PROVIDER REIMBURSEMENT REVIEW BOARD DECISION
On the Record

2025-D25

PROVIDER-
Bon Secours Rappahannock General Hospital

RECORD HEARING DATE –
April 1, 2024

Provider No.: 49-0123

Cost Reporting Period Ended –
03/31/2011

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

CASE NO. – 18-0945

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ISSUE STATEMENT

Whether the denial by Palmetto GBA c/o National Government Services (the "Medicare Contractor") of the Bon Secours Rappahannock General Hospital's ("Bon Secours" or the "Provider") request for a sole community hospital ("SCH") volume decrease adjustment ("VDA") for its fiscal year ending March 31, 2011 ("FY 2011") was improper.[1]

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 2011 for Bon Secours. The Board remands the appeal to the Medicare Contractor to recalculate the Provider's VDA consistent with *Lake Region Healthcare Corp. v. Becerra*[2] ("Lake Region") and the methodology outlined in the Provider Reimbursement Manual, Part 1 (PRM-1) § 2810.1.D.2.b (Rev. 479).[3]

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Bon Secours is a Sole Community Hospital located in Kilmarnock, VA.[4] The Medicare contractor[5] assigned to Bon Secours for this appeal is Palmetto GBA c/o National Government Services, Inc..[6] On June 6, 2016, Bon Secours filed a timely request for a VDA payment of $242,066 for FY 2011 to compensate it for a decrease in inpatient discharges during FY 2011.[7] In a final determination letter dated August 24, 2017, the Medicare Contractor denied the Provider's FY 2011 request for VDA payment, finding that the "Provider's calculated fixed operating costs exceeds DRG payments by a material amount."[8] Bon Secours 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 April 1, 2024. Bon Secours was represented by Barbara Straub Williams, Esq. of Powers, Pyles, Sutter & Verville, P.C. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Joint Stipulations of the Parties ("Stip.") at ¶ 2 (Mar. 27, 2024).
[2] 113 F.4th 1002 (D.C. Cir. 2024).
[3] 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.
[4] Stip. at ¶ 3.
[5] 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.
[6] Stip. at ¶ 6.
[7] Exhibit ("Ex.") P-3 (Provider's VDA Request).
[8] Ex. P-4.

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.[9] 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."[10]

The regulation at 42 C.F.R. § 412.92(e) directs how the Medicare Contractor must determine the VDA once an SDH 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.[11] 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."[12]

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."[13] Per the parties' Stipulations, it is undisputed that Bon Secours experienced a decrease in discharges greater than five percent (5%) from FY 2010 to FY 2011 due to circumstances beyond Bon Secours' control and that, as a result, Bon Secours was eligible to have a VDA calculation performed for FY 2011.[14] In this appeal, Bon Secours disputes the "inconsistent"[15] methodology used by the MAC to calculate the payment amount set forth in the VDA Determination, and claims that "the MAC's methodology, which prohibits a payment adjustment if the hospital's total DRG payment for inpatient operating costs is equal to or greater than the hospital's fixed Medicare inpatient operating costs, will *always* undercompensate the SCH for the fixed costs it incurs rather that fully compensate those costs, in violation of Congress's unambiguous mandate."[16]

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[9] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[10] *Id.*
[11] 82 Fed. Reg. 37990, 38179-183 (Aug. 14, 2017).
[12] *Id*. at 38180.
[13] (Emphasis added).
[14] *See* Stip. at ¶ 18.
[15] Provider's Final Position Paper at 26 (Jan. 9, 2024).
[16] *Id.* at 15-16 (italics in original).

On September 3, 2024, in *Lake Region Healthcare Corp. v. Becerra,* 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).[17] 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).[19] In the appeals following the D.C. Circuit's *Lake Region* decision, the Administrator has declined review.[20]

DECISION AND ORDER

Based on the foregoing, the Board finds that the Medicare Contractor improperly calculated the FY 2011 VDA payment for Bon Secours. 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 2011 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:

5/28/2025

X Kevin D. Smith, CPA

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

[17] 113 F.4th at 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 supra* footnote 12.
[20] *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).