute for pre-2017 fiscal years is no longer entitled to deference, and in applying Loper's "best meaning" of the statute standard, the Board's calculation methodology should be applied in this case. Moreover, the Provider argued that the MAC and CMS's reliance on prior cases upholding the Administrator decisions were not reasonable and notes that *Lake Region Healthcare Corp. v. Becerra*, 2022 WL 9936856 (D.D.C., 2022) currently pending before the D.C. Circuit Court of Appeals awaiting decision, post *Loper Bright* guidance.

CM submitted comments that recommended that the Administrator reverse the Board's decision (apart from the Board's findings that the VDA payment is clearly not intended to fully compensate the hospital for its variable costs).[1] and uphold the MAC's determination. CM disagreed with the Board that the MAC improperly calculated the VDA payment for the Provider for the same reasons set forth in multiple court decisions involving this same issue. Regarding the Provider's argument that the MAC changed the VDA calculation without following the legal notice and comment period and therefore unlawfully changed the regulations contrary to *Azar v. Allina (Allina II)*[2], CM stated that this argument fails. CM argued that CMS satisfied the obligation by utilizing notice and comment rulemaking to promulgate, revise, and clarify the implementing regulation, and describe in its regulations and preambles how the VDA is to be calculated.[3] Specifically, CM stated, CMS promulgated a regulation in 1983, which set forth factors to be considered in calculating the VDA. In 1987, CMS proposed and then finalized an amendment to the regulation to establish a ceiling for the VDA, equal to the difference between a hospital's Medicare operating costs and its DRG payments. 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. Thus, CM averred, the statute and the regulations established the standards that govern hospitals' eligibility for' VDA or DRG payments, and CMS' attempt to reconcile and harmonize the provision and the decision to implement and integrate commands and schemes is

[1] Brd. Dec. at 13.
[2] *Azar v. Allina Health Servs*., 139 S. Ct. 1804 (2019).
[3] CM Comments at 3.

not establishing a substantive legal standard for *Allina* and under section 1871 of the Social Security Act.[4] CM also disagreed with the Board's use of the update factor (1.0183) rather than the Update Factor indicated in the FY 2014 Final Rule at 78 Fed. Reg. 50,496, 50,984 (Aug. 19, 2013).[5]

CM noted that the Provider omitted critical passages in *Loper* regarding CMS' express authority. CM argued that Congress expressly delegated to HHS the authority to prescribe such regulations as may be necessary to carry out the administration of Medicare § 1871 of the Act and to provide a VDA as may be necessary to fully compensate certain hospitals for their fixed costs in providing inpatient hospital services under §1886 of the Act.[6] Therefore, CM commented that Congress expressly delegated statutory discretionary authority to HHS to prescribe regulations concerning the VDA adjustment under *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244, 2263 (2024), and that therefore, incorporating the "best reading" of the statute concerning the VDA adjustment,

CM referred the Administrator to the government's brief in *Lake Region Healthcare Corp. v. Becerra*, 2022 WL 9936856 (D.D.C., 2022), *Stephens County Hosp. v. Becerra*, No. 19-cv-3020 (DLF), 2021 WL 4502068 (Sept. 30, 2021) and in *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019), along with the decisions in that case, in *St. Anthony Regional Hospital v. Azar*, 294 F.Supp.3d 768 (N.D. Iowa 2018), and in *Trinity Regional Medical Center v. Azar*, No. 17-3029, 2018 WL 4295290 (N.D. Iowa Sept. 10, 2018) (district court decision), 2018 WL 1558451 (N.D. Iowa Mar. 19, 2018) (magistrate decision), for a comprehensive discussion of their position on the issues presented in this case.

In further support of their position, CM also referred the Administrator to the August 2017 final rule, in particular, the language at 82 Fed. Reg. 37,990, 38,179-83, 38,511 (Aug. 14, 2017).[7]

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.

In this case, the Provider, is a Sole Community Hospital (SCH) located in Fairmont, Minnesota. The Provider requested a VDA payment in the amount of $2,110,607, (prior request, $2,035,154), depending on the treatment of its "Excludable Program Cost."[8] The MAC calculated the

[4] Section 1871 of the Act requires notice and comment rulemaking procedure whenever a Medicare rule, requirement, or other statement of policy "establishes or changes a substantive legal standard governing…the payment for services" even if the rule, requirement or statement of policy is an interpretive rule.
[5] CM Comments at 4.
[6] 42 U.S.C. § 1395hh(a)(1); 42 U.S.C. § 1395ww(d)(5)(D)(ii), (G)(iii).
[7] CM Comments at 3.
[8] Rev. Stip. at ¶ 7 (Sept. 14, 2023); *See* prior Stip. at ¶ 7 (July 16, 2021).

Provider's VDA payment for FY 2014 to be $0.[9] The Provider timely appealed the MAC'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 based on the diagnosis-related group (DRG). The IPPS also allows special treatment for facilities that qualify as an SCH.

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

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, 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.

Beginning in 1983, CMS promulgated regulations setting forth factors to be considered in calculating the VDA.[10] In 1987, CMS proposed and finalized an amendment to the VDA regulation to establish a ceiling for the VDA, equal to the difference between a provider's Medicare operating costs and its DRG payments.[11]

The regulations implementing this statutory adjustment are located at 42 C.F.R. § 412.92(e) (2014). In particular, subsection (e)(1) specifies the following regarding low volume adjustment:

> The intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances. . . [beyond the hospital's control] a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period.

Once an SCH demonstrates that it has suffered a qualifying decrease in total inpatient discharges, the MAC must determine the appropriate amount, if any, due to the provider as an adjustment. The regulation at 42 C.F.R. § 412.92(e)(3) specifies the following regarding the determination of low

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[9] The MAC previously calculated the Provider's VDA and made a *tentative* final determination and interim payment of $596,876, noting that the "calculation would be revisited when the 12/31/2014 cost report is finalized." (Sept. 13, 2016).

[10] 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)); CM Comments at 3.

[11] 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)); CM Comments at 3.

volume adjustment amount:

> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs ….
>
> (i) In determining the adjustment amount, the intermediary considers –
>
> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
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> (C) The length of time the hospital has experienced a decrease in utilization.[12]

In the preamble to the August 2006 Final Rule,[13] CMS referenced the interpretive guidelines on VDAs in the Provider Reimbursement Manual, CMS Pub. No. 15-1 (PRM 15-1) § 2810.1. In the discussion included in the preamble to the August 18, 2006, final rule, it was stated that:

> 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 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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[12] 42 C.F.R. § 412.92(e)(3) (2014).
[13] 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006).

> 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 semi-fixed costs may not be included in determining the amount of the payment adjustment.
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> The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The contractor 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.[14]

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.[15]

[14] MAC's PPP at 9-10.
[15] 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,[16] 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."[17] 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.
>
> 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.[18]

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[16] *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 Administrator Sept. 4, 2014); *Lakes Regional Healthcare Spirit Lake, Iowa v. Blue Cross Blue Shield Association/Wisconsin Physicians Service*, 2014 WL 5450078 (CMS Administrator Sept. 4, 2014); *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association*, 2015 WL 5852432 (CMS Administrator, Aug. 5, 2015); *St. Anthony Regional Hospital v. Wisconsin Physicians Service*, 2016 WL 7744992 (CMS Administrator Oct. 3, 2016); and *Trinity Regional Medical Center v. Wisconsin Physician Services*, 2017 WL 2403399 (CMS Administrator Feb. 9, 2017).

[17] 82 Fed. Reg. 37,990, 38,179-83, 38,511 (Aug. 14, 2017) (Final Rule).

[18] *Id.*

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.[19]

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

[19] 82 Fed. Reg. at 38,179-83, 38,511 (Aug. 14, 2017) (Final Rule).

> changes to the volume decrease adjustment methodology will apply prospectively for cost reporting periods beginning on or after October 1, 2017.[20]

CMS acknowledged that the new methodology, effective for cost reporting periods beginning on or after October 1, 2017 (and used by the Board in past cases), was based on a pro-ration of IPPS/SCH payments between fixed and unfixed costs, although the IPPS/DRG payment itself has no relation to a hypothetical prorated payment of a specific hospital's fixed and unfixed costs. For the new methodology, such a ratio is imputed based on the Hospital's ratio of fixed to variable costs, and not based on any such ratio that was ever established in the IPPS payment. CMS reiterated that the volume decrease adjustment is intended to compensate qualifying SCHs and MDHs for their fixed costs, not for their variable costs, which the present method used here plainly does satisfy. However, to satisfy Hospitals' concerns, CMS agreed to make an effort to ascertain whether a portion of the 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, which was within CMS discretion to do. CMS addressed Hospital's concerns, pursuit to the new methodology, by attributing the hospital specific proration between fixed and variable costs to the non-hospital specific IPPS/DRG payment.

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 for the cost year at issue. 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 and statute only consider 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 statutory intent and language 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)(D)(ii) and 42 CFR 412.92(e)(3), 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. Moreover, under *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244, 2263 (2024),[21] incorporating the "best reading" of the statute concerning the VDA adjustment gives the agency discretionary authority to fill in the details of a statutory scheme as the agency did here.

Regarding the methodology and proper calculation of the Provider's payment adjustment, (apart from the Board's findings on the removal of variable costs and the inapplicability of *Allina*), 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

[20] *Id.* at 38,182.
[21] *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244, 2263 (2024).

Provider's fixed costs (which includes semi-fixed costs) were 79.41 percent[22] of the Provider's Medicare costs for FY 2014. Applying the rationale described above, the Board found the VDA in this case should be calculated as follows:

Step1: Calculation of the CAP

2013 Medicare Inpatient Operating Costs	$9,208,457[23]
Multiplied by the 2014 IPPS update factor	1.0183[24]
2013 Updated Costs (max allowed)	$9,376,972
2014 Medicare Inpatient Operating Costs	$9,861,020[25]
Lower of 2013 Updated Costs or 2014 Costs	$9,376,972
Less 2014 IPPS payment	$7,915,862[26]
2014 Payment CAP	$1,461,110

Step 2: Calculation of VDA

2014 Medicare Inpatient Operating Costs – Fixed	$7,830,636[27]
Less 2014 IPPS payment–fixed portion (79.41 percent)	$6,285,986[28]

[22] Rev. Stip. at ¶¶ 9, 10.

[23] *Id*. at ¶ 9.

[24] *Id*. at ¶ 9. While the parties stipulated to an IPPS update factor of 1.017, the Board found that the appropriate update factor for the cost reporting period was 1.0183: ((273/365) x 1.017 + (92/365) x 1.022 1/1/2014 to 12/31/2014). This reflects 273 days in FFY 2014 and 92 days in FFY 2015 with an IPPS update factor of 1.022.
CM has pointed out that the correct update factor is the update factor published in the FY 2014 Final Rule, see 78 Fed. Reg. 50,496, 50,984 (Aug. 19, 2013), rather than the prorated number that was calculated by the Board (i.e., 1.0183). That issue was not raised below for briefing or notice to the parties before the Board. However, the cap calculation is not material to the Administrator's finding in this case as to the amount of the VDA payment owed.

[25] Rev. Stip. at ¶ 9.

[26] Rev. Stip. Ex. P-31. The Board indicated that total payments are calculated: IP Operating Cost Payment (Worksheet E, Part A, Line 49) $7,103,285 + Operating Portion of the Low Volume Payments $812,577 = $7,915,862. The Low Volume Payments reported on Worksheet E, Part A, Lines 70.96 and 70.97 are reduced for the capital portion, which is based on the capital percentage of payments based on total payments on Worksheet E, Part A, Lines 49 and 50. (Capital payments = Worksheet E, Part A, Line 50 = $400,722, Operating payments = Worksheet E, Line A, Line 49 = $7,103,285); Operating percentage = 7,103,285/7,504,007 = 0.9466 rounded. Low Volume Payments = $858,417 x 94.66% (Operating percentage) = 812.577.

[27] Total Operating Costs of $9,861,020 x Fixed Cost percentage of 79.41% = 7,830,636.

[28] The $6,285,986 is calculated by multiplying $7,915,862 by 0.7941 (the fixed cost percentage determined by the MAC). The Administrator notes that the calculation of the fixed portion stipulated to by the parties in Rev. Stip. at ¶ 9 was $6,285,984 in the Provider's calculations at Rev. Stip. at ¶10.

Payment adjustment amount (subject to CAP)	$1,544,650

As the payment adjustment amount of $1,544,650 was greater than the cap of $1,461,110, the Board concluded that the Provider's VDA payment for FY 2014 should be $1,461,110.

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

2014 Medicare Inpatient Operating Costs	$9,861,020[29]
2014 Fixed Costs	$7,830,636
Total DRG/SCH Payments	$7,915,860
VDA Payment Amount	**$0**

The Provider's VDA is equal to the difference between its fixed and semi-fixed costs and its DRG/SCH payment. As the DRG/SCH payment exceeded the fixed and semi-fixed costs, the VDA payment amount would be $0. CMS' methodology directly shows that the amount of IPPS/SCH revenue received by the Provider was sufficient to cover the Provider's incurred fixed costs.

Therefore, the Administrator reverses the Board's decision as to this aspect of the calculation. The MAC used the proper methodology in calculating the Provider's VDA for FY 2014. Moreover, CM correctly observed that the VDA statute and accompanying regulations established the standards that govern hospitals' eligibility for VDA or DRG payments. Under *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244, 2263 (2024), the "best reading" of the statute which provides for the agency discretionary authority to fill in the details of a statutory scheme, as the agency has done here concerning the VDA adjustment.[30] CM properly concluded, as noted in the comments, that CMS' reconciling and harmonizing of the VDA provisions does not establish a substantive legal standard for purposes of *Allina* and, even assuming such a proposition, any rulemaking obligation that might have been imposed by *Allina* was satisfied in various notice and comment rulemaking.[31]

[29] Rev. Stipulations at ¶ 9. Current year (2014) program operating costs (*Worksheet D-1, Line 53*).
[30] *Loper,* 144 S. Ct. at 2263.
[31] CM Comments at 3.

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: August 22, 2024

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