PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2025-D40

PROVIDER-
Avera Queen of Peace Hospital

Provider No.: 43-0013

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions

RECORD HEARING DATE –
October 26, 2023

Cost Reporting Period Ended –
6/30/2014

CASE NO. – 17-2195

INDEX

ISSUE STATEMENT

Whether the denial by Noridian Healthcare Solutions (the "Medicare Contractor") of Avera Queen of Peace Hospital's ("Avera Queen" or the "Provider") request for a Sole Community Hospital ("SCH") volume decrease adjustment ("VDA") for its fiscal year ending June 30, 2014 ("FY 2014") 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 2014 for Avera Queen of Peace Hospital. 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

Avera Queen of Peace Hospital is a Sole Community Hospital located in Mitchell, South Dakota.[4] The Medicare contractor [5] assigned to Avera Queen for this appeal is Noridian Healthcare Solutions.[6]

On September 14, 2016, Avera Queen requested a VDA payment, adjusted for excess core staffing, of $1,021,260 for FY 2014 to compensate it for a decrease in inpatient discharges during FY 2014.[7] In a final determination letter dated March 15, 2017, the Medicare Contractor denied Avera Queen's FY 2014 request for a VDA payment, finding that the "facility does not qualify for the volume decrease adjustment as requested and no payment will be made."[8] Avera Queen 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 October 26, 2023. Avera Queen was represented by Barbara Straub Williams of Powers, Pyles, Sutter & Verville, P.C. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

---

[1] Joint Stipulations of the Parties (hereinafter "Stips.") at ¶ 2 (October 6, 2023).
[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] *See* Stips. 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] Stips. at ¶ 6.
[7] Exhibit (hereinafter "Ex.") P-2 at P000011.
[8] Ex. P-3 at P000544.

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."[9]

The regulation at 42 C.F.R. § 412.92(e) directs how the MACs 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.[10]

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.[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]

On September 3, 2024, in *Lake Region Healthcare Corp. v. Becerra,*[13] 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

Based on the Parties' stipulations, it has been determined that the issue to be resolved by the Board is whether the Medicare Contractor's denial of Avera Queen's VDA payment request was proper.[14]

---

[9] 42 U.S.C. § 1395ww(d)(5)(D)(ii).
[10] *See* 82 Fed. Reg. 37990, 38179 (Aug. 14, 2017).
[11] *Id*. at 38179-183.
[12] *Id.* at 38180.
[13] 113 F.4th at 1008-09.
[14] *See* Stips. at ¶ 2.

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."[15] Per the Stipulations, it is undisputed that Avera Queen experienced a decrease in discharges greater than five percent (5%) from FY 2013 to FY 2014 due to circumstances beyond Avera Queen's control and that, as a result, Avera Queen was eligible to have a VDA calculation performed for FY 2014.[16] In this appeal, Avera Queen disputes the "inconsistent"[17] methodology used by the Medicare Contractor 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 MS-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 [than] fully compensate those costs, in violation of Congress's unambiguous mandate.[18]

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).[19] 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] The Board finds that the "fixed-fixed" methodology is proper for the calculation of the FY 2014 VDA payment for Avera Queen.

Excess Core Staffing Adjustment

In the parties' stipulations, the Provider and the Medicare Contractor differ in the calculation of the excess core staffing adjustment they believe should be included in the VDA calculation.[23] As previously stated, the Board applies the methodology that CMS promulgated for cost reporting periods beginning *on or after* October 1, 2017 to cost reporting periods beginning *prior to*

---

[15] (Emphasis added).
[16] *See* Stips at ¶ 14.
[17] Provider's Final Position Paper (hereinafter, "Provider's FPP") at 25-29 (Aug 4, 2023).
[18] *Id.* at 18 (italics in original).
[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 11.
[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).
[23] *See* Stips at ¶¶ 27-31. For cost reporting periods prior to October 1 2017, the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM"), § 2810.1(C)(6) required that adjustments be made to a VDA payment to reduce costs for "excess staff". *Id*. at ¶ 27.

October 1, 2017. CMS' post-October 1, 2017 methodology no longer makes any adjustment for excess core staffing.[24] As such, the Board declines to calculate a core staffing adjustment.

DECISION AND ORDER

Based on the foregoing, the Board finds that the Medicare Contractor improperly calculated the FY 2014 VDA payment for Avera Queen of Peace Hospital. 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 2014 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:

7/30/2025

X Kevin D. Smith, CPA

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

[24] *See* PRM 15-1 § 2810.1.C.6.b. (Rev. 479) ("For cost reporting periods beginning on or after October 1, 2017, hospitals are no longer required to demonstrate that they adjusted the number of staff in hospital inpatient areas based on the decrease in the number of inpatient days. Contractors are no longer required to adjust the VDA payment amount for excess staffing, and the VDA payment is not subject to the payment ceiling (or cap), which is the lesser of the prior year inpatient operating costs updated to current year dollars or the current year Program inpatient operating costs.")