PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2025-D23

PROVIDER-
Haywood Park Community Hospital

Provider No.: 44-0174

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –
November 7, 2023

Cost Reporting Period Ended –
09/30/2013

CASE NO. – 17-1315

INDEX

ISSUE STATEMENT

Whether WPS Government Health Administrators (the "Medicare Contractor")[1] properly calculated the volume decrease adjustment ("VDA") owed to Haywood Park Community Hospital ("Haywood Park" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending September 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 Haywood Park. 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 the methodology outlined in Provider Reimbursement Manual, Part 1 (PRM-1) § 2810.1.D.2.b (Rev. 479).[4]

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Haywood Park is Medicare Dependent Hospital ("MDH") located in Brownsville, Tennessee.[5] The Medicare administrative contractor assigned to Haywood Park for this appeal is WPS Government Health Administrators (the "Medicare Contractor").

On June 27, 2016, Haywood Park filed a timely request for a VDA payment of $534,913 for FY 2013 to compensate it for a decrease in inpatient discharges during FY 2013.[6] On December 14, 2016, the Medicare Contractor denied the Provider's VDA request for the reason that it "did not establish that the decline in discharges was due to an unusual event or occurrence beyond its control."[7] The MAC did determine that, had the Provider met the circumstance requirement, the payment calculation for the VDA would have been $129,686.[8]

In its March 29, 2023 Final Position Paper, while the Medicare Contractor maintains that "its [December 14, 2016] determination was in accordance with regulations and program policy, the MAC is no longer contesting the circumstance portion. Thus, the remaining controversy is the

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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] Provider's Final Position Paper (Provider's "FPP") at 2.
[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] Stipulations at ¶ 1.
[6] Medicare Contractor's Final Position Paper (hereinafter Medicare Contractor's FPP) at 2 and Provider's FPP Exhibit P-1 at FPP 35 (VDA Request for FYE September 30, 2013).
[7] Provider's FPP Exhibit P-2 (MAC Final Determination Letter dated December 14, 2016).
[8] Medicare Contractor's FPP at 7 and Exhibit C-2 (MAC's Workpapers) at C-0010.

payment determination."[9] The Provider now believes it is due a VDA payment of $185,604.[10] The Medicare Contractor now calculates the Provider's FY 2013 VDA payment to be $139,860.[11] Haywood Park timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on November 7, 2023. Haywood Park 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 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.[12] 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."[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. In the FY 2018 IPPS/LTCH PPS final rule, 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.[14] 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."[15]

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."[16] Per the parties'

[9] Medicare Contractor's FPP at 2.
[10] Stipulations at ¶ 8.
[11] Stipulations at ¶ 11.
[12] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[13] *Id*.
[14] 82 Fed. Reg. 37990, 38179-183 (Aug. 14, 2017).
[15] *Id*. at 38180.
[16] (Emphasis added).

Stipulations, it is now undisputed that Haywood Park experienced a decrease in discharges greater than five percent (5%) from FY 2012 to FY 2013 due to circumstances beyond Haywood Park's control and that, as a result, Haywood Park was eligible to have a VDA calculation performed for FY 2013.[17] In this appeal, the Provider 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 methodology "**guarantees** that a [MDH] will **never receive** the full compensation mandated by Congress . . ."[18]

On September 3, 2024, in *Lake Region Healthcare Corp. v. Becerra.*[19] 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"[20] 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).[21] In the appeals following the D.C. Circuit's *Lake Region* decision, the Administrator has declined review. [22]

DECISION AND ORDER

Based on the foregoing, the Board finds that the Medicare Contractor improperly calculated the FY 2013 VDA payment for Haywood Park. 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

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[17] *See* Stipulations at ¶¶ 5, 6.
[18] Provider's FPP at 7.
[19] 113 F.4th 1002, 1008-09.
[20] *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.)
[21] *See supra* at footnote 14.
[22] *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).

FOR THE BOARD:

5/6/2025

X Kevin D. Smith, CPA

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