**PROVIDER REIMBURSEMENT REVIEW BOARD DECISION**
On the Record
2025-D20

**PROVIDER-**
Brattleboro Memorial Hospital

**RECORD HEARING DATE –**
July 3, 2024

**Provider No.:** 47-0011

**Cost Reporting Period Ended** –
09/30/2014

**vs.**

**MEDICARE CONTRACTOR –**
National Government Services, Inc.

**CASE NO. –** 19-0620

**INDEX**

## ISSUE STATEMENT

Whether the Medicare Contractor [1] properly calculated the revised volume decrease adjustment ("VDA") payment owed to Brattleboro Memorial Hospital ("Brattleboro" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending September 30, 2014 ("FY 2014").[2]

## DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated the VDA payment for FY 2014 for Brattleboro. The Board remands the appeal to the Medicare Contractor to recalculate the Provider's VDA consistent with *Lake Region Healthcare Corp. v. Becerra*[3] ("*Lake Region*") and § 2810.1.D.2.b (Rev. 479) of the Provider Reimbursement Manual, Part 1 (PRM-1).[4]

## STATEMENT OF FACTS AND PROCEDURAL HISTORY

Brattleboro is an acute care hospital located in Brattleboro, Vermont.[5] Per the stipulations submitted by the parties ("Stipulations"), Brattleboro was designated as a Medicare Dependent Hospital ("MDH") during the time period at issue.[6] The Medicare contractor assigned to Brattleboro for this appeal is National Government Services, Inc. (the "Medicare Contractor").

On September 5, 2017, Brattleboro filed a timely request for a VDA payment of $829,047 for FY 2014 to compensate it for a decrease in inpatient discharges during FY 2014.[7] On February 7, 2018, the Medicare Contractor requested additional information to continue its review.[8] Upon receipt and review of the additional information, the Medicare Contractor determined that the Provider met the eligibility criteria for a VDA payment for FY 2014.[9] However, on October 1, 2018, the Medicare Contractor issued a final determination denying Brattleboro's VDA payment request stating that Brattleboro had not met the requirements to actually receive a VDA payment (i.e., based on the MAC's calculation, total DRG payments exceeded the hospital's Medicare inpatient fixed operating costs, thus no additional payment could be made).[10] Brattleboro timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

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[1] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs as appropriate and relevant.
[2] *See* Provider's Final Position Paper (hereinafter "FPP") at 1.
[3] 113 F.4th 1002 (D.C. Circuit 2024).
[4] The Board notes that these instructions pertain to "Cost Reporting Periods Beginning on or after October 1, 2017," however, in the wake of the *Lake Region* decision, which used this methodology, and the Secretary's declining to appeal that decision, the Board finds this to be the correct calculation for the instant appeal.
[5] Provider's FPP at 1.
[6] Stipulations at ¶ 1.
[7] Provider's FPP at 1; *see also* Exhibit (hereinafter "Ex.") P-2 at 0020 (Provider's VDA Request).
[8] Ex. P-4 (MAC's Original Supplemental Request).
[9] Stipulations at ¶ 10.
[10] Ex. P-3 at 1; *see also* MAC's Final Position Paper at 17.

The Board approved a record hearing on July 3, 2024. Brattleboro was represented by William H. Stiles, Esq. of Verrill Dana, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

## STATUTORY AND REGULATORY BACKGROUND

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments. One of these payment adjustments is referred to as a VDA payment and it is available to MDHs if, due to circumstances beyond their control, they incur a decrease of more than five percent (5%) in their total number of inpatient cases from one cost reporting period to the next. VDA payments are designed "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."[11]

The implementing regulation located at 42 C.F.R. § 412.108(d)[12] reflects these statutory requirements. When promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals ("SCHs").[13] The regulation at 42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates that it experienced a qualifying decrease in total inpatient discharges.

## DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Pursuant to 42 C.F.R. § 412.108(d)(3)(iii), the Medicare Contractor's VDA "***determination*** is subject to [Board] review under subpart R of Part 405 of this chapter."[14] Per the Stipulations, it is undisputed that Brattleboro experienced a decrease in discharges greater than 5 percent from FY 2013 to FY 2014 due to circumstances beyond Brattleboro's control and that, as a result, Brattleboro was eligible to have a VDA calculation performed for FY 2014.[15] In this appeal, the parties dispute "the lawfulness of the methodology used by the MAC to calculate the payment amount set forth in the VDA Determination."[16]

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[11] 42 U.S.C. § 1395ww(d)(5)(G)(iii).

[12] In the FY 2018 IPPS/LTCH PPS final rule (82 Fed. Reg. 37990, 38179-183 (Aug. 14, 2017)), effective for cost reporting periods beginning on or after October 1, 2017, CMS finalized prospective changes as to how the MACs would calculate the volume decrease adjustments. This regulation requires "that the MACs compare estimated Medicare revenue for fixed costs to the hospital's [Medicare] fixed costs to remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment . . . . [i]n order to estimate the fixed portion of the Medicare revenue, the MACs [would] apply the ratio of the hospital's fixed costs to total costs in the cost reporting period when it experienced the volume decrease to the hospital's total Medicare revenue in that same cost reporting period." (82 Fed. Reg. 38180).

[13] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

[14] (Emphasis added).

[15] *See* Stipulations at ¶¶ 10, 14.

[16] Stipulations at ¶ 16.

On September 3, 2024, in *Lake Region Healthcare Corp. v. Becerra,*[17] the D.C. Circuit held that that the agency's and Administrator's longstanding approach for cost reporting periods prior to FY 2018 (under which the VDA is the difference between a hospital's fixed costs and the total DRG payments, which the Court called the "fixed-total method") violated 42 U.S.C. § 1395ww(d)(5). Since that time, the Board has continued to issue VDA decisions applying the Board's long-standing "fixed-fixed"[18] methodology for cost reporting periods before October 1, 2017(which also is the methodology CMS promulgated for cost reporting periods beginning on or after October 1, 2017). In the appeals following the D.C. Circuit's *Lake Region* decision, the Administrator has declined review. [19]

## DECISION AND ORDER

Based on the foregoing, the Board finds that the Medicare Contractor improperly calculated the FY 2014 VDA payment for Brattleboro. Accordingly, pursuant to its authority under 42 C.F.R. § 405.1845(h), the Board hereby remands the appeal to the Medicare Contractor with instructions to recalculate the Provider's FY 2014 VDA consistent with *Lake Region* and the methodology outlined in PRM-1 § 2810.1.D.2.b (Rev. 479).

## BOARD MEMBERS:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq

**FOR THE BOARD**:

4/30/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

[17] 113 F.4th 1002, 1008-09.
[18] *Id.* at 1005 (where the Court acknowledged that the Board "developed the fixed-fixed method in a series of adjudications beginning in 2015[]" and described it as "the difference between the hospital's *fixed* costs for treating Medicare beneficiaries and an estimate of what portion of its DRG payments afford compensation for those *fixed* costs.") The Board notes this may also be described as the difference between the Program inpatient operating fixed costs and the fixed cost portion of the total payment for inpatient operating costs.
[19] *See, e.g., Tennova Healthcare – Volunteer Martin v. WPS Government Health Administrators*, PRRB Dec. 2025-D06 (Dec. 17, 2024), Administrator declined review (Jan. 8, 2025).