PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2015-D9

PROVIDER –
Alta Vista Regional Hospital

Provider No.: 32-0003

vs.

INTERMEDIARY –
Wisconsin Physician Services/
Blue Cross and Blue Shield Association

DATE OF HEARING -
June 12, 2014

Cost Reporting Period Ended –
August 31, 2009

CASE NO.: 12-0146

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor's denial of Alta Vista Regional Hospital's ("Alta Vista") request for a sole community hospital volume decrease adjustment payment was proper?[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that Alta Vista is entitled to a volume decrease adjustment payment for fiscal year end ("FY") 2009 as it experienced a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control. Alta Vista's request for a volume decrease adjustment payment is remanded to the Medicare Contractor to perform the appropriate calculation.

STATEMENT OF THE FACTS

Alta Vista is a 46-bed hospital located in Las Vegas, New Mexico and participates in the Medicare program as a Sole Community Hospital ("SCH"). The Medicare contractor[2] assigned to Alta Vista is Wisconsin Physicians Services ("Medicare Contractor"). On May 16, 2011, Alta Vista submitted an application to the Medicare Contractor for a volume decrease adjustment ("VDA") payment under 42 C.F.R. § 412.92(e) for FY 2009.[3]

On August 1, 2011, the Medicare Contractor denied Alta Vista's request because Alta Vista did not demonstrate by a preponderance of evidence that it had a greater than 5 percent decrease in its total inpatient discharges due to an unusual situation or occurrence which was both externally imposed on the hospital and beyond its control.[4] Shortly thereafter, on September 30, 2011, Alta Vista submitted a request for reconsideration, which included additional documentation.[5] Upon receiving this reconsideration request, the Medicare Contractor sought further information from Alta Vista.[6] On January 20, 2012, Alta Vista responded by submitting some of the requested information.[7] After conducting a detailed analysis of the documentation and the regulatory requirements, the Medicare Contractor denied Alta Vista's VDA request on May 15, 2012.[8] Alta Vista timely appealed the Medicare Contractor's denial to the Provider Reimbursement Review Board ("Board") and satisfied the jurisdictional requirements.[9]

The Board held a live hearing on this matter on June 12, 2014. Alta Vista was represented by Ronald K. Rybar, Esq. of The Rybar Group. The Medicare Contractor was represented by Robin Sanders, Esq. of the Blue Cross and Blue Shield Association.

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[1] *See* Hearing Transcript ("Tr.") at 5-6.
[2] The term "Medicare contractor" refers to fiscal intermediary or Medicare administrative contractor as relevant.
[3] *See* Medicare Contractor Exhibit I-1 (copy of Alta Vista's VAD request).
[4] *See* Medicare Contractor Exhibit I-2 (copy of the Medicare Contractor's Aug. 1, 2011 denial); Medicare Contractor's Post Hearing Brief at 5.
[5] *See* Medicare Contractor Exhibit I-3 (copy of Alta Vista's request for reconsideration).
[6] *See* Medicare Contractor Exhibit I-4 (copy of the Medicare Contractor's request for additional information).
[7] *See* Medicare Contractor Exhibit I-5 (copy of Alta Vista's response to the request for additional information).
[8] *See* Medicare Contractor Exhibit I-6 (copy of the Medicare Contractor's May 15, 2012 denial).
[9] *See* 42 C.F.R. §§ 405.1835 – 405.1841.

Following the hearing, the parties stipulated to 2618 actual discharges for the FY 2008 and 2375 actual discharges for the FY 2009.[10] This represents an actual decrease of 243 discharges or 9.3 percent from FY 2008 to FY 2009. The parties further stipulated that, in denying Alta Vista's VAD request, the Medicare Contractor determined that only 110 of this 243 decrease in discharges related to an unusual or extraordinary occurrence outside the control of the hospital and, accordingly, there was only a 4.2 percent decrease in Alta Vista's total inpatient discharges due to an unusual situation or occurrence which was both externally imposed on the hospital and beyond its control.[11]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Alta Vista has claimed that: (1) its volume decrease in total inpatient discharges between the FY 2008 and FY 2009 cost reports was greater than 5 percent; (2) this decrease was caused by its inability to recruit and retain essential referring physicians and hospital staff and by a decline in overall regional hospital discharges ("regional use rate decline" or "RURD"); and (3) both the inability to recruit and the RURD were circumstances that were externally imposed and beyond its control which justified payment of the VDA.[12]

In contrast, the Medicare Contractor contends that Alta Vista bears the burden of proof that it is entitled to a VDA payment and must demonstrate that: (1) the decrease in total inpatient discharges was greater than 5 percent, and (2) the cause of the decrease was due to an unusual situation or occurrence that was both externally imposed on the hospital and beyond its control.[13] The Medicare Contractor asserts that Alta Vista failed to meet its burden of proof.[14]

LOSS OF PHYSICIANS

The Medicare Contractor claims that Alta Vista failed to demonstrate, that its purported inability to recruit and retain essential physician staff, was due to circumstances outside of its control. The Medicare Contractor asserts that the record is clear that Alta Vista outsourced its hospitalist program to a management company and relied entirely on the management company to recruit and hire replacement hospitalists and that Alta Vista did not take steps on its own to recruit, retain or replace departing hospitalists.[15]

Second, the Medicare Contractor asserts that the record is silent on Alta Vista's efforts during FYs 2008 and 2009 to recruit and replace certain specialty physicians. The Medicare Contractor claims that the record includes only general information regarding recruitment efforts conducted by its parent company in FYs 2010 and 2011 which should not be considered when calculating whether the hospital satisfied the greater than 5 percent threshold, for purposes of a VDA payment.[16]

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[10] *See* Stipulation dated Aug. 6, 2014 at ¶ 1 (copy included at Provider Exhibit P-13).
[11] Stipulation dated Jun. 6, 2014 at ¶ 7 (copy included at Provider Exhibit P-18).
[12] Provider's Post-Hearing Brief at 1.
[13] Medicare Contractor's Post Hearing Brief at 6.
[14] Medicare Contractor's Post Hearing Brief at 7.
[15] *See* Medicare Contractor's Post Hearing Brief at 7 (citing to Tr. at 86-89, 91-92).
[16] *See* Medicare Contractor's Post Hearing Brief at 8-9.

Finally, the Medicare Contractor rejects Alta Vista's argument that it has a *per se* inability to recruit because of its rural location. The Medicare Contractor believes that this argument should be disregarded because, under this reasoning, *every* SCH, which, by definition, is located in a rural area, would be automatically entitled to a VDA payment upon demonstrating that it had a greater than 5 percent decrease in discharges.[17]

The Board finds that the language in 42 U.S.C. § 1395ww(d)(5)(D)(ii) and 42 C.F.R. § 412.92 essentially agree. Specifically, both require that the provider demonstrate that: (1) there has been a volume decrease in discharges of 5 percent or more; and (2) the reasons for this decrease are due to circumstances beyond the hospital's control. The Board notes that, while the PRM 15-1 § 2810.1(A)(1) reflects the regulatory language, it adds language that requires the unusual occurrence to be "externally imposed" stating in pertinent part:

> 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, … or similar occurrences with substantial cost effects.(emphasis added)

As explained below, the Board finds that Alta Vista has established that the circumstances giving rise to its greater than 5 percent decrease in discharges was "externally imposed . . . and beyond its control." It is undisputed that there was a total decline in discharges of 2,618 in FY 2008 and 2,375 in FY 2009 or a 9.3 percent decrease[18] and that, at a minimum, a 4.2 percent decrease in discharges was externally imposed and beyond Alta Vista's control due to the loss of specialty physicians alone and the inability to recruit additional specialists.[19] The Board finds that the record confirms this undisputed fact because it demonstrates that Alta Vista had no control over the community physicians' personal decisions to leave the area, nor over the well-established difficulty the hospital experienced in recruiting physician replacements.[20] Thus, what remains in dispute is whether there is an additional 0.8 percent decrease in discharges for FY 2009 (approximately 21 discharges) that was externally imposed and beyond Alta Vista's control.

Regarding the loss of hospitalists, the Board finds that, at a minimum, an additional 75

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[17] *See id.* at 9-10 (citing to Tr. at 82-83; PRM 15-1 § 2810.1(A)(1)).
[18] Provider Exhibit P-18 at 3.
[19] Provider Exhibit P-6 at 323; Stipulation at ¶ 7.
[20] The record shows that Alta Vista exercised a rigorous and ongoing recruiting effort during these cost reporting periods including a dedicated physician recruiter, detailed discussions of physician recruitment during meetings of its Board of Trustees and Medical Executive Committee, use of the corporate recruiters from Alta Vista's parent company, and incentive programs to assist with physician recruitment and retention. Provider's Exhibit P-2 at 35-37; Provider Exhibit P-2B at 284-286 (summary of meeting minutes of Alta Vista's Board of Trustees and Medical Executive Committee); Tr. at 29-32. Alta Vista further established that its rural location contributed to its difficulty in recruiting and retaining physicians. To address this difficulty, Alta Vista: (1) developed its annual business plan to include ongoing analysis of the needs of the local population and expected use of the facility as it pertained to its recruitment strategy; and (2) provided an array of incentives to retain physicians, including sign-on bonus payments, school loan repayments, subsidies to support different physician practice models including supplying offices and staff for employed and independent physicians, income guarantees for independent practitioners and hiring hospitalists to provide after hours and weekend coverage. *See* Tr. at 40-41, 52.

discharges is attributed to the loss of the hospitalists who were largely responsible for admitting patients in the Emergency Department.[21] The record shows that three private practice internal medicine physicians in the community lost confidence in the hospitalists and reduced hospital admissions to Alta Vista.[22] The evidence in the record and the testimony at the hearing demonstrate that Alta Vista's Board of Trustees discussed this issue extensively, addressed the issue with its hospitalist contractor (*e.g.*, working with the contractor to rebuild its hospitalist program and recruit additional hospitalists), replaced the medical director overseeing the hospitalist program, explored alternatives to its hospitalist contractor, and ultimately replaced the hospitalist contractor to resolve this problem.[23] The Board concludes that: (1) the loss of hospitalists and the inability to recruit replacements was due to the rural location of the hospital and to the fact that the hospitalist contractor was unable to recruit and retain sufficient hospitalists to adequately staff the hospital — an unusual occurrence outside the control of the hospital; and (2) Alta Vista took steps to mitigate the issue by working first with its hospitalist contractor to resolve the issue before ultimately replacing the contractor.

REGIONAL USE DECLINE

The Medicare Contractor rejects Alta Vista's argument that its decrease in discharges was due to a regional use rate decline and that this decline was externally imposed and outside of its control.[24] The Medicare Contractor maintains that Alta Vista improperly relies on quantitative statistics regarding the Las Vegas, New Mexico market because these statistics were "insufficiently limited and based on assumptions as estimates" and do not satisfy Alta Vista's burden of proof regarding its RURD argument. [25]

The Board rejects the Medicare Contractor's position and finds that there is evidence in the record to establish a regional decline in the total number of Medicare cases in the hospital's primary and secondary service area of over 5 percent for all hospitals as well as a loss in market share by Alta Vista, in particular.[26] The Board finds that Alta Vista could neither control the regional decline in hospital admissions (*i.e.* the shrinking of the regional market itself) nor the loss of patients to St. Vincent Hospital in Santa Fe due to the loss of essential physician staff at Alta Vista.

The Board concludes that the statute and related regulations were established to grant relief to hospitals that experienced patient volume declines as did Alta Vista. The additional payments made to SCHs are necessary to help them maintain viability as rural hospitals during periods of reduced admissions. The Board concludes that Alta Vista has met its burden of proof to establish that: (1) circumstances existed that were externally imposed and beyond Alta Vista's control; and (2) it experienced a reduction in inpatient discharges of greater than 5 percent.

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[21] *See* Provider Exhibit P-4 at 293-294 (table showing a net decrease of 75 hospitalist discharges from FY 2008 to FY 2009).
[22] *See* Tr. at 60, 62-63; Provider Exhibit P-2B at 284, 286.
[23] Provider Exhibit P-2B at 283-284; Tr. at 57-59.
[24] Medicare Contractor's Post-Hearing Brief at 10.
[25] *Id.* at 10-11.
[26] *See* Provider's Post-Hearing Brief at 9-13 (providing data on Medicare discharges and market share); Tr. at 67-70, 96-98, 139-140; Provider Exhibits P-2 at 38, P-4 at 296-297, P-14.

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that Alta Vista is entitled to a volume decrease adjustment payment for FY 2009 as it experienced a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control. Alta Vista's request for a volume decrease adjustment payment is remanded to the Medicare Contractor to perform the appropriate calculation.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: May 12, 2015