PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D19

PROVIDER-
Skiff Medical Center

Provider No.: 16-0032

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

RECORD HEARING DATE –
April 6, 2021

Cost Reporting Period Ended –
6/30/2011

CASE NO. 15-3335

CONTENTS

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Skiff Medical Center ("Skiff" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2011 ("FY 2011").[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that Skiff is eligible for a VDA calculation for FY 2011. 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 2011 consistent with 42 C.F.R. § 412.108(d)(3) (2012).

INTRODUCTION

Skiff is a Medicare Dependent Hospital ("MDH") located in Newton, Iowa.[2] The Medicare contractor[3] assigned to Skiff for this appeal is WPS Government Health Administrators. ("Medicare Contractor"). Skiff initially requested a VDA adjustment on October 2, 2014.[4] The Medicare Contractor denied Skiff's request via letter dated April 2, 2015, noting that the request did not establish that the decline in discharges was due to an unusual event or occurrence beyond the Skiff's control.[5] Skiff requested reconsideration of the denial via letter dated May 29, 2015. On October 1, 2015, the Medicare Contractor denied Skiff's request for reconsideration, again noting that Skiff failed to establish that the decline in discharges was due to an unusual event or occurrence beyond Skiff's control.[6] Skiff 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 April 6, 2021. Skiff was represented by Ronald 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

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. Pursuant to 42 U.S.C. § 1395ww(d)(5)(G)(iii), VDA payments are designed to fully compensate a hospital for the fixed

[1] Provider's Consolidated Final Position Paper ("Provider's FPP"), 2 (Dec. 29, 2021); Medicare Contractor's Consolidated Final Position Paper ("Medicare Contractor's FPP"), 3 (Jan. 27, 2021).
[2] Stipulations at ¶ 1.
[3] 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 and relevant.
[4] Stipulations at ¶ 4.
[5] Medicare Contractor's FPP at 6.
[6] *Id*.

costs it incurs for providing inpatient hospital services in the period covered by the VDA, including the reasonable cost of maintaining necessary core staff and services.

The implementing regulations are located at 42 C.F.R. § 412.108(d) (2012). When promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals ("SCHs").[7] Pursuant to 42 C.F.R. § 412.108(d) (2012), a VDA adjustment is available to MDHs if, "due to circumstances beyond their control," they incur a decrease in their total number of inpatient discharges of more than 5 percent from one cost reporting year to the next:

> (d) *Additional payments to hospitals experiencing a significant volume decrease.* (1) CMS provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, **due to circumstances as described in paragraph (d)(2) of this section, a more than 5 percent decrease in its total inpatient discharges** as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.
>
> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement and **it must**-
>
> > (i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and
> >
> > (ii) **Show that the decrease is due to circumstances beyond the hospital's control.**
>
> (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 hospitals that serve a disproportionate share of low-income

[7] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> patients as determined under §412.106 and for indirect medical education costs as determined under §412.105).
>
> (i) **In determining the adjustment amount, the intermediary considers** -
>
> (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;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
>
> (C) The length of time the hospital has experienced a decrease in utilization.
> **(ii)** The intermediary makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.
> **(iii)** The intermediary determination is subject to review under subpart R of part 405 of this chapter. The time required by the intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.[8]

Significantly, § 412.108(d)(3) makes clear that, when calculating a VDA payment, the Medicare Contactor must take into account multiple factors including but not limited to "the individual hospital's needs and circumstances."

In response to Skiff's request for a VDA payment in the amount of $1,573,092, the Medicare Contractor denied Skiff's original and reconsideration requests, noting that "the Provider failed to establish that the decline in discharges was due to an unusual event or occurrence beyond the Provider's control."[9] Neither the original determination nor the reconsideration determination included a VDA calculation.

On appeal, the Medicare Contractor signed Stipulations recognizing that it "has since acquiesced on the five percent criteria, but does not agree that [Skiff] is entitled to the payment it seeks" and that it has "calculated a VDA payment of $0."[10]

The parties to this appeal dispute the application of the statute and regulations used to calculate the VDA payment.[11]

---

[8] (Emphasis added.) *See also* 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[9] Medicare Contractor's FPP at 6.
[10] *Id.*
[11] Provider's FPP at 9; Medicare Contractor's FPP at 6-7.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Pursuant to 42. C.F.R. § 412.108(d)(3)(iii), a Medicare contractor's VDA "determination is subject to [Board] review under subpart R of part 405 of this chapter." Accordingly, the Board finds it has jurisdiction in this case as a result of the original VDA denial and the reconsideration denial. Both determinations contend that Skiff did not meet the 5 percent decrease in discharges between years "due to an unusual event or occurrence beyond the Provider's control."[12] However, neither the original VDA determination nor the reconsideration that are at issue includes a formal Medicare Contractor determination on the amount Skiff would be due under § 412.108(d)(3) if it were eligible for a VDA adjustment. Similarly, the appeal request filed by Skiff does not raise the *methodology* for the VDA calculation as a disputed item for appeal, presumably because the Medicare Contactor had not yet had to issue a determination on a VDA calculation since it had determined that Skiff did not qualify for a VDA adjustment.

Consistent with 42 U.S.C. 1395ww(d)(5)(G)(iii) *and* based upon the Board's finding of jurisdiction, the parties' stipulations, the parties' agreement to conduct a hearing on record, and the record before the Board, the Board accepts Stipulation ¶ 5 and finds that Skiff is eligible for a VDA calculation for FY 2011 and, consistent with § 412.108(d)(3) (2012), the Medicare Contactor must take into account multiple factors, including but not limited to "the individual hospital's needs and circumstances," when making this calculation. Accordingly, the Board remands this appeal to the Medicare Contractor with direction to perform a VDA calculation consistent with § 412.108(d)(3) (2012) and, if indicated by the calculation, to make an additional VDA payment for FY 2011.

DECISION AND ORDER

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Skiff is eligible to have a VDA calculation performed. Accordingly, the Board remands this appeal and directs the Medicare Contractor to perform the VDA calculation for FY 2011, consistent with 42 C.F.R. § 412.108(d)(3) (2012).

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/27/2022

X Clayton J. Nix

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

[12] Medicare Contractor's FPP at 6,