PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2024-D14

PROVIDER-
Fallbrook District Hospital

Provider No.: 05-0435

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –
February 2, 2024

Cost Reporting Period Ended –
6/30/2014

CASE NO. – 17-1313

INDEX

ISSUE STATEMENT

Whether Fallbrook District Hospital (the "Provider") is entitled to a volume decrease adjustment ("VDA") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2014 ("FY 2014").[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board (the "Board") finds that the Provider is eligible for a VDA calculation for FY 2014. As the VDA determination appealed did not include a VDA calculation, the Board remands this appeal to the Medicare Contractor to perform a VDA calculation for FY 2014 consistent with 42 C.F.R. § 412.92(e)(3).[2]

INTRODUCTION

The Provider is located in Fallbrook, California and was designated as a sole community hospital ("SCH") during the fiscal year at issue.[3] The Medicare contractor[4] assigned to the Provider for this appeal is WPS Government Health Administrators ("Medicare Contractor").[5]

The Provider filed a timely request for VDA payment for FY 2014.[6] On January 11, 2017, the Medicare Contractor denied the request because it concluded that "[w]e did not find the circumstances presented as reasons for the decline in discharges qualified as an unusual event or occurrence beyond the provider's control."[7] On March 3, 2017, the Provider filed a Request for Reconsideration. On June 15, 2017, the Medicare Contractor denied the request and reaffirmed its finding that the Provider failed to establish a greater than 5 percent decrease in patient volume due to circumstances beyond its control.[8] Significantly, neither the January 11, 2017 determination nor the June 15, 2017 reconsideration denial include a VDA payment calculation.

On March 23, 2017 (prior to the issuance of the June 15, 2017 reconsideration determination), the Provider filed its appeal request with the Board and the final determination appealed was the January 11, 2017 determination. Specifically, the Provider appealed the Medicare Contractor's

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[1] Provider's Optional Responsive Brief at 2 (June 22, 2023); Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 5 (May 30, 2023).
[2] All citations to the regulations in this decision are as of June 30, 2014 unless otherwise specified.
[3] Record Hearing Request and Stipulation of Facts (hereinafter "Stipulations") at ¶ 1 (Jan. 19, 2024).
[4] 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 term "Medicare contractor" refers to both FIs and MACs, as appropriate.
[5] Stipulations at ¶ 4.
[6] *Id*. at ¶ 5.
[7] VDA Denial Letter at 1, Exhibit ("Ex.") P-2. The Board notes that Stipulations at ¶ 6 *incorrectly* state that, as part of the January 11, 2017 VDA denial letter, the MAC "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." The copy of the January 11, 2017 VDA denial included in the record as an attachment to the Provider's appeal request (as well as Ex. P-2 as attached to the Provider's Final Position Paper) does ***not*** include this finding.
[8] VDA Reconsideration Letter at 1, Ex. P-4.

finding that the Provider failed to establish that the decline in discharges was due to circumstances beyond the Provider's control.

The Provider's appeal of the January 11, 2017 VDA denial was timely and met all jurisdictional requirements for a hearing before the Board. On February 2, 2024, the Board approved a record hearing on February 2, 2024. The stipulations agreed to by the parties to facilitate the hearing on the record memorialize that: (1) the Medicare Contractor ***now*** agrees the Provider met the criteria for a greater-than-5-percent decrease in discharges beyond its control; and (2) the parties agree a VDA payment calculation should be made for FY 2014 but disagree on the methodology to make that calculation.[9]

The Provider was represented by Ronald K. Rybar of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

The Medicare program 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. Pursuant to 42 U.S.C. § 1395ww(d)(5)(D)(ii), 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."

The implementing regulations, located at 42 C.F.R. § 412.92(e), reflect these statutory requirements. Pursuant to 42 C.F.R. § 412.92(e), a VDA adjustment is available to SCHs if, "due to circumstances beyond their control," they incur a decrease in their total number of inpatient discharges of more than five percent (5%) from one cost reporting year to the next:

> (e) *Additional payments to sole community hospitals experiencing a significant volume decrease*. (1) For cost reporting periods beginning on or after October 1, 1983, the intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, **due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period**. . . .
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> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement—

[9] Stipulations at ¶ 3, 8 and 11.

> (i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and
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> (ii) Show that the decrease is due to circumstances beyond the hospital's control.
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> (3) **The intermediary determines a lump sum adjustment amount** not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).
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> (i) **In determining the adjustment amount, the intermediary considers**—
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> (A) **The individual hospital's needs and circumstances**, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
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> (B) The hospital's fixed (and semifixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
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> (C) The length of time the hospital has experienced a decrease in utilization.
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> (ii) The intermediary makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.
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> (iii) **The intermediary determination is subject to review under subpart R of part 405 of this chapter**.[10]

Significantly, 42 C.F.R. § 412.92(e)(3) makes clear that, when calculating a VDA payment, the Medicare Contactor must take into account multiple factors including but not limited to "[t]he individual hospital's needs and circumstances."

[10] (Bold and underline emphasis added.)

The Medicare Contractor denied the Provider's original and reconsideration requests for a VDA payment in the amount of $1,777,676,[11], noting that the Provider failed to establish that the decline in discharges was due to an unusual event or occurrence beyond its control. *Significantly, the original January 11, 2017 determination* that was appealed to the Board *did not include a VDA calculation*.[12]

More than seven (7) years after the Provider filed its appeal of the original January 11, 2017 determination, the Provider submitted a record hearing and, with that request, included stipulations agreed to by the Parties wherein the Medicare Contractor ***now*** recognizes that the "Provider met the criteria in 42 C.F.R. § 412.92(e) for the fiscal year at issue…"[13], "[t]he Provider experienced a decrease in discharges of more than five percent…"[14] and "[t]he remaining issue to be determined is the correct VDA payment calculation."[15]

Following the parties' stipulation that the Provider ***now*** qualifies to have a VDA payment calculation performed for FY 2014, the parties then determined that they dispute the appropriate application of the statute and regulation governing VDAs for purposes of calculating the FY 2014 VDA payment.[16]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Pursuant to 42 C.F.R. § 412.92(e)(3)(iii), a Medicare contractor's VDA "***determination*** is subject to [Board] review under subpart R of part 405 of this chapter."[17] Accordingly, the Board finds it has jurisdiction in this case as a result of the original January 11, 2017 VDA denial that was appealed to the Board. This *determination* contends that the Provider did not meet the greater than five percent (5%) decrease in discharges between years due to an unusual event or occurrence beyond its control. However, the original January 11, 2017 VDA determination that the Provider appealed did *not* include a formal Medicare Contractor determination of the amount the Provider would be due (if any) under 42 C.F.R. § 412.92(e)(3) if it were eligible for a VDA adjustment for FY 2014.[18] Similarly, the appeal request filed by the Provider does not raise the *methodology* for the VDA calculation as a disputed item for appeal, presumably because the Medicare Contactor had not yet issued a determination on a VDA calculation since it had determined that the Provider did not qualify for a VDA adjustment calculation in the first instance. Indeed, in this regard, the Board notes that its review is limited to "the intermediary determination" per 42 C.F.R. § 412.92(e)(3) and the determination appealed to the Board (the January 11, 2017 VDA denial) did not address or make any determination on a VDA payment or a methodology for that payment. Therefore, the issue properly before the Board in this case is limited to the January 11, 2017 VDA denial for FY 2014 and whether, for FY 2014, the Provider

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[11] Ex. P-1 at 26 (copy of the VDA request).
[12] Indeed, the Medicare Contractor's position did not change even in the later June 15, 2017 reconsideration denial *which was **neither** formally appealed to the Board **nor** formally added to this case*.
[13] Stipulations at ¶ 3.
[14] *Id*. at ¶ 5.
[15] *Id*. at ¶ 7.
[16] Provider's FPP at 10-11; Medicare Contractor's FPP at 22-24.
[17] (Emphasis added.)
[18] *See supra* note 11.

"experience[d], due to circumstances as described in paragraph (e)(2) of this section, a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period."[19]

Consistent with 42 U.S.C. § 1395ww(d)(5)(D)(ii) *and* based upon the Board's finding of jurisdiction, the parties' stipulations, the parties' agreement to conduct a hearing on the record, and the record before the Board, the Board:

1. Accepts the parties' agreement in the Stipulations at ¶¶ 3 and 5 that, for FY 2014, "the Provider met the criteria in 42 C.F.R. § 412.92(e)"[20] specifying that, in order to be eligible for a VDA payment calculation FY 2014, it must experience, due to circumstances beyond is control, a decrease in discharges more than five percent (5%) for FY 2014 in comparison to FY 2013; and

2. Finds that the Provider is ***now*** *eligible* to have a VDA calculation completed by the Medicare Contractor for FY 2014.

However, the record before the Board shows that the Medicare Contractor did *not* make and issue, pursuant to 42 C.F.R. § 412.92(e)(3)(i)-(ii), a determination on the VDA calculation ***in the January 11, 2017 determination that is on appeal to the Board in the instant case***.[21] This regulation specifies that, when making a VDA calculation, the Medicare Contactor must take into account multiple factors, including but not limited to "the individual hospital's needs and circumstances."[22] As 42 C.F.R. § 412.92(e)(3)(iii) limits Board review to the determination on appeal, and the January 11, 2017 determination appealed to the Board did not address or make a VDA calculation for FY 2014, the Board finds that remand to the Medicare Contractor is appropriate. Accordingly, pursuant to its authority under 42 C.F.R. § 405.1845(h), the Board hereby remands this appeal to the Medicare Contractor with direction to perform a VDA calculation consistent with 42 C.F.R. § 412.92(e)(3) and, if indicated by the calculation, to make an additional VDA payment for FY 2014. The Board's remand in this case is consistent with its remand in other cases with similar circumstances[23]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Provider is eligible for a VDA calculation for FY 2014. As the

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[19] 42 C.F.R. § 412.92(e)(1).
[20] Stipulations at ¶ 3.
[21] Provider has included with their Final Position Paper a copy (Ex. P-10) of revised cost report worksheets showing the Provider's calculation of revised inpatient operating costs.
[22] 42 C.F.R. § 412.92(e)(3)(i)(A).
[23] Examples of recent VDA cases where the Board has remanded back to the Medicare contractor include: *Methodist Hosp. South fka South Texas Reg'l Med. Ctr. v. WPS- Gov. Health Adm'rs*, PRRB Dec. 2022-D36 (Sept. 26, 2022); *Skiff Med. Ctr. v. Wisconsin Physicians Serv.*, PRRB Dec. 2022-D19 (April 27, 2022); *Grinnell Reg'l Med. Ctr. v. Wisconsin Physicians Serv.*, PRRB Dec. 2016-D03 (Dec. 1, 2015); *Alta Vista Reg'l Hosp. v. Wisconsin Physicians Serv.*, PRRB Dec. 2015-D9 (May 12, 2015); *Porter Hosp. Middlebury, Vt. v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2013-D34 (Aug. 29, 2013); *Rice Mem'l Hosp. v. National Gov. Servs.*, PRRB Dec. 2018-D51 (Sept. 28, 2018); *St. Mary's Reg'l Hosp. v. National Gov. Servs.*, PRRB Dec. 2018-D52 (Sept. 28, 2018).

VDA determination appealed did not include a VDA calculation, the Board remands this appeal to the Medicare Contractor to perform a VDA calculation for FY 2014 consistent with 42 C.F.R. § 412.92(e)(3).

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

5/17/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV