PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2025-D21

PROVIDER-
Laurens County Memorial Hospital

Provider No.: 42-0038

vs.

MEDICARE CONTRACTOR –
Palmetto, GBA (c/o National Government Services)

RECORD HEARING DATE –
December 21, 2023

Cost Reporting Period Ended –
06/30/2013

CASE NO. – 17-1674

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor[1] properly calculated the volume decrease adjustment ("VDA") payment owed to Laurens County Memorial Hospital ("Laurens County" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2013 ("FY 2013").[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 2013 for Laurens County. 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

Laurens County is a sole community hospital ("SCH") located in Clinton, South Carolina.[5] The Medicare administrative contractor assigned to Laurens County for this appeal is Palmetto GBA, c/o National Government Services (the "Medicare Contractor").

On February 4, 2016, Laurens County filed a timely request for a VDA payment of $2,271,757 for FY 2013 to compensate it for a decrease in inpatient discharges during FY 2013.[6] On February 20, 2017, the Medicare Contractor denied the Provider's VDA request indicating that it did not meet the requirement that the "[d]ecrease in discharges is in excess of 5% between years[.]"[7] On June 27, 2023, the Medicare Contractor issued an updated denial indicating that the "Provider's calculated fixed operating costs exceeds DRG payments by a material amount[.]"[8] The Medicare Contractor calculated the Provider's FY 2013 VDA payment to be $0.[9] Laurens County timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board. The Provider is now requesting a VDA payment of $1,184,073.[10]

---

[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] Provider's Final Position Paper (hereinafter Provider's "FPP") at 2 (Sept. 28, 2023).
[3] 113 F.4th 1002 (D.C. Cir. 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 2.
[6] Provider's FPP, Exhibit P-1 at FPP 22. *See also*, Stipulations at ¶ 5 (July 18, 2023).
[7] Provider's FPP, Exhibit P-2.
[8] Provider's FPP, Exhibit P-4.
[9] Medicare Contractor's Supplemental Final Position Paper, Exhibit C-2.
[10] Stipulations at ¶ 7.

The Board approved a record hearing on December 21, 2023. Laurens County was represented by Richard S. Reid of The Rybar Group, Inc. 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 SCHs 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]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Pursuant to 42 C.F.R. § 412.92 (e)(3)(iii), the Medicare Contractor's VDA "***determination*** is subject to [Board] review under subpart R of Part 405 of this chapter."[12] Per the Stipulations, it is undisputed that Laurens County experienced a decrease in discharges greater than five percent (5%) from FY 2012 to FY 2013 due to circumstances beyond Laurens County's control and that, as a result, Laurens County was eligible to have a VDA calculation performed for FY 2013.[13] In this appeal, Laurens County disputes the "inherently flawed" methodology used by the MAC to calculate the payment amount set forth in the VDA Determination, and claims that the MAC's methodology "**guarantees** that a [SCH] will **never receive** the full compensation mandated by Congress[.]"[14]

On September 3, 2024, in *Lake Region Healthcare Corp. v. Becerra,*[15] the D.C. Circuit held that the agency's and the 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"[16] methodology for cost reporting periods before October 1, 2017 (which also is the methodology CMS promulgated for cost reporting periods beginning on

[11] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[12] (Emphasis added).
[13] *See* Stipulations at ¶ 5.
[14] Provider's FPP at 9.
[15] 113 F.4th 1002, 1008-09.
[16] *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.")

or after October 1, 2017).[17] In the appeals following the D.C. Circuit's *Lake Region* decision, the Administrator has declined review. [18]

DECISION AND ORDER

Based on the foregoing, the Board finds that the Medicare Contractor improperly calculated the FY 2013 VDA payment for Laurens County. Accordingly, pursuant to its authority under 42 C.F.R. § 405.1845(h), the Board hereby remands this appeal to the Medicare Contractor with instructions to calculate the Provider's FY 2013 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:

5/1/2025

X Kevin D. Smith, CPA

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

[17] In the FY 2018 IPPS/LTCH PPS final rule (82 FR 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.

[18] *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).