PROVIDER REIMBURSEMENT REVIEW BOARD DECISION
On the Record
2026-D01

PROVIDER-
Sebasticook Valley Hospital

RECORD HEARING DATE –
October 8, 2024

Provider No.: 20-0028

Cost Reporting Period Ended –
09/30/2005

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

CASE NO. – 18-1481

INDEX

ISSUE STATEMENT

Whether National Government Services, Inc. (the "Medicare Contractor") [1] properly calculated the revised volume decrease adjustment ("VDA") payment owed to Sebasticook Valley Hospital ("Sebasticook" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending September 30, 2005 ("FY 2005").[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 2005 for Sebasticook. 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

Sebasticook is an acute care hospital located in Pittsfield, Maine.[5] Sebasticook was designated as a Medicare Dependent Hospital ("MDH") during the time period at issue.[6] The Medicare contractor assigned to Sebasticook for this appeal is National Government Services, Inc.

On December 16, 2016, Sebasticook filed a timely request for a VDA payment of $1,107,702 for FY 2005 to compensate it for a decrease in inpatient discharges during FY 2005.[7] On January 26, 2018, the Medicare Contractor approved Sebasticook's VDA payment request and determined the correct payment amount to be $801,972 (the "VDA Approval").[8] Sebasticook timely appealed the Medicare Contractor's VDA Determination and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on October 8, 2024. Sebasticook was represented by William H. Stiles, Esq. of Verrill Dana, LLP. 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* Stipulations at ¶ 13 (July 24, 2024). The Board notes that the Stipulations at ¶ 14 state: "This dispute requires the Board to resolve the following *two* legal issues: (A) the lawfulness of the MAC's *reopening* of the Original VDA Approval; and (B) the lawfulness of the methodology used by the MAC to calculate the payment amount set forth in the Revised VDA Approval." (emphasis added). However, the parties' position papers and exhibits do not show evidence of a reopening. Therefore, it remains that the sole dispute to resolve is "the correct amount of the Provider's VDA payment under the applicable laws, regulations and program instructions." *Id*. at ¶ 13.
[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 Final Position Paper (hereinafter "Provider's FPP") at 1 (July 23, 2024).
[6] Stipulations at ¶ 1.
[7] Provider's FPP at 1; *see also* Exhibit (hereinafter "Ex.") P-2 at 0009 (Provider's VDA Request).
[8] Ex. C-1 at 1.

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.[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. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates that it experienced a qualifying decrease in total inpatient discharges. For cost reporting periods prior to FY 2018, CMS calculated the VDA as the difference between a hospital's fixed costs and the total DRG payments.[11] 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.[12] 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."[13]

On September 3, 2024, in *Lake Region Healthcare Corp. v. Becerra*,[14] (hereafter *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 violated 42 U.S.C. § 1395ww(d)(5).

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."[15] Per the parties' Stipulations, it is undisputed that Sebasticook experienced a decrease in discharges greater than five percent (5%) from FY 2004 to FY 2005 due to circumstances beyond Sebasticook's control and that, as a result, Sebasticook was eligible to have a VDA calculation performed for FY

[9] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[10] *Id.*
[11] *See* 82 Fed. Reg. 37990, 38180 (Aug. 14, 2017).
[12] *Id.* at 38179-83.
[13] *Id*. at 38180.
[14] 113 F.4th 1002, 1008-09.
[15] (Emphasis added).

2005.[16] In this appeal, the sole dispute to resolve is "the correct amount of the Provider's VDA payment under the applicable laws, regulations and program instructions."[17]

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).[18] Since that time, the Board has continued to issue VDA decisions applying the Board's long-standing "fixed-fixed"[19] 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).[20] In the appeals following the D.C. Circuit's *Lake Region* decision, the Administrator has declined review.[21] The Board finds that the "fixed-fixed" methodology is proper for the calculation of the FY 2005 VDA payment for Sebasticook.

DECISION AND ORDER

Based on the foregoing, the Board finds that the Medicare Contractor improperly calculated the FY 2005 VDA payment for Sebasticook. 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 2005 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:

11/17/2025

X Kevin D. Smith, CPA

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

[16] *See* Stipulations at ¶¶ 8, 12.
[17] *Id.* at ¶ 13.
[18] 113 F.4th 1002, 1008-09.
[19] *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.
[20] *See supra* at footnote 12.
[21] *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).