PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2025-D37

PROVIDER-
Coshocton Regional Medical Center

Provider No.: 36-0109

vs.

MEDICARE CONTRACTOR –
CGS Administrators

RECORD HEARING DATE –
March 15, 2024

Cost Reporting Period Ended –
12/31/2013

CASE NO. – 19-0018

INDEX

ISSUE STATEMENT

Whether CGS Administrators (the "Medicare Contractor")[1] properly calculated the volume decrease adjustment ("VDA") owed to Coshocton Regional Medical Center ("Coshocton Regional" or "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 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 Coshocton Regional. 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 set forth in Provider Reimbursement Manual, Part 1 (PRM-1) § 2810.1.D.2.b (Rev. 479).[4]

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Coshocton Regional is a sole community hospital ("SCH") located in Coshocton, Ohio.[5] The Medicare Contractor assigned to Coshocton Regional for this appeal is CGS Administrators ("Medicare Contractor").

Coshocton Regional filed a timely request for a VDA payment of $1,584,196 for FY 2013 to compensate it for a decrease in inpatient discharges during FY 2013.[6] On May 3, 2018, the Medicare Contractor "denied the Provider's VDA request because it concluded that the Provider's inpatient prospective payment system (IPPS) payments for its operating costs exceeded the Provider's allowable inpatient fixed and semi-fixed operating costs."[7] Coshocton Regional 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 March 15, 2024. Coshocton Regional was represented by Richard Reid, Esq. of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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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 "Provider's FPP") at 2 (Dec. 11, 2023); *see also* Stipulations of the Parties (hereinafter "Stipulations") at ¶ 7.
[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. See also Stipulations at ¶ 1.
[6] Exhibit P-1 at FPP 33 (CCMS 2013 VDA Request). *See also*, Stipulations at ¶ 5.
[7] Stipulations at ¶ 6. *See also* Exhibit C-1 at 1 and Exhibit C-5 at C00026-27.

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."[8]

The regulation at 42 C.F.R. § 412.92(e) directs how the Medicare Contractor must determine the VDA once an SCH demonstrates that it experienced a qualifying decrease in total inpatient discharges. For cost reporting periods prior to FY 2018, CMS calculated the VDA as the difference between a hospital's Medicare inpatient fixed operating costs and the total DRG/SCH payments.[9]

In the FY 2018 IPPS/LTCH PPS final rule, effective for cost reporting periods beginning on or after October 1, 2017 (i.e., FY 2018 and beyond), CMS finalized prospective changes as to how the MACs would calculate the volume decrease adjustments.[10] 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."[11]

On September 3, 2024, in *Lake Region Healthcare Corp. v. Becerra,*[12] the D.C. Circuit held that the agency's and the Administrator's longstanding approach for cost reporting periods prior to FY 2018 violated 42 U.S.C. § 1395ww(d)(5).

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The parties have stipulated that the sole remaining issue to be resolved by the Board is to determine the correct calculation for Coshocton Regional's VDA payment under the applicable laws, regulations, and program instructions.[13]

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."[14] Per the parties' Stipulations, it is undisputed that Coshocton Regional experienced a decrease in discharges

[8] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[9] *Id.* at 38179.
[10] 82 Fed. Reg. 37990, 38179-183 (Aug. 14, 2017).
[11] *Id.* at 38180.
[12] 113 F.4th 1002, 1008-09.
[13] *See* Stipulations at ¶ 7.
[14] (Emphasis added).

greater than five percent (5%) from FY 2012 to FY 2013 due to circumstances beyond Coshocton Regional's control and that, as a result, Coshocton Regional was eligible to have a VDA calculation performed for FY 2013.[15] In this appeal, Coshocton Regional 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[.]"[16]

In *Lake Region,* 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"[17] 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).[18] In the appeals following the D.C. Circuit's *Lake Region* decision, the Administrator has declined review. [19] The Board finds that the "fixed-fixed" methodology is proper for the calculation of the FY 2013 VDA payment for Coshocton Regional.

DECISION AND ORDER

Based on the foregoing, the Board finds that the Medicare Contractor improperly calculated the FY 2013 VDA payment for Coshocton Regional. 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
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FOR THE BOARD:

6/26/2025

X Kevin D. Smith, CPA

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

[15] *See* Stipulations at ¶ 5.
[16] Provider's FPP at 9.
[17] 113 F.4th 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.")
[18] *See supra* at footnote 11.
[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).