VOLUME DECREASE ADJUSTMENT PROVIDER CHECKLIST:

BACKGROUND:

Per the regulations at 42 CFR 412.92(e) and 412.108(d) if a hospital that is classified as a Sole Community Hospital (SCH) or a Medicare Dependent Hospital (MDH) experiences a decrease of more than 5% in the total number of discharges compared to the immediately preceding cost reporting period, the hospital may receive a payment adjustment, referred to as a volume decrease adjustment (VDA). The payment adjustment is intended to help cover the hospital's fixed and semi-fixed costs for which the hospital cannot control as a result of the decrease in patient volume as well as the reasonable costs of maintaining necessary core staff and services. The payment is not to exceed the difference (known as the ceiling) between the hospital's Medicare inpatient operating cost and the hospital's total Diagnosis Related Group (DRG) revenue.

INFORMATION TO BE INCLUDED:

The hospital must submit a written request for an adjustment to its Medicare Administrative Contractor (MAC) within 180 days of the date on the MAC's Notice of Program Reimbursement (NPR). If the hospital has not yet filed a cost report for the period for which a payment adjustment is requested, the hospital must forward the unfiled cost report along with a request for an interim adjustment determination. If the hospital has filed the cost report but an NPR has not yet been issued, then the hospital may request an interim adjustment determination. Any interim determinations must be followed by a final adjustment determination once the NPR has been issued. Consult with the assigned desk review/audit team to determine if the NPR is expected to be issued in the near future, as this could lead to a decision to notify the provider that an NPR is expected to be issued shortly, and the request for VDA payment will be held and reviewed upon final settlement.

General Information: The provider's request must include the requesting hospital's name, address, county, urban/rural classification, bed size, provider number, and date of classification as an SCH or MDH.

Discharge Data: The SCH or MDH 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.

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.

The situation or occurrence must be unusual and externally imposed on the hospital and beyond its control. These situations may include strikes, floods, the 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.

Cost Data: The hospital must provide a general ledger trial balance in Excel format with all cost accounts categorized as either fixed, semi-fixed, or variable. Provider should include a calculation of the total fixed and semi-fixed costs as a percentage of total cost.

Per PRRB Decision 2015-D11, variable costs include the following for the purposes of this analysis.

- Medical Supplies
- Pharmaceuticals
- Cost of Goods Sold
- Food
- Dietary Formula
- Linens and Bedding
- Other Non-Medical Supplies
- Patient Surveys
- Hazardous Materials Disposal
- Collection Agency Fees
- Freight
- Advertising
- Community Relations
- Charitable Contributions

Semi-fixed Costs: The request must include a narrative description of those actions taken by the hospital to reduce semi-fixed costs.

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.

For cost reporting periods **beginning on/after 10/01/2017**, the recalculation due to excess staffing is not applicable.

Note: Please reference CMS instructions for all information necessary to determine the VDA payment calculation.

- CMS Pub 15-1, Sec 2810.1D2a is used for cost reporting periods **beginning prior to 10/01/2017**.
- CMS Pub 15-1, Sec 2810.1D2b is used for cost reporting periods **beginning on or after 10/01/2017**.

SUBMISSION:

All VDA request submissions can be made to the appropriate email box below (depending on the applicable jurisdiction):

- Jurisdiction J: **JJAUDIT.REOPENING@palmettogba.com**
- Jurisdiction M: **JMAUDIT.REOPENING@palmettogba.com**