

**PROVIDER REIMBURSEMENT REVIEW BOARD  
DECISION  
On the Record**

2025-D38

**PROVIDER-**  
Jones Memorial Hospital

**RECORD HEARING DATE –**  
January 22, 2023

**Provider No.:** 33-0096

**Cost Reporting Period Ended –**  
12/31/2012

**vs.**

**MEDICARE CONTRACTOR –**  
National Government Services

**CASE NO. –** 17-1013

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## **ISSUE STATEMENT**

Whether National Government Services, Inc. (the “Medicare Contractor”)<sup>1</sup> properly calculated the volume decrease adjustment owed to Jones Memorial Hospital (“Jones Memorial” or the “Provider”) for the significant decrease in inpatient discharges that occurred in its cost reporting period ending December 31, 2012 (“FY 2012”).<sup>2</sup>

## **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 2012 for Jones Memorial. The Board remands the appeal to the Medicare Contractor to recalculate the Provider’s VDA consistent with *Lake Region Healthcare Corp. v. Becerra*<sup>3</sup> (“Lake Region”) and the methodology outlined in Provider Reimbursement Manual, Part 1 (PRM-1) § 2810.1.D.2.b (Rev. 479).<sup>4</sup>

## **STATEMENT OF FACTS AND PROCEDURAL HISTORY**

Jones Memorial is a Sole Community Hospital (“SCH”) located in Wellsville, New York<sup>5</sup>. Jones Memorial is eligible to receive a VDA payment during the fiscal year at issue.<sup>6</sup> The Medicare administrative contractor assigned to Jones Memorial Hospital for this appeal is National Government Services, Inc. (“NGS”).

On November 1, 2013, Jones Memorial Hospital filed a timely request for a VDA payment of \$417,471 for FY 2012 to compensate it for a decrease in inpatient discharges during FY 2012.<sup>7</sup> On December 5, 2014 the Medicare Contractor granted a VDA payment in the amount of \$400,138.<sup>8</sup> On February 5, 2016, the Medicare Contractor notified the Provider that a revised determination of the VDA payment was being made, “based on direction from the Centers for Medicare and Medicaid Services (CMS)” and indicated that “[w]e have been directed to review and recalculate the VDA to remove all variable expenses.”<sup>9</sup> Subsequently, on October 11, 2016, the Medicare Contractor issued a Notice of Program Reimbursement (“NPR”) in which it reduced the payment to

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<sup>1</sup> 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.

<sup>2</sup> See Medicare Contractor’s Final Position Paper (hereinafter “Contractor’s FPP”) at 3 (Nov. 3, 2023); See also Provider’s Final Position Paper (hereinafter “Provider’s FPP”) at 3 (Oct. 4, 2023).

<sup>3</sup> 113 F.4<sup>th</sup> 1002 (D.C. Cir. 2024).

<sup>4</sup> 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.

<sup>5</sup> Stipulations at ¶ 1 (Dec. 5, 2023).

<sup>6</sup> See Stipulations at ¶ 2.

<sup>7</sup> See Provider’s FPP Exhibit (hereinafter “Ex.”) P-5 at 7 (Provider’s VDA Request).

<sup>8</sup> Ex. P-6 (SCH Volume Decrease Adjustment – Final Determination).

<sup>9</sup> Ex. C-5 (Request for Revised Volume Decrease Adjustment – Variable Expense Review).

\$0.<sup>10</sup> Jones Memorial timely appealed the Medicare Contractor's revised final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on December 22, 2023. Jones Memorial was represented by Leslie Goldsmith, Esq. of Bass, Berry & Sims, PLC. 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."<sup>11</sup>

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, the VDA was calculated by CMS as the difference between a hospital's fixed costs and the total DRG payments.<sup>12</sup>

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.<sup>13</sup> 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."<sup>14</sup>

On September 3, 2024, in *Lake Region Healthcare Corp. v. Becerra*,<sup>15</sup> 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).

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<sup>10</sup>Ex. P-7.

<sup>11</sup> 42 U.S.C. § 1395ww(d)(5)(D)(ii).

<sup>12</sup> See 82 Fed. Reg. 37990, 38180 (Aug. 14, 2017).

<sup>13</sup> *Id.* at 38179-183.

<sup>14</sup> *Id.* at 38180.

<sup>15</sup> 113 F.4<sup>th</sup> 1002, 1008-09.

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

The parties have stipulated that “[t]he sole issue to be determined is the correct VDA payment calculation.”<sup>16</sup> 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.”<sup>17</sup> Per the Stipulations, it is undisputed that Jones Memorial experienced a decrease in discharges greater than five percent (5%) from FY 2011 to FY 2012 due to circumstances beyond Jones Memorial’s control and that, as a result, Jones Memorial was eligible to have a VDA calculation performed for FY 2012.<sup>18</sup> In this appeal, the Provider disputes the Medicare Contractor’s calculation and claims the Medicare Contractor “used a calculation not found in or even supported by the statute regulation or PRM” and “without any legal basis, created a ‘modified’ ceiling calculation comparing only fixed and semi-fixed costs to DRG payments, which include fixed, semi-fixed and variable costs.”<sup>19</sup>

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).<sup>20</sup> Since that time, the Board has continued to issue VDA decisions applying the Board’s long-standing “fixed-fixed”<sup>21</sup> methodology for cost reporting periods before October 1, 2017 (which also is the methodology CMS promulgated for cost reporting periods beginning or on after October 1, 2017).<sup>22</sup> In the appeals following the D.C. Circuit’s *Lake Region* decision, the Administrator has declined review.<sup>23</sup> The Board finds that the “fixed-fixed” methodology is proper for the calculation of the FY 2012 VDA payment for Jones Memorial.

## **DECISION AND ORDER**

Based on the foregoing, the Board finds that the Medicare Contractor improperly calculated the FY 2012 VDA payment for Jones Memorial. 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 2012 VDA consistent with *Lake Region* and the methodology outlined in PRM-1, § 2810.1.D.2.b (Rev. 479).

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<sup>16</sup> Stipulations at ¶ 9.

<sup>17</sup> (Emphasis added).

<sup>18</sup> See Stipulations at ¶ 6.

<sup>19</sup> Provider’s FPP at 14 – 15.

<sup>20</sup> 113 F.4<sup>th</sup> 1002, 1008-09.

<sup>21</sup> *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.)

<sup>22</sup> See *supra* at footnote 13.

<sup>23</sup> 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).

**BOARD MEMBERS:**

Kevin D. Smith, CPA  
Ratina Kelly, CPA  
Nicole E. Musgrave, Esq.  
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**FOR THE BOARD:**

6/26/2025

**X** Kevin D. Smith, CPA

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Kevin D. Smith, CPA

Board Chair

Signed by: Kevin D. Smith -A