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|  | Whether the MAC’s final determination of the Provider’s Medicare Dependent Hospital (“MDH”) Volume Decrease Adjustment (“VDA”) was properly calculated and denied. |

**A. Facts**

The Provider was issued an initial Notice of Program Reimbursement (NPR) on July 23, 2021. The Provider timely filed a request to the MAC for a Medicare Dependent Hospital (MDH) Volume Decrease Adjustment (VDA) on July 22, 2021. **Reference P-1.[[1]](#footnote-1)** The MAC reviewed this request and determined that the Provider did not qualify for a VDA payment because the Provider’s DRG payments exceeded the calculated fixed operating costs. Therefore, the MAC denied the Provider’s request on May 18, 2022. **Reference Exhibit C-1.** The Provider timely filed an appeal to the Board on November 11, 2022, contesting the methodology of the MAC’s calculation and the resulting denial of a VDA payment.

The MAC’s VDA Payment Calculation was properly calculated in accordance with PRM instructions and is supported by court decisions. **Reference Exhibit C-2.**  The Provider’s calculation is based on recent CMS Administrator’s methodology and requested a balance of $1,435,269. **Reference Exhibit C-3, page 1.**

Section 1886(d)(5)(D)(ii) of the Act requires that the Secretary make a payment adjustment to an SCH that experiences a decrease of more than 5% in its total number of inpatient discharges from one cost reporting period to the next, if the circumstances leading to the decline in discharges were beyond its control.

The implementing regulation was codified at 42 C.F.R. § 412.108(d) (**Exhibit C-4**), with language similar to the statute referenced above, requiring the MDH to submit its request no later than 180 days after the date of the intermediary’s Notice of Program Reimbursement (“NPR”), accompanied by documentation demonstrating the size of decrease in discharges and that the circumstances were beyond the hospital’s control. The regulation states:

(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.

In addition, CMS PRM 15-1, Section 2810.1(C)[[2]](#footnote-2) (**Exhibit C-5, page 10**), requires the request to include the following documentation:

1. General Information. – The request must include the requesting hospital's name, address, provider number and date of classification as an SCH.

2. Discharge Data. – The SCH must submit data on the number of discharges in the cost reporting period for which the payment adjustment is being requested and the number of discharges in the cost reporting period immediately preceding the period in question. If either the preceding cost reporting period or the period in which the decline occurred is not 12 months in duration, the hospital must annualize discharges in the short cost reporting period. …

3. Circumstances. – The hospital's request must include documentation outlining the circumstances that resulted in the decrease in discharges. This must include a narrative description of the occurrence, date of its onset, and how it affected the number of discharges.

4. Cost Data. – The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding pass-through costs, exceeds DRG payments, including outlier payments. No adjustment is allowed if DRG payments exceeded program inpatient operating cost.

5. Semi fixed Costs. – The request must include a narrative description of those actions taken by the hospital to reduce semifixed costs.

6. Core Staff and Services. – A comparison, by cost center, of full-time equivalent employees and salaries in both cost reporting periods must be submitted. The requesting hospital must identify core staff and services in each center and the cost of these staff and services. The request must include justification of the selection of core staff and services including minimum staffing requirements imposed by an external source. The intermediary's analysis of core staff is limited to those cost centers (General Service, Inpatient, Ancillary, etc.) whose costs are components of Medicare inpatient operating cost.

CMS defines “circumstances beyond the hospital’s control” at PRM 15-1, Section 2810.1(A)(1) (**Exhibit C-5, page 8**):

1. Circumstances Beyond the Hospital's Control. – In order for an SCH to qualify for additional payment, the decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects.

CMS reiterated the necessity to test circumstances beyond the provider’s control after

the 1987 Final Rule. CMS stated in the April 20, 1990, Federal Register, Vol 55, Page 15155 (**Exhibit C-6**) that:

The basic test for evaluating a hospital’s request for special payments due to circumstances beyond its control (in this case, a decrease in volume) is whether the decrease in volume is the result of an unusual situation or occurrence that is both externally imposed on the hospital and beyond its control. These situations may include, but are not limited to, strikes, fires, floods, inability to recruit essential physician staff, unusual, prolonged, and severe weather conditions that affect the local economy, the closing of a major employer in the hospital’s service area resulting in decreased population or loss of inpatient health insurance coverage for large numbers of people, and similar unusual occurrences with substantial cost effects.

Fairmont Regional Medical Center was designated as an Medicare Dependent Hospital (MDH) for its cost reporting period ending December 31, 2017. The Provider contends that it met the criteria set forth in the regulations to qualify for a VDA for the cost reporting period. It cites a 7.49% decline in discharges due to two competing hospitals that opened new medical facilities that resulted in a large staff turnover during 2017 (**Exhibit C-3, page 2**). This resulted in increased physician transfers out of Fairmont Regional, reduced inpatient volume and failed recruitment of new physicians and RNs, all of which are circumstances claimed to be beyond the Hospital’s control. The parties do not dispute that the Provider experienced a greater than 5% decline in discharges between years from circumstances that were beyond the hospital’s control. However, the parties disagree on the calculation of the amount of the VDA payment in accordance with the statute and regulations. More specifically, the Provider disagrees with the MAC’s calculation of the VDA payment as the MAC’s methodology calculated the Provider’s VDA payment by comparing the Provider’s fixed program operating costs to its total DRG payment.

Both parties used the Current Year (CY) Total Inpatient Operating Cost (as the lessor amount between CY and Prior Year (PY) Updated Cost) to find the difference between costs and the CY Total DRG Payments for the period. No reduction was required to be made to the 2017 Inpatient Operating Expenses for excess core staffing salary under PRM-1, Section 2810.1.C.6. Reference **Exhibit C-5**. This initial calculation established the VDA maximum, or ceiling.

The MAC then determined how much of the total expenses were attributable to variable expenses and fixed/semi-fixed expenses using the documentation submitted by the Provider as the basis for the calculation. This resulted in a fixed cost ratio of 85.59%. The Provider does not disagree with the fixed cost ratio used by the MAC, as the ratio was used in the Provider’s own calculation (**Exhibit C-3, page 3**). It is here, the use of the fixed cost ratio in the calculation, in which the MAC and Provider disagree. The MAC applied the fixed ratio to the CY Total Inpatient Operating Costs to determine the amount attributable to fixed/semi-fixed costs (Total Inpatient Operating Costs – Fixed). The difference between the Total Inpatient Operating Costs - Fixed and the Total DRG Payments for the year resulted in a negative amount and no allowable VDA payment to the Provider. Reference **Exhibit C-2**. The Provider’s calculations apply the fixed cost ratio to both the Total Inpatient Operating Costs and Total DRG Payments before finding the difference between the two components, resulting in a VDA payment amount of $1,435,269. Reference **Exhibit C-3, page 1**. This methodology is nearly identical to the methodology adopted by CMS in the IPPS Final Rule for FY 2018.

The parties disagree on the methodology used to calculate the VDA payment, specifically as it relates to the use of the fixed cost ratio to arrive at the components (Total Inpatient Operating Costs and Total DRG Payments) used in the VDA calculation to the Provider. The Provider contends that the MAC’s payment calculation applies an inherently flawed methodology for calculating the Provider’s VDA, which did not fully compensate the Provider for all of its fixed costs as Congress requires. The MAC contends that its calculation of the Provider’s VDA was reasonable, proper and supported by recent CMS Administrator and Court decisions.

**B. Arguments**

1. **The MAC’s Calculation of the VDA is a Reasonable and Proper Treatment**

The Provider contends that the MAC’S calculation does not fully compensate Provider for its fixed costs because (a) DRG payments include payments for both fixed and variable costs and (b) the MAC cannot compare Provider’s fixed costs to the DRG payments for fixed and variable costs to assert that the MDH has been fully compensated for its fixed costs.[[3]](#footnote-3) The Provider refers to the Board’s decision in *Galesburg Cottage* to show that it was not fully compensated for its fixed costs. However, in *Galesburg Cottage Hospital v. WPS Government Health Administrators*, Adm. Rev. PRRB Dec. 2023-D9 (April 7, 2023), the Administrator finds that the MAC properly determined that the Provider had been fully compensated for its fixed costs and denied the Provider’s additional payment request. Reference **Exhibit C-7.**

PRM 15-1, Section 2810.1(B), Amount of Payment Adjustment, details the methodology for calculating the VDA payment. This section, along with PRM 15-1, Section 2810.1(C), provides examples of fixed, semifixed, and variable costs. Reference **Exhibit C-5**. However, the PRM examples do not show how to exclude the variable cost factor. PRM 15-I, Section 2810.1B states:

B. Amount of Payment Adjustment. – **Additional payment is made to an eligible SCH 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, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.

Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital related costs and are paid on a reasonable cost basis, regardless of volume. **Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.**

In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semifixed costs, such as personnel-related costs, may be considered as fixed on a case-by case basis.

In evaluating semifixed costs, the intermediary considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment.

The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The intermediary reviews the determination of core staff and services based on an individual hospital’s needs and circumstances; e.g. minimum staff requirements imposed by State agencies. (Emphasis added, **Exhibit C-5, page 9**)

The MAC’s calculation is consistent with the PRM 15-1, Section 2810.1B. The MAC utilized the Provider’s categorized expense documentation as it was submitted to the MAC. The MAC evaluated the semi-fixed and fixed costs to determine the fixed cost ratio of 85.59%.

As evidenced by the explicit wording of the regulations at 42 C.F.R. § 412.108(d)(3),

the additional payment should not exceed the difference between the hospital’s Medicare inpatient operating costs and the hospital’s DRG revenue.

(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 …

(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. (**Exhibit C-4, pages 3-4**)

The law is quite clear when it states that the payment adjustment is “… to fully compensate the hospital for the **fixed costs** it incurs in the period in providing inpatient hospital services, including the reasonable costs of maintaining necessary core staff and services.” 42 USC § 1395ww(d)(5)(D)(ii). (Emphasis Added.) Neither the statute nor the regulation include a reference to compensation for ***variable costs***. Again, the regulations mirror the wording of the statute, with no mention of variable costs. Program policy is also consistent with the aforesaid regulation.

1. **The MAC’s Methodology for Calculating the VDA Payment is Consistent with Administrator and District Court Decisions**

The MAC asserts that the additional payment is to compensate for the fixed and semifixed costs only, not variable costs. Under similar circumstances, the Board decided in *Greenwood County Hospital v. BCBSA/Blue Cross Blue Shield of Kansas,* PRRB Dec. 2006-D43, dated August 29, 2006, (**Exhibit C-8**), that the Intermediary correctly chose not to consider variable costs in its payment adjustment amount and that 42 C.F.R. § 412.92(e) and PRM 15-1, Section 2810.1 (**Exhibit C-5**), explicitly dictate the adjustment is limited to fixed and semi-fixed costs.

Likewise, the CMS Administrator also affirmed this methodology in *Lakes Regional Healthcare v. BCBSA*/*Wisconsin Physicians Service*, Adm. Dec. 2014-D16, dated September 4, 2014 (**Exhibit C-9**), and *Unity Healthcare v. BCBSA/Wisconsin Physicians Service*, Adm. Dec. 2014-D15, dated September 4, 2014 (**Exhibit C-10**). Both *Lakes Regional Healthcare* and *Unity Healthcare* appealed the Administrator’s decisions to the United States District Court for the Southern District of Iowa. On January 30, 2018, the District Court found “the Secretary’s decision regarding VDA payments to plaintiff hospitals was not arbitrary, capricious or contrary to law and was supported by substantial evidence” and as such affirmed the Secretary’s decision. (**Exhibit C-11**)The District Court’s decision was affirmed by the Eighth Circuit Court of Appeals. *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019). (**Exhibit C-12**)

In addition, the removal of variable costs from the VDA calculation has also been affirmed in the Administrator’s Decision in *Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association,* Adm. Dec. 2015-D11, dated August 5, 2015 (**Exhibit C-13, page 5**)**.** The Administrator’s Decision states:

The plain language of the relevant statute and regulation, § 1886(d)(5)(G)(iii) and 42 C.F.R § 412.108(d), make it clear that the VDA is intended to compensate qualifying hospitals for their fixed costs, not for their variable costs. Therefore, pursuant to the statute, regulation and CMS guidance from the Federal Register and PRM, variable costs are to be excluded from the VDA calculation. This is consistent with the statute, CMS regulations and the Board's previous decision regarding VDAs in the case of *Greenwood County Hospital,* PRRB Decision No. 2006-D43 *("Greenwood'').*

Additionally, In *Fairbanks*, the Administrator commented:

[T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue … in contrast to the DRG revenue used by the MAC … In doing so the Board created a “fixed cost percentage” which does not have any source of authority pursuant to CMS guidance, regulations or the underlying purpose of the VDA amount.

The SCH VDA payments are intended to compensate SCHs that incur losses or reductions that are recognized under the statute and regulations for their fixed costs due to a decrease in patient discharges of more than five percent from one cost reporting year to the next, due to circumstances beyond their control. The VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider by comparing the provider's actual costs exclusive of variable costs to the actual amounts paid to the provider under the IPPS/DRG methodology. (**Exhibit C-13, page 8**)

CMS has remained consistent in supporting the methodology used by the MAC, as evidenced by the Administrator Decisions in *St. Anthony Regional Hospital v. Wisconsin Physicians Service*, Adm. Rev. PRRB Dec. 2016-D16 (October 3, 2016) (**Exhibit C-14**) and *Trinity Regional Medical Center v. Wisconsin Physician Services*, Adm. Rev. PRRB Dec. 2017-D1 (February 9, 2017)[[4]](#footnote-4) (**Exhibit C-15**).

In addition, in *St. Anthony Regional Hospital v. Hargan*, U.S. District Court, N.D. Iowa (December 29, 2017) (**Exhibit C-16**)**,** the magistrate judge of the U.S. District Court for the Northern District of Iowa Central Division and the U.S. District Court for the Southern District of Iowa recommended that the district judge uphold the Secretary’s decision. The District Judge reviewed the St. Anthony case and agreed that the Secretary’s decision should be upheld. Reference *St. Anthony Regional Hospital v. Azar*, U.S. District Court, N.D. Iowa (February 6, 2018) (**Exhibit C-17**).

Further, the MAC contends that the current approach in calculating the volume decrease adjustment is reasonable and consistent with the statute. In the FY 2018 IPPS Final Rule (82 FR 38179-38183), CMS addressed hospitals’ concerns regarding the comparison of fixed costs to total revenue. The August 14, 2017, Federal Register states in part:

We continue to believe that our current approach in calculating volume decrease adjustments is reasonable and consistent with the statute. The relevant statutory provisions, at sections 1886(d)(5)(D)(ii) and 1886(d)(5)(G)(iii) of the Act, are silent about and thus delegate to the Secretary the responsibility of determining which costs are to be deemed “fixed” and what level of adjustment to IPPS payments may be necessary to ensure that total Medicare payments have fully compensated an SCH or MDH for its “fixed” costs. These provisions suggest that the volume decrease adjustment amount should be reduced (or eliminated as the case may be) to the extent that some or all of an SCH’s or MDH’s fixed costs have already been compensated through other Medicare subsection (d) payments. The Secretary’s current approach is also consistent with the regulations and the PRM-1. Like the statute, the relevant regulations do not address variable costs, and the regulations and the PRM-1 (along with the Secretary’s preambles to issued rules (48 FR 39781 through 39782 and 55 FR 15156) and adjudications) all make it clear that the volume decrease adjustment is intended to compensate SCHs and MDHs for their fixed costs, not for their variable costs, and the variable costs should be excluded from the volume decrease calculation.

82 FR 38180 (**Exhibit C-18, page 2**)

Regarding the revised VDA calculation methodology finalized in the FY 2018 IPPS Final Rule, the U.S. District Court for the Southern District of Iowa (**Exhibit C-11**, **pages 20-21**) further opined:

While this matter has been pending, CMS posted notice of a proposed rule change on April 28, 2017, which plaintiff Lakes Regional has brought to the Court's attention. The proposed rule change directly addresses the VDA calculation methodology discussed above, albeit prospectively only for cost reporting periods beginning on or after October 1, 2017. Federal Register, Vol. 82, No. 081, Part II, 82 FR 19796, 19935. […]

The Court does not reach the issue how the Proposed Rule or Final Rule apply to plaintiffs' VDA calculations as it agrees neither have any effect in the present case. With respect to the Proposed Rule, under Eighth Circuit law, “proposed regulations … have no legal effect.” *United States v. Springer*, 354 F.3d 772, 776 (8th Cir. 2004) (quoting *Sweet v. Sheahan*, 235 F.3d 80, 87, 2d Cir. 2000)). As for the Final Rule, by its terms it applies to “cost reporting periods beginning on or after October 1, 2017.” (Ex. A at 14)(“We also do not agree that we should apply our proposed methodology retroactively.” (Id. at 13)). Plaintiff does not specifically seek retroactive application of the Final Rule but argues it is evidence the Secretary's application of the VDA methodology in the present case was arbitrary, capricious, and an abuse of discretion. (Pl. Brief [33-1] at 4). “The mere fact that regulations were modified, without more, is simply not enough to demonstrate that the prior regulations were invalid.” *LaRouche v. Fed. Election Comm'n*, 28 F.3d 137, 141 (D.C. Cir. 1994). *See also Nat'l Cable & Telcomms. Ass'n v. Brand X Internet Servs*., 545 U.S. 967, 981-82 (2005)(“An initial agency interpretation is not instantly carved in stone. On the contrary, the agency … must consider varying interpretations and the wisdom of its policy on a continuing basis …,” quoting *Chevron, USA v. Nat'l Resources Defense Council, Inc*., 467 U.S. 837, 863-64 (2008)); *Smiley v. Citibank*, 517 U.S. 735, 741-42 (1996)(“change is not invalidating”). The fact that the Secretary has made modifications to VDA methodology to be applied to future cases has no effect on the Court's findings in the present case.

Therefore, the MAC contends that its VDA determination was properly calculated in accordance with the guidelines and requirements under the existing statute, regulations and policy instructions and various court decisions.

The evidence clearly demonstrates that **variable** **costs** are not to be considered in the calculation of the VDA. Furthermore, the evidence does not mention removing **payments** from the calculation that are associated with variable costs. The MAC concludes its calculation is reasonable and proper as the VDA payment amount is calculated by removing the **variable costs** only as described in the PRM.

Lastly, the MAC contends that the Board is bound by 42 CFR § 405.1867, in which, “[T]he Board must comply with all provisions of Title XVIII of the Act and regulations issued thereunder as well as CMS Rulings. … The Board must afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.” Based on 42 CFR § 405.1867, the Board must comply with the above cited statutes, regulations, PRM and Court decisions and does not have the authority to revise the VDA calculation methodology established prior to the FY 2018 Final Rule[[5]](#footnote-5).

**C. Conclusion**

In accordance with 42 C.F.R. § 412.108(d), PRM 15-1, Section 2810.1 and the above mentioned case law, the MAC respectfully requests that the Board affirm the MAC’s MDH Volume Decrease Adjustment calculation.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

**Laws**:

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| SSA §1886(d)(5)(D)(ii) | Payment to hospitals for inpatient hospital services – Sole Community Hospital (volume decrease payment) |
| 42 U.S.C.§1395ww(d)(5)(G) | Payment to hospitals for inpatient hospital services |

**Regulations:**

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| 42 C.F.R. § 412.92 | Special treatment: Sole Community Hospitals |
| 42 C.F.R. § 412.108(d) | Special treatment: Medicare Dependent, small rural hospitals |
| 42 C.F.R. § 405.1867 | Scope of Board’s Legal Authority |

**Program Instructions:**

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| PRM 15-1, §2810.1 | Additional Payments to SCHs That Experience a Decrease in Discharges |

**Federal Registers:**

|  |  |
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| 55 FR 15155 | April 20, 1990 |
| 82 FR 38179 - 38182 | August 14, 2017 |

**Case Law:**

*Fairbanks Memorial Hospital v. Wisconsin Physician Services/BlueCross BlueShield Association*, Adm. Dec. 2015-D11, (August 5, 2015)

*Galesburg Cottage Hospital v. WPS Government Health Administrators*, Adm. Rev. PRRB Dec. 2023-D9 (April 7, 2023)

*Greenwood County Hospital v. BlueCross BlueShield Association/BlueCross BlueShield of Kansas,* PRRB Dec. 2006-D43 (August 29, 2006)

*Lakes Regional Healthcare v. BlueCross BlueShield Association/Wisconsin Physicians Service,* Adm. Dec. 2014-D16 (September 4, 2014)

*St. Anthony Regional Hospital v. Wisconsin Physicians Services*, Adm. Rev. PRRB Dec. 2016-D16 (October 3, 2016)

*St. Anthony Regional Hospital v. Hargan*, U.S. District Court, S.D. Iowa (December 29, 2017)

*St. Anthony Regional Hospital v. Azar*, U.S. District Court, N.D. Iowa (February 6, 2018)

*Trinity Regional Medical Center v. Wisconsin Physician Services*, Adm. Rev. PRRB Dec. 2017-D1 (February 9, 2017)

*Unity Healthcare v. BlueCross BlueShield Association/Wisconsin Physicians Service,* Adm. Dec. 2014-D15 (September 4, 2014)

*Unity Healthcare/Lakes Regional Healthcare v. Hargan*, U.S. District Court, S.D. Iowa (January 30, 2018)

*Unity HealthCare v. Azar,* 918 F. 3d 571 (8th Cir. 2019)

*Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Intermediar[ies]*, 2017-D11 (March 27, 2017)

*Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Medicare Contractor[s]*, 2017-D12 (March 28, 2017)

V. EXHIBITS

|  |  |
| --- | --- |
| C-1 | Request for Additional Payment Due to Decrease in Discharges for SCH Denial Notice, dated 5/18/2022 |
|  |  |
| C-2 | MAC’s Volume Decrease Adjustment Calculation |
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| C-3 | Provider’s Volume Decrease Adjustment Calculation |
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| C-4 | 42 C.F.R. §412.108 |
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| C-5 | PRM 15-1 §2810 |
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| C-6 | 55 FR 15155 |
|  |  |
| C-7 | *Galesburg Cottage Hospital v. WPS Government Health Administrators*, Adm. Rev. PRRB Dec. 2023-D9 (April 7, 2023) |
|  |  |
| C-8 | *Greenwood County Hospital v. BlueCross BlueShield Association/ BlueCross BlueShield of Kansas,* PRRB Decision 2006-D43 (August 29, 2006) |
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| C-9 | *Lakes Regional Healthcare v. BlueCross BlueShield Association/Wisconsin Physicians Service,* Adm. Dec. 2014-D16 (September 4, 2014) |
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| C-10 | *Unity Healthcare v. BlueCross BlueShield Association/Wisconsin Physicians Service,* Adm. Dec. 2014-D15 (September 4, 2014) |
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| C-11 | *Unity Healthcare/Lakes Regional Healthcare v. Hargan*, U.S. District Court, S.D. Iowa (January 30, 2018) |
|  |  |
| C-12 | *Unity HealthCare v. Azar*, 918 F. 3d 571 (8th Cir. 2019) |
|  |  |
| C-13 | *Fairbanks Memorial Hospital v. Wisconsin Physician Services/ BlueCross BlueShield Association*, Adm. Rev. PRRB Dec. 2015-D11 (August 5, 2015) |
|  |  |
| C-14 | *St. Anthony Regional Hospital v. Wisconsin Physicians Service*, Adm. Rev. PRRB Dec. 2016-D16 (October 3, 2016) |
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| C-15 | *Trinity Regional Medical Center v. Wisconsin Physician Services*, Adm. Rev. PRRB Dec. 2017-D1 (February 9, 2017) |
|  |  |
| C-16 | *St. Anthony Regional Hospital v. Hargan*, U.S. District Court, N.D. Iowa (December 29, 2017) |
|  |  |
| C-17 | *St. Anthony Regional Hospital v. Azar*, U.S. District Court, N.D. Iowa (February 6, 2018) |
|  |  |
| C-18 | 82 FR 38179-38183 (August 14, 2017) |

1. The request letter from the Provider for the VDA is dated July 8, 2021; however, the request was emailed and received on July 22, 2021. [↑](#footnote-ref-1)
2. PRM 15-1, Section 2810.1 refers to the Additional Payments to SCHs [Sole Community Hospitals] That Experience a Decrease in Discharges. Per 55 FR 15155 (April 20, 1990) (**Exhibit C-6**) the criteria for a SCH and MDH Volume Decrease Adjustment is identical. The corresponding regulation for the SCH VDA is 42 C.F.R. § 412.92(e). [↑](#footnote-ref-2)
3. Reference page 8 of the PPPP. [↑](#footnote-ref-3)
4. *Trinity* is similar to the Provider’s case in that the Total DRG payments are greater than the Provider’s fixed costs, thus creating a negative adjustment or a net amount due to the Provider of $0. [↑](#footnote-ref-4)
5. Reference the Board’s decisions in *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, 2017-D11 and *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, 2017-D12 dated March 28, 2017. [↑](#footnote-ref-5)