PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2022-D36

PROVIDER-
Methodist Hospital South,
formerly known as South Texas Regional
Medical Center

Provider No.: 45-0165

vs.

MEDICARE CONTRACTOR –
WPS- Government Health Administrators

RECORD HEARING DATE –
April 12, 2021

Cost Reporting Period Ended –
6/30/2013

CASE NO. – 17-0182

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Methodist Hospital South, formerly known as South Texas Regional Medical Center, ("Methodist Hospital" or the "Provider") for the significant decrease in inpatient discharges that occurred in its cost reporting period ending June 30, 2013 ("FY 2013").[1]

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that Methodist Hospital is eligible for a VDA calculation for FY 2013. 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 2013 consistent with 42 C.F.R. § 412.92(e)(3) (2013).

INTRODUCTION

Methodist Hospital is located in Jourdanton, Texas and was designated as a sole community hospital ("SCH") during the fiscal year at issue.[2] The Medicare contractor[3] assigned to Methodist Hospital for this appeal is WPS Government Health Administrators ("Medicare Contractor").[4] Methodist Hospital filed a timely request for VDA payment for FY 2013.[5] On May 20, 2016, the Medicare Contractor denied the request because it concluded that Methodist Hospital "did not suffer a decrease in patient volume of greater than five percent due to circumstances beyond its control."[6] On July 27, 2016, Methodist Hospital filed a Request for Reconsideration. On October 13, 2016, the Medicare Contractor denied the request and reaffirmed its finding that Methodist Hospital failed to establish a 5 percent decrease in patient volume due to circumstances beyond its control.[7] Significantly, neither the May 20, 2016 determination nor the October 13, 2016 reconsideration denial include a VDA payment calculation.

On October 19, 2016, the Board received Methodist Hospital's appeal request. The stipulations attached to the request memorialize that the Medicare Contractor now agrees Methodist Hospital

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[1] Provider Final Position Paper ("Provider's FPP") at 3; Medicare Contractor Final Position Paper ("Medicare Contractor's FPP") at 2.

[2] Record Hearing Request and Stipulation of Facts, dated March 2, 2021 (hereinafter "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.

[4] Stipulations at ¶ 3

[5] Stipulations at ¶ 4.

[6] Medicare Contractor's FPP at 6.

[7] Stipulations at ¶ 6. The Board notes that Stipulations at ¶ 6 *incorrectly* state that, as part of the October 13, 2016 reconsideration denial, "[t]he 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 October 13, 2016 reconsideration denial included in the record as an attachment to the Provider's appeal request (as well as Exhibit P-4 as attached to the Provider's FPP) does ***not*** include this finding.

met the 5 percent criteria and, as a result, only the VDA payment calculation remains in dispute.[8] Methodist Hospital 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 12, 2021. Methodist Hospital South 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) (2013), 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 5 percent 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**. . . .
>
> (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—
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> (i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and

[8] *Id.*

(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 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).

(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 semifixed) 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**.[9]

Significantly, § 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."

In response to Methodist Hospital's request for a VDA payment in the amount of $1,035,743,[10] the Medicare Contractor denied Methodist Hospital's original and reconsideration requests,

[9] (Bold and underline emphasis added.)
[10] Exhibit P-1 (copy of the VDA request).

noting that Methodist Hospital failed to establish that the decline in discharges was due to an unusual event or occurrence beyond its control. *Significantly, neither the original determination nor the reconsideration denial included a VDA calculation*.

Following Methodist Hospital's appeal, the Medicare Contractor signed stipulations recognizing that "[t]he parties [*sic* Parties] have since stipulated that the Provider met the five percent criteria, but the Parties still disagree on the [VDA] payment calculation."

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

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."[12] 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 Methodist Hospital did not meet the 5 percent decrease in discharges between years due to an unusual event or occurrence beyond its control. However, neither the original VDA determination nor the reconsideration denial that are at issue included a formal Medicare Contractor determination of the amount Methodist Hospital would be due under § 412.92(e)(3) if it were eligible for a VDA adjustment for FY 2013. Similarly, the appeal request filed by Methodist Hospital 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 Methodist Hospital did not qualify for a VDA adjustment. Therefore, the issue properly before the Board in this case is limited to whether Methodist Hospital is *eligible* to have a VDA calculation performed.

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 accepts the parties' agreement in Stipulation ¶ 6 that "the Provider met the five percent criteria" and finds that Methodist Hospital is *eligible* for a VDA calculation for FY 2013. However, the record before the Board shows that the Medicare Contractor did *not* make and issue a ***determination*** on the VDA calculation pursuant to 42 C.F.R. § 412.92(e)(3)(i)-(ii).[13] 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." Accordingly, pursuant to its authority under 42

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[11] Provider's FPP at 11-14; Medicare Contractor's FPP at 7-12.

[12] (Emphasis added.)

[13] Provider's Amended Responsive Brief includes as Exhibit P-1, attached thereto, a copy of the Medicare Contractor's workpapers. However, these workpapers are not a determination and were not finalized and issued to the Provider with appeal rights. Examples of recent VDA cases where the Board has remanded back to the Medicare contractor include: *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).

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 § 412.92(e)(3) (2013) and, if indicated by the calculation, to make an additional VDA payment for FY 2013.

DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that Methodist Hospital is eligible for a VDA calculation for FY 2013. 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 2013 consistent with 42 C.F.R. § 412.92(e)(3) (2013).

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FOR THE BOARD:

9/26/2022

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