PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2024-D27

PROVIDER –
Lincoln Trail Behavioral Health System

Provider No.: 18-4012

vs.

MEDICARE CONTRACTOR –
CGS Administrators

HEARING DATE –
August 29, 2023

Cost Reporting Period Ended –
April 30, 2017

CASE NO. – 19-1917

INDEX

ISSUE STATEMENT

Whether the Elizabethtown Core Based Statistical Area ("CBSA") 21060 Wage Index was correctly established for Medicare payments made to the Provider during its fiscal year ending April 30, 2017 ("FY 2017").[1]

DECISION

After considering Medicare law, regulations, program guidance, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that:

1. The Elizabethtown CBSA 21060 Wage Index was properly established for Medicare payments made under the inpatient psychiatric facility prospective payment system ("IPF-PPS") to the Provider during its FY 2017; and

2. Lincoln Trail failed to include an appropriate cost report claim on its as-filed FY 2017 cost report for the wage index AHW issue under appeal in this case, as required under 42 C.F.R. § 413.424(j)(1).

INTRODUCTION

Lincoln Trail Behavioral Health[2] ("Lincoln Trail" or "Provider") is an inpatient psychiatric facility ("IPF") located in Radcliff, Kentucky.[3] The assigned Medicare Contractor[4] is CGS Administrators, Inc. ("Medicare Contractor" or "MAC").

Lincoln Trail filed an individual appeal request on May 14, 2019 from its Notice of Program Reimbursement ("NPR") dated February 13, 2019. The sole issue in this appeal relates to alleged Wage Index errors that affect Lincoln Trail's reimbursement under the IPF-PPS where the IPF-PPS Wage Index is based on the Wage Index used by the Medicare program in the inpatient prospective payment system ("IPPS") for short-term acute care hospitals. Lincoln Trail has stated the amount in controversy for this issue is $863,557.[5]

Lincoln Trail disputes the Medicare Wage Index for the Elizabethtown CBSA 21060 as used in its Medicare payments for FY 2017 and is seeking correction of certain alleged errors in the

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[1] Hearing Transcript (hereinafter "Tr") at 5. The Board recognizes that there was an additional issue in the appeal, namely whether an inpatient psychiatric facility can appeal the accuracy of the inpatient prospective payment system wage index for CBSA 21060 where it is geographically located. However, prior to holding the hearing, the Board confirmed that it addressed this issue and found that it had jurisdiction to hear this appeal. *See infra* note 69 and accompanying text. Thus, this decision finalizes that determination and incorporates it into the decision by reference.
[2] Tr. at 4.
[3] *Id.* at 9.
[4] 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.
[5] Provider's Appeal Request (May 14, 2019).

wage data of Hardin Memorial Hospital ("Hardin")[6] which was used to determine the Elizabethtown CBSA 21060 Wage Index for IPPS for federal fiscal years ("FFY") 2015 and 2016 and which, in turn, was used for the IPF-PPS for FFYs 2016 and 2017, respectively. Significantly, Hardin is the ***only*** IPPS hospital contributing to the Wage Index for this CBSA. However, Hardin has reclassified to a different CBSA for purposes of IPPS reimbursement. In pursuing this appeal, Lincoln Trail has not challenged the Wage Index policy or the regulation (*i.e.*, there is no procedural challenge of the Wage Index process, whether related to the IPPS or to the IPF-PPS adoption of the IPPS Wage Index).[7]

The Board determined that the appeal was timely filed and the $10,000 threshold for Board jurisdiction has been met. With regard to the wage index issue, the Board finalizes its jurisdictional decision, dated September 1, 2021, confirming it has substantive jurisdiction to hear this appeal based on its review of the controlling statute for the IPF-PPS at 42 U.S.C. § 1395ww(s); the IPF regulations at 42 C.F.R. §§ 412.428-412.432; and the Federal Register notices regarding IPF-PPS payments.

As the Board determined it had jurisdiction over this appeal, it conducted a live video hearing on August 29, 2023. Lincoln Trail was represented by Elizabeth A. Elias, Esq. of Hall, Render, Killian, Heath & Lyman. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF LAW AND FACTS

A. Relevant Law, Regulations, and Policy

In general, Medicare pays hospitals for inpatient services through the IPPS.[8] IPPS provides Medicare payments for hospital inpatient operating and capital related costs at predetermined, specific rates for each hospital discharge.[9] These rates are based on average costs that consist of a labor-related portion and a non-labor-related portion.[10] The labor-related portion is adjusted by the wage index applicable to the geographic area where the hospital is located.[11] The wage index is intended to reflect the relative hospital wage level in that geographic area, as compared to the national average hospital wage level.[12] It is calculated by dividing the average hourly wage ("AHW") in each CBSA area by the national average hourly hospital wage.[13]

CMS is required to update the wage index annually on the basis of a survey of wages and wage-related costs taken from the cost reports filed by each hospital paid under the IPPS.[14] CMS

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[6] Hardin Memorial Hospital d/b/a Baptist Health Hardin is located in Elizabethtown, KY; CMS Prov. No. 18-0012. *Also see* Provider's Final Position Paper (hereinafter "Provider's FPP") at 4-5 and Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 7.
[7] Provider's FPP at 4.
[8] *See* 42 U.S.C. § 1395ww(d).
[9] *Id.*
[10] 42 C.F.R. § 412.64(h).
[11] *Id.*
[12] 42 U.S.C. § 1395ww(d)(2)(H).
[13] 42 C.F.R. § 412.64(h).
[14] 42 U.S.C. § 1395ww(d)(3)(E).

publishes the wage data at intermittent intervals so that hospitals can review it for accuracy. As discussed below, if the hospital disagrees with the accuracy of the data, a hospital may request that the data be corrected and the wage index recomputed; however, a hospital requesting a correction must do so within a specified time limit and must provide relevant documentation to support the correction.[15]

1. Wage Index Applied to Short-Term Acute Care Hospitals Subject to IPPS

The statute, 42 U.S.C. § 1395ww(d)(3)(E), specifies that, as part of the methodology for determining the prospective payment rates *applied to short term acute care hospitals*, the Secretary must adjust the standardized amounts[16] for area differences in hospital wage areas by a factor established by the Secretary reflecting the relative hospital wage level in a geographical area of the hospital compared to the national average hospital wage level. The Secretary defines the hospital labor market areas "based on the delineations of statistical areas established by the Office of Management and Budget ("OMB")."[17]

As noted above, 42 U.S.C. § 1395ww(d)(3)(E) requires the Secretary to update the wage index annually and to base the update on a survey of wages and wage-related costs of *short-term, acute care hospitals*.[18] This data is collected on the Medicare Cost Report, CMS Form 2552-10, Worksheet S-3, Parts II, III, and IV.[19] The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Pursuant to 42 U.S.C. § 1395ww(d)(3)(E), the Secretary delineated hospital labor markets based on their OMB-established CBSAs.[20] The data collected for the inpatient prospective payment system wage index are also used to recalculate wage indexes applicable to other supplier and providers such as home health agencies, skilled nursing facilities and hospices. In addition, they are used for prospective payments for IPFs as well as for inpatient rehabilitation facilities, long-term care hospitals, and hospital outpatient services.[21]

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[15] *See infra* notes 22-23 and accompanying text.

[16] The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS and they were used in computing the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. § 1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww (d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E) requires that 62 percent of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).

[17] 81 Fed. Reg. 56762, 56912 (Aug. 22, 2016).

[18] (emphasis added).

[19] 81 Fed. Reg. at 56912.

[20] *Id.* at 56913.

[21] *Id.* at 56914.

The Secretary has developed a correction process for the wage index. The correction process is driven by the Hospital Wage Index Development Timetable[22] which sets dates for the release of wage index files and deadlines for hospitals to request revisions to cost report worksheets, occupational mix data and pension data prior to the Medicare contractors' desk reviews of the hospital's wage data. In January of a given calendar year, CMS releases public use files on its website containing urban and rural area's average hourly wages and preliminary wage indexes. By mid-February, hospitals must request corrections to the wage data and desk review adjustment to wage index data; Medicare contractors must complete their review of this information by late March and notify the hospitals and CMS of final results of their reviews. CMS then permits hospitals to appeal the Medicare contractor determinations that had not been resolved earlier in the process, although if a hospital does not request a Medicare contractor correction of its wage data, it is precluded from making an initial request from CMS at this point. The proposed IPPS rule is then published in in the Federal Register in April or May. Hospitals can seek correct of errors found in the proposed IPPS rule that were made by the Medicare contractor or CMS that could not be known prior to the publication of the proposed rule. The final IPPS rule is published in August.[23]

In the July 30, 1999 Final IPPS Rule for 2000, the Secretary announced that, "while there is no formal appeals process that culminates before the publication of the final rule, hospitals may later seek formal review of denials of requests for wage data revisions made as a result of [the wage data correction] process."[24] The Secretary pointed out that, as noted in the September 1, 1995 Federal Register,[25] hospitals are entitled to appeal any denial of a request for a wage data revision made as a result of the agency's wage data correction process to the [Board] consistent with the rules for Board appeals. Further, the Secretary stated as noted in the September 1, 1995 Federal Register **"**any subsequent reversal of a denial of a wage revision request that results from a hospital's appeal to the [Board] or beyond will be given effect by paying the hospital under a revised wage index that reflects the revised wage data at issue."[26]

More recently in the FY 2017 IPPS Rule, the Secretary reiterated that the processes previously described had been created "to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2017 payment rates."[27] The Secretary emphasized that "hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the MAC's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the [Board], the failure of CMS to make a requested data revision."[28]

Further, the Secretary stated:

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[22] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2015-WI-Timeline.pdf. *See also* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2016-WI-Time-Table-Final.pdf (last visited Jul. 30, 2024).
[23] *See* 81 Fed. Reg. at 56932-33.
[24] 64 Fed. Reg. 41490, 41513 (Jul. 30, 1999).
[25] *See* 60 Fed. Reg. 45778, 45792-45903.
[26] 64 Fed. Reg. 41490, 41513.
[27] 81 Fed. Reg. 56762, 56933 (Aug. 22, 2016).
[28] *Id*.

> [B]ecause hospitals had access to the final wage index data [public use files] by late April 2016, they had the opportunity to detect any data entry or tabulation errors made by the MAC or CMS before the development and publication of the final FY 2017 wage index by August 2016, and the implementation of the FY 2017 wage index on October 1, 2016. Given these processes, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified by hospitals and brought to CMS' attention after May 23, 2016, we retain the right to make midyear changes to the wage index under very limited circumstances.[29]

Specifically, 42 C.F.R. § 412.64(k) states:

> (1) CMS makes a midyear correction to the wage index for an area only if a hospital can show that—
>
> (i) *The intermediary or CMS made* ***an error in tabulating its data****;* ***and***
>
> (ii) *The hospital* ***could not have known about the error****, or did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.*
>
> (2) (i) Except as provided in paragraph (k)(2)(ii) of this section, a midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.
>
> (ii) Effective October 1, 2005, a change to the wage index may be made retroactively to the beginning of the Federal fiscal year, if, for the fiscal year in question, CMS determines ***all*** of the following—
>
> (A) The fiscal intermediary or CMS made an error in tabulating data used for the wage index calculation;
>
> (B) The hospital knew about the error in its wage data and requested the fiscal intermediary and CMS to correct the error ***both*** within the established schedule for requesting corrections to the wage data (which is at least before the beginning of the fiscal year for the applicable update to the hospital inpatient prospective payment system) and using the established process; and
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> (C) CMS agreed before October 1 that the fiscal intermediary or CMS made an error in tabulating the hospital's wage data and the wage index should be corrected. [30]

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[29] *Id.*

[30] 42 C.F.R. § 412.64(k) (bold and italics emphasis added).

For purposes of this provision, "before the beginning of the fiscal year" means by the May deadline for making corrections to the wage data for the following fiscal year's wage index (for example, May 23, 2016 for the FY 2017 wage index). The Secretary cautioned that *"*this provision is *not* available to a hospital seeking *to revise* ***another*** *hospital's data"* that may be affecting the requesting hospital's wage index for the labor market area.[31]

2. Wage Index Applied to Psychiatric Hospitals Subject to the IPF-PPS

In § 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA"), Congress mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units (as well as critical access hospitals).[32] The Secretary implemented the IPF-PPS in the final rule in the November 15, 2004 Federal Register. As part of the IPF-PPS payment methodologies and policies, the Secretary included a wage index adjustment.[33]

In the November 15, 2004 final rule, the Secretary explained that she had initially "proposed to use the unadjusted, pre-reclassified hospital wage index to account for geographic differences in labor costs."[34] The Secretary explained that she "proposed to use the inpatient acute care hospital wage data to compute the IPF wage since there is not an IPF-specific wage index available . . . [and] IPFs generally compete in the same labor market as acute care hospitals."[35] Accordingly, the Secretary maintained that this was "the best available data to use as proxy for an IPF specific wage index."[36] The Secretary further explained that "the actual location of the IPF as opposed to the location of affiliated providers is most appropriate for determining the wage adjustment because the data support the premise that the prevailing wages in the area in which the IPF is located influence the cost of a case."[37] Thus, the Secretary decided to use the inpatient acute care hospital wage data from IPPS "without regard to any approved geographic reclassification."[38]

Accordingly, in that final rule, the Secretary finalized her proposal to use "the FY 2005 IPPS hospital wage index (unadjusted, pre-reclassified) based on [Metropolitan Statistical Area ("MSA")] definitions defined by OMB in 1993 (as opposed to the new MSA definitions that were used to define labor markets for the FY 2005 IPPS)"[39] to determine the IPF-PPS wage index for the initial year. Once the IPF-PPS was implemented, the Secretary would:

> assess the implications of the new MSA definitions on IPFs. At the time of the proposed rule, the 2003 MSA definition had not been implemented for any medicare programs and consequently, were not proposed. We note that, after the publication of the IPF PPS proposed rule, new MSA definitions have been adopted for use in

[31] 81 Fed. Reg. 56762, 56933 (emphasis added).
[32] BBRA, Pub. L. 106-113, § 124, 113 Stat. 1501, 1501A-332 (1999).
[33] 69 Fed. Reg. 66922 (Nov. 15, 2004).
[34] *Id.* at 66952.
[35] *Id*.
[36] *Id.*
[37] *Id*.
[38] *Id*.
[39] *Id.*

> the IPPS; We, however, are not adopting those new definitions in this [FFY 2005 IPF-PPS] final rule.[40]

In the FFY 2007 IPF-PPS Final Rule,[41] the Secretary adopted the new statistical area CBSA-based labor market area definitions for IPF-PPS.[42] At the time, CBSAs were the OMB's latest Metropolitan Area definitions based on the 2000 census, and because the Secretary felt that these "Metropolitan Area designations more accurately reflect the local economies and wage levels of the areas in which hospitals are currently located,"[43] they were adopted, "effective October 1, 2004."[44] The Secretary noted that, when implementing the wage index adjustment at § 412.424(d)(1)(i) under the November 2004 IPF PPS final rule[45] it had "explained that the IPF PPS wage index adjustment was intended to reflect the relative hospital wage levels in the geographical area of the hospital as compared to the national average hospital wage level. . . . The IPF-PPS uses the acute care inpatient hospitals' wage data in calculating the IPF PPS wage index. However, unlike IPPS. . . IPF PPS uses the pre-floor, pre-reclassified hospital wage index."[46] In addition, with the adoption of the new CBSA-based designations, the Secretary continued "to have 2 types of labor market areas: urban and rural."[47] Because the majority of IPF were not significantly impacted by the new labor market areas, no transition payment to the new CBSA-based labor market areas for the purpose of IPF-PPS was created.[48]

In the ensuing IPF-PPS final rules, the Secretary has continued to adopt and apply the IPPS Wage Index from the prior FFY in setting the Wage Index for IPF-PPS for the relevant rate year.[49] Consistent with this practice, as part of the FFY 2016 IPF-PPS Final Rule, the Secretary established the IPF-PPS wage index by using the FFY 2015 IPPS Wage Index.[50] Similarly, as

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[40] *Id.*
[41] 71 Fed. Reg. 27040 (May 9, 2006).
[42] *Id.* at 27061.
[43] *Id.* at 27062.
[44] *Id.*
[45] 69 Fed. Reg. 66952-54.
[46] 71 Fed. Reg. 27062.
[47] *Id.* at 27062.
[48] *Id.* at 27065.
[49] *See, e.g.*, 77 Fed. Reg. 47224, 47233 (Aug. 7, 2012) ("For FY 2013, we are applying the most recent hospital wage index (that is, the FY 2012 pre-floor, pre-reclassified hospital wage index because this is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data . . . , and applying an adjustment in accordance with our budget neutrality policy."); 78 Fed. Reg. 46734, 46743 (Aug. 1, 2013) ("For FY 2014, we are applying the most recent hospital wage index (that is, the FY 2013 pre-floor, pre-reclassified hospital wage index because this is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data . . . , and applying an adjustment in accordance with our budget neutrality policy."); 79 Fed. Reg. 45938, 45956 (Aug. 6, 2014) ("For FY 2015, we are applying the most recent hospital wage index (that is, the FY 2014 pre-floor, pre-reclassified hospital wage index which is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data . . .), and applying an adjustment in accordance with our budget-neutrality policy.").
[50] 80 Fed. Reg. 46652, 46682 (Aug. 5, 2015) ("For FY 2016, we will continue to apply the most recent hospital wage index (that is, the FY 2015 pre-floor, pre-reclassified hospital wage index, which is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data . . . without any geographic reclassifications, floors, or other adjustments.").

part of the FFY 2017 IPF-PPS Final Rule, the Secretary established the IPF-PPS wage index by using used the FFY 2016 IPPS Wage Index.[51]

3. Appropriate Cost Report Claim: 42 C.F.R. §§ 413.24(j) and 405.1873

The regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable to cost report periods beginning on or after January 1, 2016 and address the "Substantive reimbursement requirement of an appropriate cost report claim" and "Board review of compliance with the reimbursement requirement of an appropriate cost report claim," respectively.[52] The regulation at § 413.24(j) requires that:

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and

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[51] 81 Fed. Reg. 50502, 50509 (Aug. 1, 2016) ("For FY 2017, we will continue to apply the most recent hospital wage index (the FY 2016 pre-floor, pre-reclassified hospital wage index, which is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data . . . without any geographic reclassifications, floors, or other adjustments.").

[52] 42 C.F.R. § 413.24 is applicable to IPFs as made clear by § 413.1(a)(3) which specifies that the policies in Part 413 are binding on the entities in paragraph (a)(2) which includes "hospitals" of which an IPF is a type of hospital for purposes of 42 C.F.R. Part 413. This is made clear in § 413.1(d) which sets forth the different types of hospitals providing inpatient hospital services (*e.g.*, short-term acute care hospitals, children's hospitals, inpatient rehabilitation hospitals, long-term acute care hospitals, and IPFs). *See also* 42 U.S.C. §§ 1395x(e), 1395ww(d)(1)(B).

> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). ***If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item***, the Board must address such question in accordance with the procedures set forth in this section.[53]

The Board implemented 42 C.F.R. § 405.1873(a) at Board Rules 44.5 and 44.6. In this respect, Board Rule 44.5 states:

> Effective for cost reporting periods beginning on or after January 1, 2016, 42 C.F.R. § 413.24(j) (as restated at 42 C.F.R. § 405.1873(a)) includes a "[s]ubstantive reimbursement requirement of an appropriate cost report claim." Specifically, § 413.24(j)(1) states that, "[i]n order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, *the provider's cost report*, whether determined on an as-submitted, as-amended, or as-adjusted basis . . ., must include an appropriate claim for the specific item . . . ." (Emphasis added.) If any party to an appeal before the Board questions whether *the provider's cost report at issue in an appeal* complied with this regulatory requirement (*i.e.*, questions whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed), then that party must follow the applicable process described below to file this "Substantive Claim Challenge" in order to initiate Board review of such question(s) under 42 C.F.R. § 405.1873(b).
>
> NOTE: The Board adoption of the term "Substantive Claim Challenge" simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items.[54]

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[53] (Bold and italics emphasis added.)
[54] (Italics emphasis in original.)

B. Procedural History

On **May 14, 2019**, Lincoln trail filed its appeal request to establish this case. In that filing, Lincoln Trail described the issue in this appeal as follows:

> Upon review of the Medicare Wage Index data for the Elizabethtown CBSA (20160), it became apparent that the average hourly wage for the CBSA was aberrantly low. After examining the information reported by PPS providers physically located in this CBSA, errors in the data used to determine the Medicare Wage Index were identified.
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> ****
>
> More specifically, Hardin Memorial Hospital had reported salaried physician part B information for excluded areas on both Wage Index line 5 and then again on the excluded area lines 9 & 10 of Worksheet S-3 part II. There was also an improper allocation of Wage Related Costs resulting from the double counting of Physician Part B salaries. This error in the reporting of the part B physician salaries and benefits has resulted in a significant understatement of the average hourly wage (AHW) for both Hardin Memorial Hospital and the Elizabethtown CBSA.
>
> Consequently, the wage index factor derived from this AHW and the corresponding Wage Index information was significantly understated. The erroneous reporting caused an understatement of the Wage Index factor for the Elizabethtown CBSA.
>
> The understated Wage Index factor of the Elizabethtown CBSA directly influenced the PPS payments made to Lincoln Trail.
>
> In order to calculate the accurate Wage Index factor, in 2017 the following items were addressed on Hardin Memorial Hospital Wage Index schedule:
>
> - Part B physician salaries have been adjusted for proper reporting. Excluded area physicians are now reported only on the excluded area line.
> - Wage related costs were reallocated based on the adjustments made to S-3, part II lines 5, 9 and 11.
>
> The revised AHW was then used to determine a more accurate wage index factor for the Elizabethtown CBSA, effective with the FFY 2019 Wage Index for the CBSA 20160. The wage index

> factor for CBSA 20160 has risen once the CBSA was correctly reported beginning with FFY 2019.[55]

On **January 7, 2020**, Lincoln Trail filed an EJR request. It argued that the Board lacks the authority "to address the legal question of whether CMS correctly followed the statutory mandates for setting a uniform wage index."[56] In essence, through this appeal, Lincoln Trail is seeking correction of what it believes are errors in the wage index data from another hospital, Hardin Memorial Hospital ("Hardin"), that was used to determine the Wage Index for the CBSA assigned to Lincoln Trail and to settle Lincoln Trail's FY 2017 cost report. In requesting EJR, Lincoln Trail asserted that the Board "is without authority to implement the relief sought by the Provider to correct the wage data used to set the wage index used to settle Provider's FYE 4/30/17 cost report."[57]

On **January 30, 2020**, the Board issued a Request for Information ("RFI") and Scheduling Order to obtain additional information that was needed prior to the Board ruling on the EJR request. In the RFI, the Board noted it had not heard "an appeal of a wage index issue by a hospital not participating in IPPS."[58] Accordingly, it requested the parties brief "the novel issue of whether the Board has jurisdiction to hear an appeal by a psychiatric hospital of a wage index which is established for acute care hospitals subject to IPPS and to which the psychiatric hospital contributed no wage index data but is subject to that wage index under IPF PPS."[59] The Board also set a deadline for the parties to file any notice of any questions or challenges related to substantive claims and/or compliance with 42 C.F.R. § 413.24(j).[60]

On **February 27, 2020**, Lincoln Trail submitted its response to the Board's RFI. With regard to the Board's jurisdiction, Lincoln Trail noted that, even though it is an IPF, the acute care hospital wage index is used in the IPF-PPS.[61] It also argued that the Board generally "has jurisdiction over providers paid under the IPF PPS because 42 U.S.C. §1395oo permits 'any provider of services which has filed a required cost report' to obtain a hearing before the Board."[62]

On **March 2, 2020**, the Medicare Contractor filed its response to the Board's RFI and concurred that the Board had jurisdiction over the appeal and that EJR was appropriate.[63] On that same date, the Medicare Contractor also filed a Substantive Claim Challenge[64] asserting Lincoln Trail failed to properly claim or protest the wage index issue as part of its FY 2017 as-filed cost report:

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[55] Provider Appeal Request, Issue Statement. The Board notes that the Provider lists the incorrect CBSA for Elizabethtown, KY in its Issue Statement. The correct CBSA is 21060, as verified in the various IPPS Final Rules related to this case, and further supported by the fact that there is no CBSA 20160 listed in those IPPS Final Rules.
[56] EJR Request at 6 (Jan. 7, 2020).
[57] *Id.* at 1.
[58] Board's RFI at 6 (Jan. 30, 2020).
[59] *Id*.
[60] *Id.* at 7.
[61] Provider's Brief in Support of the Board's Jurisdiction of its Timely Appeal of its Medicare Cost Report (hereinafter "Provider's RFI Brief") at 2 (Feb. 27, 2020).
[62] *Id.*
[63] Medicare Contractor's Responsive Brief (hereinafter "Contractor's RFI Brief") at 2 (Mar. 2, 2020).
[64] As noted in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or

> Based on the procedures at 42 C.F.R. § 413.24(j)(3), the MAC contends that there is not an appropriate cost report claim for this specific item included in the Provider's [FY 2017] cost report. The Provider has not claimed the item on the [FY 2017] cost report. The Provider is appealing adjustment number 9 in which the MAC has updated the settlement data to the current PS&R. The MAC has verified that the amounts claimed on the accepted as filed [FY 2017] cost report came from the PS&R which included the disputed IPF DRG Rates. During the desk review, the MAC adjusted settlement data to an updated PS&R for the Notice of Program Reimbursement [for FY 2017]. The Provider did not claim an amount it thought it was owed, which stemmed from the 'reduced' IPF DRG amounts. Therefore, the MAC's DRG adjustment was not based upon the Wage Index errors the Provider is disputing in this appeal.[65]

On **March 26, 2020**, Lincoln Trail filed a response to the Medicare Contractor's Substantive Claim Challenge. Lincoln Trail argued that the Medicare Contractor's conclusion that "it is bound by the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 . . . is incorrect," and that an appeal to the Board is "[t]he only way to express its dissatisfaction with its reimbursement."[66] Lincoln Trail noted that 42 C.F.R. §§ 413.24(j) and 405.1873 were promulgated via an Outpatient PPS Final Rule in 2015 which is not related to Lincoln Trail's reimbursement scheme in the IPF-PPS. As such, it argued it had insufficient notice of these new regulations. It also argued that these regulations are invalid as Lincoln Trail need only be dissatisfied in order to appeal and, in support of that contention, cites to the following four (4) court decisions: (A) *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 401-406 (1988); (B) *Banner Heart Hosp. v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016); (C) *Bayshore Comm. Hosp. v. Hargan*, 285 F. Supp. 3d 9 (D.D.C. 2017); and (D) *Azar v. Allina Health Servs*., 139 S. Ct. 1804 (2019).[67]

In its response, Lincoln Trail further disagreed with the Medicare Contractor's contention that it could have include a protested item for the AHW wage index issue with its as-filed FY 2017 cost report:

> [T]he MAC's Substantive Claim Letter, is premised around an assumption that Provider could have included a protested amount for this issue when it filed its cost report.
>
> Provider filed the cost report under appeal herein on August 31, 2017. It did not learn of a potential error to the wage index for the Elizabethtown CBSA 21060 until a consultant brought the error to the Provider's attention almost a year later in early August 2018.

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more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items." (Emphasis in original.)

[65] Medicare Contractor's Substantive Claim Letter at 3 (Mar. 2, 2020).

[66] Provider's Response to Medicare Contractor's Substantive Claim Letter at 2 (Mar. 26, 2020).

[67] *Id.* at 3-5.

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> At the time the Provider's cost report was filed, it was filed in accordance with the knowledge in possession of the cost report preparer at that time. The Provider could not have ever included a claim for a protested amount on the cost report under appeal herein because the Provider filed its cost report without any knowledge that its wage index was flawed.[68]

On **September 1, 2021**, the Board issued a Ruling on Jurisdiction And Substantive Claim Challenge And Notice of Own Motion EJR Relative to 42 C.F.R. §§ 413.24(j) and 405.1873. The Board stated:

> The Board finds that the appeal was timely filed and the $10,000 threshold for Board jurisdiction has been met. With regard to the wage index issue, the Board reviewed the controlling statute for the IPF PPS at 42 U.S.C. § 1395ww(s); the IPF regulations at 42 C.F.R. §§ 412.428-412.432; and the Federal Register notices regarding IPF PPS payments. The Board did not identify any bar for an IPF from appealing the wage index issue. Accordingly, the Board concludes that there is no bar to IPF appeals of this issue and that the Board has jurisdiction over this appeal.[69]

The Board also found that Lincoln Trail did not include an appropriate cost report claim for the AHW wage index issue as required by 42 C.F.R. § 413.24(j)(1) because Lincoln "failed to make a claim for the 'specific item,' namely the allegedly aberrantly low AHW for the Elizabethtown CBSA (20160)."[70] The Board also noted "that the Provider did not file any items under protest and Audit Adjustment No. 9, the subject of this appeal, did not adjust any aspect of the AHW component of the wage index."[71] Indeed, the Board also found that Lincoln Trail conceded it did not comply with its obligation under § 413.24(j)(1).[72] Finally, the Board gave notice to the parties it was considering, on its own motion, EJR with regard to the procedural and substantive validity of 42 C.F.R. §§ 413.24(j) and 405.1873 and requested comments from the parties on those issues.[73]

On **September 29, 2021**, the Board issued a letter to clarify that its September 1, 2021 ruling, including the factual and legal findings related to the substantive claim challenge, was ***not*** a final disposition.[74] Though these findings were *preliminary* in nature, the Board confirmed in a letter

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[68] *Id.* at 5.
[69] Board Ruling on Jurisdiction & Substantive Claim Challenge and Notice of Own Motion EJR Relative to 42 C.F.R. §§ 413.24(j) and 405.1873 at 13 (Sept. 1, 2021).
[70] *Id.* at 14.
[71] *Id.*
[72] *Id.*
[73] The Board notes that it also issued Notice of Own Motion EJR Relative to the Provider's response to the MAC's Substantive Claim Challenge, in which the Provider questions the procedural and substantive validity of 42 C.F.R. §§ 413.24(j) and 405.1873.
[74] *See also* Expedited Judicial Review Decision (hereinafter "Board's EJR Decision") at 1 (Jan. 26, 2022) (noting that the Board's findings in the September 21, 2021 letter were "preliminary determinations regarding jurisdiction and the substantive claim challenge . . .").

to the parties on August 21, 2023, that it intended to incorporate these factual and legal findings into its final decision in this case unless a party moved to reopen the substantive claim issue.

On **November 4, 2021**, the Board issued another RFI because Lincoln Trail had not specifically identified "what Federal Register provisions that published the IPF-PPS wage index are being challenged."[75] Similarly, it was unclear whether Lincoln Trail's appeal also challenged "the underlying policy of how the wage index is to be calculated for use in the IPF PPS, or whether it is alleging that the calculation was done improperly."[76] The uncertainty was further illustrated in that Lincoln Trail's EJR Request appeared to be challenging certain policies or practices, but the Issue Statement alleged errors in Hardin's actual reporting of Part B Physician costs and salaries.[77] Thus, the Board requested that Lincoln Trail: (1) clarify which IPF IPPS rates are being challenged (and the relevant Federal Register Provisions); (2) confirm whether the alleged errors in the Hardin wage data impacted the IPPS wage index that was used to set the IPF-PPS rates identified in No. 1; (3) explain in additional detail whether it is challenging the underlying policy of the calculation of the wage index, and, if so, the specific policy(ies) being challenged; and (4) demonstrate that there are no factual issues in dispute.[78]

On **December 2, 2021**, Lincoln Trail filed its response to the Board's RFI and clarified that the wage indices used for the cost reporting period under appeal (*i.e.*, FY 2017 which ran from May 1, 2016 through April 30, 2017) included: (1) the IPPS FFY 2015 index (used for Inpatient Psych PPS for FFY 2016, for Lincoln Trail's May 1 through September 30, 2016 discharges); and (2) the IPPS FFY 2016 wage index (used for Inpatient Psych PPS 2017, for Lincoln Trail's October 1, 2016 through April 30, 2017 discharges).[79] Lincoln Trail also provided figures to illustrate how it was impacted by Hardin's inaccurate wage data.[80] Next, Lincoln Trail confirmed that it is ***not*** challenging a wage index policy or regulation; but rather, is seeking a correction of the data used for the Elizabethtown CBSA as required by wage index reporting guidance.[81] Finally, Lincoln Trail acknowledged that there are factual issues in dispute, but asserted that it cannot resolve the factual issues because CMS is the only party with access to the necessary data.[82] Citing to the *Pomona Valley*[83] case for support, Lincoln Trail contends that it has provided sufficient documentation to suggest Hardin's wage index data was incorrect, thereby shifting the burden of proof to the Medicare Contractor to show that it correctly audited Hardin's cost report.[84]

On **December 30, 2021**, the Medicare Contractor filed a response to the Provider's Response to the Board's RFI, arguing that it is inappropriate to shift the burden of proof to the Medicare Contractor simply because Lincoln Trail finds it difficult to prove its case, especially since it ***never*** sought discovery from the Medicare Contractor for the information Lincoln Trail allegedly

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[75] Board's RFI at 3 (Nov. 4, 2021). *See supra* note 55 and accompanying text (the issue statement).
[76] *Id.*
[77] *Id.* at 4-5.
[78] *Id.* at 5.
[79] Provider's Response to the Board's Nov. 4 RFI at 2 (Dec. 2, 2021).
[80] *Id.* at 3.
[81] *Id.*
[82] *Id.* at 5-6.
[83] *Pomona Valley Hospital Medical Center v. Azar*, 1:18-cv-02763-ABJ, 2020 WL 5816486 (Sept. 30, 2020).
[84] Provider's Response to the Board's Nov. 4 RFI at 6.

does not possess. Since Lincoln Trail is not challenging the wage index policy, the Medicare Contractor claims that EJR is also inappropriate.[85]

On **January 26, 2022**, the Board issued an EJR Decision, and found that there are material facts in dispute and that there is insufficient information in the record to determine whether granting EJR is appropriate.[86] The Board noted that Lincoln Trail's legal question "is dependent upon certain facts being true, namely that Hardin's wage data for the years in question contained certain material errors and that those errors were not corrected as part of the wage index audit for those years."[87] The Board also noted that the Medicare Contractor is subject to discovery in Board proceedings, but that Lincoln Trail had not yet served any discovery requests in this case.[88] Specifically, 42 C.F.R. § 405.1853(e) states in relevant part:

> (e) *Discovery*—(1) *General rules*. (i) Discovery is limited in Board proceedings.
>
> (ii) The Board may permit discovery of a **matter that is relevant to the specific subject matter of the Board hearing**, provided the matter is not privileged or otherwise protected from disclosure and the discovery request is not unreasonable, unduly burdensome or expensive, or otherwise inappropriate.
>
> (iii) Any discovery initiated by a party must comply with all requirements and limitations of this section, and with any further requirements or limitations ordered by the Board.
>
> (iv) The applicable provisions of the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence serve as guidance for any discovery that is permitted under this section or by Board order.
>
> (2) *Limitations on discovery*. Any discovery before the Board is limited as follows:
>
> (i) **A party may request** of another party, or **of a nonparty** other than CMS, the Secretary or any Federal agency, the reasonable production of documents for inspection and copying.
>
> (ii) A party may also request another party to respond to a reasonable number of written interrogatories.[89]

The Board further pointed out that the Medicare Contractor is not in *sole* possession of the relevant information because Hardin itself possesses the information and, as a nonparty, can also

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[85] Medicare Contractor's Response to Provider's Response to the Board's RFI at 1-2 (Dec. 30, 2021).
[86] Board's EJR Decision at 9-10 (Jan. 26, 2022). *See* 42 C.F.R § 405.1842(f).
[87] Board's EJR Decision at 10.
[88] *Id.* at 12.
[89] (Bold and underline emphasis added and italics in original.)

be served discovery under 42 C.F.R. § 405.1853(e)(2)(i). Based on the foregoing, the Board denied the EJR request. [90]

On **October 25, 2022**, the Board issued a notice of hearing setting forth the hearing date for August 29, 2023 and setting critical due dates for final position papers. On **May 31, 2023**, Lincoln Trail filed its Final Position Paper. On **June 26, 2023**, the Medicare Contractor filed its Final Position Paper.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

IPFs do not contribute data to the wage index rate setting process but rather only IPPS hospitals contribute to this process. Here, there was only one IPPS provider that contributed to wage index data for CBSA 21060 (Elizabethtown-Fort Knox, KY) – Hardin which, for purposes of IPPS reimbursement was reclassified to another CBSA.[91]

In general, there is a delay between a hospital's cost reporting year and when its wage and wage-related data is finalized during the IPPS wage index-setting process. In the case of Lincoln Trail, it is Hardin's FY 2012 cost report (*i.e.*, the cost report for the fiscal year ending June 30, 2012) which is used in the development of the FFY 2015 IPPS wage index factor, and Hardin's FY 2013 cost report which is used in the development of the FFY 2016 IPPS wage index factor. For IPFs, there is an additional one-year delay before that wage index factor is used.[92] As Lincoln Trail's appeal is for its FY 2017 reporting year (*i.e.*, the fiscal year ending April 30, 2017), Hardin's wage index data from its FYs 2012 and 2013 impact Lincoln Trail's FY 2017 cost report as follows:

Lincoln Trail FY 2017	IPF-PPS Rate Year	IPPS Wage Index Used	Relevant Hardin Wage Index Data
May 1, 2016 to Sept. 30, 2016	FY 2016	FY 2015	FY 2012
Oct. 1, 2016 to Apr. 30, 2017	FY 2017	FY 2016	FY 2013

Worksheets S-3 Part II, III and IV of the Medicare Cost Report "provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the PPS."[93]

A. Parties' Positions on the Substance of this Appeal

Lincoln Trail argues that it is simply requesting the wage index reporting guidance be followed in correcting the AHW of CBSA 21060 (Elizabethtown-Fort Knox, KY) based on its contention that Hardin did not properly follow the Medicare cost reporting instructions.[94] Specifically, Lincoln

[90] *See also* Board's EJR Decision at 13.
[91] Medicare Contractor's FPP at 7 and Exhibit (hereinafter "Ex.") at C-5.
[92] *See supra* notes 49-51 and accompanying text.
[93] Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), § 4005.2.
[94] Provider's FPP at 4-5.

Trail asserts Hardin's reporting of "Physician Part B" salaries was incorrect. In support, Lincoln Trail notes that the cost report instructions specify that salaries should be gathered as follows:

> Line 5--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist on-call salaries and salaries associated with services that are billable under Part B that are included in line 1. Under Medicare, these services are related to direct patient care and can be billed separately under Part B. Also include physician salaries for patient care services reported for rural health clinics (RHC) and FQHCs included on Worksheet A, column 1, lines 88 and/or 89, as applicable. Do not include on this line amounts that are included on lines 9 and 10 for the SNF or excluded area salaries. Refer to CMS Pub. 15-1, §§2313.2.E. and 2182.3.E., for instructions related to keeping time studies to track time spent in Part A versus Part B activities. However, although §2313.2.E.2. states that, "A minimally acceptable time study must encompass at least one full week per month of the cost reporting period," the contractor makes the final determination on the adequacy of the records maintained. A 2-week semi-annual (every 6 months) time study can be adequate unless the contractor believes that a significant change in the pattern of physician time is likely to occur from one quarter to the next, in which case, the contractor may require more frequent time studies. Adequate documentation must be maintained to support total hours in a manner that is verifiable, and to serve as a condition of payment under Part A. In the absence of a written allocation agreement, the contractor assumes that 100 percent of the physician compensation cost is allocated to Part B services. Include non-allowable services that are neither Part A nor Part B services (e.g., stand-by time, physician availability services, time spent in research activities) with the time spent in Part B activities. In accordance with 42 CFR 415.55(a) and 415.60, reasonable ER physician availability cost can be considered Part A services.[95]

Further, Lincoln Trail contends Hardin's improper reporting of Physician Part B salaries contributed to an improper allocation of wage related costs, resulting in a significant understatement of the AHW.[96]

Ultimately, Lincoln Trail argues Hardin included wage related expense for excluded physicians in two different places on Worksheet S-3, Part II:

> [T]he MAC allowed precisely what the agency tells it not to do: Hardin did not correctly report salaries on Line 5 and instead ***likely*** included them in Lines 9 and 10. Exhibit P-15 confirms that Line 5 of the FYE 6/30/10 Worksheet S-3 Part II only contains "Hospitalist

[95] *Id.* (quoting PRM 15-2 § 4005.2).
[96] Provider's FPP at 7.

> and Sign on Bonuses" when that line is supposed to include all physician salaries associated with direct patient care billed separately under Part B.[97]

On or about April 23, 2023, Lincoln Trail served a discovery request on the Medicare Contractor and, in part, requested that the Medicare Contractor produce copies of certain cost report work papers relating to Hardin.[98] However, in its May 24, 2023 response, the Medicare Contractor refused to comply with that request, asserting confidentiality and raising questions about their relevance:

> The MAC refused to comply with any Request for Production, citing "on the grounds that it seeks information regarding a hospital who is not a party to this appeal, is confidential, irrelevant and not likely to lead to the discovery of admissible evidence."[99]

Finally, Lincoln Trail contends that it has supplied enough evidence to shift the burden of proof to the Medicare Contractor based on its contention that this must happen when, as here, a Medicare contractor is in sole possession of the key data.[100]

In further support of its position, Lincoln Trail contends Hardin *agreed* there was a reporting error, and further notes that it is not in possession of the information in question:

> The Provider has documented that Hardin does not have the relevant cost report and wage index audit information in its possession, and Provider continues to work with Hardin as Hardin attempts to obtain the cost report information from the MAC; however, given the MAC has already thrown up roadblocks to this information, Provider plans to file a Motion to Compel upon the MAC for relevant information as well as seek an affidavit from Hardin.[101]

The Medicare Contractor disagrees with Lincoln Trail's arguments, and contends Lincoln Trail has not supplied sufficient documentation to show errors existing in the wage index:

> The MAC asserts that the Provider has not provided support to show errors in Hardin Memorial Hospital [Wage Index] data for FFY 2015 and 2016, which impacted its FYE April 30, 2017 cost report. As the Provider failed to demonstrate that errors actually existed in the [Wage Index] in dispute, the Provider's entire argument is based upon supposition. Without evidence that the [Wage Index] was

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[97] *Id.* at 10.
[98] A copy is included at Ex. P-16; however, the document does not include a service date nor does the Provider's final position paper filed on May 31, 2023 indicate when it was served on the Medicare Contractor. The Medicare Contractor in its final position paper at 21 confirms that it received the discovery request on April 24, 2023 and gave Lincoln Trail its response to that request on May 24, 2023.
[99] Provider's FPP at 13. *See also* Medicare Contractor's FPP at 21-25.
[100] *Id.* at 14.
[101] *Id.* at 15. *See also* Board's EJR Decision at 12-13 (Jan. 26, 2022).

> incorrect and based on the inadequate data, the MAC contends that the Provider is not able to prove its dissatisfaction and consequently is not entitled to appeal of errors that may not exist.[102]

Specifically, the Medicare Contractor notes Lincoln Trail has not supplied data showing Hardin's FFY 2015 and 2016 Wage Index data were incorrect, and claims they are making assertions with no support.

> Here the Provider is grasping at straws and tries to make the wildly outrageous suggestion that an alleged "inconsistency" in the 6/30/2009[103] and 6/30/2010[104] cost report indicates there is an error in Hardin's 6/30/2012 and 6/30/2013 S-3 WI data. The MAC contends each cost report stands on its own merit. A perceived inconsistency in a cost report two years prior does not indicate an error in Hardin's FFY 2015 and 2016 WI data.[105]

The Medicare Contractor cites to the Provider Reimbursement Manual, CMS Pub 15-2 ("PRM 15-2"), relating to supporting documentation necessary for Wage Index data:

> Salary cost--The required source for costs on Worksheet A is the general ledger (see §4013 and 42 CFR 413.24(e)). Worksheet S- 3, Part II, (wage index) data are derived from Worksheet A; therefore, the proper source for costs for the wage index is also the general ledger. A hospital's current year general ledger includes both costs that are paid during the current year and costs that are expensed in the current year but paid in the subsequent year (current year accruals). Include on Worksheet S-3, Part II, the current year costs incurred from the general ledger; that is, both the current year costs paid and the current year accruals. (Costs that are expensed in the prior year but paid in the current year (prior year accruals) are not included on a hospital's current year general ledger; do not include on the hospital's current year Worksheet S-3, Part II.)
>
> Hours--The source for paid hours on Worksheet S-3, Part II, is the provider's payroll report. Hours are included on the payroll report in the period the associated expense is paid. Include on Worksheet S-3, Part II, the hours from the current year payroll report, including hours associated with costs expensed in the prior year but paid in the current year. The payroll report time period must cover the weeks that best match the provider's cost reporting period. (Hours associated with costs expensed in the current year but not paid until the subsequent year (current year accrual) are not included on the

[102] Medicare Contractor's FPP at 10.
[103] Provider's FPP at Ex. P-14.
[104] *Id.* at Ex. P-15.
[105] *Id.* at 13.

> current year payroll report; do not include on the hospital's current year Worksheet S-3, Part II.) [Although his methodology does not provide a] perfect match between paid costs and paid [hours for a given] year, it approximates a match between costs and hours.
>
> ****
>
> **The hospital must ensure that supporting documentation for both salaries and hours are based on actual data maintained in a form that permits validation by the contractor.** For example, the hospital must be able to provide a payroll report that is summarized by individual employee and type of pay, e.g., vacation, holiday, sick, etc.) so that the Medicare contractor can validate the hours reported. The use of estimates for these amounts is unacceptable for the wage index.[106]

Further, the Medicare Contractor reviewed the data and, in doing so, suggests there were no errors in Hardin's cost reports, specific to Physician Part B salaries:

> In its Final Position Paper, the Provider submitted Hardin's cost report worksheets S-3 Part II and Part III for the years June 30, 2012, and 2013. A review of the June 30, 2012, worksheet shows there was no salaries and hours reported on line 5. Therefore, it is impossible for the physician Part B salaries and hours to be excluded twice on the June 30, 2012 cost report. Here, the Provider believes Hardin incorrectly reported its Worksheet S-3, Part II, Lines 5, 9, and 10, in violation of the cost report instructions because Hardin reported nothing on Line 5. According to PRM 15-2, Section 4005.2, for S-3, Part II, line 5 instruction, it states: "Do not include on this line amounts that are include on line 9 and 10 for the SNF or excluded area salaries." This reading suggests that if Hardin has included the Part B physician salaries and hours on line 9 and 10, then the Provider do not need to include any amount here. Therefore, it is appropriate for the Provider to include nothing on this line. Hardin did not violate any cost report instructions because it reported nothing on Line 5. In addition, as lines 5, 9 and 10 would have reduced the net salaries used to calculate the AHW, the Provider did not explain why reported nothing on Line 5 would have resulted in a significant understatement of the AHW.[107]

Finally, the Medicare Contractor contends Lincoln Trail did not exhaust all its options available, including a discovery request to Hardin, and additionally details that its discovery response was appropriate:

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[106] *Id.* at 14-15. *See also* PRM 15-2 § 4005.2.
[107] Medicare Contractor's FPP at 18-19 (footnotes omitted).

> While the cost report itself is publicly accessible, the WI workpapers are confidential, privileged and are not privy to the Provider. Specifically, that is *Hardin's data* and not the Provider's. It would be abnormal for any medical facility to publicly publish its own workpapers for anyone to see, including the Provider. Therefore, the Provider should respect Hardin's privacy. It is Hardin's prerogative whether to furnish its WI workpapers to the Provider.[108]

B. The Elizabethtown CBSA Wage Index was properly established for FFY 2016 and 2017 IPS-PPS as related to IPS-PPS payments during Lincoln Trail's FY 2017.

In reviewing the record, the Board finds that Lincoln Trail did not "carr[y] its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that [it] is entitled to relief on the merits of the matter at issue," in accordance with 42 C.F.R. § 405.1871(a)(3). Specifically, Lincoln Trail has failed to establish consistent with these burdens that errors existed in Hardin's wage index data *for the periods at issue* and, accordingly, the Elizabethtown CBSA was properly established for purposes of the FFY 2016 and 2017 IPS-PPS.

First, the specifics of Lincoln Trail's argument stem from its contention that Hardin misrepresented costs on Lines 5, 9 and 10 of Worksheet S-3 Part II during the years in question. Provider Exhibits P-10 and P-11 detail Worksheet S-3 Part II for Hardin's FY 2012 and 2013 filed and settled cost reports, respectively. The table below depicts Hardin's settled salaries and hours for these lines for the applicable years, as reported in Provider Exhibits P-10 and P-11:

Hardin Memorial Hospital (18-0012) S-3 Part II	FYE 06/30/2012[109]			FYE 06/30/2013[110]		
	Adjusted Salaries	Paid Hours	AHW	Adjusted Salaries	Paid Hours	AHW
1. Total Salaries	87,680,213	3,386,810	25.89	101,280,596	3,773,265	26.84
5. Physician and Non-Physician Part B Salaries	-	-	-	2,816,827	13,241	212.74
9. SNF	1,040,013	45,165	23.03	1,109,825	45,833	24.21
10. Excluded Area Salaries	15,980,173	319,838	49.96	19,345,267	413,758	46.76

After a cursory review, it is clear that the AHW for Line 1 total salaries, Line 9 SNF and Line 10 Excluded areas are within a reasonable range of one another. With the exception of Excluded Area Salaries, all other lines (lines 1 and 9) show a year-over-year increase in adjusted salaries and paid hours, with the resulting AHW increasing a few percentage points. Hardin's Line 5 salaries and hours for FY 2013 are the only new amounts presented, in comparison to its prior year. However, the Board finds it hard to justify Lincoln Trail's contention of *duplication*

[108] *Id.* at 22.
[109] Provider's FPP at Ex. P-10.
[110] *Id.* at Ex. P-11.

between Line 5 and Lines 9 and 10, when the AHW for Excluded Area Salaries (line 10) *dropped* year-over-year, from $49.96 to $46.76.

Moreover, Lincoln Trail offered no documentation in the record that Hardin reported data on Line 5 that was duplicated in the data it reported on Lines 9 and 10. All salary costs to be reported on Worksheet S-3, Part II, Lines 9 and 10 are derived from Medicare Cost Report Worksheet A.[111] The instructions for Worksheet S-3, Part II, Lines 9 and 10 state:

> Lines 9 and 10--Enter on line 9 the amount reported on Worksheet A, column 1, for line 44 for the SNF. On line 10, enter from Worksheet A, column 1, the sum of lines 20, 23, 40 through 42, 45, 45.01, 46, 94, 95, 98 through 101, 105 through 112, 114, 115 through 117, and 190 through 194. DO NOT include on lines 9 and 10 any salaries for general service personnel (e.g., housekeeping) which, on Worksheet A, column 1, may have been included directly in the SNF and the other cost centers detailed in the instructions for line 10.[112]

Had Lincoln Trail included Hardin's Worksheet A in the record, it would have provided, *at a minimum*, an opportunity to reconcile which costs were claimed to determine if there was, in fact, a potential for duplication. Further, PRM 15-2 § 4013 specifies the data to be reported on Worksheet A, Columns 1, 2, and 3 (Salaries/Other/Total), stating: "The expenses listed in these columns must be the same as listed in your accounting books and records and/or trial balance." However, even after communication with Hardin (as discussed below), Lincoln Trail did not provide the trial balance/accounting records which could also provide an opportunity for reconciliation of Worksheets A and S-3, Part II.

Indeed, during the hearing, Lincoln Trail's witness was asked by the Board how duplication *could* have occurred if Hardin's FY 2012 Worksheet S-3, Part II, Line 5 included $0 but was unable to provide an answer due to lack of access to Hardn's FY 2012 workpapers:

> [BOARD MEMBER]: That actually brings up my next question. We've argued that it was doubled. Is there any exhibit in the record where I can see the summary of data that makes up the number on line 5 versus the number on line 10 for any year?
>
> THE WITNESS: I'm not going to speak for [Provider Representative], but I would say no, and that's been part of the issue with not having access to the full complement a [work] papers.
>
> [BOARD MEMBER]: Okay. Because it makes it difficult to verify that something is duplicated if I can't see that.
>
> THE WITNESS: Sure.[113]

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[111] PRM 15-2 § 4013.
[112] PRM 15-2 § 4005.2.
[113] Tr. at 113.

The Board also notes that, while Hardin reported $0 on Line 5 of Worksheet S-3, Part II for FY 2012, but then reported $2,816,827 in salaries over 13,241 paid hours in FY 2013, it is *possible* that Hardin's administrative practices for capturing this time were implemented during its FY 2013. This is further corroborated by the fact that Hardin's Worksheets S-3, Part II for FYs 2014, 2015 and 2016 included salaries and hours amounts on Line 5. Throughout the record, Lincoln Trail points to *purported* inconsistencies[114] in the average hourly rate listed on Line 5, but then fails to demonstrate *exactly how* Hardin's FY 2012 and 2013 data (the years in question for this appeal) were incorrect.

Lincoln Trail included certain records of Hardin's cost report years *surrounding* the year in question and aspired to develop its case by demonstrating how their reporting of salaries and hours changed in comparison to the two fiscal years at issue, in an effort to highlight their contention that the wage indices for the two fiscal years in question were incorrect. Lincoln Trail offered Exhibits P-20, P-21 and P-22 to denote Hardin's reporting for its FYs 2014, 2015 and 2016, respectively, years which all occurred ***after*** the appealed year in question. Lincoln Trail notes that the Hospital AHW used in the IPPS rule for CBSA 21060 for FFY 2017, which was then used for the IPF PPS rule for FFY 2018 (and based upon hospital fiscal year data from 2014) was $28.49. In the next year, it increased to $28.91 (FFY 2018 for IPPS/2019 for IPF PPS), and then to $34.62 in the following year.[115] The Board notes that this is not simply Hardin's specific AHW reported on Worksheet S-3, Part III, Line 6[116] for these years. The table below shows both the IPPS Final Rule AHW and Hardin's specific AHW for the same years, based upon Lincoln Trail's Exhibits.

Hospital FY Wage Data	CBSA 21060 Wage Index AHW per Final Rule	IPPS Effective Year	IPF PPS Effective Year	Hardin FYE Wage Data	Hardin S-3, Pt. III, line 6 Wage Index AHW	Per Prov. Exhibit
2012	$ 29.78	2015	2016	06/30/2012	$ 30.01	P-10
2013	$ 29.55	2016	2017	06/30/2013	$ 29.65	P-11
2014	$ 28.49	2017	2018	06/30/2014	$ 28.63	P-20
2015	$ 28.91	2018	2019	06/30/2015	$ 29.11	P-21
2016	$ 34.62	2019	2020	06/30/2016	$ 32.60	P-22

Lincoln Trail "believes Hardin incorrectly reported its Worksheet S-3, Part II, Line 5 in FYE 6/30/15 because the AHW was nearly $100 more in FYE 6/30/14 due to more than double the amount reported and less than 25% of the hours as compared to the prior year."[117] While this belief may be *possible*, Lincoln Trail offers no further evidence or documentation to support or substantiate *their belief*. Indeed, it is also possible that the reverse could be true, *i.e.*, the information could have been correct in FY 2015 but incorrect in FY 2014. Significantly, the hospital's overall AHW between FY 2014 and FY 2015, as shown in the table above, is comparable, having increased from $28.63 to $29.11, or 1.68 percent. Without documentation, there is no way to verify that Lincoln Trail's *suggested possibility* is accurate or whether the data is correct as reported.

[114] Provider's Responsive Brief at 5-7 (Jul. 31, 2023).
[115] *Id.* at 8.
[116] PRM 15-2 § 4005.4.
[117] Provider's Responsive Brief at 5.

During Lincoln Trail's cross-examination of the Medicare Contractor's witness, the witness responded to Lincoln Trail's question about whether a change of this magnitude would trigger a review and the witness confirmed that it could, but also noted that what is scoped for review fluctuates from year to year:

> MS. ELIAS: When you were an auditor, would a change like that have triggered you to look at why that number more than doubled on line five from the prior year?
>
> THE WITNESS: It just depended on what was scoped during the review.
>
> MS. ELIAS: So you had to confine your review to what was scoped in a wage index audit?
>
> THE WITNESS: Yes. For the -- most of the time. You know, the MACs has [*sic*] a tight time period to conduct review of all the wage index reviews. I believe it's nine weeks. So it's a very tight time frame to review a lot of wage index. So the MAC would typically review areas that was scope for review.
>
> MS. ELIAS: And there was no scoping procedure for aberrant numbers that changed dramatically from one year to the next?
>
> THE WITNESS: It depends on the line.
>
> MS. ELIAS: So -- is it safe to say that there are some lines on the wage index audit that the MAC never reviews?
>
> THE WITNESS: Theoretically there could be. It – you know, it fluctuates year by year and, you know, each line has it's own, you know, scope.
>
> MS. ELIAS: What is the -- is there a percent change from one year to the next or a change in a dollar amount from prior that would trigger a determination of aberrant data and require you to look at a particular number?
>
> THE WITNESS: Some areas are compared for variances between years.
>
> MS. ELIAS: Is line five typically a line that is included in the scoping instructions?
>
> THE WITNESS: The entire wage index is included.
>
> MS. ELIAS: The entire wage index is included in scoping instructions? So do you mean all of worksheet S3, Part 2?

> THE WITNESS: Yes, mm-hmm.
>
> MS. ELIAS: So if you saw something that looked out of line from the prior year, that's within your scoping instruction to examine it, correct?
>
> THE WITNESS: Yes.
>
> MS. ELIAS: Would a doubling of wages be triggered in a scoping instruction? Would that be a typical scoping instruction, to look at something that had changed more than double from a prior year?
>
> THE WITNESS: It could be.[118]

Again, while the Board notes the data could *potentially* be inferred as being incorrectly reported year-over-year, Lincoln Trail has not supplied any evidence or support that the data was, in fact, aberrant or more likely-than-not aberrant.

Moreover, the Board rejects Lincoln Trail's contention that Hardin was not "impacted" by the alleged errors in the wage index data at issue because it was subject to IPPS and reclassed out of CBSA 21060. As made clear by Exhibit C-11, Hardin did have a 15-bed psychiatric subunit that was excluded from IPPS and was paid under IPF-PPS.[119] As such, Hardin was impacted and did have an incentive to ensure it carried out its responsibility to correctly report its wage data and, to this end, there is no evidence in the record to suggest Harding disputed, or otherwise sought to correct, its wage data that is at issue in this case.[120]

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[118] Tr. at 162-164.

[119] Ex. C-11 at 1-3 (Line 16 of Worksheet S-3, Part I for Hardin's FY 2012 cost report shows Hardin had an IPF subprovider with 15 beds having 5,490 available bed days for which it reported 681 discharges and 2,271 total inpatient days (of which 524 days were for Medicare patients and 433 days were for Medicaid patients) in that year); *Id*. at 4-6 (Line 16 of Worksheet S-3, Part I for Hardin's FY 2013 cost report shows Hardin had an IPF subprovider with 15 beds having 5,475 available bed days for which it reported 2,186 total inpatient days (of which 437 days were for Medicare patients and 262 days were for Medicaid patients)).

[120] *See* 42 C.F.R. §§ 413.20, 413.24; PRM 15-2 Ch. 40. In particular, 42 C.F.R. § 413.24(f)(4)(iv)(B) specifies that the following certification statement must immediately precede the signature of the Provider's administrator or chief financial officer:

> MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.
>
> I hereby certify that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ____ (Provider Name(s) and Number(s)) for the cost reporting period beginning ___ and ending ___ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that

Additionally, Lincoln Trail represented that Exhibits P-14 and P-15 contained certain wage index data information from Hardin's FY 2009 and 2010 cost reports, respectively, and then asserted that they contained certain inconsistencies:

> Although these are not the cost reports affecting the year under appeal for Provider, Hardin's FYE 6/30/09 and FYE 6/3/10 Worksheets S-3, Parts II and II do show some inconsistency with the Line 5 instructions above.[121]

However, upon review and as discussed during the hearing, the Board determined that, contrary to Lincoln Trail's representation, these exhibits do ***not*** pertain to Hardin in Kentucky but rather pertain to a *different* provider (Hardin Medical Center) in a *different* state (Tennessee).[122] Accordingly, it is clear that these exhibits have *absolutely* no relevance and no evidentiary value.

42 C.F.R. § 413.24(c) details the maintenance of sufficient documentation from a provider's records:

> (c) *Adequacy of cost information*. Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of **adequacy of data** implies that the data be accurate and **in sufficient detail to accomplish the purposes for which it is intended**. **Adequate data capable of being audited is consistent with good business concepts** and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, **financial and statistical records should be maintained in a manner consistent from one period to another**. **However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.**[123]

Further, while Lincoln Trail offers certain Hardin cost report pages as exhibits, the value of those pages is minimal because these pages were not the *audited* figures that were ultimately used as part of the wage index development.[124] Medicare Cost Reports are due five months following a provider's fiscal year end. Corrections to a provider's as-filed Worksheet S-3, Parts II, III and

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the services identified in this cost report were provided in compliance with such laws and regulations.

[121] Provider's Responsive Brief at 8-9.

[122] Hardin Memorial Hospital is located in Kentucky and is assigned CCN 18-0012 (where 18 represents Kentucky); however, Exhibits P-14 and P-15 relate to Hardin Medical Center located in Tennessee with a CCN of 44-0109 (where 44 represents Tennessee). *See* State Operations Manual, CMS Pub. 100-07, Ch. 2, § 2779A1 (listing the state codes used in CCNs). *See also* Tr. at 108-111.

[123] 42 C.F.R. § 413.24(c) (Bold and underline emphasis added and italics in original).

[124] CMS periodically publishes Wage Index data and Public Use Files ("PUF") in accordance with its Wage Index Development Timetable.

IV data are submitted directly to the Medicare Contractor by the noted deadline.[125] For Hardin's FY 2012 cost report, any wage index corrections were due to be submitted by a November 21, 2013 deadline, [126] or approximately one year after its as-filed Medicare Cost Report was due. Corrections to Medicare Wage index data are not submitted via an amended Medicare Cost Report; instead, corrections requested must be sent to the provider's designated Medicare Contractor *directly* along with applicable supporting documentation for any requested changes:

> Deadline for hospitals to request revisions to their Worksheet S-3 wage data and occupational mix data as included in the September [Public Use Files] and to provide documentation to support the request. ***FIs/MACs must receive the revision requests and supporting documentation by this date.*** FIs/MACs will have approximately 9 weeks to complete their reviews, make determinations, and transmit revised data to CMS's Division of Acute Care (DAC).[127]

Finally, and significantly, the Board notes that Lincoln Trail never exhausted efforts to *attempt* to file a dispute, via an amended cost report filing, or raise a concern during the wage index appeal process. Lincoln Trail claims it only discovered the error around November 2017, shortly after it had filed its FY 2017 cost report (which was due September 30, 2017).[128] However, the following Board questioning of Lincoln Trail's witness at the hearing confirms that it was possible to file an amended cost report; but it did not do so, notwithstanding its discovery of the issue shortly after filing its FY 2017 cost report:

> [BOARD MEMBER]: So, it would be possible to have amended this filed cost report to add a protested amount if you -- when you found the problem in November?
>
> THE WITNESS: It would have been possible. But in my experience, the MAC would have rejected it because there was no impact on the settlement.
>
> [BOARD MEMBER]: But it would have created a record of an attempt, similar to the exhibits we've provided where we attempted to reopen.
>
> THE WITNESS: Correct.[129]

In reference to the Medicare Wage Index timetable, the Board notes that, in general, Lincoln Trail had several opportunities to raise its concerns to the Medicare Contractor or CMS after the initial Hardin data was published, following the deadlines for providers to request revisions.

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[125] *See supra* at notes 22-23 and accompanying text.
[126] *Id.*
[127] *Id.*
[128] Tr. at 38-40.
[129] *Id.* at 114-16.

Below is a depiction of the timetable for Hardin's FY 2012 data, which was used for five (5) months of Lincoln Trail's appealed period:

> February 20, 2014 – Release of revised FY 2015 wage index and occupational mix files as PUFs on the CMS Web site. These data will have been desk reviewed and verified by the FIs/MACs before being published. Also, a file including each urban and rural area's average hourly wages for the FYs 2014 (final) and 2015 (preliminary) wage indexes will be provided on the CMS Web site.
>
> March 3, 2014 – Deadline for hospitals to submit requests (including supporting documentation) for: ***1) corrections to errors in the February PUFs due to CMS or FI/MAC mishandling of the wage index data,*** or ***2) revisions of desk review adjustments to their wage index data as included in the February PUFs (and to provide documentation to support the request).*** FIs/MACs must receive the requests and supporting documentation by this date. No new requests for wage index and occupational mix data revisions will be accepted by the FIs/MACs at this point, as it is too late in the process for FIs/MACs to handle data that is new in a timely manner.
>
> April/May, 2014 – Approximate date proposed rule will be published; includes proposed wage index, which is calculated based on the revised wage index data from February; 60-day public comment period and 45-day withdrawal deadline for hospitals applying for geographic reclassification.
>
> April 9, 2014 – Deadline for the following:
>
> 1. FIs/MACs to transmit final revised wage index data (in HCRIS hdt format) to DAC for inclusion in the final wage index. Worksheet S-3 wage data must be transmitted in HCRIS hdt format. Occupational mix data must be sent to DAC on the electronic Excel spreadsheet provided by DAC for specific use by FIs/MACs. All wage index data revisions must be transmitted to DAC by this date.
>
> 2. FIs/MACs must also send written notification to hospitals regarding the hospitals' March 3, 2014, correction/revision requests by this date.
>
> April 16, 2014 – ***Deadline for hospitals to appeal FI/MAC determinations and request CMS' intervention in cases where the hospital disagrees with the FI's/MAC's determination. It should be noted that during this review, CMS does not consider issues such as the adequacy of a hospital's supporting documentation, as CMS believes that the FIs/MACs are generally in the best position to***

make evaluations regarding the appropriateness of these types of issues (which should have been resolved earlier in the process). ***Requests must be received by CMS by this date. A copy of the appeal with complete documentation shall be sent to the FI/MAC.*** The request must include all correspondence between the hospital and FI/MAC that documents the hospital's attempt to resolve the dispute earlier in the process. Data that was incorrect in the September or February wage index data PUFs, but for which no correction request was received by the March 3, 2014 deadline, will not be considered for correction at this stage.

Note: Hospitals shall send an electronic and a hard copy of the appeal with complete documentation supporting their request; appeals submitted via fax will NOT be accepted. Electronic copies (including all supporting documentation) shall preferably be sent in PDF files to ensure compatibility with CMS software. Spreadsheets can be sent in Excel.

Appeals shall be sent electronically to wageindexreview@cms.hhs.gov

Hard Copies shall be sent to the CMS Central Office at:

Centers for Medicare & Medicaid Services
c/o Wage Index, CMM/HAPG/DAC
Room C4-08-06
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Note: If the supporting documentation files being sent via email are too large to be sent through email, then send an electronic copy of only the appeal letter to the email address above (and note in the email that complete supporting documentation will be sent via hard copy); hospitals must still send a complete hard copy with supporting documentation to the address above.

Late April, 2014 – Final FY 2015 wage index data compiled and sent by CMS to FIs/MACs for verification. This verification of the final wage and occupational mix data by the FIs/MACs is necessary to ensure that the correct data for each hospital has been properly transmitted and received. The FIs/MACs will have approximately 1 week in which to complete the verification.

Notice sent from CMS to each FI/MAC regarding the May 2, 2014, release of the final FY 2015 wage index data PUFs and the June 2, 2014, deadline for hospitals to request corrections to the wage and occupational mix data as reflected in the final files.

> Notice must be forwarded by FIs/MACs to hospitals they service to alert hospitals to the availability of the final wage index and occupational mix data files for their review in the May 2, 2014 PUF, and to inform hospitals that this will be their last opportunity to request corrections to errors in the final data. Changes to data will be limited to situations involving errors by CMS or the FI/MAC that the hospital could not have known about before review of the final May PUFs. Data that was incorrect in the September or February wage index data PUFs, but for which no correction request was received by the March 3, 2014 deadline, will not be considered for correction at this stage.
>
> May 2, 2014 – Release of final FY 2015 wage index and occupational mix data PUFs on CMS Web page. Hospitals will have approximately 1 month to verify their data and submit correction requests to **both** CMS and their FI/MAC to correct errors due to CMS or FI/MAC mishandling of the final wage and occupational mix data.
>
> June 2, 2014 – ***Deadline for hospitals to submit correction requests to both CMS and their FI/MAC to correct errors due to CMS or FI/MAC mishandling of the final wage and occupational mix data as posted in the May 2, 2014 PUF.*** Changes to data will be limited to situations involving errors by CMS or the FI/MAC that the hospital could not have known about before review of the final May PUFs. CMS and the FIs/MACs must receive all requests by this date via mail and email to the addresses above**.** NOTE: CMS emphasizes that data that were incorrect in the September or February wage index data PUFs, but for which no correction request was received by the March 3, 2014, deadline, will not be changed at this stage for inclusion in the wage index. Each correction request must include all information and supporting documentation needed for CMS and the FI/MAC to determine whether or not the hospital's request meets the criteria for a correction to their data at this point in the wage index development. The FIs/MACs and DAC will review each request upon receipt and consult to determine whether or not the request qualifies for correction of the final wage or occupational mix data.
>
> August 1, 2014 – Approximate date for publication of the FY 2015 final rule; wage index includes final wage index data corrections.
>
> October 1, 2014 – Effective date of FY 2015 wage index.[130]

While the Board recognizes that Lincoln Trail claims that it only discovered the error in 2017, the Wage Index Development timetable, in general, is similar year-to-year and provides for several

[130] *Supra* note 22 (bold, italics and underline emphasis added).

opportunities for Lincoln Trail and other providers to raise concerns about their data, or the data of other IPPS hospitals. Lincoln Trail had the ability to discover the alleged error sooner, as demonstrated by the fact that PUFs are *publicly available* containing Worksheet S-3, Parts II, III and IV data for all hospitals contributing to the wage index process, and the IPPS Proposed Rule gives providers an *expectation* of what its wage index factor could be for the relevant upcoming Federal Fiscal Year. Accordingly, it is unclear to the Board, with the publication of *publicly available* data files, why Lincoln Trail ***never*** raised a concern earlier.[131]

Finally, the Board notes that, while Lincoln Trail served discovery on the Medicare Contractor on April 24, 2023, in an effort to obtain certain Hardin wage index data, Hardin itself also possesses key cost report data and supporting work papers, as the Board explained in its EJR decision:

> Indeed, it is clear that the MAC is not in sole possession of the relevant information and documents. ***Here, Hardin clearly possesses key information and documents*** *such as the relevant as-filed and audited cost reports and supporting workpapers.* Similarly, it is also clear that the Provider has had access to certain relevant documents and information through its cost report preparer as well as the "subscription service" that it referenced in its December 2, 2021 filing.
>
> However, the Provider has not explained to what extent the Provider has contacted Hardin (including conducting discovery permitted from nonparties under § 405.1853(e)) or to what extent it exhausted information available through the sources it has used, namely its cost report preparer and "subscription service."[132]

The Board further notes that Lincoln Trail's attempts to obtain Hardin's data were *belated* since they occurred only ***after*** *the Board raised the issue in its January 26, 2022 EJR decision*. The last-minute nature of these efforts is highlighted by the fact that they did not begin until April 25, 2022,[133] almost 3 years after this appeal was filed on May 14, 2019 and roughly 4½ years after Lincoln Trail allegedly discovered this issue in or around November 2017.[134] Given the fact that the underlying Hardin related records were (at that time) 7 to 9 years old, Lincoln Trail's delay impacted its ability to obtain information from Hardin as highlighted by the following responses from Hardin: (1) an August 30, 2022 email from Hardin confirmed that "[t]he individual who worked on the cost reports during those years [*i.e.*, FYs 2012 and 2013] is no longer with the organization";[135] and (2) an August 26, 2022 email from Harding confirming that "Hardin was able to double check in records at Hardin and with others at the hospital and they have not been

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[131] Regardless of whether Lincoln Trail as an IPF was bound by this schedule or the midyear corrections to the wage index scheduling codified in 42 C.F.R. 412.64(k), Lincoln Trail could have availed itself of that process but failed to do so.

[132] *See* Board's EJR Decision at 12-13 (Jan. 26, 2022).

[133] Ex. P-17.

[134] Provider's FPP at Ex. P-17 details communications between Lincoln Trail and Hardin, which began on April 25, 2022. The Board's Expedited Judicial Review Decision was issued approximately three months prior to Lincoln Trail's first attempt to gather any information from Hardin whatsoever.

[135] Ex. P-18.

successful in attempts to locate workpapers from 2015."[136] The Board recognizes that an August 26, 2022 email from the Associate General Counsel states that "her team believe the conclusion you have reached related to the error is accurate";[137] however, this statement has no evidentiary value since (1) it is unclear what that belief is based on given that fact that Hardin states that none of the relevant cost report workpapers are available and the employee who prepared the Hardin cost reports at issue is no longer with Hardin; (2) Hardin declined to offer any assistance that might otherwise potentially substantiate that belief as "[w]e also don't want to expose Hardin to risk in doing so"; and (3) there is no evidence in the record suggesting that Hardin previously disputed, or otherwise sought correction of, the wage index data at issue.[138]

Based on the above findings, the Board concludes that Lincoln Trail has failed to establish, consistent with its burdens under 42 C.F.R. § 405.1871(a)(3), that errors existed within Hardin's wage index data as used in the Elizabethtown CBSA for the FFY 2016 and 2017 IPF-PPS wage indices.[139]

C. Lincoln Trail failed to include an appropriate cost report claim for the AHW issue as required by 42 C.F.R. § 413.24(j)(1).

With regard to the Substantive Claim Challenge, the Board finalizes its September 1, 2021 ruling, finding that, based upon review of the record, Lincoln Trail did *not* include an appropriate cost report claim for the AHW issue on its as-filed FY 2017 cost report, as required by 42 C.F.R. § 413.24(j)(1)) (whether by claiming or protesting) and did not qualify under any of the exceptions in 42 C.F.R. § 413.24(j)(3). Indeed, Lincoln Trail concedes in its March 26, 2020 letter, responding to the Medicare Contractor's Substantive Claim Letter, that it failed to comply with its obligation under § 413.24(j)(1) to make a claim or include a protested amount for the Wage Index issue on its FY 2017 cost report.

The Board recognizes that, at the hearing, Lincoln Trail raised an additional argument asserting that § 413.24(j) is not applicable to IPFs because Transmittal 253, dated December 14, 2018, of the Medicare Benefit Policy Manual[140] did not extend 42 C.F.R. § 413.24 to IPFs. The Board disagrees with Lincoln Trail's contention and finds that § 413.24 is applicable to IPFs as made clear by § 413.1(a)(3) which specifies that the policies in Part 413 are binding on the entities in paragraph (a)(2), which includes "hospitals," and the Board notes that an IPF is a type of hospital for purposes of 42 C.F.R. Part 413. Indeed, § 413.1(d) sets forth the different types of hospitals providing inpatient hospital services and includes IPFs which are and specifically listed consistent with 42 U.S.C. §§ 1395x(e) and 1395ww(d)(1)(B). Accordingly, this additional argument does not alter the Board's original September 1, 2021 ruling and the Board affirms its finding that Lincoln Trail failed to specifically include a substantive claim for the wage index AHW issue under appeal in this case on its FY 2017 cost report, as required under 42 C.F.R. § 413.424(j)(1).

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[136] Ex. P-19.
[137] *Id.*
[138] *Id.*
[139] In this respect, the Board's findings make clear that Lincoln Trail's evidentiary production in this case was not robust enough to qualify for burden shifting under the rationale in *Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252 (D.C. Cir. 2023).
[140] Medicare Benefit Policy Manual, CMS Pub. 100-02, Transmittal 253, Change Req. 11062 (Dec. 14, 2018) (revising Chapter 2 at §§ 10 and 80).

DECISION

After considering Medicare law, regulations, program guidance, the arguments presented, and the evidence admitted, the Board finds that:

1. The Elizabethtown CBSA 21060 Wage Index was properly established for Medicare payments made under the IPF-PPS to Lincoln Trail during its FY 2017; and

2. Lincoln Trail failed to include an appropriate cost report claim on its as-filed FY 2017 cost report for the wage index AHW issue under appeal in this case, as required under 42 C.F.R. § 413.424(j)(1).

BOARD MEMBERS:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

9/6/2024

X Clayton J. Nix

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