DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision – SSI Percentage (Provider Specific) and Medicaid Eligible Days***
LV Stabler Memorial Hospital (Prov. No. 01-0150)
FYE 01/31/2017
Case No. 20-0475

Dear Mr. Ravindran and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or Board") reviewed the documentation in Case No. 20-0475 in response to two jurisdictional challenges filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 20-0475*

On **November 19 2019,** LV Stabler Memorial Hospital ("Provider") appealed an original Notice of Program Reimbursement ("NPR") dated **May 24, 2019** for its fiscal year end ("FYE") January 31, 2017 cost reporting period. The Provider filed an individual appeal request which contained the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage[1]
- Issue 3: DSH- Medicaid Eligible Days
- Issue 4: Uncompensated Care Distribution Pool[2]
- Issue 5: 2 Midnight Census IPPS Payment Reduction[3]

As the Provider is commonly owned by Quorum Health, the Provider transferred Issue 2 and 5 to common issue related party ("CIRP") groups for Quorum Health. On July 9, 2020, the

[1] On June 18, 2020, the Provider transferred the issue to PRRB Case No. 20-1339GC.
[2] On July 9, 2020, the Provider withdrew this issue.
[3] On June 18, 2020, the Provider transferred the issue to PRRB Case No. 20-1340GC.

Provider withdrew Issue 4 addressing the Uncompensated Care Distribution Pool in the cover letter for its Preliminary Position Paper. As a result of these transfers and withdrawal, the remaining issues in this appeal are Issue 1 (DSH/SSI Provider Specific) and Issue 3 (DSH Medicaid Eligible Days).

On **September 23, 2020**, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue 1, (DSH SSI Provider Specific) requesting that the Board dismiss this issue.[4] On **March 2, 2023**, the Medicare Contractor filed a second Jurisdictional Challenge regarding Issue 3, Medicaid Eligible Days.

Significantly, the Provider did not respond to the MAC's Jurisdictional Challenges. Pursuant to Board Rule 44.4.3: "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1339GC - Quorum Health CY 2017 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> [T]he MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[5]

[4] MAC's Jurisdictional Challenge, at 2 (September 23, 2020).
[5] Issue Statement at 1 (November 20, 2019).

The Group issue Statement in Case No. 20-1339GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[6]

On July 9, 2020, the Board received the Provider's preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients

[6] Group Appeal Issue Statement in Case No. 20-1339GC.

> that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (January 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to Loma Linda Community Hospital v. Dept of Health and Human Services, No. CV -94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. See 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR. data, the Provider will seek to reconcile its' records with that of CMS, and identify' patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. See Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $5,000.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

In the MAC's jurisdictional challenge dated September 23, 2020, the MAC contends the aspect of Issue 1 - DSH SSI Percentage (Provider Specific) which concerns SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment should be dismissed because it is duplicative of Issue 2. The MAC adds that the aspect of Issue 1 which addresses DSH SSI realignment is not an appealable issue as there has not been a final determination regarding this issue as required by 42 C.F.R. § 405.1835, and the Provider decision to change the DSH Medicare computation fiscal year end ("realignment") is a Provider election. The Provider is required to make a realignment request in writing to the intermediary and CMS in order to receive a realigned SSI percentage. The MAC's position is that appeal of realignment is premature as there has not been a formal request for SSI realignment in accordance with 42 C.F.R. § 412.106(b)(3). Additionally, the Provider has not exhausted all available remedies prior

[7] Provider's Preliminary Position Paper at 8-9.

to appeal of this issue. [8]

Issue 3 – DSH – Medicaid Eligible Days

The MAC has challenged jurisdiction over the DSH Medicaid Eligible Days issue in its March 2, 2023 Jurisdictional Challenge. The MAC argues that the Providers have abandoned the issue when they failed to properly develop their arguments within their Preliminary Position paper in accordance with Board Rule 25.[9] Additionally, the Providers have failed to provide a list of additional Medicaid eligible days or any other supporting documents without explanation for why it cannot produce those documents.[10]

Provider's Response

The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. As previously noted, Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. Issue 1 - DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1 involves the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage.

[8] Jurisdictional Challenge (September 23, 2020)
[9] Jurisdictional Challenge (March 2, 2023) at pg. 1-4.
[10] Jurisdictional Challenge at 1 (March 2, 2023) at pg. 4-7.

This issue concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[11] Per the appeal request, the Provider's legal basis for its DSH/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues that "the SSI percentage published by CMS [the Centers for Medicare and Medicaid Services] was incorrectly computed . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

The Provider's Issue 2 for DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1339GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 20-0475 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1339GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[14], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 20-1339GC (which it is required to do since it is subject to the mandatory CIRP group regulation). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] The Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1339GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1339GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the

[11] Individual Appeal Request, Tab 3 - Issue Statement at 1.
[12] *Id.*
[13] *Id.*
[14] PRRB Rules v. 2.0 (Aug. 2018).
[15] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

year in question consistent with its obligations under Board Rule 25.2.[16] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[17]

Moreover, the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

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[16] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

[17] (Italics and underline emphasis added.)

https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[18]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[19]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 20-1332GC.

Accordingly, *based on the record before it*,[20] the Board finds that the SSI Provider Specific issue in Case No. 20-0475 and the group issue from the CHS CIRP group under Case No. 20-1339GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

B. Issue 3- DSH Payment – Medicaid Eligible Days

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers.

[18] Last accessed August 14, 2024.
[19] Emphasis added.
[20] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> **No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[21]

So, essentially, the regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Aug. 2018) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

[21] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[22]

> **COMMENTARY**:
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> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 The Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

[22] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

COMMENTARY: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on December 10, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this

> paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[23]

Along the same line, 42 C.F.R. 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> 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.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On July 9, 2020, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[24] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request. The Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that

[23] (Emphasis added.)
[24] Provider's Preliminary Position Paper at 11 (May 4, 2020).

> all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Medicare Contractor sent two (2) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on July 28, 2021, and the final request was sent to the Provider on January 18, 2023.

On **March 2, 2023**, the Medicare Contractor filed a Jurisdictional Challenge, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when request by the

Medicare Contractor 3 separate times after that). The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[25]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Jurisdictional Challenge. However, the Provider ***failed*** timely respond by the April 3, 2023[26], filing deadline (*i.e.*, 30 days after March 2, 2023).

The Board concurs with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e.*, the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[27] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[28]

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[25] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[26] April 2, 2023, falls on a Sunday.

[27] (Emphasis added.)

[28] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2).

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 20-0475 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/13/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: Ratina S. Kelly -S

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244-1850
410-786-2671

Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 West Butterfield Rd., Ste. 310
Elmhurst, IL 60126

RE: ***Notice of Dismissal***
SRI Aurora 2009 Unmatched Medicaid Days CIRP Group
Case No. 15-0217GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("Board" or "PRRB") received the Group Appeal Request on October 21, 2014 to establish the common issue related party ("CIRP") group under Case No. 15-0217GC and entitled "SRI Aurora 2009 Unmatched Medicaid Days CIRP Group."

On November 14, 2023, the Board issued the Notice of Hearing and Critical Due Dates that set the hearing in this case for September 17, 2024 at 9:00 am eastern time and specified that the hearing would be conducted in person at 7111 Security Boulevard, Suite 120, Baltimore, MD 21244. This Notice warned that "Failure to appear without a finding of good cause will result in dismissal of the case with prejudice."

On September 17, 2024, the Provider failed to appear by 9 am eastern time for the hearing for this case.

The Board may dismiss an appeal due to a Provider's failure to appear for a scheduled hearing pursuant to Board Rule 30.2 (Dec. 2023), which states that "[e]xcept for good cause beyond a provider's control, the Board will dismiss a case if the provider fails to appear at the hearing." Further, Board Rule 41.2 provides that the Board may dismiss a case on its own motion upon failure of the provider to comply with Board procedures, citing 42 C.F.R. § 405.1868, and upon failure to appear for a scheduled hearing. The regulation at 42 C.F.R. § 405.1868 provides, in pertinent part:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

The Providers in this group and their representative failed to appear at the hearing. Accordingly, the Board hereby dismisses Case No. 15-0217GC with prejudice and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/17/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Pamela VanArsdale, National Government Services, Inc. (J-6)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244 1850
410-786-2671

Via Electronic Delivery

Diane Haines
Sr. Reimbursement Coordinator
Bryan Health
1600 South 48th Street
Lincoln, NE 68506-1299

Re: ***Notice of Noncompliance with Mandatory Electronic Filing Requirements***
Bryan Medical Center, Prov. No. 28-0003
FYE 12/31/2020
Case No. 24-2521[1]

Dear Ms. Haines:

On September 16, 2024, the Centers for Medicare and Medicaid Services ("CMS") received hard-copy correspondence from you via United States Postal Service ("USPS") and, on September 17, 2024, CMS forwarded that correspondence to the Provider Reimbursement Review Board ("Board"). Upon review, this hard-copy correspondence appears to be an attempt to file an appeal request with the Board on behalf of Bryan Medical Center (the "Provider"). *As set forth below, (1)* ***all filings must be filed electronically*** *using the Board's electronic docketing system known as the Office of Hearing Case and Document Management System ("OH-CDMS"); and (2) this requirement applies to appeal requests unless the Board has given advance-approval of an exemption.* ***Thus, the Board cannot accept or docket this correspondence as a filing of an appeal request.*** Note that, if you desire to pursue an appeal of the matter contained in the correspondence, then you must electronically file an appeal request via OH CDMS using the process described below in **Subsection B** of the RELEVANT REGULATIONS AND RULES.

Relevant Regulations and Rules:

A. Provider Appeal Rights

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

[1] While the Board issued this correspondence under a case number, the Board has not created a case *per se*. Rather, the Board's creation of a case number was done so *only* to permit it to issue this correspondence via OH CDMS. As this letter describes, the Board has not docketed or accepted the hard-copy correspondence as a filing and this letter closes out this case number, *i.e.,* closes out the Board's correspondence with the Provider on its improper submission. To the extent the Provider properly files an appeal request using OH CDMS, then OH CDMS will automatically assign the appeal request to a *different* case number for that filing.

Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, unless a provider qualifies for a good cause extension under § 405.1836,[2] the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with 5 days allotted for mailing and receipt.[3]

Further, 42 C.F.R. § 405.1801(d) specifies the method for submissions and advises that ". . . the reviewing entity may prescribe the method(s) by which a party must make a submission, including the requirement to use an electronic filing system for submission of documents."[4] Pursuant to the authority of this regulation, the Board issued Board Rule 2.1.1 specifying that, effective November 1, 2021, all filings, including appeal requests, must be made electronically via OH CDMS.[5] Please refer to **Subsection B**, below, discussing the process for filing electronically via OH CDMS.

Board Rules 6 and 7 address individual appeal requirements and support for the appealed final determination, availability of issue-related information, and the basis for dissatisfaction. Specifically, Board Rule 6.4, advises that, "[a] calculation of the amount in controversy with supporting documentation must be provided for each issue." Similarly, the individual filing an appeal request on behalf of the provider must be authorized to do so and, as explained in Board Rule 5.4, a letter of representation confirming that authorization must be included with the appeal request. Consistent with its authority under 42 C.F.R. § 405.1835(b), the Board may dismiss appeal requests that do not meet the *minimum* filing and content requirements (*e.g*, dismissal for failure to attach a copy of the determination being appealed).

Finally, Board Rule 5.2 makes it clear that the Provider's representative is responsible for being familiar with Board Rules and Regulations, meeting the Board's deadlines and responding to correspondence or requests from the Board.

B. Board Rules on Mandatory Electronic Filing

Board Rule 2.1 addresses filings with the Board and specifies in 2.1.1 that, effective November 1, 2021, all filings with the Board ***must*** *be made electronically via OH CDMS*.[6] This Rule also provides information on how representatives of parties appearing before the Board can register as users of OH CDMS. Specifically, Board Rule 2.1 (Dec. 2023) states in pertinent part:

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[2] *See* Board Rule 2.1.4. This Rule is entitled "Extension to Filing an Appeal Under 42 C.F.R. § 405.1836 (Including Direct Adds to a Group)" and is quoted below.

[3] For purposes of filings before the Board, 42 C.F.R. § 405.1801(a) defines "date of receipt" in paragraph (1)(iii) as follows: "The date of receipt by a party . . . involved in proceedings before a reviewing entity is presumed to be 5 days after the date of issuance of a contractor notice or a reviewing entity document. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date."

[4] The Board's authority to mandate electronic filing is based the Final Rule published on September 18, 2020, 85 Fed. Reg. 58432, 58986 (Sept. 18, 2020) as incorporated into the regulations at 42 C.F.R. § 405.1801(d).

[5] On June 16, 2021, Board Alert 21 and Board Order No. 1 were issued by the Board to give the provider community more than 120 days' notice of this new requirement.

[6] *See also* Board Rule 3.1 (stating: "Effective November 1, 2021, parties must submit documents and information electronically to the Board through OH CDMS unless an exemption granted under Rule 2.1.2 applies."); Board Rule 2.2.1 (stating: "Pursuant to Rule 2.1.1, all submissions (e.g., appeal requests, correspondence, position papers) must be filed electronically using OH CDMS unless an exemption granted under Rule 2.1.2 applies.").

2.1.1 Mandatory Electronic Filing

Effective November 1, 2021, all filings must be submitted electronically using OH CDMS unless an **exemption** granted under Rule 2.1.2 applies. OH CDMS is a web-based portal for parties to electronically file and maintain their cases and to correspond with the Board. Access to the system is granted to registered users, as needed, based on their roles. Access to specific cases is limited to the parties of each case, including party representatives.

Individuals registering for access to OH CDMS should allow for up to ***ten (10) days*** to complete registration as it is a multi-step process to obtain secure access to the web-based portal itself and to OH CDMS.

Refer to the webpage at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing to access links for the following:

1. *The CMS Salesforce Enterprise Integration (SEI) Portal*.— . . . .

2. *The OH CDMS External Registration Manual*.— . . . .

3. *The OH CDMS PRRB User Manual*.— . . . .

. . . . For any technical system issues, please contact the OH CDMS Help Desk at 1-833-783-8255 or email helpdesk_ohcdms@cms.hhs.gov.

2.1.2 Exemptions to Mandatory Electronic Filing

The Board recognizes that, in limited circumstances, it may be necessary for a party to request to file an appeal or other documents in an existing case(s), in ***hard copy***, outside of OH CDMS. A party who desires an exemption to the mandatory electronic filing requirement of Rule 2.1 must file a request as described below. An exemption may be granted for a specified period of time or on a permanent basis. If the Board grants a request, then the Board will explain the scope and duration of the exemption.

A. Disability under Rule 1.6.—If filing through the electronic appeals system cannot be completed or is materially hindered due to a disability (see Rule 1.6), the party should contact the Board at least ***ten (10) days*** prior to the filing deadline.

B. Extraordinary Circumstances.—A party may file in ***hard copy*** a request for an exemption due to extraordinary circumstances. Except in cases of impossibility, the request must be filed in hard copy and

> received by the Board at least ***ten (10) days*** prior to any filing deadline(s) impacted by the extraordinary circumstances. Please contact the Board at 410-786-2671 and PRRB@cms.hhs.gov for additional information if the request is time sensitive.
>
> ****
>
> **2.1.4 Extension to Filing an Appeal Under 42 C.F.R. § 405.1836 (Including Direct Adds to a Group)**
>
> The Board has limited authority under 42 C.F.R. § 405.1836 to extend the deadline for filing an appeal (including a direct add to a group appeal). Specifically, this regulation states that "[t]he Board may find good cause to extend the time limit ***only if*** the provider demonstrates in writing it could not be expected to file timely ***due to extraordinary circumstances beyond its control*** (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) . . . ." Accordingly, the case representative must file the request for extension electronically and provide any relevant information and documents "demonstrat[ing] . . . [the provider] could not be expected to file timely due to extraordinary circumstances beyond its control." Note that the term "good cause" as used elsewhere in the Rules is not synonymous with how that term is used in 42 C.F.R. § 405.1836.[7]

Finally, Board Rules 2.2.2 and 3.4 make clear that the Providers' representatives will receive email notice of Board issuances made in OH CDMS (as well as any filings similarly made in OH CDMS by the opposing party).

Board Determination:

The Provider sent hard-copy correspondence containing an appeal request that was received by CMS on September 16, 2024 and forwarded to the Board on September 17, 2024 (hereinafter the "Provider's Hard-Copy Correspondence"). The Board notes that the Provider's Hard-Copy Correspondence contained a copy of the Notice of Program Reimbursement ("NPR") dated March 20, 2024. Thus, any appeal of this NPR must be filed within 185 days of March 20, 2024.[8] As the 185th day of the appeal period[9] for the Provider falls on Saturday, September 21, 2024, the deadline to file an appeal becomes the following business day, which is Monday, September 23, 2024.[10]

---

[7] (Emphasis in original.)
[8] "The date of receipt […] is presumed to be 5 days after the date of issuance of a contractor notice or a reviewing entity document." 42 C.F.R. § 405.1801(a) (within the definition of "Date of receipt").
[9] *See supra* note 3 and accompanying text.
[10] 42 C.F.R. § 405.1801(d)(3) (stating: "If the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which

Upon review, the Board cannot accept or docket the Provider's Hard-Copy Correspondence as a filing because it was not filed electronically using OH CDMS in accordance with Board Rule 2.1.1 and the Board has not granted the Provider an exemption under Board Rule 2.1.2. Board Rule 2.1.1 went into effect on November 1, 2021, and requires that ***all*** filings must be submitted to the Board electronically using OH CDMS unless a limited exemption is granted, in advance, under Board Rule 2.1.2. The Provider's Hard-Copy Correspondence violates this Rule since no advance exemption was granted. As such, the Board hereby notifies the Provider that: (1) the Provider's Hard-Copy Correspondence does not comply with the mandatory electronic filing requirement and, as a consequence, was neither accepted nor docketed by the Board as a filing; and (2) no appeal or case has been established for the Provider based on the Provider's Hard-Copy Correspondence.[11]

To the extent it seeks to timely and properly file an appeal of the March 20, 2024 NPR, the Provider has a limited amount of time to do so. ***Specifically, any such appeal request must be filed electronically no later than Monday, September 23, 2024) using OH CDMS.*** Please refer, above, to **Subsection B** of the RELEVANT REGULATIONS AND RULES discussing the process filing electronically using OH CDMS.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

Board Members:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/18/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)

the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days.).

[11] *See supra* note 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Danelle Decker
National Government Services, Inc.
Mailpoint INA102-AF42 P.O. Box 6474
Indianapolis, IN 46206-6474

RE: ***Board Jurisdictional Decision***
The Stamford Hospital (Provider Number 07-0006)
FYE: 9/30/2013
Case Number: 16-1223

Dear Mr. Ravindran and Ms. Decker,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-reference appeal pursuant to a jurisdictional challenge filed by the Medicare Contractor. The jurisdictional decision of the Board is set forth below.

Background:

On **September 14, 2015**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2013.

On **March 14, 2016**, Stamford filed its appeal request. The Individual Appeal Request contained eleven (11) issues:

1. DSH Payment/SSI Percentage (Provider Specific)[1]
2. DSH SSI Percentage (Systemic Errors)[2]
3. DSH Payment/SSI Fraction – Medicare Managed Care Part C Days[3]
4. DSH Payment/SSI Fraction – Dual Eligible Days[4]
5. DSH Payment/Medicaid Fraction – Medicare Managed Care Part C Days[5]
6. DSH Payment/Medicaid Fraction – Dual Eligible Days[6]
7. DSH Payment – Medicaid Eligible Days[7]
8. DSH Payment – Medicare Managed Care Part C Days[8]

[1] This issue was dismissed in a Board Jurisdictional Decision issued November 28, 2022.
[2] On November 29, 2016, this issue was transferred to Case No. 16-1141G.
[3] On November 29, 2016, this issue was transferred to Case No. 16-1143G.
[4] On November 29, 2016, this issue was transferred to Case No. 16-1142G.
[5] On November 29, 2016, this issue was transferred to Case No. 16-1144G.
[6] On November 29, 2016, this issue was transferred to Case No. 16-1145G.
[7] The Provider withdrew this issue on September 5, 2024.
[8] On November 29, 2016, this issue was transferred to Case No. 16-1144G.

9. DSH Payment – Dual Eligible Days[9]
10. DSH Payment – Medicaid Eligible Days – Connecticut State Administered General Assistance[10]
11. Intern & Resident FTE Cap (Provider Specific)

After issue dismissals, issue transfers, and issue withdrawals, Issue 11 – Intern & Resident FTE Cap (Provider Specific) is the sole remaining issue in the appeal.

On **March 17, 2016**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. The Notice referred to Board Rule 25 for preliminary position paper requirements.

On **November 28, 2016**, the Provider timely filed its preliminary position paper ("PPP") with the Board. On **March 27, 2017**, the Medicare Contractor timely filed its PPP with the Board. Each filing only represents the cover page of the preliminary position paper, the preliminary documentation list, and a good faith effort to confer statement as that was all that was required to be filed with the Board under the Board Rules in effect at that time. The Board Rules did however require that the Provider send a **complete** copy of its PPP to the Medicare Contractor.

On **December 18, 2023,** the Provider timely filed its final position paper ("FPP"). The full extent of the Provider's briefing on Issue 11 is as follows:

> The Provider contends that the MAC did not use the correct FTE Cap in determination of Medicare General Medical Education (GME reimbursement in accordance with the Statutory Instructions set forth at 42 CFR 413.75 to 413.85 of the Secretary's Regulations.
>
> The Provider also contends that the MAC's use of the reduced FTE Cap negatively affected the Provider's FTE request per Form 5506 Application for the redistribution of FTEs. We contend our FTE approvals may have been increased if our cap was lower prior to our application. Therefore, the use of an incorrect FTE Cap has negatively affected reimbursement for FYE 9/30/2013 and will negatively affect reimbursement in subsequent years.
>
> The Provider is seeking FTE data from CMS in order to reconcile its records with CMS data and identify records that CMS is using in their determination of the FTE Cap.[11]

There were no exhibits related to Issue 11 filed with the Provider's preliminary position paper or final position paper.

---

[9] On November 29, 2016, this issue was transferred to Case No. 16-1145G.
[10] On November 28, 2016, this issue was transferred to Case No. 17-0566G.
[11] Provider's Final Position Paper at 9-10.

On **August 5, 2024,** the Medicare Contractor filed a jurisdictional challenge over Issue 11 in the appeal, requesting that the Board dismiss the issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. To date the Provider has not filed a response.

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor begins by stating that "[t]he Provider did not include a list of the expected FTE count to be included in the calculation of its GME reimbursement. The Provider indicates it is seeking FTE data from CMS to reconcile its records with CMS data and identify records that CMS used to determine the Provider's FTE Cap."[12]

The Medicare Contractor contends that:

> the Provider failed to file a **complete** preliminary position paper for the Intern and Resident FTE Cap issue. Pursuant to Board Rule 25.3, parties must file a **complete** preliminary position paper with a fully developed narrative, *all exhibits*, a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. The Board also added commentary to its rules stating that failure to file a complete preliminary position paper with the Board will result in dismissal of the appeal or other actions.
>
> The [Medicare Contractor] contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary and also its final position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the Intern and Resident FTE Cap issue should be dismissed.
>
> Within its final position paper, the Provider makes the broad allegation that, "…the use of the reduced FTE Cap negatively affected the Provider's FTE request per Form 5506 Application for the redistribution of FTEs…" The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies of the reduced FTE Cap used at issue.
>
> Notably, the Provider has not included a complete list demonstrating that there was an FTE increase. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide

[12] Medicare Contractor's Jurisdictional Challenge at 10.

> supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules. Therefore, the Medicare Contractor respectfully requests that the Board dismiss Issue 11.[13]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[14] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[15]

[13] Medicare Contractor's Jurisdictional Challenge at 11 (bold emphasis added).
[14] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[15] (Bold emphasis added.)

These regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

The relevant Board Rules (2021, based upon the filing date of the Provider's Final Position Paper) state the following:

> **Rule 27 Final Position Papers**
>
> 27.2 Content
>
> The final position paper should address each issue remaining in the appeal. The *minimum* requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.
>
> * * *
>
> **Rule 25 Preliminary Position Papers**
>
> 25.1 Content of Position Paper Narrative
>
> The text of the position papers must include the elements addressed in the applicable sub-section.
>
> 25.1.1 **Provider's Position Paper**
>
> The provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:
>
> - States the material facts that support the provider's claim
> - Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
> - Provides a conclusion applying the material facts to the controlling authorities.
>
> C. Comply with Rule 25.2 addressing Exhibits.
>
> * * *

> **25.2 Position Paper Exhibits**
>
> 25.2.1 **General**
>
> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . .
>
> 25.2.2 **Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. . . .

The regulations at 42 C.F.R. § 405.1868 state the following:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may-
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

Finally, Board Rule 41.2 (2021) permits dismissal or closure of a case on the Board's own motion:

> - if it has reasonable basis to believe that the issues have been

fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On December 18, 2023, the Provider filed its final position paper. With respect to the Intern & Resident FTE Cap (Provider Specific) issue, the Board finds that the Provider did not set forth a fully developed narrative that states the material facts that support the provider's claim, identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position, or provides a conclusion applying the material facts to the controlling authorities as required by Board Rule 27. The entire discussion of the issue is four sentences, does not quantify the issue, or cite an application of material facts to the controlling authorities. It is unclear as to the number of FTEs at issue. The Provider fails to support its arguments entirely.

Moreover, the Board finds that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Neither of the Provider's two exhibits relate to the Intern & Resident FTE Cap (Provider Specific) issue.

The regulations at 42 C.F.R. § 405.1868 and Board Rule 41.2 permit dismissal or closure of a case if the Provider fails to comply with Board procedures. Acccordingly, the Board dismisses the Intern & Resident FTE Cap (Provider Specific) issue from the appeal.

As no issues remain in the appeal, the Board closes Case No. 16-1223 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/20/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Notice of Dismissal* - SSI Percentage (Provider Specific) Issue**
Barnes Jewish Hospital (Prov. No. 26-0032)
FYE 12/31/2018
Case No. 23-0664

Dear Mr. Kramer and Mr. Lamprecht:

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background

A. *Procedural History for Case No. 23-0664*

On **August 11, 2022,** the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **January 26, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH Medicaid Eligible Days[1]

On **January 30, 2023,** the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the*

[1] The Provider withdrew this issue on September 21, 2023.

> *Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[2]

On **September 22, 2023**, the Provider filed its Preliminary Position Paper.

On **January 2, 2024,** the Medicare Contractor filed a Jurisdictional Challenge[3] over Issue 1: DSH SSI Percentage (Provider Specific).

On **January 12, 2024,** the Medicare Contractor filed its preliminary position paper.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 23-0186GC – BJC Healthcare CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not

---

[2] (Emphasis added.)

[3] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

> require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[4]

The group issue statement in Case No. 23-0186GC, BJC Healthcare CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group, to which the Provider is a participant, states:

> **Statement of the Issue:**
> The provider protests CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.
>
> CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI Payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affected the patient's indigency.
>
> CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed…..[5]

On September 22, 2023, the Board received the Provider's preliminary position paper in 23-0664. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**

[4] Issue Statement at 1 (Jan. 26, 2023).
[5] Group Appeal Issue Statement in Case No. 23-0186GC.

> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a full and complete set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. See 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates 8 all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[6]

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first sub-issue should be dismissed because they are duplicative of Case No. 23-0186GC. The portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[7]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[8] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare

[6] Provider's Preliminary Position Paper at 7-8 (Sept. 22, 2023).
[7] Medicare Contractor's Jurisdictional Challenge at 2 (Jan. 2, 2024).
[8] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's remaining issue.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the issue that was appealed in Case No. 23-0186GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[9] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[10] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[11]

The Provider's issue in group Case No. 23-0186GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider

[9] Issue Statement at 1.
[10] *Id.*
[11] *Id.*

Specific) issue in Case No. 23-0664 is duplicative of the DSH SSI Unduly Narrow Definition of SSI Entitlement Group issue in Case No. 23-0186GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[12], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[13] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 23-0186GC, but instead refers to systemic *Baystate* data matching issues and a failure to include all patients that were entitled to SSI benefits. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Nov. 1, 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Nov. 1, 2021), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Nov. 1, 2021)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[14]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For

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[12] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[13] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[14] (Italics and underline emphasis added.)

example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from CMS, as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[15]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data.[16]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 23-0186GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 23-0664 and the group issue from the CIRP group under Case No. 23-0186GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

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[15] Last accessed July 16, 2024.
[16] Emphasis added.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

* * * *

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 23-0186GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 23-0664 and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/20/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, Federal Specialized Services

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RE: ***Board Dismissal of SSI Percentage (Provider Specific)***
Parkland Health Center (Provider No. 26-0163)
FYE 12/31/2018
Case No. 23-0666

Dear Mr. Kramer and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

A. Procedural History for Case No. 23-0666

On **August 19, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **January 26, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
2. DSH – Medicaid Eligible Days[1]

After the withdrawal of Issue 2, there is one (1) remaining issue in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)).

On **September 22, 2023**, the Provider submitted its preliminary position paper.

On **December 14, 2023**, the Medicare Contractor filed a Jurisdictional Challenge.

On **January 12, 2024**, the Medicare Contractor submitted its preliminary position paper.

[1] September 21, 2023, this issue was withdrawn by the Provider.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 23-0186GC – BJC Healthcare CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment. [2]

As the Provider is commonly owned by BJC Healthcare, the Provider is also a party in the CIRP group under 23-0186GC, BJC Healthcare CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group.

The Group Issue Statement in Case No. 23-0186GC reads, in part:

> **Statement of the Issue:**
> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his

[2] Issue Statement at 1 (Jan. 26, 2023).

or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.

CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.

CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. See Northeast Hosp. Corp. v. Sebelius, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); see also Walter O. Boswell Mem'l Hosp. v. Heckler, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets….").

In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. Id. For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or a change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.

Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr., 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will

> necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect eligibility for SSI benefits.[3]

On September 22, 2023, the Provider submitted its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[4]

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the SSI realignment portion of the issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary

[3] PRRB Case No. 23-0186GC Group Appeal Issue Statement (Nov. 8, 2022).
[4] Provider's Preliminary Position Paper at 7-8 (Sep. 22, 2023).

> determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[5]

Furthermore, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH SSI Unduly Narrow Definition of SSI Entitlement issue are duplicates.[6] The MAC expands up on the similarities between the issues in its preliminary position paper:

> In describing the issues in its individual appeal request, the provider basically disputes whether the MAC used the correct SSI percentage in computing its DSH calculation. The provider referenced the same audit adjustment numbers for both cases. For Issue 1, the "Provider Specific" issue, the provider contends that it is based on CMS not including all patients entitled to SSI benefits, the SSI percentage is flawed, and they are seeking data from CMS. The provider presents a similar statement for the DSH SSI Narrow Definition of Entitlement issue.[7]

The MAC also contends that the Provider has failed to file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. [8]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different

[5] Jurisdictional Challenge at 6-7 (Dec. 14, 2023).
[6] *Id*. at 4-6.
[7] Medicare Administrative Contractor's Preliminary Position Paper at 11-12 (Jan. 12, 2024).
[8] Jurisdictional Challenge at 8-9.
[9] Board Rule 44.4.3, v. 3.1 (Nov. 2021)

deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Unduly Narrow Definition of SSI Entitlement issue that was appealed in PRRB Case No. 23-0186GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12]

The Provider's DSH SSI Unduly Narrow Definition of SSI Entitlement issue in group Case No. 23-0186GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of

[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*

the DSH SSI Unduly Narrow Definition of SSI Entitlement issue that was appealed in Case No. 23-0186GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[13], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 23-0186GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from or not subsumed by the DSH SSI Unduly Narrow Definition of SSI Entitlement issue appealed in Case No. 23-0186GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 23-0186GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available.

[13] PRRB Rules v. 3.1 (Nov. 2021).
[14] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

> Once the documents become available, promptly forward them to the Board and the opposing party.[15]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

> "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[16]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data.[17]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

---

[15] (Emphasis added).
[16] Last accessed July 16, 2024.
[17] Emphasis added.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 23-0186GC are the same issue.[18] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 23-0186GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 23-0666 and removes it from the Board's docket.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/20/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services

[18] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a BJC CIRP group per 42 C.F.R. § 405.1837(b)(1).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision***
SRI Presence 2011 Medicaid Eligible Medicare Unmatched Days CIRP Group
Calendar Year 2011
Case Number: 16-0134GC

Dear Mr. Putnam and Ms. VanArsdale:

The Provider Reimbursement Review Board ("Board") has reviewed the document filed in Case No. 16-0134GC in response to the Medicare Contractor's Jurisdictional Challenge dated December 15, 2023. Set forth below is the decision of the Board to dismiss the appeal.

Pertinent Facts

On **October 26, 2015**, the Board received a group appeal request from the Provider Representative, Strategic Reimbursement Group, LLC. The initial appeal contained three (3) Providers, transferred from individual cases:

- Provena St. Mary's Hospital (14-0155), FYE: 12/31/2011
- Provena Mercy Center (14-0174), FYE: 12/31/2011
- Our Lady of the Resurrection (14-0251), FYE: 06/30/2011

On **January 23, 2017**, the Provider transferred Provena St. Joseph Medical Center (14-0007), FYE: 12/31/**2010**. Note that this is a CY 2011 group appeal.

On **June 6, 2023**, the Board issued a CIRP Group Status request, and the Provider responded on June 26, 2023, indicating that the group was complete.

On **June 27, 2023**, the Board issued the Group Complete Notice and Critical Due Dates, which set due dates for Preliminary Position Papers and MAC Jurisdictional Review.

On **August 7, 2023**, the Provider submitted its Preliminary Position Paper, and the Medicare Contractor filed its Preliminary Position Paper on November 28, 2023.

On **October 24, 2023**, the Medicare Contractor, National Government Services, submitted a Rule 22 Jurisdictional Review. The Medicare Contractor noted that the Provider did not file a Rule 20 letter and found several jurisdictional issues. The MAC noted the following errors:

(1) 14-0155 Amita St. Mary's Hospital FYE 12/31/2011

The Provider's name is listed in the supporting documentation as Provena St. Mary's Hospital, however, it is listed in OHCDMS as AMITA Health St. Mary's Hospital. A merger happened after the individual appeal was filed, and the name of the facility was changed from Provena to Amita to reflect the merger.

OHCDMS is missing the transfer case #16-0022.

(2) 14-0174 Presence Mercy Medical Center FYE 12/31/2011

The Provider's name is listed in the supporting documentation as Provena Mercy Medical Center, however, in OHCDMS it is listed as Presence Mercy Medical Center. A merger happened after the individual appeal was filed, and the name of the facility was changed from Provena to Presence to reflect the merger.

OHCDMS is missing the transfer case #15-1628.

(3) 14-0251 Our Lady of the Resurrection Medical Center FYE 6/30/2011

The Provider's name is listed in the supporting documentation as Our Lady of Resurrection Medical Center, however, it is listed in OHCDMS as Community First Medical Center. A merger happened after the individual appeal was filed, and the name of the facility was changed from Our Lady of the Resurrection Medical Center to Community First Medical Center to reflect the merger.

OHCDMS is missing the transfer case #15-1601.

(4) 14-0007 Presence Saint Joseph Medical Center FYE 12/31/2010

The Provider's name is listed in the supporting documentation as Provena Saint Joseph Medical Center, however, it is listed in OHCDMS as Presence Saint Joseph Medical Center. A merger happened after the individual appeal was filed, and the name of the facility was changed from Provena to Presence to reflect the merger.

The NPR date is listed incorrectly AS 12/10/2016 on the Model Form A, however the correct NPR date is 12/10/2015.

OHCDMS is missing the transfer case #16-1774.

Lastly, the Provider transferred DSH – Medicaid Eligible Medicare Unmatched Days

(FYE 12/31/2010) from Case No. 16-1774. No request was made of the Board for permission for a CY 2010 provider to join a CY 2011 appeal. The MAC has verified the supporting documentation confirms it is for CY 2010.[1]

On **October 26, 2023**, the Board issued a Scheduling Order Rule 20 Certification and the Provider responded with a Rule 20 Certification on November 7, 2023.

On **December 15, 2023**, the Medicare Contractor filed a Jurisdictional Challenge. The Provider did not file a Jurisdictional Response. The Provider had until January 15, 2024, to file a timely response.

The Group Issue Statement in Case No. 16-0134GC reads:

> **Issue Statement:**
>
> The Provider challenges the exclusion of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients from the calculation of the Provider's Medicaid ratio used in the determination of the Provider's Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations").
>
> The Provider contends that these days have been incorrectly identified as Medicare days and that they are not included in the Medicare Fraction (or SSI ratio) of the DSH calculation as indicated by CMS. Provider requests that the necessary files be provided to review the Medicare Fraction and determine if the omitted days were or were not included in the Medicare Fraction. The Provider requests any days omitted from their Calculations on the premise that these days were in fact included in the Medicare Fraction, but as a result of review were identified to have not been included in the Medicare Fraction, be instead properly included in the hospital's Calculations in order to correct the Calculations to be consistent with statute 42 U.S. C.1395ww(d)(5)(F)(vi)(II).

On August 7, 2023, the Board received the Provider's Preliminary Position paper. The following is the Provider's ***complete*** position set forth therein:

> **C. Position**
>
> The Provider challenges the exclusion of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients from the calculation of the Provider's

[1] Medicare Contractor's Jurisdictional Review at 2-3 (Oct. 24, 2023).

> Medicaid ratio used in the determination of the Provider's Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations").
>
> The Provider contends that these days have been incorrectly identified as Medicare days during filing and audit of the hospital's cost report and that they are not included in the Medicare Fraction (or SSI ratio) of the Calculations as indicated by CMS.
>
> The information needed to perform the necessary review of the Calculations is contained in CMS' data sets referred to as "MedPAR SSI Data Files" and had been temporarily unavailable pending the release of CMS' revised SSI ratios. During 2012, CMS issued revised SSI ratios for FFY 2006 –2010 as required by CMS' Ruling 1498R (April 28th, 2010) and, at the same time, the MedPAR SSI Data Files became available for review by hospitals receiving IPPS DSH payments.
>
> The provider has requested the necessary MedPAR SSI Data Files and is performing a review to identify Medicaid days incorrectly omitted from the Medicaid Fraction of their Calculations. The detailed listing will be provided forthcoming.[2]

MAC's Contentions

A. Provider No. 14-0007 was improperly transferred from individual appeal Case No. 16-1744 to this group appeal

The MAC requests that the Board dismiss Provider No. 14-0007 from the instant case in accordance with PRRB Rule 12.5 and argues that the Board should determine that it has not approved the transfer of from individual Case No. 16-1774, FYE 12/31/2010, to the instant Group Appeal. The MAC points out that this is a 2011 Medicaid Eligible Medicare Unmatched days group, however Provider No. 14-0007 requested to transfer the issue for ***2010*** without officially requesting permission for the Board to expand the group to FY 2010. The supporting documents included with the transfer also reflect FY 2010.[3] The Provider's individual appeal was closed on January 31, 2017, after transferring this and several other issues to group appeals.

The Medicare Contractor argues that, because the Provider did not request approval to expand the year of the group under appeal, Provider No. 14-0007 (FYE 12/31/2010) should be dismissed.[4]

---

[2] Provider's Preliminary Position Paper at 6.
[3] Medicare Contractor's Jurisdictional Challenge at 2-3 (Dec. 15, 2023).
[4] *Id.* at 2.

B. The Providers have failed to file a Complete Preliminary Position Paper.

Additionally, the MAC contends that the Providers have failed to file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues that the Providers failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of the case, and that they failed "to include all supporting documentation, such as listings of days in question, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable."[5] Therefore, the MAC requests that the Board dismiss this case in its entirety. [6]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[7] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. Improper Transfer

The MAC is challenging the inclusion of the Provider No. 14-0007 to the group appeal as it was improperly transferred from individual Case No. 16-1774 because there was no request to expand the CYs under appeal to include the 2010 CY. The MAC cites to PRRB Rule 12.5 (v 3.1, 2021), which states:

> A group may cover only one calendar year unless the Board allows the group to be expanded. Specifically, providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. **However, a group may submit a written request to include more than one calendar**

[5] *Id.* at 4.
[6] *Id.* at 5.
[7] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

> **year** if it cannot meet the minimum number of providers or the $50,000 amount in controversy requirements.[8]

However, the request to transfer the issue was submitted in 2017, which is before the version of the rules the MAC quoted was in effect. Instead, the 2015 rules were in effect at the time of the transfer request. PRRB Rule 12.2 (v. 1.3 July 2015) reads:

> Providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. **However, groups may submit a written request to include more than one calendar year to meet the $50,000 amount in controversy**.
>
> Commonly owned or controlled Providers with the same issue in cost reporting periods ending in the same calendar year must file a mandatory group appeal if the combined amount in controversy is $50,000 or more. (See Rule 12.5 B.)[9]

Although the Medicare Contractor cited the incorrect version of the Board Rules, the Rules in effect at the time of the transfer request also explained that groups may submit a written request to include more than one calendar year to meet the amount in controversy requirement. According to the Schedule of Providers for Case No. 16-0143GC, the amounts in controversy for the other 3 participants is well over $50,000, as they are $119,000, $155,900, and $170,900, respectively.

The Board determines Provider 14-0007 (Presence St. Joseph) for FYE 12/31/2010 was improperly transferred to a CIRP Group for FY 2011. Board Rule 12.2 (2015) indicates that groups must have final determinations for their cost reporting periods that end withing the same calendar year, or may request, in writing, to expand a group. However, no such request was received by the Board. Therefore, the Board dismisses Provider 14-0007 (Presence St. Joseph) from the instant group appeal as the group appeal does not cover the CY in dispute in this group appeal.

B. Incomplete Position Paper

The Medicare Contractor asserts that the Providers failed to file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the

[8] Emphasis added.
[9] Emphasis added.

> Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[10]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

Board Rule 25 (Nov. 2021) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation and gives the following instruction on the content of position papers:

> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the applicable sub-section.
>
> **25.1.1 The Provider's Position Paper**
>
> The Provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, provide a ***fully*** developed narrative that:
> - states the material facts that support the provider's claim.
> - Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
> - Provides a conclusion applying the material facts to the controlling authorities.

[10] (Bold emphasis added.)

C. Comply with Rule 25.2 addressing Exhibits.

* * * *

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (*see* 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

> The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> 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.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

The Board finds that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[11] and, pursuant to Board Rule 25, the Provider has the burden to present

[11] (Emphasis added).

that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it, consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board assumes that there are no days or amount in dispute for this issue.

Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or to describe why said evidence is unavailable.[12] Accordingly, the Board dismisses the remaining providers from this appeal.

Conclusion

The Board dismisses Provider St. Joseph Medical Center (14-0007) for failure to establish that it was properly transferred from Group Case No. 16-1774 (FYE 12/31/2010) to the instant Group Appeal, 16-0134GC (FYE 12/31/2011). Additionally, the Board dismisses the remaining providers in their entirety as the Providers did not file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3. As the appeal is being dismissed in its entirety, the Board hereby closes Case No. 16-0134GC and removes it from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/23/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

cc: Wilson Leong, FSS

[12] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Notice of Dismissal***
Steward Rockledge Hospital (Provider Number 10-0092)
FYE: 09/30/2015
Case Number: 19-0362

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-0362. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days issues.

Background

A. *Procedural History for Case No. 19-0362*

On **May 7, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **October 29, 2018**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH SSI Percentage (Systemic Errors)[1]
3. DSH SSI Fraction / Medicare Managed Care Part C Days[2]
4. DSH SSI Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH – Medicaid Eligible Days[4]

[1] On May 23, 2019, this issue was transferred to Case No. 18-0588GC.
[2] On May 23, 2019, this issue was transferred to Case No. 18-0589GC.
[3] On May 23, 2019, this issue was transferred to Case No. 18-0584GC.
[4] On April 19, 2024, the Medicare Contractor filed a jurisdictional challenge over Issue 5.

6. DSH Medicaid Fraction / Medicare Managed Care Part C Days[5]
7. DSH Medicaid Fraction / Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. Uncompensated Care ("UCC") Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 23, 2019**, the Provider transferred Issues 2, 3, 4, 6, 7, 8 and 9 to CHS CIRP groups.
As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (DSH – SSI Percentage Provider Specific) and Issue 5 (DSH – Medicaid Eligible Days).

On **November 20, 2018**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[9]

On **June 6, 2019**, the Provider timely filed its preliminary position paper. With respect to Issue 5, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover.[10] However, no such filing was made, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the

[5] On May 23, 2019, this issue was transferred to Case No. 18-0591GC.
[6] On May 23, 2019, this issue was transferred to Case No. 18-0585GC.
[7] On May 23, 2019, this issue was transferred to Case No. 18-0587GC,
[8] On May 23, 2019, this issue was transferred to Case No. 18-0592GC.
[9] (Emphasis added.)
[10] Provider's Preliminary Position Paper ("Provider's PPP") at 8 (June 6, 2019).

Provider included, as an Exhibit, the original "estimated impact" for this issue of $51,163 based on an *estimated* 100 days.

On **September 27, 2019**, the Medicare Contractor timely filed a Jurisdictional Challenge[11] with the Board over Issue 1 requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. The Provider filed a response on **October 29, 2019**, one day past the deadline to do so.

On **September 26, 2019**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 5, the Medicare Contractor's position paper noted that the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position.[12]

The Provider's Final Position Paper was filed on **March 7, 2024,** and the Medicare Contractor's Final Position Paper was filed on **April 3, 2024.**

On **April 19, 2024**, the Medicare Contractor filed a second Jurisdictional Challenge relative to Issue 5 and requested that the Board dismiss this issue. The Provider had 30 days to respond to the Challenge and did so on **August 5, 2024**, almost four months past its filing deadline.

On **May 2, 2024**, the Provider changed its designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0588GC – QRS HMA 2015 DSH SSI Percentage CIRP Group

In their Individual Appeal Request, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the

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[11] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[12] Medicare Contractor's Preliminary Position Paper ("Contractor's PPP") at 10 (Sept. 26, 2019).

> DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interpret the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[13]

The Group issue Statement in Case No. 18-0588GC, to which the Provider transferred Issue No. 2, reads:

> **Statement of the Issue**:
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?

[13] Provider's Individual Appeal at 10 (Oct. 29, 2018).

Statement of the Legal Basis:

The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.

The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CM5") fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.

Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

1. Availability of MEDPAR and SSA Records

2. Failure to adhere to required notice and comment rulemaking procedures

3. Fundamental problems in the SSI percentage calculation

4. Not in agreement with provider's records

5. Paid days vs. Eligible days, and

6. Covered days vs. Total days)[14]

On June 6, 2019, the Board received the Provider's preliminary position paper in 19-0362. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Florida and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Florida and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services,* No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[15]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $61,000.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board should dismiss the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is duplicative:

[14] Group Appeal Issue in Case No. 18-0588GC (Jan. 19, 2018).
[15] Provider's Preliminary Position Paper at 8-9 (Jun. 6, 2019).

> In Issue 1, the Provider contends that "…its' (sic) SSI percentage published by the Centers for Medicare and Medicaid Services ('CMS') was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." In Issue 2, the Provider asserts "…that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ('CMS') and used by the Lead MAC to settle their Cost Report were incorrectly computed." In both Issue 1 and Issue 2, the Provider is disputing whether the correct SSI percentage was used in computing its DSH payments. The accuracy of the SSI data is a common issue in both the DSH – SSI (Provider Specific) issue and the DSH – SSI issue.
>
> …
>
> Issue 2 has been transferred to group case 18-0588GC. Thus, the Provider has ventured an attempt to appeal the same issue in more than one appeal at the same time.
>
> The PRRB's rules are clear on this matter: No duplicate filings. Rule 4.6 states:
>
> A provider may not appeal an issue from a single final determination in more than one appeal.
>
> The fact pattern in this case is not new to the Board. The Board has dealt with it in other cases – and there are many such cases. Moreover, the Board has consistently ruled that these issues are considered the same issue. The MAC maintains that a similar decision should be reached in this case. [16]

The MAC also argues that the appeal is premature because the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper (*see* Exhibit C-3). PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

[16] Jurisdictional Challenge at 3-4 (Sept. 27, 2019).

> Even if the Board finds that the issue of SSI realignment is still active it should still be dismissed. The Board has consistently ruled that a provider's appeal of the SSI issue to preserve its right to a recalculation is not a valid issue. The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> …
>
> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue.[17]

Issue 5 – DSH – Medicaid Eligible Days

The MAC argues that the Board should dismiss the DSH – Medicaid Eligible Days issue because the Provider has effectively abandoned the issue:

> The MAC contends that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules. Therefore, the MAC respectfully requests that the Board dismiss the DSH – Medicaid Eligible Days issue.[18]

The Medicare Contractor also argues that the Provider attempts to improperly and untimely add the Section 1115 waiver days issue to the appeal in the narrative of its final position paper. The Medicare Contractor contends:

> Added issues must be added within 60 days of the expiration of the appeal filing deadline. In this case, that would be 240 days from the date of the original Notice of Program Reimbursement (NPR). The inclusion of any added issues in the Provider's position paper would have occurred after the deadline to add issues (i.e., 240 days after the NPR date).

[17] *Id.* at 4-5.
[18] Medicare Contractor's Jurisdictional Challenge at 7 (Apr. 19, 2024).

A provider's inclusion of this sub-issue in its final position paper does not qualify as adding an issue.

…

Moreover, pursuant to Board Rule 8.1, "each contested component must be appealed as a separate issue and described as narrowly as possible…"

…

According to Board Rule 6.2.1, an issue may be added if the provider "timely files a request with the Board to add issues to an open appeal no later than 60 days after the expiration of the applicable 180-day period for filing the initial hearing request". The original NPR was issued on May 7, 2018, thereby setting the period to add issues to close on January 2, 2019. The Provider did not raise the issue of Section 1115 Waiver Days in its appeal request or in its preliminary position paper. Rather, the Provider first introduced the issue of Section 1115 Waiver Days in its final position paper which was filed on March 7, 2024, over five years after the deadline to add new issues.

Specifically, the Provider modified Issue 5 in its final position paper as follows:

> The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (<u>including section 1115 waiver days</u>).

Again, the issue the Provider is now trying to address was not timely added, and even if it had been timely as part of the position paper, this does not constitute adding an issue. Moreover, the Provider did not formally add the disputed issue to the appeal request via a Model Form C. Therefore, the Section 1115 Waiver Days issue should be dismissed.[19]

[19] *Id.* at 7-8.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[20] The Provider filed a response to the Medicare Contractor's first Jurisdictional Challenge on October 29, 2019, one day after the time for doing so had elapsed. The Provider responded to the Medicare Contractor's second Jurisdictional Challenge, addressing Issue 5, on August 5, 2024, over three months past the deadline for doing so, therefore the Board will not consider the 2024 response in its decision.

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

In Provider's response to the Medicare Contractor's jurisdictional challenges over Issue 1, the Provider argues the following:

> FSS, on behalf of First Coast Service Options, Inc., the Medicare Administrative Contractor ("MAC"), challenges the Board's jurisdiction, stating that the Provider does not have a right to a hearing before the Board on the DSH/SSI realignment issue because it is duplicative of the SSI Systemic issue. However, Provider contends that FSS is incorrect. Provider is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. In Baystate, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.[21]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in

[20] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[21] Provider's Response to Jurisdictional Challenge at 2 (Oct. 29, 2019).

controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 18-0588GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[22] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[23] The Provider argues in its issue statement, filed as part of the original appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[24]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0588GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Both the issue statement in Case No. 19-0362 and the issue statement in CIRP Group Case No. 18-0588GC use the exact same paragraph discussing the definition of "entitled," as well. Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-0362 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0588GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[25], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

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[22] Issue Statement at 1.
[23] *Id.*
[24] *Id.*
[25] PRRB Rules v. 2.0 (Aug. 2018).

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[26] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0588GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records"[27] but fails to explain how it can be done, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[28] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[29]

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[26] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[27] Provider's PPP at 9.
[28] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.
[29] (Italics and underline emphasis added.)

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

> [b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [30]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data.[31]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-0588GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 19-0362 and the group issue from the CHS CIRP group under Case No. 18-0588GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the

[30] Last accessed September 23, 2024.
[31] Emphasis added.

same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Further, the Board notes that the Provider's fiscal year ends on 9/30, which is congruent with the Federal Fiscal Year. In such a case, realignment of the SSI percentage would have no effect on DSH reimbursement for such a provider, as the periods are the same. Therefore, the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal request or the position papers.

Regarding the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> **7.3.2 No Access to Data**
>
> If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[32]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

As cited above, Board Rule 25 requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation.

> **Rule 25 Preliminary Position Papers**
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 The Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
> C. Identify the controlling authority (e.g. statutes, regulations,

[32] (Bold emphasis added.)

policy, or case law) supporting the provider's position.

D. Provide a conclusion applying the material facts to the controlling authorities.

* * * *

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

Parties should file with the Board a **complete** preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

Further, the Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on November 20, 2018, included instructions on the content of the Provider's preliminary position paper consistent with the above-referenced Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[33]

Along the same line, 42 C.F.R. 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> 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.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),

[33] (Emphasis added.)

- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On June 6, 2019, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[34] The position paper did not identify how many Medicaid eligible days remained in dispute in this case.

The Provider's complete briefing of this issue in its final position paper, filed on March 7, 2024, is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

[34] Provider's Preliminary Position Paper at 8.

…

> Based on the Listing of Medicaid Eligible days being sent under separate cover directly to the MAC, including Section 1115 waiver days (a redacted copy is attached), the Provider contends that the total number of days reflected in its 2015 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[35]

In its Jurisdictional Challenge, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

The Provider failed to timely include a list of additional Medicaid eligible days with its preliminary position paper, or submit such list under separate cover as instructed. The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[36]

The Board thereby finds the issue abandoned due to the Provider's failure to file a listing. The Medicare Contractor contends that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[37] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filings, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board dismisses this issue from the appeal.

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[35] Provider's Final Position Paper at 9-10 (Mar. 7, 2024).
[36] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[37] (Emphasis added.)

Section 1115 Waiver Days

The Board finds that the § 1115 Waiver Days issue is *not* properly part of this appeal because it was not properly included in the original appeal request, and it was not properly or timely added to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the § 1115 Waiver Days as recognized by multiple Board, Administrator and Court decisions[38] (many of which were issued prior to the Provider's January 7, 2019 deadline for adding issues to this appeal).[39]

The appeal was filed with the Board in October of 2018 and 42 C.F.R. § 405.1835(b) gives the following "contents" requirements for an initial appeal request for a Board hearing:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include** the elements described in paragraphs (b)(1) through (b)(4) of this section. **If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss** with prejudice the appeal or take any other remedial action it considers appropriate.
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the

[38] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom*. *HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018-D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389 F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Cir. 2020).

[39] Here, the NPR at issue was issued on May 7, 2018 and the Provider had until Thursday, November 8, 2018 to file the appeal (where receipt is presumed to be 5 days later and the Provider had 180 from that date to file an appeal request). Accordingly, the deadline to add issues is 60 days beyond that date, *i.e.*, Monday, January 7, 2019.

> specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
> (i) Why the provider believes Medicare payment is incorrect for **each** disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
> (iii) If the provider self-disallows a specific item (as specified in §413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
> (3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[40]

Board Rule 7 (Aug. 29, 2018) elaborated on these regulatory "contents" requirements instructing providers:

> **7 - Support for Final Determination, Issue-Related Information and Claim of Dissatisfaction**
>
> The Provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Board Rules 7.2 and 7.3 provider further information regarding issue pleading and specificity:

> **7.2 - Issue Related Information**
>
> **7.2.1 General Information**
>
> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
> • An issue title and a concise issue statement describing:

[40] (Italics emphasis in original and bold and underline emphasis added).

- the adjustment, including the adjustment number,
- the controlling authority,
- why the adjustment is incorrect,
- how the payment should be determined differently,
- the reimbursement effect, and
- the basis for jurisdiction before the PRRB.

• A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
• A calculation or other support for the reimbursement effect noted in the issue statement.
• Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

7.2.2. Additional Information

Providers must submit additional information not specifically addressed above in order to support jurisdiction or appropriate claim for the appealed issue(s). Example: Revised NPR workpapers and applicable cost report worksheets to document that the issue under appeal was specifically adjusted.

7.3 Self Disallowed Items (Applies to Cost Reporting Periods Ending On or Before 12/31/15)

7.3.1 Authority Requires Disallowance
If the Provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:

- a concise issue statement describing the self-disallowed item,
- the reimbursement or payment sought for the item, and
- the authority that predetermined that the claim would be disallowed.

7.3.2 No Access to Data

If the Provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the

> underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.
>
> **7.3.3 Protest**
>
> Effective for cost reporting periods ending on or after December 31, 2008, items claimed under protest on the cost report must follow the applicable procedures as contained in CMS Pub. 15-2, Section 115. See 42 C.F.R.§ 405.1835(a)(1)(ii). [*March 2013*][41]
>
> For the appeal, you must:
>
> • identify the amount that was protested for the specific item being appealed,
> • attach a copy of the protested items worksheet submitted with your as-filed cost report, and
> • the as-filed Worksheet E or audit adjustment report to demonstrate the total protested claim.
> Note: CMS Ruling 1727-R governs for cost reporting periods ending on or after 12/31/08 and beginning before 1/1/16.

Board Rule 8 (Aug. 29, 2018) provides "*special instructions*" for issue statements *involving* ***multi-component disputes***. In particular, 8.1 explains that, when framing issues for adjustments *involving multiple components*, that providers must "***specifically*** identify" each cost item in dispute, and "…each contested component must be appealed as a *separate* issue and described as ***narrowly as possible***…".[42] Board Rule 8.1 (Aug. 29, 2018) gives common *examples* of different components of the Disproportionate Share Hospital payment calculation that may be in dispute. Specifically, Board Rule 8 states:

> **Rule 8 – Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 – General**
> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. Several examples are identified below, ***but these are not exhaustive lists of categories or issues.***[43]

[41] (Underline emphasis in initial paragraph for Rule 7 added.)
[42] (Emphasis added.)
[43] (Emphasis added.)

> **A. Disproportionate Share Hospital Payments**
> Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, Section 1115 waiver days (program/waiver specific), and observation bed days.
>
> **B. Bad Debts**
> Common examples include: crossover bad debts, collection effort, use of collection agency, 120-day presumption, and indigence determination.
>
> **C. Graduate Medical Education/Indirect Medical Education**
> Common examples include: managed care days, new programs, current year resident count, prior year count, penultimate year count, intern to bed ratio, and rotations to non-hospital settings.
>
> **D. Wage Index**
> Common examples include: wage data corrections, occupational mix, wage vs. wage-related costs, pension, rural floor, and data corrections.[44]

Pursuant to the May 23, 2008 final rule, new Board regulations went into effect on August 21, 2008 *that limited the **addition** of issues to appeals*.[45] As a result of this final rule, 42 C.F.R. § 405.1835(e) (Sept. 2015) provides in relevant part:

> (b) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
>
> ****
>
> The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to establish that the Provider timely and properly added the § 1115 Waiver Days to the case. In this regard, the first discussion of § 1115 waiver days in this case occurred in the Provider's March 7, 2024 final position paper, well after the deadline for adding issues had passed.

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[44]Board Rules are available https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (last visited September 23, 2024).
[45] *See* 73 Fed. Reg. 30190 (May 23, 2008).

In this regard, the Board notes that § 1115 Waiver days are *not* traditional Medicaid eligible days. Indeed, it was only effective January 20, 2000 that the Secretary incorporated, ***at her discretion*** *by regulation*, only ***certain*** types of § 1115 waiver days into the DSH calculation (*i.e.,* the Secretary maintains that no statute requires that days associated with § 1115 waiver/expansion programs be included in the DSH calculation and that she exercised her discretion to include only certain such days).[46] Rather, § 1115 waiver days relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R.§ 412.106(b)(4) relating to § 1115 waiver days. Specifically, § 412.106(b)(4) states in pertinent part:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> (ii) **Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to

[46] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000). *See also* 68 Fed. Reg. 45346, 45420 (Aug. 1, 2003) (stating: "On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), to allow hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the Medicare DSH adjustment. Previously, hospitals were to include only those days for populations under the section 1115 demonstration project who were, or could have been made, eligible under a State plan. Patient days of those expansion waiver groups who could not be made eligible for medical assistance under the State plan were not to be included for determining Medicaid patient days in calculating the Medicare DSH patient percentage. Under the January 20, 2000 interim final rule with comment period (65 FR 3137), hospitals could include in the numerator of the Medicaid fraction those patient days for individuals who receive benefits under a section 1115 expansion waiver demonstration project (effective with discharges occurring on or after January 20, 2000).").

> prove eligibility for **each** Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during **each** claimed patient hospital day.[47]

*Significantly, **§ 1115 waiver programs can pertain** to not just Medicaid (Title XIX), but also **to other programs under Titles I, X, XIV, XIV or part A or D of Title IV of the Social Security Act**.*[48] Hence, an important limitation is that the § 1115 waiver program receive Title XIX matching payments. Moreover, not every state Medicaid program has a qualifying § 1115 expansion program receiving Title XIX matching payments[49] and not every inpatient day associated with a beneficiary enrolled in such a § 1115 waiver program qualifies to be included in the numerator of the DSH Medicaid fraction.[50] In contrast, every state has a Medicaid state

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[47] (Bold emphasis added.)

[48] Section 1115 of the Social Security Act (42 U.S.C. § 1315] pertains to "experimental, pilot, or demonstration project[s] which, in the judgment of the Secretary, is likely to assist in promoting the objectives of ***title I, X, XIV, XVI, or XIX, or part A or D of title IV***, in a State or States." 1115(a) of the Social Security Act (emphasis added). As such, § 1115 waiver programs are not just limited to Title XIX Medicaid programs but may also relate to programs under Titles I, X, XIV, XVI, or part A or D of Title IV.

[49] Further, a specific approved state § 1115 waiver day program is not necessarily static and may vary from one year to the next.

[50] Unlike traditional Medicaid eligible days under a State Plan, the following discussion from the FY 2004 IPPS Final Rule, 68 Fed. Reg.at 45420-21 highlights that not all § 1115 waiver days can be included in the numerator of the Medicaid fraction and that factual determinations must be made regarding any § 1115 waiver day program to determine if 42 C.F.R. § 412.106(b)(4) is applicable to that program:

> Since that revision, we have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries.
> In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, in the May 19, 2003 proposed rule, we proposed that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).
> For example, a State may extend a family planning benefit to an individual for 2 years after she has received the 60- day postpartum benefit under Medicaid, or a State may choose to provide a family planning benefit to all individuals below a certain income level, regardless of having previously received the Medicaid postpartum benefit. This is a limited, temporary benefit that is generally administered in a clinic setting (see section 1905(a)(4)(C) of the Act). Also, a number of States are developing demonstrations that are limited to providing beneficiaries an outpatient prescription drug benefit.
> Generally, these limited benefits under a demonstration project do not include inpatient benefits. If a hospital were to include the days attributable to patients receiving benefits under such a limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for

plan; every state Medicaid plan includes inpatient hospital benefits; and by statute at 42 U.S.C.§ 1395ww(d)(5)(F)(vi)(II), the numerator of the DSH Medicaid fraction must include inpatient days of patients "who . . . were eligible for medical assistance ***under a State plan*** approved under subchapter XIX" but who were not entitled to Medicare Part A.[51]

In this regard, documentation needed to verify eligibility for a § 1115 waiver day is materially different than that for a traditional Medicaid eligible day[52] and, similarly, it is not a given that *all* § 1115 waiver days (even those under a program receiving Title XIX matching payments) necessarily would qualify under § 412.106(b)(4) as demonstrated by Board decisions and case law.[53] Here, 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8 required each separate issue to be identified in the appeal request. Here, the Provider failed to do so, notwithstanding including a ***detailed*** description of "The Process That The Provider Used To Identify And Accumulate The Actual Medicaid Paid And Unpaid Days That Were Reported And Filed On The Medicare Cost Report At Issue" to support its assertion that the Medicaid eligible days at issue in the appeal were ones that could not have been identified through that process.[54]

> individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX.
>
> ****
>
> Therefore, we proposed to revise § 412.106(b)(4)(i) to clarify that patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits, including inpatient hospital benefits, under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. Under the proposed clarification, hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved State plan or through a section 1115 demonstration would not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH patient percentage.
> Under this reading, in the examples given above, the days associated with a hospital inpatient who receives coverage of prescription drugs or family planning services on an outpatient basis, but no inpatient hospital coverage, through either a Medicaid State plan or a section 1115 demonstration, would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

[51] (Emphasis added.)

[52] In addition to providing proof that the patient at issue was eligible for the § 1115 waiver program for each day claimed, the Provider must also establish that the particular § 1115 waiver program at issue relates to Title XIX and qualified under 42 C.F.R. § 412.106(b)(4) as demonstrated by the preamble discussion in *supra* note 50 and litigation in *supra* note 38.

[53] *See* litigation in *supra* note 38.

[54] The Board recognizes that the appeal request states that "The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation." However, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or § 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of an issue on an ***untimely*** basis in contravention of Board Rules and regulations. Indeed, neither the appeal request or the preliminary position paper include any description (much less identification of) § 1115 waiver days as being an issue, notwithstanding the obligation to do

Regardless, of whether the Provider *properly* included the § 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the merits of § 1115 waiver day issue in any of the Provider's position papers. Specifically, neither the Provider's preliminary position paper nor the final position paper mention, much less identify, the **specific state** § 1115 waiver program(s) at issue[55] or how any days under such program(s) would qualify under 42 C.F.R.§ 412.106(b) to be included in the numerator of the DSH Medicaid fraction, notwithstanding its obligation to do so consistent with the position paper content requirements at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.[56] This is an independent basis for dismissal of the § 1115 waiver day issue. Specifically, the material facts and legal arguments needed to establish the merits of the Provider's claims regarding the § 1115 waiver days issue along with the relevant supporting documentation were not properly briefed and included in the position paper filings.

Finally, even if the Board were to find that Issue 5 encompassed § 1115 waiver days, **there is no indication that any of the § 1115 waiver days, not included in any listing, were included with the as-filed cost report and, if true,** this would make them an *unclaimed* cost and provide an independent basis for dismissal (*see* Board Alert 10). In raising this issue, the Board notes that it has found that when a class of days (*e.g.*, § 1115 waiver days) is excluded due to choice, error, and/or inadvertence from the as-filed cost report,[57] then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(1)(i)-(ii) (2012) as clarified by CMS Ruling 1727-R.[58] The Provider's briefings generally address this jurisdictional issue by generically asserting that its process did not identify certain Medicaid eligible days. However, this discussion did not identify or discuss the class of days involving § 1115 waiver days and whether that class of days were included on the cost

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so under the requirements for the content of position papers at 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 25 and 27.

[55] In failing to identify the specific state § waiver program(s) at issue, the Provider fails to address whether such § 1115 waiver program(s) are under Titles I, X, XIV, XVI, XIX, or IV and whether such § 1115 waiver program(s) received Title XIX matching funds and would otherwise qualify under 42 C.F.R. § 412.106(b) to be counted in the numerator of the DSH Medicaid fraction.

[56] 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (Aug. 2018) required a fully-developed preliminary position paper that includes the legal merits and material facts of the Provider's position as well as all available supporting documents as required Board Rule 25.2 (Aug. 2018).

[57] CMS Transmittal 11912 (Mar. 16, 2023) makes clear that hospitals must maintain records on § 1115 waiver days:

> Each provider with an approved [§] 1115 waiver program ***has a method for identifying the days*** that are applicable to such waiver for reimbursement from the Medicaid program. As such, ***the provider is responsible for maintaining the appropriate supporting documentation*** *for the accrual of the days associated with [§] 1115 waiver reimbursements. Providers typically keep this information in the form of a listing of specific patient accounts for each individual acute hospital stay ([§] 1115 log) that is subject to [§] 1115 reimbursement. This [§] 1115 log is similar to a provider's DSH Medicaid eligible days listing. (Emphasis added.)*

[58] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed September 19, 2024)).

report. In this regard, if the Provider purposefully excluded § 1115 waiver days from the as-filed cost report, then CMS Ruling 1727-R confirms that the Provider only had a right to appeal those days if it "***had a good faith belief*** *that claiming reimbursement for [the § 1115 waiver days at issue] in the cost report would be futile because [the § 1115 waiver days at issue] was subject to a regulation or other payment policy* ***that bound the Medicare contractor and left the contractor with no authority or discretion to make payment in the manner sought by the provider***."[59] Here the Provider has failed to specifically address or discuss the Board's jurisdiction over this unique class of days. This is an independent basis for the Board to dismiss the § 1115 waiver days issue (*i.e.*, in addition to and independent from dismissal for failure to properly include the issue in its appeal request or properly brief and develop the issue).

In summary, as the DSH Medicaid Eligible Days issue as stated in the original appeal request did not include the § 1115 waiver days and the issue was not timely added to the appeal, the Board is dismissing it from this appeal. Because the Provider did not raise the § 1115 Waiver Days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be construed to include Section 1115 Waiver Days. Indeed, even if the Provider had properly included the issue as part of its appeal request, there are multiple independent bases upon which the Board would dismiss the issue, namely the failure to establish the Board's jurisdiction over the issue and the failure to properly develop the merits of the issue in its position paper filings.

* * * * *

Based on the foregoing, the Board dismisses the final two (2) remaining issues in this case – (Issues 1 and 5). As no issues remain, the Board hereby closes Case No. 19-0362 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/23/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

cc: Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Wilson Leong, FSS

[59] CMS Ruling 1727-R (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision***
Eastern New Mexico Medical Center (Provider Number 32-0006)
FYE: 05/31/2018
Case Number: 22-0427

Dear Messrs. Ravindran and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0427, pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 22-0427

On **January 14, 2022**, Eastern New Mexico Medical Center ("Eastern" or "Provider"), appealed a Notice of Program Reimbursement (NPR) dated August 9, 2021, for its fiscal year end (FYE) May 31, 2018 cost reporting period. The Provider appealed the following issues:[1]

- Issue 1: Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)[2]
- Issue 3: DSH -Medicaid Eligible Days
- Issue 4: DSH – Dual Eligible Days – Exhausted[3]
- Issue 5: DSH Part C Days – Post 10/1/2013[4]

As the Provider is commonly owned/controlled by Community Health Services ("CHS"), the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 15 and 16, 2022**, the Provider transferred Issues 2, 4, and 5 to CHS CIRP groups.

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Jan. 14, 2022).
[2] The Provider transferred this issue to Case No. 21-1206GC on August 15, 2022.
[3] The Provider transferred this issue to Case No. 21-0066GC on August 16, 2022.
[4] The Provider transferred this issue to Case No. 20-2149GC on August 15, 2022.

As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (DSH – SSI Percentage Provider Specific), Issue 3 (DSH Medicaid Eligible Days).

On **January 18, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* Board Rule 25.[5]

On **September 7, 2022**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover.[6] However, no such filing was made until November 20, 2023, and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the preliminary position paper failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days."[7] As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $60,143.

On **September 7, 2022**, and **November 30, 2022**, the Medicare Contractor sent requests for the DSH package to the Provider. In its November 30, 2022 Second and Final Request for DSH Package, the Medicare Contractor noted its previous attempts to acquire information regarding Medicaid Eligible days from the Provider, and the lack of any response.[8] The Provider did not respond (in OHCDMS) to this request.

On **December 16, 2022**, the Medicare Contractor filed its preliminary position paper. Regarding Issue 3, the Medicare Contractor's position paper noted that the Provider had failed to include "documenting evidence that the provider was entitled to additional Medicaid eligible days."[9]

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[5] (Emphasis added.)
[6] Provider's Preliminary Position Paper at 8 (Sept. 7, 2022).
[7] *Id.*
[8] MAC's 2nd and Final Request for DSH package – DSH Package (Nov. 30, 2022).
[9] MAC's Preliminary Position Paper at 8 (Dec. 16, 2022).

On **January 23, 2023**, the Medicare Contractor filed a Jurisdictional Challenge[10] with the Board over Issue 1 and Issue 3, requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. On **February 28, 2023**, the Provider requested a change of representative to Quality Reimbursement Services ("QRS"), which the Board acknowledged on March 1, 2023.

On **March 14, 2023**, more than 30 days after the Jurisdictional Challenge was filed, QRS filed an untimely Jurisdictional Challenge response.

On **November 20, 2023**, over a year after the provider submitted its preliminary position paper listing Issue 3 at issue, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days."

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC

The Provider's appeal request describes Issue 1 – DSH SSI Percentage (Provider Specific) issue, in part, as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that

[10] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timeliness or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[11]

The Provider was also transferred into a mandatory group under Case No. 21-1206GC, "CHS CY 2018 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[12]

The amount in controversy listed for the Provider for both Issue 1 and Issue 2 in Case No. 22-0427, and as a participant in 21-1206GC is $28,747.

On September 7, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[11] Provider's Request for Hearing, Issue Statement (Jan. 14, 2022).
[12] Group Issue Statement, Case No. 21-1206GC.

Calculation of the SSI Percentage

Provider Specific

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (May 31).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time the Provider has been unable to analyze the Medicare part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believe to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[13]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which was identified as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $28,747. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 21-1206GC.

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The Medicare Contractor contends that "Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment."[14] It also notes that Issue 2 was transferred into Group Case No. 21-1206GC, "CHS CY 2018 DSH

[13] Provider's Preliminary Position Paper, at 8-9 (Sept. 7, 2022).
[14] Medicare Contractor's Jurisdictional Challenge at 2 (Mar. 14, 2023).

SSI Percentage CIRP Group".[15] The Medicare Contractor contends that "the first and third sub-issues should be dismissed because they are duplicative of the issue under appeal in Group Case No. 21-1206GC."[16] The Medicare Contractor relies on PRRB Rule 4.6.1, which prohibits a provider from appealing the same issue from a single final determination in more than one appeal. The Medicare Contractor further argues that the Board should also dismiss the portion related to SSI realignment because there was no final determination over SSI realignment and the appeal is premature, as the Provider has not exhausted all available remedies.[17]

Lastly, the Medicare Contractor asserts Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[18]

Issue 3 – DSH – Medicaid Eligible Days

The Medicare Contractor contends that the Provider abandoned Issue 3 when it failed to properly develop its arguments within its preliminary position paper in accordance with Board Rule 25. Additionally, the Provider has failed to submit a list of additional Medicaid eligible days or any other supporting documents or explanation for why it cannot produce those documents.[19]

Provider's Response

The Board Rules require that Provider Responses to the Medicare Contractor's Jurisdictional Response must be filed ***within thirty (30) days*** of the filing of the Jurisdictional Challenge.[20] The Provider has not ***timely*** filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

As the Provider failed to ***timely*** file a response to the jurisdictional challenge, the Board will not include the response in its decision.

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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[15] *Id.*
[16] *Id.*
[17] *Id.* at 6-7.
[18] *Id.* at 7-9.
[19] *Id.* at 11-12.
[20] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

As set forth below, the Board ***dismisses*** both remaining issues in the appeal.

A. SSI Provider Specific

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue directly filed into Group Case No. 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group.

The first aspect of Issue 1 in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[21] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[22] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[23] The DSH systemic issues group issue filed into Case No. 21-1206GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $28,747.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 21-1206GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (Nov. 1, 2021), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 21-1206GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[24] The Provider's

[21] Individual Appeal Request, Issue 1.
[22] *Id.*
[23] *Id.*
[24] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins.*

reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

> [b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for

Co., PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

> a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [25]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data.[26]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 21-1206GC.

Accordingly, the Board must find that Issue 1 and the group issue in Group Case 21-1206GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis, the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

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[25] Last accessed September 24, 2024.
[26] Emphasis added.

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

B. DSH – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal request or the preliminary position paper.

Regarding the filing of an individual appeal, Board Rule 7.3.1.2 (Nov. 2021) states:

> **No Access to Data**
>
> If the Provider elects not to claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[27]

The regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

[27] (Bold emphasis added.)

Board Rule 25 (2021) requires the Provider to file its complete, *fully* developed preliminary position paper with all available documentation:

> **Rule 25 Preliminary Position Papers**
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the applicable sub-section.
>
> **25.1.1 The Provider's Position Paper**
>
> The Provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:
>
> - states the material facts that support the provider's claim.
> - Identifies the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
> - Provides a conclusion applying the material facts to the controlling authorities.
>
> C. Comply with Rule 25.2 addressing Exhibits.
>
> * * * *
>
> **25.2 Position Paper Exhibits**
>
> **25.2.1 General**
>
> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party. . . .

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to the Board

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

COMMENTARY: Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

Further, the Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on January 18, 2022, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the

Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[28]

Along the same line, 42 C.F.R. § 405.1871(a)(3) makes clear that, in connection with appeals to the Board, "the provider carrie[s the] burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> 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.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

On September 7, 2022, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[29] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. The Provider's complete briefing of this issue in its preliminary position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

[28] (Emphasis added.)
[29] Provider's Preliminary Position Paper at 8.

> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[30]

On November 20, 2023, ***over a year after*** the provider submitted its preliminary position paper addressing Issue 3, and over a year after the Medicare Contractor's final request for DSH package, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days."

The Medicare Contractor contends that the Provider failed to ***timely*** include a list of additional Medicaid eligible days with its preliminary position paper, or submit such list under separate cover as it implied, or when requested, multiple times, by the Medicare Contractor. The Medicare Contractor thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[31] The

[30] Provider's Preliminary Position Paper at 7-8.

[31] Medicare Contractor's Jurisdictional Challenge at 10-11. *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation

Medicare Contractor contends that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.[32]

The Board thereby finds the issue abandoned after the Provider waited for over four years to file a listing. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days).

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[33] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filings, notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board dismisses this issue from the appeal.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. The Board also dismisses Issue 3, DSH Medicaid Eligible days, as it is in violation of the Board Rules. As there are no issues pending in the appeal, Case No. 22-0427 is closed and removed from the Board's docket.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
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For the Board:

9/24/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

cc: Wilson Leong, Federal Specialized Services

was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[32] Medicare Contractor's Jurisdictional Challenge at 11.

[33] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Leslie Goldsmith, Esq.
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RE: ***Expedited Judicial Review Decision***
23-1580G: *Bass, Berry & Sims, PLC CYs 2017- 2018 Capital DSH Group*
23-1581GC: *HonorHealth CY 2019 Capital DSH CIRP Group*
24-1931GC: *Sentara Healthcare CY 2020 Capital DSH CIRP Group*
24-2168GC: *Mount Sinai Health System CY 2020 Capital DSH CIRP Group*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the July 30, 2024 consolidated request for expedited judicial review[1] ("EJR") for the above-referenced optional and common issue related party ("CIRP") group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute:

In these group cases, the Providers are challenging:

> [t]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs

[1] Providers' Petition for Expedited Judicial Review (July 30, 2024) ("Request for EJR").
[2] The Request for EJR encompasses six (6) group cases. On August 22, 2024, the Board issued a Request for Information and Scheduling Order in Cases 23-1580G, 23-1581GC, 24-1931GC, and 24-2168GC. That order stayed the 30-day period for the Board to rule on the Request for EJR in those cases. The Board issued a separate determination adjudicating cases 22-1271GC and 23-1683G on August 28, 2024.
[3] Request for EJR at 1.

("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that "serve[] a significantly disproportionate number of low-income patients."[10]

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 20, 2022) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12]

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment were adopted by the Secretary for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the

[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to take into account variations in the relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low-income patients.[15]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To this end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).
[16] 56 Fed. Reg. 43358 (Aug. 30, 1991).

> activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0\text{-}4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not

[17] *Id.* at 43369-70 (emphasis added).
[18] *Id* at 43377.

> extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1,1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l){ii) of the regulations.[20]

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals,

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[19] *Id.* at 43409-10 (bold and underline emphasis added).
[20] *Id.* at 43377.

hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approach, based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

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[21] *Id.* at 43378.
[22] *Id.* at 43379.
[23] *Id.* (Emphasis added.)

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.
>
> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[24]

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 x the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), -1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

[24] *Id.*
[25] *Id*. at 43452-53.

2. Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[27]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural, pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

[26] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[27] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

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Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113*. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

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> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http://www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

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[28] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).
[29] 65 Fed. Reg. 47026, at 47048.

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area",[30] it would appear that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[31]

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural, pursuant to BBRA § 401 which, as noted above, was implemented at § 412.103.

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[32] Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[33] On June 6, 2003, OMB announced the new

[30] 56 Fed. Reg. at 43452.
[31] (Bold and underline emphasis added.)
[32] Pub. L. 108–173.
[33] 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[34]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[35] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—
>
> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
>
> (C) The term *rural area* means any area outside an urban area.
>
> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was

[34] *Id.*
[35] 69 Fed. Reg. 48916 (Aug. 11, 2004).

> redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.
>
> (2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.
>
> (3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[36]

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[37] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments if either of the following conditions is met:

[36] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[37] (Emphasis added.)

> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.[38]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
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> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment

[38] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[39]

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[40] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[41]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[42]

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

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[39] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[40] of the Department of Health and Human Services.
[41] 71 Fed. Reg. 23996, 24122 (Apr. 25, 2006).
[42] *Id.*

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[43]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[44]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the

[43] 71 Fed. Reg. 47870, 48104-48105 (Aug. 18, 2006).
[44] *Id.*

> payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[45]**

5. Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* ("*Toledo*"),[46] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[47]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[48] The Court also noted how Congress enacted legislation in 1999[49] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[50] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. §

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[45] (Bold emphasis added.)
[46] 2021 WL 4502052 (D.D.C. 2021).
[47] *Id.* at *8 (citations omitted).
[48] *Id.* at *2.
[49] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[50] *Toledo* at *3.

412.320 for large urban hospitals (the capital DSH payment).[51] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[52]

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in in an arbitrary and capricious manner.[53]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from "treating [§] 401 reclassified hospitals as rural for operating PPS purposes and denying them urban status for purposes of the capital DSH adjustment".[54] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[55]

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

    - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[56]

    - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[57]

    - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[58]

    - "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43, 103 S. Ct. 2856. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals

[51] *Id.* at *3-4.
[52] *Id.* at *4.
[53] *Id.* at *5.
[54] *Id.* at *6-8.
[55] *Id.* at *11.
[56] *Id.*
[57] *Id.*
[58] *Id.*

> should receive a capital DSH adjustment, nor did he take costs into account at all."[59]

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an adjudication."[60] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[61]

Providers' Request for EJR

As background, "[e]ach of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital [prospective payment systems]. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and, for all or part of the year, received [§] 401 rural reclassifications pursuant to 42 C.F.R. § 412.103."[62]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The Providers note that "[t]he *capital* PPS provisions are located in an entirely different section of the statute, in 42 U.S.C. § 1395ww(g), and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes."[63]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[64] The Providers assert that "the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d)", and provides as an example, that "the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustments to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification 'affects only payments under section 1886(d) of the Act,' and 'payments for direct GME are made under section 1886(h) of the Act.'"[65] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[66]

The Providers assert that "the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act " [because] he failed to establish that adoption of

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[59] *Id.* at *11-12.
[60] *Id.* at *12.
[61] *Id.*
[62] Request for EJR at 7.
[63] *Id.* at 7.
[64] *See id.* at 7-8.
[65] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[66] *Id.*

the exception to the capital DSH adjustment, for providers that reclassified as rural, took 'into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.'"[67]

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[68] Further, the Providers contend that the Secretary adopted the FY 2024 hospital IPPS proposed rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii). Specifically, effective for discharges occurring on or after October 1, 2023, an urban hospital that is reclassified as rural under § 412.103 "will no longer be considered rural for purposes of determining capital DSH eligibility. Instead, for purposes of § 412.320, the geographic classifications specified under § 412.64 will apply."[69] However, the Providers explain that "for the periods under appeal, CMS and its contractors will continue to apply the 2006 regulation, denying capital DSH to the Providers for these periods."[70]

The Providers further contend that since the Board is bound by the regulation being challenged,[71] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[72]

Board Decision

1. *Jurisdiction – Appropriate Cost Report Claim (FYEs beginning on or after to December 31 ,2016)*

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[73] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[74] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction

[67] *Id.* at 8-9.
[68] *Id.* at 9-12.
[69] *Id.* at 10 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023).
[70] *Id.* at 10.
[71] *See* 42 C.F.R. § 405.1867.
[72] Request for EJR at 10-12.
[73] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[74] *Id.* at 70555.

requirement"). Since all the participants in Case Nos. 23-1580G, 23-1581GC, 24-1931GC & 24-2168GC have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The Providers have appealed from original NPRs or from the failure of the Medicare Contractor to timely issue an NPR.

Based on its review of the record, the Board should find that each of the participants in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations, or within 180 days after the twelve month period in which the Medicare Contractor was to issue a final determination,[75] as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals; and that the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

2. *Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)*

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, 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

[75] Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost* report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .

> (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
>
> (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.

These regulations are applicable to the cost reporting periods under appeal for all of the participants in these group appeals, which all have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[76] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[77]

On August 2, 2024, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed a Response to Providers' EJR Request, stating that no jurisdictional impediments existed for these four (4) cases, but that substantive claim challenges would be filed. Based on this timely certification, the deadline for any Substantive Claim Challenges in these cases was Monday, August 19, 2024. The Board notes that FSS filed timely Substantive Claim Challenges in all four group cases. The Substantive Claim Challenges encompassed the following participants in each case ("the Challenged Participants"):

- Case No. 23-1580G
  - Yale New Haven Hospital (Provider No. 07-0022, FYE 09/30/2018)
  - Lehigh Valley Hospital (Provider No. 39-0133, FYE 06/30/2018)
  - McLeod Regional Medical Center – Pee Dee (Provider No. 42-0051, FYE 09/30/2018)
  - Camden-Clark Memorial Hospital (Provider No. 51-0058, FYE 12/31/2018)
  - The Moses H. Cone Memorial Hospital (Provider No. 34-0091, FYE 09/30/2017)
- Case No. 23-1581GC
  - John C. Lincoln Medical Center (Provider No. 03-0014, FYE 12/31/2019)
  - Scottsdale Osborn Medical Center (Provider No. 03-0038, FYE 12/31/2019)
  - Scottsdale Shea Medical Center (Provider No. 03-0087, FYE 12/31/2019)
  - Deer Valley Medical Center (Provider No. 03-0092, FYE 12/31/2019)
- Case No. 24-1931GC
  - Sentara RMH Medical Center (Provider No. 49-0004, FYE 12/31/2020)
  - Sentara Norfolk General Hospital (Provider No. 49-0007, FYE 12/31/2020)
  - Sentara Leigh Hospital (Provider No. 49-0046, FYE 12/31/2020)
  - Sentara Virginia Beach Hospital (Provider No.49-0057, FYE 12/31/2020)
  - Sentara Careplex Hospital (Provider No.49-0093, FYE 12/31/2020)
  - Sentara Princess Anne Hospital (Provider No. 49-0119, FYE 12/31/2020)
- Case No. 24-2168GC
  - Mount Sinai Beth Israel (Provider No. 33-0169, FYE 12/31/2020)

Based on the foregoing, and pursuant to Board Rule 44.6, the Board issued a Scheduling Order to set a deadline (Monday, September 9, 2024) for the Providers' responses to the four Substantive Claim Challenges filed in Case Nos. 23-1580G, 23-1581GC, 24-1931GC, and 24-2168GC.

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[76] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[77] *See* 42 C.F.R. § 405.1873(a).

For all remaining participants in these four group cases (collectively "the Non-Challenged Participants"), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[78] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the Non-Challenged Participants.

A. Medicare Contractor's Argument for the Challenged Participants

For the Challenged Participants in Case Nos, 23-1580G, 23-1581GC, and 24-1931GC, the Medicare Contractor claims they have not claimed reimbursement for Capital DSH in their cost reports in accordance with Medicare policy nor have they self-disallowed the specific item in their respective cost reports. For those appealing from an NPR, these Challenged Participants have not cited an audit adjustment related to the appealed Capital DSH issue. For those appealing from the failure to issue a timely determination, these Challenged Participants have not demonstrated that they claimed reimbursement for the appealed Capital DSH issue. The Medicare Contractor states that these Challenged Participants did not self-disallow the appealed Capital DSH issue or list it in their respective Summary of Protested Amounts. Finally, the Medicare Contractor claims that none of the exceptions found at 42 C.F.R. § 413.24(j)(3)(i) through (3)(iii) apply.

For the sole Challenged Participant in Case No. 24-2168GC (Mount Sinai Beth Israel), the Medicare Contractor notes that there is a discrepancy between the Part A protested amounts filed with its amended cost report ($10,117,660)[79] an its summary of protested amounts ($10,056,126).[80] It argues that, while the summary of protested amounts does include a line item for "Capital DSH Loss-Rural Reclass," the variance of $61,534 precludes the Medicare Contractor from determining if it was actually protested since the total protested amount on the amended cost report is inconsistent with the associated summary/workpapers.

B. Group Representative's Response to Substantive Claim Challenges

The Providers filed a consolidated response to the Substantive Claim Challenges.[81] For the sole Challenged Participant in Case No. 24-2168GC (Mount Sinai Beth Israel), the Provider claims it complied with the substantive claim criteria at 42 C.F.R. § 413.24(j)(1). It argues that the fact that the protested amount in the cost report differs slightly from the amount on the workpapers accompanying the cost report does not mean the issue was not protested. It was clearly identified as a protested issue on the workpapers as a protested issue.

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[78] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[79] Case 24-2168GC, Medicare Administrative Contractor's Substantive Claim Challenge, Ex. C-2, page 127.
[80] *Id.* at Ex. C-3, page 1.
[81] Providers' Response to FSS's Substantive Claim Challenges and Petition for Expedited Judicial Review of the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (Sept. 6, 2024) ("Response to Substantive Claim Challenges").

For the Challenged Participants in Case Nos. 23-1580G, 23-1581GC, and 24-1931GC, the Providers do not dispute that the Challenged Participants "did not claim the capital DSH costs at issue either as an allowable cost or a protested amount."[82] Instead, "the Providers challenge the validity of 42 C.F.R. §§ 413.24 (j) and 405.1873" because they "contravene the Board's authority as set forth in 42 U.S.C. § 1395oo."[83] They cite *Bethesda Hosp. Ass'n v. Bowen*[84] and *Banner Heart Hospital v. Burwell*[85] in support of their position that these regulations are unlawful.[86]

The Providers request the Board grant EJR for all four cases over the Capital DSH issue, as well as the substantive claim regulations for Case Nos. 23-1580G, 23-1581GC, and 24-1931GC.

C. Appropriate Cost Report Claim: Findings of Fact and Conclusions of Law

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[87] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law as to whether an appropriate claim was included.

The Challenged Participants in Case Nos. 23-1580G, 23-1581GC, and 24-1931GC do not dispute that they failed to comply with the substantive claim requirements set forth at 42 C.F.R. §§ 413.24 (j) and 405.1873. The Board concurs that there is nothing in the record to demonstrate that they complied with the substantive claim requirements set forth at 42 C.F.R. §§ 413.24 (j) and 405.1873 and adopts these findings.

The Providers argue that the sole Challenged Participant in Case No. 24-2168GC (Mount Sinai Beth Israel) did comply with the substantive claim criteria at 42 C.F.R. § 413.24(j)(1). The Board agrees with the Providers that the minor discrepancy between the protested amount in the cost report and the amount on the workpapers accompanying the cost report is immaterial and that the appealed Capital DSH issue was clearly identified as a protested issue on the workpapers. Based on the foregoing, the Board finds that the sole Challenged Participant in Case No. 24-2168GC (Mount Sinai Beth Israel) did comply with the substantive claim requirements set forth at 42 C.F.R. §§ 413.24 (j) and 405.1873.

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[82] *Id.* at 9-10.
[83] *Id.* at 10.
[84] 485 U.S. 399 (1988).
[85] 201 F.Supp.3d 131 (D.D.C. 2016)
[86] Response to Substantive Claim Challenges at 11-12.
[87] (Emphasis added.)

3. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that all of the participants in Case Nos. 23-1580G, 23-1581GC, 24-1931GC and 24-2168GC are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for the Challenged Providers and the Board specifically finds that it is undisputed that these participants failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1) ***except for*** that the sole Challenged Participant in Case No. 24-2168GC (Mount Sinai Beth Israel, Provider No. 33-0169, FYE 12/31/2020);

3) The sole Challenged Participant in Case No. 24-2168GC (Mount Sinai Beth Israel, Provider No. 33-0169, FYE 12/31/2020) ***did*** include an appropriate claim for the specific item at issue in its appeal;

4) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered for the remaining Non-Challenged Providers and, therefore, there are no findings regarding whether their cost reports included appropriate claims for the specific item at issue in these appeals;

5) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

6) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

7) It is without the authority to decide the legal questions of:

   a. Whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid; and

   b. For the Challenged Providers (***except for*** that the sole Challenged Participant in Case No. 24-2168GC (Mount Sinai Beth Israel, Provider No. 33-0169, FYE 12/31/2020)), whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.[88]

[88] The Board recognizes that this question relates only to some of the participants in these groups and, as such, does not apply to the groups as a whole. As a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to review under 42 C.F.R. § 405.1840 of jurisdictional or claims-filing requirements, a provider's compliance with § 413.24(j) relates to the nature of the provider's *participation* in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) *as a procedural matter in the proceedings before the Board*, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Case Nos. 23-1580G, 23-1581GC, 24-1931GC and 24-2168GC. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Challenged Providers' (***except for*** that the sole Challenged Participant in Case No. 24-2168GC (Mount Sinai Beth Israel, Provider No. 33-0169, FYE 12/31/2020)) requests for EJR for the issue and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877 upon final disposition of the appeal. Since this is the only issue under dispute in these cases, the Board hereby closes the cases and removes them from the Board's docket.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

9/25/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

Enclosure: Schedules of Providers

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc., (J-M)
Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Esq., FSS

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that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Judicial review remains available on appeal for these discreet group participation issues regardless of whether they relate to the jurisdiction or claims-filing requirements under § 405.1840 or the substantive claims requirements under § 413.24(j).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Joanne Erde
Duane Morris
200 South Biscayne Boulevard, Suite 3400
Miami, FL 33131

RE: ***Motion for Reinstatement***
Ardent Health Services 2009 Post Rule 1498-R Dual Eligible Days Disproportionate Patient Percentage Group Appeal
Case Number: 14-0370GC

Dear Ms. Erde,

The Provider Reimbursement Review Board ("Board") has reviewed the above referenced appeal in response to the Ardent Health Services CIRP Group's request for reinstatement ("Motion for Reinstatement") submitted on December 5, 2022. The decision of the Board is set forth below.

Pertinent Facts:

On **October 26, 2022**, the Board requested a status update to confirm whether the group was fully formed, as no providers had been added to the group appeal since March 4, 2014. The group representative was advised that there was a deadline to respond of **November 25, 2022**, and a failure to timely respond would result in the dismissal of the case.

On **December 2, 2022**, after no action or communication from the group representative and pursuant to Board Rule 41.2, the case was dismissed by the Board. The Board found that the appeal was effectively abandoned through a failure to respond by the deadline.

On **December 5, 2022**, the Board received a letter from the Group Representative requesting reinstatement. The Group Representative provided the following reason for failing to respond:

> The undersigned believed that it had transferred all of the Ardent group appeals to QRS. When I received the letter October 26, 2022 letter (sic) from the Board requesting an update, I was surprised and followed up to determine why it was coming to me. It turned out that this one group had not been transferred.
>
> Accordingly, I follow up (sic) with Ardent. It turned out that Ardent changed its Director of Reimbursement and it took me a while to contact the correct person. As he was relatively new, he

> was unaware of this case and indicated that he would follow up and get back to me. When I did not hear back, I understood him to have taken care of this appeal with QRS, as all of the other appeals had been transferred to them. He believed that QRS was handling it. However, QRS believed that I had taken care of this. There was clearly a misunderstanding. Under no circumstances was there a lack of interest in pursuing this appeal. Accordingly, we request that you reinstated (sic) this appeal.

The Group Representative also advised that the Group is fully formed.

Board Decision:

The Board ***denies*** the motion for reinstatement for the reasons set forth below.

Failure to comply with the Board's deadline for submission of a required filing can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
>
> > (1) Dismiss the appeal with prejudice;
> > (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> > (3) Take any other remedial action it considers appropriate.

Board Rule 47.1 (Nov. 2021) governs motions to reinstate an issue:

> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). ***The Board will not reinstate an issue(s)/case if the provider was at fault.*** If an issue(s)/case was remanded pursuant to

> a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rule 47.2 below.[1]

More specifically, Board Rule 47.3 governs Dismissals for Failure to Comply with Board Procedures:

> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, ***administrative oversight***, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[2]

The Board will not generally reinstate an appeal that was closed due to untimely filing based on administrative oversight except for good cause. The Group Representative did not provide any "good cause" to explain why the response to the CIRP Group Status request was missed. The Group Representative's explanation for untimely filing was due to a new Director of Reimbursement at Ardent, as well as miscommunication between the Group Representative, and another representative company, Quality Reimbursement Services, Inc. This explanation is clearly administrative oversight, and is, therefore, the Group Representative's fault. Board Rule 47.1 and 47.3 state the Board will not reinstate an issue if the Providers are at fault and administrative oversight is not "good cause" to reinstate. As such, the Board ***denies*** the request for reconsideration and Case No. 14-0370GC remains closed.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

9/25/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

[1] Emphasis added.
[2] Emphasis added.

cc: Wilson C. Leong, Esq., Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc.(J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Notice of Dismissal – Updated Rationale***
Hall Render Standardized Amount CIRP Group Cases
Case Nos. 18-1646G (*see* **Appendix A** listing 502 CIRP & optional group cases)

Dear Ms. Elias:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the five hundred and two (502) above-referenced group cases set forth in **Appendix A** relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in each of these group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board Majority has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and, therefore, is dismissing these group cases in their entirety. This issue is not new to the Board and this determination is consistent with the its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget-neutrality-adjusted federal rates.

In summary, the Board Majority finds that it lacks substantive jurisdiction over the issue raised in these group appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment ("BNA") made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board Majority has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 BNAs. These intervening adjustments for FFYs 1986 and 2018 include

intertwined with those applicable BNAs.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the BNAs applied to those years reduced the standardized amounts (by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs, the Board Majority finds that it may not review the standardized amount used for the FFYs appealed as it relates to the common issues in these appeals. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget -neutrality-adjusted rates. Accordingly, the Providers assertion that the initial FFY 1984 standardized amount continues to serve as the base for all future calculations is incorrect as causal link is broken. Specifically, they may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

The Board Majority also notes that the Provider raises new legal issues that are beyond the scope of the original group issue statement in these group cases. Per their group issue statements, these group appeals challenge the standardized amount established for the ***initial*** year of IPPS, namely FFY 1984 running from October 1, 1983 to September 30, 1984. More specifically, the group issue statements alleged that "the Secretary[] fail[ed] to remove transfer cases ***from his initial*** *calculation* of the standardized amount in 1983"[7] as set forth at 42 U.S.C. § 1395ww(d)(2)(A).[8] Pursuant to 42 C.F.R. §§ 405.1837(a)(2) and (f)(1), a group may contain only one issue and no issues may be added to the group appeal. In their Response to the Medicare Contractor's Jurisdictional Challenge, the Providers have ***improperly*** raised new legal issues that are not part of this appeal. Specifically, the Providers have challenged the FFY 1986 standardized amount rates and subsequent years as being *improperly* based on the FFY 1985 budget-neutrality adjusted rates. This is a newly-added issue and is ***dismissed*** from these appeals pursuant to 42 C.F.R. §§ 405.1837(a)(2), (c) and (f)(1).

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both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 64 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 45 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 BNA).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *E.g.*, group issue statement for Case No. 18-1646.

[8] *See also* Providers' Response to the Medicare Contractors' Jurisdictional Challenge at 5-6 (describing the Secretary's interpretation of the "simple formula" at 42 U.S.C. § 1395ww(d)(2)(A) as the genesis of the Providers' dispute).

Finally, as a side note, the Board Majority notes that the Providers' claims that the 1981 data has not been available to the provider community is not correct. In addition to the FOIA process recognized in the Providers' Response to the Medicare Contractors' Jurisdictional Challenge, the Secretary has not produced certain 1981 cost report data that was used to determine the base year amount. The Board Majority notes that this information that the information sought by the Providers appears to have been available to the public roughly 25 years ago (close in time to when the initial IPPS was established), as explained in the proposed rule issued on May 27, 1988:

> *B. Public Requests for Data*
>
> In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format and are listed below with the cost of each tape. Anyone wishing to purchase data tapes should submit a written request along with a check to cover the cost of the tapes to the following address: HCFA Office of Statistics and Data Management, Bureau of Data Management and Strategy, Room l-F-2 Oak Meadows Building, 6325 Security Boulevard, Baltimore, MD 21207.
>
> ****
>
> 4. H180 **Extract, Cost Reporting Periods Ending January 1, 1981 through December 31, 1981**
>
> This file contains selected data items from cost reports. **These data were used in computing the initial Federal prospective payment rate**.
>
> Price: $530.00[9]

[9] 53 Fed. Reg. 19498, 19526 (May 27, 1988). Apparently, the Secretary made the data available in this manner due to demand, as previously the Secretary made this information available through FOIA as discussed in the following excerpt from the January 3, 1984 Final Rule:

> *We agree hospitals should have access to the data used in connection with the development of the prospective payment system*. We would like to point out that public access to disclosable information is provided under the Freedom of Information Act (5 U.S.C. 552). While we cannot guarantee that all requested information will be disclosed in the format desired by the requester, we will continue to respond promptly to all information requests and provide all available data to assist the hospital industry and other interested parties in the evaluation of the prospective payment system.
>
> In fact, much of the applicable data has already been made available to requesters. For example, the cost report file used as a basis for determining the budget neutrality adjustment factor and other factors had already been made available for public use before publication of the interim rule. This data, together with our descriptions of the budget neutrality determination published in

Prior to May 1988, it appears as if this information was available through FOIA as recognized by the Providers.[10] However, the Providers do not recognize that the above information was previously available beginning in May 1988.

PROCEDURAL BACKGROUND:

A. Group Issue – Limited to Alleged Error in the Initial Calculation of the Standardized Amount for the Initial Year of IPPS

Hall, Render, Killian, Heath & Lyman, P.C. ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. Various Medicare Contractors filed Jurisdictional Challenges covering the 502 group cases over the past year or so, as described in **Appendix A**.[11] In the majority of these cases, Hall Render requested postponements for their jurisdictional response deadlines, which the Board granted, extending the deadline to respond until May 2024. In other cases with more recent challenges, Hall Render filed the response vs. requesting another postponement. The group issue statements are materially identical and can be considered together.

The group issue statement presented is, in part:

> Providers request a group appeal hearing in accordance with 42 C.F.R. §§ 405.1835 and 405.1837 to challenge the federal standardized amount(s) ("Standardized Amount") established under the Medicare Inpatient Prospective Payment System (IPPS) for federal fiscal year ("FFY") 1983 as improper. **The 1983 error reduces the FFY 2024 Standardized Amount,** and will reduce each subsequent fiscal year's Standardized Amount until this challenge is resolved. On August 28, 2023, the Secretary of the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("Secretary") published a Standardized Amount for FFY 2024 that contains an approximately negative 0.9% understatement **due to the Secretary's failure to remove transfer cases from his initial calculation of the standardized Amount in 1983**, an error that continues to this day. 88 Fed. Reg. 58640, 59030-59037 (August 28, 2023). It has been long recognized that the Board has jurisdiction over an appeal timely filed from a Federal Register promulgation. See *Washington Hospital Center v.*

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section VIII of the Addendum to the interim rule, should allow our budget neutrality determination to be replicated. 49 Fed. Reg. at 251.

(Emphasis added.) It is unclear to what extent any of this 1981 information continues to be available to the public at this late date and, if not, to what extent CMS is obligated to continue to make it available to the public at this late date. These questions could become relevant if the Board were to have jurisdiction and, following additional input from the parties, were to determine that material factual disputes exist, resulting in further record development by the parties.

[10] *See supra* note 9; Providers' Response to the Jurisdictional Challenge at 7.

[11] *See* **Appendix A**.

> *Bowen*, 795 F.2d 139 (D.C. Cir. 1986). The Secretary's error resulted in an understatement of the Standardized Amount, and consequently all Medicare IPPS payments to the Providers for the federal fiscal year at issue. The Secretary's error will result in an underpayment to hospitals in FFY 2024 of approximately $860 million nationwide.[12]

Thus, the Providers challenge the federal standardized amount established under the IPPS for the initial year as improper based on the allegation that "the Secretary[] fail[ed] to remove transfer cases ***from his initial*** *calculation* of the standardized amount in 1983."[13] In the Providers' group appeal requests, they further explain that:

> When the Prospective Payment System was developed in 1983, transfers from one hospital to another should have not been counted as discharges from each respective hospital because of the special reimbursement rules created for transfers under the Prospective Payment System. *See* 48 Fed. Reg. 39,752, 39,759 (Sept. 1, 1983) and 49 Fed. Reg. 234, 245-46 (Jan. 3, 1984). However, CMS (then HCFA) used 1981 cost report data to compute the initial standardized amount, and transfers were counted as two discharges rather than one because the cost report at that time did not separately quantify transfers. As a result, the additional discharges had the effect of understating the standardized amount. The agency attempted to downplay the effect of its decision: With respect to the Federal rates, *we would expect any discrepancy between the "old" and "new" definitions of discharge to have no significant effect on the rates*. 49 Fed. Reg. 234, 245-46 (Jan. 3, 1984). However, CMS declined then and continues to decline to quantify the exact effect of its decision, and it is the only entity in possession of this information.[14]

CMS opted to use 1981 as a "base year" to calculate these initial FFY 1984 rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[15]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to

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[12] *E.g.*, Case 24-0998GC Issue Statement (bold and underline emphasis added).
[13] *Id.* (emphasis added).
[14] *Id*.
[15] *Id.*

another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges.[16]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[17] They claim that the average cost per discharge as initially set should not have included transfers. They also argue that hospitals have not been permitted to appeal the rate under CMS' improper interpretation of 42 C.F.R. 405.1885(a)(1). They go on to argue:

> The Secretary acknowledged it committed this error [the inclusion of transfers] . . . The Secretary has also refused to correct it. The Secretary's inclusion of transferred patients swelled the denominator and understated the cost-per-discharge ratio and was not authorized by law.[18]

B. Jurisdictional Challenges

The Medicare Contractor filed a challenge in the 502 different group cases, and the Providers failed to file a timely response in each.[19] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that BNAs after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

C. Providers' Response to Jurisdictional Challenge

The Providers argue that they are appealing a "straightforward issue:"

> the Secretary's improper calculation of—and the MAC's continued use of—this understated standardized amount. Instead of determining "the allowable operating costs per discharge:"
>
> **Allowable Operating Costs**
> **Number of Discharges**

[16] *See id* at 5-6.
[17] *See e.g.,* Case 18-1646G, Providers' Preliminary Position Paper at 1.
[18] *Id.* at 1-2.
[19] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.

> the Secretary divided "the allowable operating costs" by the number of discharges **and** transfers:
>
> $$\frac{\textbf{Allowable Operating Costs}}{\textbf{Number of Discharges + Number of Transfers}}$$[20]

The Providers go on to argue that the preclusion of FFY 1984 and 1985 Budget Neutrality Adjustments (BNAs) are not "inextricably intertwined" with the average standardized amounts because "Congress commanded the Secretary not to incorporate the FFY 1984 BNA into the FFY 1985 prospective payment rate; Congress likewise commanded the Secretary not to incorporate the 1985 BNA into the FFY 1986 prospective payment rate."[21] Further, the Providers argue that "no part of § 1395(d)(7)(A) precludes review of the Secretary's failure to meet Congress' mandate to calculate each hospital's cost-per-discharge as the first step of finding the average standardized amounts."[22]

The Providers also argue that "the Secretary further understated the average standardized amounts by improperly including the FFY 1985 BNA in the FFY 1986 average standardized amounts" and therefore, "Providers are limited in their ability to state exactly the amount of reimbursement in dispute—given CMS and the Secretary have repeatedly refused requests to produce data used in these calculations."[23]

BOARD DECISION:

As described more fully below, the Board Majority finds that it lacks substantive jurisdiction over each of the 502 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[24] are ***inextricably*** tied to the FFY 1984 and 1985 BNAs to the "applicable percentage increases" for IPPS[25]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs;[26] and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985

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[20] Jurisdictional Response in Case No. 18-1646G at 1.
[21] *Id*. at 2.
[22] *Id*.
[23] *Id*.
[24] The Board Majority notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[25] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 BNAs are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[26] *But see* **Appendix B**. The Board has not traced the standardized amount after FFY 1986 all the way up to the each of the years in question. **Appendix B** highlights how, in addition to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and forward, there could be other intervening statutory or regulatory events (whether discretionary or mandatory) that could break the Providers' alleged causal link between the alleged error in the initial FFY 1984 rates and the standardize amounts used in the years at issue.

BNAs. Further, the fact that the Secretary's BNA to the FY 1984 Federal Rates was 0.970[27] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e*., 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[28] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[29]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[30] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[31] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1981 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount and then *updated* by an inflationary factor to bring it forward to FFY 1984.[32] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding

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[27] In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[28] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[29] *Id.*
[30] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[31] *Id.* (emphasis added).
[32] *Id*. at 39763-64.

costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[33] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary (*see also* **Appendix B**). In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the BNA for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[34]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

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[33] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[34] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[35]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[36]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average

[35] (Italics emphasis in original and bold and underline emphasis added.)
[36] (Italics emphasis in original and bold and underline emphasis added.)

payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[37] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the BNA).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1⁄2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points

[37] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board Majority's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 percentage point for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year ***1998***, 0 percent,

(XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[38]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the

[38] (Emphasis added.)

> Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 BNAs (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in

determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
>
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.
>
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—
>
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.

> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[39]

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[39] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the* ***initial*** *FFY 1984 standardized amount*.[40]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the BNAs for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[41] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***roughly 20 to 35 years*** to increase the ***initial*** FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward by the relevant 20 to 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue[42] *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[43]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 BNAs which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the BNAs had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to

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[40] *See e.g.,* Case 24-0998GC, Issue Statement at 1.
[41] *See* **Appendix B.**
[42] *See supra* note 24 accompanying text.
[43] *See id.*

(*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[44] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 BNA (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those BNAs). Thus, in the Board Majority's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 BNAs. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[45]

Accordingly, the Board Majority finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the BNAs made for FFY 1984 and 1985.[46]

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[44] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[45] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the BNAs would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[46] The Board Majority notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 BNAs given the statutory provision precluding administrative and judicial review of those adjustments. Further,

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 BNAs. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[47]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 BNAs are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board Majority finds that the FFYs 1984 and 1985 BNAs effectively fixed the standardized amounts from that point forward for use in the IPPS system.[48]

Saint Francis did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[47] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[48] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 BNAs confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 BNA as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 BNA to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.

> • *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
>
> • *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
>
> • *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[49]

In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970 using the same methodology.[50] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the BNA factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[51]

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[49] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[50] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[51] *Id.* at 255 (emphasis added.) *See also id.* at 331 (stating as part of the discussion on the BNAs: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing

Accordingly, while the Providers did not appeal the BNAs, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the BNA for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the BNA for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[52]

Regardless, the Secretary's application of a 0.970 BNA factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 BNA. Moreover, as previously noted, since the FFY 1984 BNA is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 BNA effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 BNA also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a BNA of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable

reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[52] *Id.* at 255.

> cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1, 1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[53]
>
> ****

By finalizing an adjustment factor less than one (1), the Secretary confirmed that the standardized amounts were too high. Thus, like her BNA made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[54]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget-neutrality-adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical

[53] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[54] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

> explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[55]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[56] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a

[55] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").
[56] *Id.* (emphasis added).

> zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[57]

The Board Majority has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that:

- The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

- The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Indeed, the Providers acknowledge that they are not challenging the FFY 1985 BNA and acknowledge that the Secretary used the FFY 1985 budget-neutrality adjusted standardized amounts to set the standardized amounts for FFY 1986 and subsequent years.[58] Accordingly, given the incorporation of the FFY 1985 budget-neutrality-adjusted rates into subsequent years, the Board Majority finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 BNA.

*4. The Provider **improperly** raises new issues in its Response to the Medicare Contractors' Jurisdictional Challenge that are not part of these appeals.*

As discussed above, the Providers admit that the Secretary used the FFY 1985-budget-neutrality adjusted rates to set the standardized amounts for FFY 1986 and subsequent years and that they do not challenge the FFY 1985 BNA.[59] However, the Providers then try to use their Response to the Medicare Contractor's Jurisdictional Challenge to ***improperly*** add new issues to their appeal by challenging the Secretary's implementation of the FFY 1984 and 1985 BNAs, including but not limited to challenging the Secretary's use of the 1985-budget-neutrality adjusted rates to set the standardize amount rates for FFY 1986 and subsequent years by claiming the Secretary failed to follow the statutory directives of Congress in calculating the standardized amount rates for FFY 1986 and subsequent years. These challenges are new issues that are not part of the groups' original appeal.

Pursuant to 42 C.F.R. § 405.1837(a)(2), a group must *only* "involve[] a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Consistent with this requirement, 42 C.F.R. § 405.1837(c)(3) specifies that a group appeal request must include "a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group

[57] 87 Fed. Reg. 16772, 16773 (May 6, 1986).
[58] Providers' Response to MAC Jurisdictional Challenge at 12, 22, 58.
[59] Providers' Response to MAC Jurisdictional Challenge at 12, 22.

appeal." Further, the group appeal request must explain "why the provider[s] believe[] Medicare payment is incorrect for each disputed item" and "[h]ow and why the provider[s] believe[] Medicare payment must be determined differently for each disputed item." Consistent with these two (2) regulatory provisions, 42 C.F.R. § 405.1837(f)(1) specifies that, after a group appeal request is filed, "a provider *may* ***not*** *add* other questions of fact or law to the appeal, *regardless of whether the question is common to other members of the appeal*."

Here, the Providers only challenged the ***initial*** federal standardized amounts established under the IPP for FFY 1984 as improper by asserting that the Secretary failed to exclude transfers when determining the base cost per discharge rate mandated in 42 U.S.C. § 1395ww(d)(2)(A) as demonstrated in the excerpts taken from the group issue statements quoted above. The Providers *belated* focus on the Secretary's use of the 1985-budget-neutrality adjusted rates in the FFY 1986 rates and subsequent years illustrates the underlying problem with these appeals, namely the failure to trace the causality of the alleged error in setting the original FFY 1984 standardize amount rates and those at issue as used roughly from 24 to 37 years later.[60]

The Providers stance on this discovery suggests that the real issue with the standardized amounts used in the years at issue may now be their new allegation that the Secretary improperly used the FFY 1985 budget neutrality-adjusted rates in setting their current rates:

> As for FFY 1985, the MACs are plain wrong. For FFY 1984, the Secretary proposed and finalized its regulation only carrying forward the FFY 1984 § 405.473(b)(7) values to start the FFY 1985 calculation. *See* § 405.473(c)(2)(i) at Exhibit P-17.
>
> As for FFY 1986, the MACs are correct: the Secretary did violate Congress's command. **Congress precluded the Secretary from bringing the FFY 1985 § (d)(3)(C)/§ 405.473(c)(3)(i)(D) BNA forward into the FFY 1986 calculation (*see* § (d)(3)(A))—but the Secretary did so anyway**. *See* § 405.473(c)(4) at Exhibit P-17; Exhibits P-23& P-24 § 412.63(c)(3).
>
> ****
>
> Through the course of responding to the MAC's *Jurisdictional Challenge*, it has come to Providers' attention that **the Secretary erroneously applied** the FFY 1985 BNA—in addition to the error they originally raised (the understated standardized amounts).
>
> ****
>
> **The Secretary's subsequent incorporation of the FFY 1985** § (d)(3)(C) **BNA into the FFY 1986** § (d)(3)(A) average standardized amounts **violated Congress's command** that the

[60] *See* **Appendix B** (providing examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue).

> Secretary start with the FFY 1985 § (d)(3)(A) value, which did not include the FFY 1985 (d)(3)(C) BNA. Exhibit P-3 § 1395ww(d)(3)(A), Nov. 8, 1984; see also Exhibit P-3 at PL 99-272, April 7, 1986, 100 Stat 82; PL 99-349, July 2, 1986, 100 Stat 710; PL 99-509, Oct. 21, 1986, 100 Stat 1874; & PL 99-514, Oct. 22, 1986, 100 Stat 2085.[61]

The Providers' group issue statements do not challenge the use of the FFY 1985 budget neutrality-adjusted rates in setting the rates for FFY 1986 and subsequent years and the Providers may not now add that issue to their appeal. Accordingly, the Board ***dismisses*** the Providers' new issue related to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and subsequent years pursuant to 42 C.F.R. §§ 405.1837(a)(2), (c), and (f)(1).[62]

* * * * *

The Board Majority finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the BNA made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[63] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable BNAs.[64]

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[61] Provider's Response to the Medicare Contractors' Jurisdictional Challenge at 58, 61, 63.

[62] *See also* Board Rule 8. Consistent with these regulations, Board Rule 8.1 (July 2015) specifies: "Some issues may have multiple components. To comply with the regulatory requirement to ***specifically*** *identify* the items in dispute, ***each*** contested component must be appealed as a ***separate*** *issue* ***and*** *described as* ***narrowly*** *as possible* using the applicable format outlined in Rule 7." (Emphasis added.) *See also Evangelical Comty. Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[63] The Board Majority has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 BNAs. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[64] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the

Indeed, the Secretary applied a BNA to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[65] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board Majority finds that it may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals.[66] In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates and the Providers may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board Majority finds that: (1) the appealed issue is *inextricably* tied with the FFY 1984 and 1985 BNAs to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY

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shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board Majority notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board Majority's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing BNAs made for FFYs 1984 and 1985.

[65] *See supra* note 45 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 BNA).

[66] *But see supra* note 26.

1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[67]) prohibit administrative and judicial review of those BNAs. Based on these findings, the Board Majority concludes that it does not have substantive jurisdiction[68] over the issue in the five hundred and two (502) group cases listed in **Appendix A**, and hereby closes these five hundred and two (502) group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (concurring in part, dissenting in part)

For the Board:

9/27/2024

X Clayton J. Nix

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

Appendices A – Listing of Cases Covered by this Notice of Dismissal
B – Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue
C – Additional Excepts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

cc: Byron Lamprecht, WPS Government Health Administrators (J-8, J-5)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Danelle Decker, National Government Services, Inc. (J-K)
Cecile Huggins, Palmetto GBA (J-J)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Judith Cummings, CGS Administrators (J-15)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

[67] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).
[68] The Board has not formally reviewed the 504 plus cases for other aspects of jurisdiction, including claims filing requirements (*e.g.*, timeliness) or whether any revised NPRs were appeal and, if so, whether the relevant Provider(s) properly appealed the revised NPR(s).

Concurring in part, dissenting in part

I concur with the majority's dismissal of the Providers' challenge to the FFY 1986 standardized amount rates and subsequent years as being improperly based on the FFY 1985 budget-neutrality adjusted rates. However, for the reasons explained below, I dissent from the Board Majority's decision regarding the issue of whether CMS' failure to remove transfer cases from its discharge data decreased the Standardized Amount, and would find that the Board has substantive jurisdiction in this case.

The Providers' issue statement is essentially the same as that in *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023) ("St. Mary's")*[69], an appeal from the Board's "Dismissal Based on Lack of Substantive Jurisdiction" dated April 6, 2023,[70] the Board's first decision on the topic of "Understated IPPS Standardized Amount" after the D.C. Circuit ruled in *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) ruling that the reopening regulation – and thus its predicate facts position – does not apply to appeals made to the Board.

In these "Understated IPPS Standardized Amount" cases, the providers consistently argue that a computational error at the inception of the IPPS has not been corrected,[71] that "the Secretary failed to properly distinguish between patient transfers and discharges in establishing the PPS1983 base year amounts,[72] and that "the resulting understated initial base year amounts were carried forward across 35 years resulting in the alleged understated standardized amount used for setting the FFY 2019 IPPS payment rates."[73]

The majority finds that the Board has no jurisdiction based on the presupposition that the final FFY 1984 and 1985 standardized amounts (which were based on 1981 discharge data) were adjusted for budget neutrality, thus, the final rates in those years are *inextricably tied* with budget neutrality adjustments for which administrative and judicial review is prohibited by 42 U.S.C. § 1395ww(d)(7). The Board Majority rationalizes its conclusion by stating that the initial 1983

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[69] "The Hospitals challenge their Medicare inpatient hospital payments for Federal Fiscal Year ("FFY") 2019 as being unlawfully understated because the Secretary calculated them using a "standardized amount" that was invalidly low because of an embedded error from the Secretary's original implementation of the Medicare Hospital Inpatient Prospective Payment System ("IPPS") in FFY 1984." *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023), Complaint at 25.*

[70] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024); *see also*, *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023),* Complaint at 28 ("on April 6, 2023, the Board dismissed the Hospitals' administrative appeals, holding *for the first time* in any administrative appeal raising this substantive issue that the Budget Neutrality Preclusion Provisions strip it of jurisdiction over the Hospitals' claims.")

[71] See Saint Francis Med. Ctr. v. Azar, 894 F.3d 290 (D.C. Cir. 2018).

[72] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), at 3, available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024);

[73] *Id*.

standardized amount was overstated, so therefore the initial base rate that was set using 1981 data could not have been erroneous. I respectfully disagree.

The Providers have presented several arguments as to why the standardized amount is understated; that is not for me to decide today. My dissent over the majority's conclusion that the Board has no substantive jurisdiction over this appeal solely because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. To reach their conclusion, my colleagues have skipped ahead to an analysis of the budget neutrality adjustments, and passed over the Providers' challenge to the accuracy of the 1981 discharge data.[74] The Providers are not challenging the "determination of the requirement, or the proportional amount, of any budget neutrality adjustment" in IPPS rates, which is what the plain language of 42 U.S.C. § 1395ww(d)(7) prohibits. Rather than consider the issue to be that CMS did not properly calculate the average cost per discharge, my colleagues prejudicate that the data cannot be reviewed because a subsequent calculation utilizing that data was later incorporated into an adjustment which was deemed sacrosanct by a Congress that readily admitted the data was flawed.[75]

In reaching my decision, I am persuaded by the concurring opinion in *St. Francis* asserting "it is not reasonable for HHS to 'cement misclassified' costs into 'future reimbursements, thus perpetuating literally million-dollar mistakes.'"[76] Additionally, I note the rulemaking for the Capital PPS Final Rule, whereby CMS applied a correction factor for capital-related costs in the

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[74] *See* Providers' PPP at 10.

[75] "The case mix index values used in the PPS model were based on billing information reported in 1981. At that time, the patient diagnostic information necessary for DRG assignment was completely unrelated to payment. ***As a result, the 1981 bills contain a variety of errors which tend to cause the hospital case mix values to be understated.*** Hospital PPS payments, however, are based on the diagnostic information reported on the current bills, under very different incentives. Therefore, an increase in overall hospital case mix under PPS was anticipated." Adjustments in Medicare's Prospective Payment System, S. Hrg. 98-1122, Hearing before the Subcommittee on Health of the Committee on Finance, United States Senate, Ninety-Eighth Congress, Second Session, August 8, 1984, available at https://www.finance.senate.gov/imo/media/doc/HRG98-1122.pdf, page 14 of 147 (accessed July 11, 2024) (***emphasis added***). *See also*, Providers' PPP at 27, citing the FFY 1984 IPPS Final Rule and the 1992 Capital PPS Final Rule; *see also* 56 Fed. Reg. 43358 at 43387 (Aug. 30, 1991) (Prospective Payment System for Inpatient Hospital Capital-Related Costs – Final Rule). ("*Comment*: Several commenters questioned the treatment of transfers in determining the hospital-specific rate. Some commenters suggested that transfer should not be included in the discharge count because payment is not made for all transfers on a per discharge basis. One commenter suggested that each transfer case should be counted as a fraction based on the amount paid for the transfer case as a portion of the full case payment. Others believed that including transfers in the case-mix index would distort the hospital-specific rate because transfer cases tend to have a higher DRG weight. *Response*: We agree with the commenters that the treatment of transfers in the discharge count is problematic. To the extent a transfer is paid on a per diem basis, including the transfer in the discharge count will understate the hospital-specific rate. If the transfer were not counted at all, as suggested by some commenters, the hospital-specific rate would be overstated. In contrast, there is no distortion in the hospital-specific rate if the transfer is paid at the full DRG rate. Since some transfers are paid on a per diem basis and other transfers are paid at the full DRG amount, either the total include or the total exclusion of transfers will distort the hospital-specific rate unless the costs of all transfer cases are removed from the base period costs. We do not believe that it is administratively feasible to remove the costs associated with transfer cases. Instead, to account for transfers, as recommended by one commenter, we are adopting and adjustment to the discharge count used to calculation the hospital-specific rate. [. . . .].)

[76] *St. Francis* at 298, citing *Regions Hospital v. Shalala*, 522 U.S. 448, 462, 118 S.Ct. 909, 139 L.Ed.2d 895 (1998).

Capital PPS Final Rule in 1991, thus setting a possible precent for making such a change.[77] Finally, I believe that the Board jurisdictional statute, 42 U.S.C. § 1395oo, should be read broadly to support the "strong presumption that Congress intends judicial review of administrative action."[78]

In conclusion, the Providers should be afforded the due process of proving to the Board that the 1981 discharge data were indeed flawed, leading to understated amounts in the Federal Fiscal Years at issue.

9/27/2024

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

[77] 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991)..
[78] *Bowen v. Academy of Family Physicians*, 476 U.S. 667, 670 (1986).

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On September 8, 2023, the Medicare Contractor filed a challenge to the following seventy-seven (75) cases which all share a common lead Medicare Contractor, WPS Government Health Administrators (J-8):

18-1646G	Hall Render CY 2015 Understated Standardized Amount Predicate Fact Group I
18-1676GC	Indiana University CY 2015 Understated Standardized Amount Predicate Fact CIRP Group
18-1693GC	Community Healthcare CY 2016 Understated Standard. Amt. Predicate Fact CIRP Group
18-1711GC	Comty. Health Netwk CY 2015 Unde.rstated Stand. Amt. Pred Fact Grp for Settled C/Rs CIRP
18-1713GC	Franciscan Alliance CY 2015 Understated Standardized Amount Predicate Fact CIRP Group
19-0026GC	Spectrum Health CY 2016 Understated Standardized Amount Predicate Fact CIRP Group
19-0461GC	Franciscan Alliance CY 2014 Understated Standardized Amount Predicate Fact CIRP Group
19-0580GC	McLaren Health CY 2015 Understated Standardized Amount Predicate Fact CIRP Group
19-0588GC	Beacon Health System FFY 2019 Understated Standardized Amt. Predicate Fact CIRP Group
19-0589GC	Community Healthcare FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
19-0897GC	Community Health Network FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Grp
19-0971GC	IU Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-0987GC	Franciscan Alliance FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1015GC	McLaren Health FFY 2019 Understated Standardized Amt. Pred. Fact CIRP Group
19-1065GC	Parkview Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1130GC	Spectrum Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1238GC	Community Health Network CY 2016 Understated Standard. Base Amt. Pred. Fact CIRP Grp.
19-1661G	Hall Render FFY 2019 Understated Standardized Amount Predicate Fact Group I Group
19-1975GC	Beacon Health CY 2015 1983 Understated Standardized Amount Predicate Fact CIRP Group
19-2556GC	Ascension Health CY 2017 1983 Understated Standardized Amt. Predicate Fact CIRP Group
19-2590GC	Spectrum Health CY 2017 1983 Understated Standardized Amt. Predicate Fact CIRP Group
20-0630GC	Community Healthcare FFY 2020 Understated Standardized Amount CIRP Group
20-0633GC	Beacon Health FFY 2020 Understated Standardized Amount CIRP Group
20-0649GC	IU Health FFY 2020 Understated Standardized Amount CIRP Group
20-0688GC	Spectrum Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0707GC	Parkview Health CY 2015 1983 Understated Standardized Amt. Predicate Fact CIRP Group
20-0758GC	Franciscan Alliance FFY 2020 Understated Standardized Amt. Predicated Fact CIRP Group
20-0773GC	Parkview Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0890GC	McLaren Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0916GC	Community Health Network FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Grp.
20-1090G	Hall Render FFY 2020 1983 Understated Standardized Amount Group I Group
20-1425GC	Community Healthcare Systems (IN) CY 2017 1983 Understated Standard. Amt. CIRP Group
20-1552GC	McLaren Health CY 2016 1983 Understated Standardized Amount CIRP Group
20-1899GC	McLaren Health CY 2017 1983 Understated Standardized Amt. Predicate Fact CIRP Group
21-0473GC	Beacon Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0481GC	Community Health Network FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Grp.

21-0482GC Community Healthcare FFY 2021 Understated Standardized Amt. Predicate Fact CIRP Group
21-0483GC Deaconess Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0492GC IU Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0549GC Franciscan Alliance FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0568GC Parkview Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0622GC Spectrum Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0936GC McLaren Health FFY 2021 1983 Understated Standardized Amt. Predicate Fact CIRP Group
21-1233GC IU Health CY 2016 Understated Standardized Amount Predicate Fact CIRP Group
21-1342GC IU Health CY 2017 Understated Standardized Amount Predicate Fact CIRP Group
22-0092GC Parkview Health CYs 2016- 2017 Understated Standardized Amt. Predicate Fact CIRP Group
22-0371GC Beacon Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0380GC Community Health Network FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Grp.
22-0382GC Deaconess Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0385GC Parkview Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0402GC IU Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0409GC Spectrum Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0414GC Franciscan Alliance FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0511GC Community Healthcare FFY 2022 Understated Standardized Amt. Predicate Fact CIRP Group
22-0516GC Community Health Network CY 2017 Understated Standard. Amt. Predicate Fact CIRP Grp.
22-0535GC McLaren Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0629GC Franciscan Alliance CY 2017 Understated Standardized Amount Predicate Fact CIRP Group
22-0653GC Ascension Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-1234GC Community Healthcare CY 2018 Understated Standardized Amt. Predicate Fact CIRP Group
22-1345G Hall Render CY 2017 Understated Standardized Amount Predicate Fact Group
23-0442GC Community Health Network FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Grp.
23-0451GC IU Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0453GC Beacon Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0455GC Community Healthcare FFY 2023 Understated Standardized Amt. Predicate Fact CIRP Group
23-0462GC Parkview Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0489GC Deaconess Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0537GC Ascension Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0546GC Franciscan Alliance FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0735G Hall Render FFY 2023 Understated Standardized Amount Predicate Fact Group
23-0737GC McLaren Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0747GC Beacon Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
23-0914G Hall Render CY 2018 Understated Standardized Amount Predicate Fact Group
23-0964GC Franciscan Alliance CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
23-0993GC Community Health Network CY 2018 Understated Standard. Amt. Predicate Fact CIRP Grp.
23-1052GC Community Healthcare CY 2019 Understated Standardized Amt. Predicate Fact CIRP Group

On September 11, 2023, the Medicare Contractor filed a challenge to the following thirty-six (36) cases which all share a common lead Medicare Contractor, WPS Government Health Administrators (J-5):

19-0605GC	Mercy Health CY 2015 1983 Understated Standardized Amount Predicate Fact CIRP Group
19-1016GC	Methodist Health System FFY 2019 Understated Standardized Amt. Pred. Fact CIRP Group
19-1199GC	UnityPoint Health CY 2015 1983 Understated Standard. Amt. Predicate Fact CIRP Group
19-1486GC	Truman Med Ctr FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1487GC	Mercy FFY 2019 Understated Standardized Amount CIRP Group
19-1734GC	UnityPoint Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-2218G	Hall Render CY 2017 1983 Understated Standardized Amount Predicate Fact Group
19-2414GC	UnityPoint Health CY 2016 1983 Understated Standard. Amt. Predicate Fact CIRP Group
20-0132G	Hall Render CY 2016 1983 Understated Standardized Amount Predicate Fact Group
20-0825GC	Mercy FFY 2020 1983 Understated Standardized Amount CIRP Group
20-0888GC	Truman Med Ctr FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0905GC	UnityPoint Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0936GC	Methodist Health System FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
20-1607GC	Mercy CY 2017 1983 Understated Standardized Amount CIRP Group
20-1902GC	Truman Med Ctr CY 2017 1983 Understated Standard. Amt. Predicate Fact CIRP Group
20-2003GC	UnityPoint Health CY 2017 Understated Standardized Amount Predicate Fact CIRP Group
21-0502GC	Mercy FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0567GC	UnityPoint Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0569GC	Methodist Health System FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0623GC	Truman Med Ctr FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0676GC	West TN Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0708GC	Ascension Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0783G	Hall Render FFY 2021 Understated Standardized Amount Predicate Fact Group I
22-0408GC	Methodist Health System FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0624GC	UnityPoint Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0670GC	West TN Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0720GC	Truman Med Ctr FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0744GC	Mercy FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0814GC	LCMC Health CY 2017 Understated Standardized Amount Predicate Fact CIRP Group
22-1213GC	UnityPoint Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
23-0456GC	Methodist Health System FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0607GC	UnityPoint Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0643GC	West TN Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0649GC	Mercy FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0868GC	Truman Med Ctr FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0952GC	Truman Med Ctr CYs 2018- 2019 Understated Standard. Amt. Predicate Fact CIRP Group

On September 13, 2023, the Medicare Contractor filed a challenge to the following sixty-seven (64) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-6):

18-1626GC Ascension Health CY 2016 Understated Standardized Amount Predicate Fact CIRP Group
18-1730GC Ascension Health CY 2015 Understated Standardized Amount Predicate Fact CIRP Group
19-0155GC Advocate Aurora Health CY 2014 Understated Standardized Amount CIRP Group
19-0213GC Edward-Elmhurst Health CY 2015 Understated Standard. Amt. Predicate Fact CIRP Group
19-0892GC Edward-Elmhurst Health FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
19-0967GC Aspirus Health System FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
19-0972GC Froedtert Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1097GC ProHealth Care FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1115G Hall Render FFY 2019 Understated Standardized Amount Predicate Fact Group IV
19-1242GC Advocate Aurora Health CY 2013 Understated Standardized Amount CIRP Group
19-1249GC Froedtert Health CY 2016 1983 Understated Standard. Amt. Predicate Fact CIRP Group
19-1264GC Advocate Aurora Health CY 2015 1983 Understated Standard. Amt. Pred. Fact CIRP Grp.
19-1460GC Advocate Aurora Health CY 2012 1983 Understated Standard. Amt. Pred. Fact CIRP Grp.
19-1505GC Rush FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1506GC Southern Illinois FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1664GC Ascension Health FFY 2019 Understated Standardized Amount CIRP Group
19-1705GC Advocate Aurora Health FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
19-2360GC Southern Illinois CY 2016 Understated Standardized Amount Predicate Fact CIRP Group
20-0091GC Edward-Elmhurst Health CY 2016 1983 Understated Standard. Amt. Pred. Fact CIRP Grp.
20-0428GC Southern Illinois CY 2017 1983 Understated Standard. Amt. Predicate Fact CIRP Group
20-0493GC Advocate Aurora Health CY 2016 1983 Understated Standard. Amt. Pred. Fact CIRP Group
20-0645GC Ascension Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0689GC Southern Illinois FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0714G Hall Render CY 2012- 2013 1983 Understated Standard. Amt. Predicate Fact Group II
20-0753GC Froedtert Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0859GC Edward-Elmhurst Health FFY 2020 1983 Understated Standardized Amount CIRP Group
20-0860GC Advocate Aurora Health FFY 2020 1983 Understated Standardized Amount CIRP Group
20-1044G Hall Render CY 2014 Understated Standardized Amount Predicate Fact II Group
20-1056GC Rush FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-1059GC ProHealth Care FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-1094GC Aspirus Health System FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
20-1756GC Ascension Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
20-1767GC Froedtert Health CY 2017 Understated Standardized Amount Predicate Fact CIRP Group
20-1858G Hall Render CY 2017 1983 Understated Standardized Amount Predicate Fact Group
20-1982GC Edward-Elmhurst Health CY 2017 Understated Standard. Amt. Predicate Fact CIRP Group
21-0485GC Northshore-Edward-Elmhurst Health FFY 2021 Understated Standard. Amt. Pred. Fact CIRP
21-0552GC Southern Illinois FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0556GC Rush FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0686GC ProHealth Care FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group

21-0689GC Froedtert Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0717GC Aspirus Health System FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0950GC Advocate Aurora Health FFY 2021 1983 Understated Standard. Amt. Pred. Fact CIRP Group
21-1154GC Southern Illinois CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
21-1325G Hall Render CY 2015 Understated Standardized Amount Predicate Fact Group
21-1706GC Advocate Aurora Health CY 2018 Understated Standard. Amt. Predicate Fact CIRP Group
22-0148GC Edward-Elmhurst Health CY 2018 Understated Standard. Amt. Predicate Fact CIRP Group
22-0269GC Southern Illinois CY 2019 Understated Standardized Amount Predicate Fact CIRP Group
22-0384GC Froedtert Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0403GC NorthShore-Edward-Elmhurst Health FFY2022 Understated Standard. Amt. Pred. Fact CIRP
22-0441GC Southern Illinois FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0510GC Rush FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0533GC Aspirus Health System FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0534GC ProHealth Care FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0563GC Advocate Aurora Health FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0723GC Froedtert Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
22-1433GC Froedtert Health CY 2019 Understated Standardized Amount Predicate Fact CIRP Group
23-0414GC NorthShore FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
23-0463GC Southern Illinois FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0490GC NorthShore EdwardElmhurst FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Grp
23-0493GC Aspirus Health System FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0494GC Froedtert Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0509GC ProHealth Care FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0736GC Rush FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0746GC Advocate Aurora Health FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group

On September 14, 2023, the Medicare Contractor filed a challenge to the following seven (6) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-K):

19-1482GC UMass Memorial Health FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
20-0197GC UMass Mem'l Health CYs 2015 – 2016 1983 Understated Standard. Amt. Pred. Fact CIRP
20-0937GC UMass Memorial Health FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
21-0621GC UMass Memorial Health FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
22-0621GC UMass Memorial Health FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
23-0642GC UMass Memorial Health FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group

On September 15, 2023, the Medicare Contractor filed a challenge to the following twenty-five (25) cases which all share a common lead Medicare Contractor, Palmetto GBA (J-J):

19-0984GC Huntsville Hosp. System FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
20-0195GC Huntsville Hosp. System CY 2016 1983 Understated Standard. Amt. Pred. Fact CIRP Group
20-0635GC Ballad Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0833GC West TN Health FFY 2020 1983 Understated Standardized Amount CIRP Group

20-0907GC Huntsville Hosp. System FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
20-1049GC Maury Reg'l Healthcare FFY 2020 1983 Understated Standard. Amt. Pred. Fact CIRP Grp.
20-1058GC RMC Health System FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
21-0127G Hall Render CY 2016 Understated Standardized Amount Predicate Fact Group
21-0446GC Huntsville Hosp. System FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0464GC Ballad Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0664GC Huntsville Hosp. System CY 2017 Understated Standard. Amt. Predicate Fact CIRP Group
21-0702GC RMC Health System FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0931GC East Alabama Health FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0946GC Maury Regional FFY 2021 1983 Understated Standard. Amt. Predicate Fact CIRP Group
21-1421GC RMC Health System CY 2017 Understated Standard. Amt. Predicate Fact CIRP Group
22-0381GC Ballad Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0469GC East Alabama Health FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0509GC Huntsville Hosp. System FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0564GC Maury Regional FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0699GC Huntsville Hosp. System CY 2018 Understated Standard. Amt. Predicate Fact CIRP Group
23-0443GC Ballad Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0445GC East Alabama Health FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0452GC Huntsville Hosp. System FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0594G Hall Render FFY 2023 Understated Standardized Amount Predicate Fact Group
23-0710GC Maury Regional FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-1195GC Huntsville Hosp. System CY 2019 Understated Standard. Amt. Predicate Fact CIRP Group

On September 19, 2023, the Medicare Contractor filed a challenge to the following fifty (50) cases which all share a common lead Medicare Contractor, Palmetto GBA c/o National Government Services, Inc. (J-M):

19-0281GC Prisma Health CY 2014 Understated Standardized Base Rate Predicate Fact CIRP Group
19-0282GC Prisma Health CY 2012 Understated Standardized Amount Predicate Fact CIRP Group
19-1131GC Vidant Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1205GC Prisma Health CY 2015 1983 Understated Standardized Amount Predicate Fact CIRP Group
19-1245GC Vidant Health CY 2015 1983 Understated Standardized Amount Predicate Fact CIRP Group
19-1276GC Prisma Health CY 2013 1983 Understated Standardized Amount Predicate Fact CIRP Group
19-1423GC Cabell Huntington FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1425GC Prisma Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1438GC Thomas Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-2509GC Thomas Health CY 2015 1983 Understated Standard. Amt. Predicate Fact CIRP Group
19-2585GC Roper St. Francis CY 2013 1983 Understated Standard. Amt. Predicate Fact CIRP Group
19-2589GC Roper St. Francis CY 2014 1983 Understated Standard. Amt. Predicate Fact CIRP Group
19-2698G Hall Render CY 2015 Understated Standardized Amount Predicate Fact Group
20-0013GC Roper St. Francis CY 2015 1983 Understated Standard. Amt. Predicate Fact CIRP Group
20-0918GC Prisma Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0933GC Thomas Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group

20-0959GC Roper St. Francis FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0960GC Vidant Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-1048GC Cabell Huntington FFY 2020 1983 Understated Standardized Amount CIRP Group
20-1269GC Cabell Huntington CY 2014 1983 Understated Standardized Amount Appeal CIRP Group
20-2079GC Cone Health CY 2015 1983 Understated Standardized Amount Predicate Fact CIRP Group
21-0345GC Thomas Health CY 2016 Understated Standardized Amount Predicate Fact CIRP Group
21-0480GC Cone Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0633GC Vidant Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0675GC Roper St. Francis FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0744GC Cone Health CY 2016 1983 Understated Standardized Amount Predicate Fact CIRP Group
21-0940GC Thomas Health FFY 2021 1983 Understated Standard. Amt. Predicate Fact CIRP Group
21-1006GC Cabell Huntington FFY 2021 1983 Understated Standard. Amt. Predicate Fact CIRP Group
21-1014GC Prisma Health FFY 2021 1983 Understated Standard. Amt. Predicate Fact CIRP Group
21-1440GC Vidant Health CY 2016 Understated Standardized Amount Predicate Fact CIRP Group
21-1476GC Prisma Health CY 2016 Understated Standardized Amount Predicate Fact CIRP Group
21-1512GC Roper St. Francis CY 2016 Understated Standardized Amount Predicate Fact CIRP Group
22-0232GC Prisma Health CY 2017 1983 Understated Standardized Amount Predicate Fact CIRP Group
22-0319GC Thomas Health CY 2017 Understated Standardized Amount Predicate Fact CIRP Group
22-0401GC Vidant Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0514GC Thomas Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0565GC Prisma Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0623GC Cone Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0688GC Roper St. Francis FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0715GC Cabell Huntington FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-1183GC Cone Health CY 2017 Understated Standardized Amount Predicate Fact CIRP Group
23-0339GC Thomas Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
23-0491GC Cone Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0547GC Thomas Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0655GC Prisma Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0662GC Mountain Health Network FFY 2023 Understated Standard. Amt. Pred. Fact CIRP Group
23-0744GC Vidant Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0781GC Roper St. Francis FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0913GC Cone Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
23-1056G Hall Render CY 2018 Understated Standardized Amount Predicate Fact Group

On October 11, 2023, the Medicare Contractor filed a challenge to the following fifty-seven (57) cases which all share a common lead Medicare Contractor, CGS Administrators, LLC (J-15):

18-1648GC Premier Health Partners CYs 2014-2015 Understated Standard. Amt. Pred. Fact CIRP Grp.
19-0030G Hall Render CY 2016 Understated Standardized Amount Predicate Fact Group
19-0274GC ARH (KY) CY 2016 Understated Standardized Base Rate Predicate Fact CIRP Group
19-0287G Hall Render CY 2014 Understated Standardized Amount Predicate Fact Group

19-0585GC Baptist Healthcare CY 2016 Understated Standardized Amount Predicate Fact CIRP
19-0586GC ARH (KY) FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-0616GC Premier Health Partners CY 2016 1983 Understated Standard. Amt. Pred. Fact CIRP Group
19-0666GC St. Elizabeth Healthcare CY 2016 Understated Standard. Amt. Predicate Fact CIRP Group
19-1067GC St. Elizabeth Healthcare FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
19-1069GC Premier Health Partners FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
19-1072GC St. Elizabeth Healthcare CY 2015 Understated Standard. Amt. Predicate Fact CIRP Group
19-1129G Hall Render CY 2010-2011 1983 Understated Standardized Amount Predicate Fact Group
19-1426GC Baptist Healthcare KY FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
19-1488GC TriHealth FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1804G Hall Render FFY 2019 Understated Standardized Amount Predicate Fact III Group
19-2551GC Baptist Healthcare KY CY 2017 1983 Understated Standard. Amt. Pred. Fact CIRP Group
19-2733GC ARH (KY) CY 2017 1983 Understated Standardized Amount Predicate Fact CIRP Group
20-0761GC Premier Health Partners FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
20-0762GC St. Elizabeth Healthcare FFY 2020 1983 Understated Standardized Amount CIRP Group
20-0889GC TriHealth FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0919GC ARH (KY) FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-1096G Hall Render FFY 2020 1983 Understated Standardized Amount II Group
20-1583GC St. Elizabeth Healthcare CY 2017 1983 Understated Standardized Amount CIRP Group
20-1744GC Premier Health Partners CY 2017 Understated Standard. Amt. Predicate Fact CIRP Group
21-0126G Hall Render CY 2018 Understated Standardized Amount Predicate Fact Group
21-0166GC St. Elizabeth Healthcare CY 2018 1983 Understated Standard. Amt. Pred. Fact CIRP Group
21-0619GC St. Elizabeth Healthcare FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0629GC Baptist Healthcare KY FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0640GC Premier Health Partners FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0739GC Aultman Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0816G Hall Render FFY 2021 Understated Standardized Amount Predicate Fact Group II
21-0938GC TriHealth FFY 2021 1983 Understated Standardized Amount Predicate Fact CIRP Group
21-1008GC ARH (KY) FFY 2021 1983 Understated Standardized Amount Predicate Fact CIRP Group
21-1009G Hall Render FFY 2021 1983 Understated Standardized Amount Predicate Fact Group III
21-1283GC Baptist Healthcare KY CY 2018 Understated Standard. Amt. Predicate Fact CIRP Group
21-1624G Hall Render CY 2017 Understated Standardized Amount Predicate Fact Group
22-0152GC Premier Health Partners CY 2018 Understated Standard. Amt. Predicate Fact CIRP Group
22-0370GC Aultman Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0386GC St. Elizabeth Healthcare FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0387GC TriHealth FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0399GC Premier Health Partners FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0405GC ARH (KY) FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0454G Hall Render FFY 2022 Understated Standardized Amount Predicate Fact Group I
22-0622GC Baptist Healthcare KY FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0630G Hall Render CY 2018 Understated Standardized Amount Predicate Fact Group

22-0685G	Hall Render FFY 2022 Understated Standardized Amount Predicate Fact Group II
22-1141GC	Baptist Healthcare KY CY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
22-1288GC	Aultman Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
22-1510GC	Baptist Healthcare KY CY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
23-0387G	Hall Render CY 2019 Understated Standardized Amount Predicate Fact Group
23-0430GC	Aultman Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0444GC	Baptist Healthcare KY FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0464GC	St. Elizabeth Healthcare FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0508GC	Premier Health Partners FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0684GC	TriHealth CY 2019 Understated Standardized Amount Predicate Fact CIRP Group
23-0754G	Hall Render FFY 2023 Understated Standardized Amount Predicate Fact Group
23-0879GC	ARH (KY) FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group

On October 31, 2023, the Medicare Contractor filed a challenge to the following seventy (70) cases which all share a common lead Medicare Contractor, Novitas Solutions, Inc. (J-H):

18-1691G	Hall Render CY 2015 Understated Standardized Amount Predicate Fact Group II
18-1696GC	Ascension Health CY 2012 Understated Standardized Amount Predicate Fact CIRP Group
18-1772GC	Ascension CY 2011 Understated Standardized Amount Predicate Fact CIRP Group
18-1775GC	Ascension Health CY 2013 Understated Standardized Amount Predicate Fact CIRP Group
19-0025GC	Baptist Health – Arkansas CY 2014 Understated Standard. Amt. Predicate Fact CIRP Group
19-0031GC	Ascension Health CY 2014 Understated Standardized Amount Predicate Fact CIRP Group
19-0232GC	North Mississippi Health CY 2014 Understated Standard. Amt. Predicate Fact CIRP Group
19-0240GC	Forrest Health CY 2015 Understated Standardized Amount Predicate Fact CIRP Group
19-0411G	Hall Render CY 2013 Understated Standardized Amount Predicate Fact Group
19-0414GC	Integris Health CY 2009 Understated Standardized Amount Predicate Fact CIRP Group
19-0494GC	North Mississippi Health CY 2015 Understated Standard. Amt. Predicate Fact CIRP Group
19-0576GC	Univ of Colorado Health CY 2015 1983 Understated Standard. Amt. Pred. Fact CIRP Group
19-0612GC	Univ of Colorado Health CY 2016 1983 Understated Standard. Amt. Pred. Fact CIRP Group
19-0974GC	Baptist Health – Arkansas FFY 2019 Understated Standard. Amt. Pred. Fact CIRP Group
19-0988GC	Mercy Health CY 2016 1983 Understated Standardized Amount Predicate Fact CIRP Group
19-1010GC	Integris Health FFY 2019 Understated Standardized Amount Pred. Fact CIRP Group
19-1012GC	North Mississippi Health FFY 2019 Understated Standard. Amt. Pred. Fact CIRP Group
19-1093GC	Integris Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1163GC	LCMC Health FFY 2019 Understated Standardized Amount Pred. Fact CIRP Group
19-1279GC	Baptist Health – Arkansas CY 2015 1983 Understated Standard. Amt. Pred. Fact CIRP Grp.
19-1459GC	Univ of Colorado Health FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
19-1532GC	LCMC Health CY 2015 1983 Understated Standardized Amount Predicate Fact CIRP Group
19-1538GC	North Mississippi Health CY 2016 1983 Understated Standard. Amt. Pred. Fact CIRP Group
19-1737G	Hall Render FFY 2019 Understated Standardized Amount Predicate Fact II Group
20-0359GC	Baptist Health – Arkansas CY 2016 1983 Understated Standard. Amt. Pred. Fact CIRP Grp.
20-0429GC	Integris Health CY 2010 1983 Understated Standard. Amt. Predicate Fact CIRP Group

20-0699GC Integris Health CY 2017 1983 Understated Standard. Amt. Predicate Fact CIRP Group
20-0767GC North Mississippi Health FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
20-0862GC Univ of Colorado Health FFY 2020 1983 Understated Standardized Amount CIRP Group
20-0882GC LCMC Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0886GC Baptist Health - Arkansas FFY 2020 Understated Standard. Amt. Pred. Fact CIRP Group
20-1043GC St. Bernards Healthcare FFY 2020 1983 Understated Standardized Amount CIRP Group
20-1061GC Integris Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-1127G Hall Render FFY 2020 1983 Understated Standardized Amount Predicate Fact Group III
20-1420GC North Mississippi Health CY 2017 1983 Understated Standardized Amount CIRP Group
20-1769GC Integris Health CY 2012 Understated Standardized Amount Predicate Fact CIRP Group
20-1770GC Integris Health CY 2015 Understated Standardized Amount Predicate Fact CIRP Group
20-2028GC Good Shepherd Health CY 2016 1983 Understated Standard. Amt. Pred. Fact CIRP Group
21-0467GC Baptist Health - Arkansas FFY 2021 Understated Standard. Amt. Pred. Fact CIRP Group
21-0489GC Integris Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0494GC LCMC Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0537GC St. Bernards Healthcare FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0551GC Integris Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
21-0628GC Univ of Colorado Health FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0957GC North Mississippi Health FFY 2021 1983 Understated Standard. Amt. Pred. Fact CIRP Grp.
21-1027GC Forrest Health CY 2016 1983 Understated Standardized Amount Predicate Fact CIRP Group
21-1152GC Integris Health CY 2011 Understated Standardized Amount Predicate Fact CIRP Group
21-1161GC Forrest Health CYs 2017-2018 Understated Standard. Amt. Predicate Fact CIRP Group
21-1286GC Mercy CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
21-1459GC Baptist Health - Arkansas CY 2017 Understated Standard. Amt. Predicate Fact CIRP Group
21-1507GC Univ of Colorado Health CY 2017 Understated Standard. Amt. Predicate Fact CIRP Group
22-0227GC Baptist Health - Arkansas CY 2018 1983 Understated Standard. Amt. Pred. Fact CIRP Grp.
22-0325GC Univ of Colorado Health CY 2018 Understated Standard. Amt. Predicate Fact CIRP Group
22-0379GC Baptist Health - Arkansas FFY 2022 Understated Standard. Amt. Pred. Fact CIRP Group
22-0443GC Integris Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0508GC North Mississippi Health FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0512GC LCMC Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0532GC St. Bernards Healthcare FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0640GC UCHealth FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0713G Hall Render FFY 2022 Understated Standardized Amount Predicate Fact Group III
22-1471GC Integris Health CY 2019 Understated Standardized Amount Predicate Fact CIRP Group
23-0178GC Univ of Colorado Health CY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
23-0210GC LCMC Health CYs 2015-2016 Understated Standard. Amt. Predicate Fact CIRP Group
23-0450GC Integris Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0454GC St. Bernards Healthcare FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0492GC Baptist Health - Arkansas FFY 2023 Understated Standard. Amt. Pred. Fact CIRP Group
23-0702GC Univ of Colorado Health FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group

23-0709GC North Mississippi Health FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0882GC LCMC Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0912GC North Mississippi Health CY 2018 Understated Standard. Amt. Predicate Fact CIRP Group
24-0057GC Univ of Colorado Health CY 2020 Understated Standard. Amt. Predicate Fact CIRP Group

On December 13 and 14, 2023, the Medicare Contractor filed a challenge to the following fifty-four (54) cases which all share a common lead Medicare Contractor, Novitas Solutions, Inc. (J-H):

18-1673GC Penn Medicine CY 2015 Understated Standardized Amount Predicate Fact CIRP Group
19-0169GC UPMC CY 2016 Understate Standardized Amount Predicate Fact CIRP Group
19-0171GC UPMC CY 2015 Understated Standardized Amount Predicate Fact CIRP Group
19-0493GC Einstein Healthcare Netwo CY 2016 Understated Standard. Amt. Predicate Fact CIRP Grp.
19-0587GC Bayhealth FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-0889GC Einstein Healthcare FFY 2019 Understated Standardized Amount Predicate Fact CIRP Grp.
19-0968GC Forrest Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1009GC Lehigh Valley Health CY 2016 1983 Understated Standard. Amt. Predicate Fact CIRP Grp.
19-1020GC Lehigh Valley Health FFY 2019 Understated Standardized Amt. Pred. Fact CIRP Group
19-1066GC Univ. of PA Health System FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Grp.
19-1437GC Temple Univ Health FFY 2017 & FFY 2019 Understated Standard. Amt. Pred. Fact CIRP Gp.
19-1440GC Penn State Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1713GC UPMC FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1869GC Einstein Healthcare CY 2017 1983 Understated Standard. Amt. Predicate Fact CIRP Grp.
19-2463GC UPMC CY 2017 1983 Understated Standardized Amount Predicate Fact CIRP Group
19-2699GC Univ. of PA Health System CY 2016 1983 Understated Standard. Amt. Pred. Fact CIRP Grp
20-0638GC Lehigh Valley Health FFY 2020 1983 Understated Standardized Amount CIRP Group
20-0657GC Penn State Health FFY 2020 Understated Standardized Amount CIRP Group
20-0716GC Bayhealth FFY 2020 1983 Understated Standardized Amount CIRP Group
20-0743GC Einstein Healthcare FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
20-0754GC Univ. of PA Health System FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Grp
20-0858GC Temple Univ Health FFY 2020 1983 Understated Standardized Amount CIRP Group
20-0929GC UPMC FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-1349GC Einstein Healthcare CY 2018 1983 Understated Standardized Amount CIRP Group
20-1785GC Lehigh Valley Health CY 2017 Understated Standard. Amt. Predicate Fact CIRP Grp
20-1838GC Lehigh Valley Health CY 2011 Understated Standard. Amt. Predicate Fact CIRP Grp
20-1949GC UPMC CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
20-2043GC Lehigh Valley Health CY 2018 1983 Understated Standard. Amt. Pred. Fact CIRP Group
21-0469GC Bayhealth FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0632GC Univ. of PA Health System FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-0665GC Einstein Healthcare FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0685GC UPMC FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group

21-0740GC Penn State Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-1112GC Atlantic Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-1147GC Univ. of PA Health System CY 2017 Understated Standard. Amt. Predicate Fact CIRP Group
21-1160GC Univ. of PA Health System CY 2018 Understated Standard. Amt. Predicate Fact CIRP Group
21-1458GC Univ. of PA Health System CY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
22-0400GC UPMC FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0413GC Einstein Healthcare FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0442GC Lehigh Valley Health FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0444GC Univ. of PA Health System FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
22-0466GC Penn State Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0625GC Bayhealth FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0674GC Atlantic Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
23-0065GC UPMC CY 2019 Understated Standardized Amount Predicate Fact CIRP Group
23-0149GC Penn State Health CY 2019 Understated Standardized Amount Predicate Fact CIRP Group
23-0505GC Univ. of PA Health System FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-0507GC Penn State Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0561GC Lehigh Valley Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0604GC Atlantic Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0605GC Bayhealth FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0651GC UPMC FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0742GC Einstein Healthcare FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
21-0496GC Lehigh Valley Health FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group

On January 31, February 2, and March 4, 2024, the Medicare Contractor filed a challenge to the following three (3) cases which all share a common lead Medicare Contractor, Palmetto GBA (L-L):

19-0290GC Ballad Health CY 2015 1983 Understated Standard. Amt. Predicate Fact CIRP Group
20-0253GC Ballad Health CY 2017 1983 Understated Standard. Amt. Predicate Fact CIRP Group
20-0012GC Ballad Health CY 2016 1983 Understated Standard. Amt. Predicate Fact CIRP Group

On April 11, 2024 the Medicare Contractor filed a challenge to the following thirty-five (35) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions (J-F):

18-1630GC Sanford Health CY 2015 Understated Standard. Amt. Predicate Fact CIRP CIRP Group
19-0404GC Sanford Health CY 2016 1983 Understated Standard. Amt. Predicate Fact CIRP Group
19-0610GC Asante Health System CYs 2015-2016 1983 Understated Standard. Amt. Pred. Fact CIRP
19-0962GC Asante Health System FFY 2019 Understated Standard. Amt. Predicate Fact CIRP Group
19-1068GC Avera Health CY 2016 1983 Understated Standardized Amount Predicate Fact CIRP Grp.
19-1424GC Sanford Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Grp.
19-1610GC Avera Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group

19-1680GC	PeaceHealth FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-2614GC	PeaceHealth CY 2016 1983 Understated Standardized Amount Predicate Fact CIRP Group
20-0687GC	Avera Health CY 2017 1983 Understated Standardized Amount Predicate Fact CIRP Grp.
20-0735GC	Sanford Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0760GC	PeaceHealth FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
20-0808GC	Avera Health FFY 2020 1983 Understated Standardized Amount CIRP Group
20-0932GC	Asante Health System FFY 2020 Understated Standard. Amt. Predicate Fact CIRP Group
21-0533GC	Avera Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0639GC	Sanford Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0642GC	PeaceHealth FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-0763GC	Asante Health System FFY 2021 Understated Standard. Amt. Predicate Fact CIRP Group
21-1529GC	Sanford Health CY 2017 Understated Standardized Amount Predicate Fact CIRP Group
22-0411GC	Sanford Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0513GC	PeaceHealth FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0541GC	Avera Health FFY 2022 Understated Standardized Amount Predicate Fact CIRP Group
22-0542GC	Asante Health System FFY 2022 Understated Standard. Amt. Predicate Fact CIRP Group
23-0068GC	Sanford Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
23-0260GC	PeaceHealth CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
23-0496GC	PeaceHealth FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0510GC	Sanford Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0574GC	Avera Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
23-0613GC	Asante Health System FFY 2023 Understated Standard. Amt. Predicate Fact CIRP Group
23-1760GC	PeaceHealth CY 2019 Understated Standardized Amount Predicate Fact CIRP Group
23-1793GC	Asante Health CYs 2017-2018 Understated Standard. Amt. Predicate Fact CIRP Group
24-1234GC	Sanford Health FFY 2024 Understated Standardized Amount Predicate Fact CIRP Group
24-1245GC	Avera Health FFY 2024 Understated Standardized Amount Predicate Fact CIRP Group
24-1327GC	Asante Health System FFY 2024 Understated Standard. Amt. Predicate Fact CIRP Group
24-1356GC	PeaceHealth FFY 2024 Understated Standardized Amount Predicate Fact CIRP Group

On April 25, 2024 the Medicare Contractor filed a challenge to the following six (6) cases which all share a common lead Medicare Contractor, Novitas Solutions, Inc. c/o GuideWell Source (J-H):

24-0998GC	Integris Health FFY 2024 Understated Standardized Amount Predicate Fact CIRP Group
24-1010GC	Baptist Health - Arkansas CY 2019 Understated Standard. Amt. Pred. Fact CIRP Group
24-1329GC	Baptist Health - Arkansas FFY 2024 Understated Standard. Amt. Pred. Fact CIRP Group
24-1393GC	LCMC Health FFY 2024 Understated Standardized Amount Predicate Fact CIRP Group
24-1441GC	Univ of Colorado Health FFY 2024 Understated Standard. Amt. Predicate Fact CIRP Grp.
24-1481GC	North Mississippi Health FFY 2024 Understated Standard. Amt. Predicate Fact CIRP Grp.

On May 16, and July 12, 2024 the Medicare Contractor filed a challenge to the following eleven (11) cases which all share a common lead Medicare Contractor, Palmetto GBA (J-J):

19-0623G	Hall Render CY 2012 1983 Understated Standardized Amount Predicate Fact Group
19-0745GC	Huntsville Hospital Syste CY 2015 1983 Understated Standard. Amt. Pred. Fact CIRP Grp.
19-0904GC	Ballad Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-1096GC	RMC Health System FFY 2019 Understated Standardized Amount Pred. Fact CIRP Group
19-1169GC	Huntsville Hosp. System CY 2014 Understated Standardized Amount Pred. Fact CIRP Grp.
19-1491GC	West TN Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
23-0914G	Hall Render CY 2018 Understated Standardized Amount Predicate Fact Group
24-0996GC	Huntsville Hosp. System FFY 2024 Understated Standardized Amount Pred. Fact CIRP Grp.
24-1307GC	Ballad Health FFY 2024 Understated Standardized Amount Predicate Fact CIRP Group
24-1358GC	Maury Regional FFY 2024 Understated Standardized Amount Predicate Fact CIRP Group
20-0636GC	Ballad Health CY 2018 1983 Understated Standardized Amount Predicate Fact CIRP Group

On June 4, 2024 the Medicare Contractor filed a challenge to the following ten (10) cases which all share a common lead Medicare Contractor, First Coast Service Options, Inc. c/o GuideWell Source (J-N):

19-1011GC	Broward Health CY 2016 1983 Understated Standard. Amt. Predicate Fact CIRP Group
19-1455GC	Broward Health FFY 2019 Understated Standardized Amount Predicate Fact CIRP Group
19-2172GC	Broward Health CY 2017 1983 Understated Standard. Amt. Predicate Fact CIRP Group
20-0734GC	Broward Health FFY 2020 Understated Standardized Amount Predicate Fact CIRP Group
21-0476GC	Broward Health FFY 2021 Understated Standardized Amount Predicate Fact CIRP Group
21-1616GC	Ascension Health CY 2019 Understated Standardized Amount Predicate Fact CIRP Group
22-0445GC	Broward Health FFY 2022 1983 Understated Standardized Amount CIRP Group
22-0647GC	Broward Health CY 2018 Understated Standardized Amount Predicate Fact CIRP Group
23-0572GC	Broward Health FFY 2023 Understated Standardized Amount Predicate Fact CIRP Group
24-1290GC	Broward Health FFY 2024 Understated Standardized Amount Predicate Fact CIRP Group

APPENDIX B
Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue

Set forth below are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments ("BNAs") and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). These other example raise questions about the causal link between the standardized amount rates at issue and the initial standardize amounts set for FFY 1984. Curiously, the Providers stopped their analysis at 1986 and did not carry forward their analysis for years 1987 through the particular year at issue (*e.g.*, for the lead case under Case No. 18-1646G, there are an additional 28 intervening years since the standardize amount issue is the FFY 2015 standard amount rate).

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[79] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[80]

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[79] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[80] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.

c. BNAs made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[81]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[82] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[83]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[84]

> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

[81] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[82] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 24.

[83] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[84] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[85] and 1997[86] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[87]

To illustrate the complex nature of these issues, the Board Majority points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[88] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[89] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous*

[85] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[86] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[87] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[88] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[89] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have***

***been demonstrated to be overstated**, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[90]

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(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[90] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[91] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[92] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[93]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[94] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[95] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

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[91] *Id.* at 35703-04 (bold and underline emphasis added).
[92] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[93] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[94] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[95] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as* ***now*** *proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C
Additional Excerpts from FFY 1985 IPPS Final Rule
Affirming Application of FFY 1985 budget-neutrality-adjusted rates to
FFY 1986 and subsequent years.

In its decision, the Board Majority has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 BNA accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[96]

[96] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). The Board Majority notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 BNA accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her BNAs for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 BNA to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[97]

[97] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
20-0756GC *et al* (30 cases) (*See* Appendix A)

Dear Mr. Vernon:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' consolidated request for expedited judicial review ("EJR") filed on August 28, 2024, in the thirty (30) above-referenced group appeals. The Board's decision on jurisdiction and EJR for the thirty (30) above-referenced group appeals is set forth below.

Issue:

The issue for which EJR has been requested is:

> [W]hether the Providers' FFY 2020 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.2016% for FFY 2020.[1]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[2] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals

[1] Consolidated request for Expedited Judicial Review at 3 (Aug. 28, 2024).
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[3] The standardized amount is 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 from the cost data the effects of 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. 27708, 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

located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[6]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[7]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[8] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[9] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[10] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by

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labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[4] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[5] of the Department of Health and Human Services.
[6] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited Sept. 27, 2024).
[7] 42 U.S.C. § 1395ww(d)(3)(E).
[8] 83 Fed. Reg. 20164 (May 7, 2018).
[9] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[10] *Id.* at 19162.

"reduc[ing] the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values for budget neutrality purposes, as well as changing the calculation of the rural floor . . . ."[11]

In the FY 2020 IPPS final rule, the Secretary summarized his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure." Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[12]

In the FFY 2020 IPPS Final Rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals, as proposed without modification. Based on the data for this final rule, for FY 2020, the 25th percentile wage index value across all hospitals is 0.8457."[13] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is then a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[14]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our

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[11] *Id.*
[12] 84 Fed. Reg. at 42326 (citations omitted).
[13] *Id.* at 42328.
[14] *Id.* at 42326.

approach is consistent with approaches used in other areas of the Medicare program."[15] The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[16] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[17]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[18] The Secretary also confirmed that he was "finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner" and asserted that his authority to do so "falls within the scope of the authority of section 1886(d)(3)(E) of the Act" and "even if [budget neutrality] were not required [under section 1886(d)(3)(E)], we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending."[19]

The Secretary announced that the low wage index policy would be *in effect* ***for at least*** *four years beginning in FFY 2020*, "in order to allow employee compensation increases implemented by [low wage index value hospitals] sufficient time to be reflected in the wage index calculation."[20] The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and "four years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index data."[21] The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[22]

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that "while it would not be appropriate to create a wage index floor or a wage index ceiling", it would be appropriate to "provide a mechanism to increase the wage index of low wage index hospitals . . . while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals."[23] The Secretary maintained that this action had two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the

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[15] *Id.*
[16] *Id.*
[17] *Id.* at 42328.
[18] *Id.*
[19] *Id.* at 42331.
[20] *Id.* at 42326.
[21] *Id.* at 42326-7.
[22] *Id.* at 42327.
[23] 84 Fed. Reg. at 42329.

impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage index is not considered high or low, do not have their wage index values affected by this proposed policy."[24] Thus, the Secretary concluded that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . . it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[25]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[26] Based on this feedback, the Secretary decided to "finaliz[e] a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) "budget neutrality is required under [§ 1395ww(d)(3)(E)];" (2) "even if it were not required, [he believes that] it would be inappropriate to use the wage index to increase or decrease overall IPPS spending;" and (3) he "wish[ed] to consider further the policy arguments raised by commenters regarding [the] budget neutrality proposal."[27] Specifically, "consistent with [the Secretary's] current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in [the] rule, [was] implemented in a budget neutral manner."[28]

The Secretary has continued the low wage index hospital policy in the following four years, for FFYs 2021 to 2024, and continued to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[29]

Providers' Position:

The Providers are challenging their IPPS payments for FFY 2020 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.[30]

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[24] *Id*.
[25] *Id.*
[26] *Id.* at 42331.
[27] *Id*.
[28] *Id*.
[29] 85 Fed. Reg. at 58436 (Sept. 18, 2020); 86 Fed. Reg. at 44778 (Aug. 13, 2021); 87 Fed. Reg. at 49006 (Aug. 10, 2022); 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[30] Consolidated Request for EJR at 1 (Aug. 28, 2024).

The Providers explain that the Secretary has implemented a policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") beginning in FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that the Low Wage Index Redistribution increases the AWI values of hospitals with AWI values in the lowest quartile, nationally, by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values.[31]

The Providers note that in the FFY 2020 IPPS Final Rule, the Secretary asserted that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E). This section of the statute (42 U.S.C. § 1395ww(d)(3)(E)(i)) authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) "reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." The Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States."[32]

The Providers contend that the Secretary "decided to institute its new Low Wage Index [Redistribution] in a budget neutral manner" for FFY 2020. As a result, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.2016% to offset the AWI increases to those hospitals in the lowest AWI quartile.[33]

The Providers point out that the Secretary asserted that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E), however, he noted that even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke his statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment.[34] This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." The Providers contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).[35]

The Providers argue that the Secretary lacks the "authority to (a) establish the Low Wage Index [Redistribution] in the manner set forth in the FFY 2020 Final IPPS Rule; and (b) implement such policy in a budget neutral manner under the [AWI] statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, [the Providers] are challenging the adjustment to the standardized amount on [several] grounds, including, but not limited to, that it: exceeds statutory authority, contradicts the [AWI] congressional mandate, was developed in an arbitrary

[31] *Id.* at 3.
[32] 42 U.S.C. § 1395ww(d)(3)(E)(i).
[33] Consolidated Request for EJR at 4.
[34] *Id.*
[35] *Id.*

and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively."[36]

The Providers note that "[t]he initial detrimental effect will be a 0.2016% negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2020 for every IPPS hospital, resulting in a reduction in overall MS-DRG IPPS payments for all IPPS hospitals, including the [Providers]."[37]

The Providers summarize their request as follows:

> Based on the foregoing, the [Providers] are challenging the Low Wage Index [Redistribution] in this group appeal for several reasons, including but not limited to, whether [the Secretary] (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I)(i); and (2) improperly reduced FFY 2020 payments to IPPS hospitals, including the [Providers], as a result of the budget neutral implementation of the Low Wage Index [Redistribution], effective October 1, 2019. The [Providers] seek their proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).[38]

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, but the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.2016% reduction issued by the Secretary in the FFY 2020 IPPS Final Rule.[39]

Medicare Contractor's Position:

Following receipt of the Consolidated Request for EJR on August 28, 2024, the Medicare Contractor's representative, Federal Specialized Services ("FSS") filed a notice on September 5, 2024 certifying that that it would be filing Substantive Claim Challenges in twenty-nine (29) of the cases in the Consolidated Request for EJR.[40]

In Cases 20-0849GC and 20-0851GC, Substantive Claim Challenges were filed on July 3 and July 20, 2023, respectively, prior to the Consolidated Request for EJR.

In Cases 20-0826GC and 20-0845GC, individual Substantive Claim Challenges were filed on September 17, 2024.

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[36] *Id.*
[37] *Id.*
[38] *Id.* at 5.
[39] *Id.* at 6-8.
[40] FSS EJR Response at 1-2 (Sept. 5, 2024).

In the remaining twenty-five (25) cases, a Consolidated Substantive Claim Challenge was filed on September 17, 2024.

In Case 20-0787GC, there has been no substantive claim or jurisdictional challenge filed.[41]

Substantive Claim Challenges:

A. Medicare Contractor's Challenges

As detailed below, Substantive Claim Challenges have been filed in twenty-nine (29) cases. FSS notes throughout the Substantive Claim Challenges that the FFY 2020 overlaps with portions of two or three separate cost reporting periods for most the Providers.[42] The Arguments raised in all of the Substantive Claim Challenges are materially identical. The specific Participants and FYEs being challenged in each case (the "Challenged Participants") are set forth in Appendix B to this decision. The Medicare Contractor generally notes that the appeals were taken from the Federal Register, but that on the impacted cost reports, each Challenged Participant failed to submit any documentation to support they claimed reimbursement for the appealed issue. It also notes that, while the Challenged Participants may have filed their cost reports identifying certain amounts as Part A Protested amounts, "A review of the Provider's supporting workpapers shows that the Provider did not establish a self-disallowed item for the [AWI] Lowest Quartile IPPS Payment Reduction. Accordingly, there is nothing in the record to demonstrate that the Provider properly established a self-disallowed item for the [AWI] Lowest Quartile IPP[S] Payment Reduction in its FYE 12/31/2019 cost report as described at 42 C.F.R. § 413.24(j)(2)."[43]

B. Providers' Responses to Substantive Claim Challenges

The Providers filed responses to the Substantive Claim Challenges on the following dates:

- Case 20-0849GC: August 1, 2023
- Case 20-0851GC: August 11, 2023
- All remaining cases; September 19, 2024

The responses are all materially identical, except where noted in the Board's discussion, below. In fact, in response to the Consolidated Substantive Claim Challenge covering twenty-five (25) cases, each individual response is preceded by a "Consolidated Executive Summary" which specifically states:

> The purpose of this Consolidated Executive Summary letter is to notify the PRRB that these separate Responses <u>are materially identical in terms of the Hospitals' arguments in opposition to the FSS SCLs</u>. The <u>only</u>

[41] *See* Appendix A for a listing of cases in the Consolidated EJR Request.
[42] PRRB Case 20-0849GC, Substantive Claim Letter, 1-2 (July 3, 2023).
[43] *E.g.*, *id.* at 6 (citing Ex. C-3).

> variations in the Responses are factual matters involving certain Hospitals' unique cost-report information and documentation.[44]

First, they argue that the Board should not consider the Substantive Claim Challenges because they were untimely. Citing Board Rule 44.5.2, the Providers note that the challenges were filed more than 60 days after the Providers certified that the respective groups were complete pursuant to Board Rule 20, and also more than 60 days after the Board resumed normal operations following the issuance of Board Alert 3.[45]

Second, the Providers also argue that the substantive claim requirement at 42 C.F.R. § 413.24(j) is substantively and procedurally invalid pursuant to the holdings in *Bethesda Hospital Ass'n. v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*") and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) ("*Banner Heart Hospital*").[46]

Third, the Providers note they have exercised their statutory right to appeal from a Federal Register publication, namely the FFY 2020 IPPS Final Rule, which was published on August 16, 2019. Thus, their appeals from this final determination were due by mid-February, 2020, while the first cost reports for the Providers in this appeal were not due until after that date. For this reason, "it would have been factually impossible for the Hospitals to have protested the Group issue in any cost reports for their FYEs applicable to this Group Appeal before filing the Group Appeal."[47] They also claim that by filing the group appeal, the Providers gave notice that they were all protesting their IPPS payments based on the reasons set forth in the appeal.[48]

The Providers also argue that a challenge to the policy being appealed is not a "specific item" of reimbursement that could be claimed because it arises from IPPS claims and cuts across all IPPS payments. They also believe that all of the participants in this appeal satisfied the substantive claim requirements by submitting claims on their cost reports for all operating IPPS payments, that their cost report claims sought reimbursement for all amounts due under the law, and that the AWI payment reduction issue seeks payment of amounts that would have been paid if the law had been properly applied.[49] Similarly, the Providers believe it is unreasonable to require cost-reporting protests on the AWI Payment Reduction Issue because "the Secretary has long been aware of the AWI Payment Reduction Issue, because it was presented more than two years ago in the *Bridgeport* and *Kaweah Delta* Board appeals and federal court litigation, and in subsequent board appeals every year since."[50]

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[44] *E.g.*, PRRB Case 20-0756GC, Consolidated Executive Summary for Providers' Responses to FSS' September 17, 2024 (1) Consolidated Substantive Claim Letter; (2) 20-0826GC, Prospect FFY 2020 AWI Group, Substantive Claim Letter; and (3) 20-0854GC, Providence Health FFY 2020 AWI Group, Substantive Claim Letter; *EJR Request Pending*, 2 (Sept. 19, 2024) (emphasis in original).
[45] *E.g.*, PRRB Case 20-0849GC, Provider's Response to MAC's July 3, 2023 Substantive Claim Letter, at 2 (Aug. 1, 2023).
[46] *Id.*
[47] *Id.* at 1-2 & n.2.
[48] *Id.* at 3.
[49] *Id.*
[50] *Id.* at 14.

For the vast majority of the Challenged Participants[51] the Providers concede that, with the "MAC is correct that the [challenged] Hospitals did not explicitly repeat their protest of the AWI Payment Reduction Issue on the identified as-filed Medicare cost reports."[52] Arguments related to specific Challenged Participants for which the Providers argue that they *did* comply with the substantive claim requirements are outlined, below.

Decision of the Board:

A. Jurisdiction and Request for EJR

Each of the participants in these thirty (30) group cases appealed from the FFY 2020 IPPS Final Rule.[53] The Board has determined that: (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[54] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy ("AiC") calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.2016 percent (*i.e.,* the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j) are applicable. The regulation 42 C.F.R. § 413.24(j) requires that:

> (1) *General Requirement*. 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—

[51] *See* Appendix B.
[52] *E.g.*, PRRB Case 20-0849GC, Provider's Response to MAC's July 3, 2023 Substantive Claim Letter at 5.
[53] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*), rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[54] *See* 42 C.F.R. § 405.1837.

> (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
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> (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.
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> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
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> (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
>
> (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.[55]

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.
> (b) *Summary of Procedures*.
>
> ****
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny,**

[55] (Bold and underline emphasis added.)

> **or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ****
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ****
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section*—(1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[56]

These regulations are applicable to the cost reporting periods in these group cases.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

a. Case 20-0787GC

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[57] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[58] may not be invoked or relied on by the Board to decline

[56] (Bold and underline emphasis added.)
[57] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[58] (Emphasis added.)

jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included *if review under subsection (b)(1) has been triggered by a party raising a question under subsection (a) of whether a provider made an appropriate claim for the specific item under appeal on the relevant as-filed cost report*.

Accordingly, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[59] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made on the relevant as-filed cost report.[60] The Board further notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[61] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on the Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these type of instances, any Substantive Claim Challenge would be premature. That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position.

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[59] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[60] *See* 42 C.F.R. § 405.1873(a),
[61] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

Here, for Case 20-0787GC, while FSS indicated that it would be filing a Substantive Claim Challenge, it failed to do so within the time required by the Board's Rules. In this regard, all of the participants in Case 20-0787GC are appealing the FFY 2020 Federal Register Notice and FSS has not challenged whether the as-filed cost reports included an appropriate claim for the appealed issue. Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings of fact on substantive claim requirements in the Unchallenged Cases for any of the participants.

b. Challenged Cases and Challenged Participants

As previously noted, for the vast majority of the Challenged Participants, the Providers concede that the "MAC is correct that the [challenged] Hospitals did not explicitly repeat their protest of the AWI Payment Reduction Issue on the identified as-filed Medicare cost reports."[62] Except as noted below, the Board specifically finds that it is undisputed that the Challenged Participants failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1).

In responding to the challenges, the Providers first argue that all the Substantive Claim Challenges filed by FSS should be disregarded because they are not timely. Board Rule 44.5.2 (2021) generally requires Substantive Claim Challenges be filed within sixty (60) days after the group files its final Schedule of Providers ("SOP") unless the moving party's filing demonstrates good cause. But in all twenty-nine (29) of the Challenged Cases, the Final Schedule of Providers was received by the Board on August 4, 2020 or March 26, 2021.[63] Board Rule 44.5.2 governing Substantive Claim Challenges was not in effect until November, 2021 – FSS was not on notice of a deadline to file a challenge within any specific timeframe following the receipt of a Final Schedule of Providers.

Assuming, *arguendo*, that FSS was on notice of the timeline set forth in Board Rule 44.5.2 (2021) once it was published, then challenges would have been due no later than October 5, 2020 or May 25, 2021. Any deadlines during this time period, however, were indefinitely stayed via Board Alert 19 due to the public health emergency created by the COVID-19 pandemic.[64] This indefinite stay was lifted, effective December 7, 2022, via Board Alert 23, which stated:

> ***Effective Wednesday, December 7, 2022***, Board Order No. 3 ceases suspension of deadlines and will hold parties to the deadline specified in: (1) *any* Board rule or instruction; and/or (2) *any* Board notice or correspondence issued ***on or after that date***.[65]

There was no correspondence in these twenty-nine cases, or general notice applicable to these cases, which re-established deadlines for Substantive Claim Challenges.

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[62] *E.g.*, PRRB Case 20-0849GC, Provider's Response to MAC's July 3, 2023 Substantive Claim Letter at 5.
[63] *See* Appendix A.
[64] Available at https://www.cms.gov/files/document/prrb-alerts.pdf.
[65] Available at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/current-prrb-alerts. (Emphasis in original).

The Providers posit that that the challenges should have been filed, at the latest, within 60 days of the Alert 19-stay being lifted (*i.e.*, within 60 days of December 7, 2022). When Alert 19 was lifted, however, the Board did not automatically reimpose deadlines that had passed through the application of Board Rules. Instead, Alert 23 informed the Provider community that the Board would be reissuing Notices of Hearing on a rolling basis to re-establish certain deadlines. Alert 23 intended to notify the Provider community that the deadlines set forth in Board Rules would be applicable on a prospective basis. Indeed, while responses to motions are generally due within 30 days of the motion's filing,[66] it is not realistic to think that every single motion filed while Alert 19 was active (a period of nearly three years) would be due no later than January 6, 2023.

The Providers also argue they have complied with the 42 C.F.R. §§ 413.24(j) and 405.1873 because (1) they submitted claims on their cost reports for all operating IPPS payments, that their cost report claims sought reimbursement for all amounts due under the law, and that the AWI payment reduction issue seeks payment of amounts that would have been paid if the law had been properly applied;[67] (2) by filing the group appeal, the Providers gave notice that they were all protesting their IPPS payments based on AWI payment issue;[68] and (3) the Secretary is aware of the AWI payment issue because it has been litigated several times.[69] The Board rejects these arguments. The Providers cannot satisfy the requirements to make an appropriate cost report claim by implication. 42 C.F.R. § 413.24(j) requires a Provider to make a ***specific*** claim on its cost report, or to actually self-disallow the claim, and the Board is bound by this regulation.[70]

For four Challenged Participants, however, the Providers raise different arguments.

i. Case 20-0849GC, Northern Nevada Medical Center (Prov. No. 29-0032, 12/31/2020)

In Case 20-0849GC, the Medicare Contractor notes that for FYE 12/31/2020, Northern Nevada Medical Center (Prov. No. 29-0032) identified $709,498 in Part A Protested amounts on its cost report, and a Summary of Protested Amounts with the same total. It claims that the workpapers, which list the protested items, accompanying the FYE 2020 cost report reflect a total of $432,674.[71] It claims the $709,498 figure was actually from its FYE 2019 cost report and was listed in error,[72] and as a result this Provider did not establish a self-disallowed item for the Area Wage Index issue for its FYE 2020.

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[66] Board Rule 44.3.
[67] *E.g.*, PRRB Case 20-0849GC, Provider's Response to MAC's July 3, 2023 Substantive Claim Letter, 3 (Aug. 1, 2023).
[68] *Id.*
[69] *Id.* at 14.
[70] 42 C.F.R. § 405.1867.
[71] PRRB Case 20-0849GC, Substantive Claim Letter, 17 & Ex. C-23 (July 3, 2023).
[72] *Id.* (citing Ex. C-12).

The Provider argues that it did properly protest the issue for its FYE 2020[73] but does not address the discrepancy between the protested amount listed on its cost report and the amount on its workpapers.

The Board agrees with the Providers and specifically finds that this participant complied with the Substantive Claim requirements.

42 C.F.R. §§ 413.24(j) can be satisfied if a provider (1) claims full reimbursement for a specific item on its cost report, or (2) self-disallows the specific item. To properly self-disallow an item, a provider must (i) ***include an estimated reimbursement amount for each item in the protested amount line on its cost report***, and (ii) attach a separate worksheet to the cost report for each specific self-disallowed item.

There is a protested amount listed on Line 75, Worksheet E, Part A of this Provider's FYE 12/31/2020 cost report. It lists $709,498 in total Part A Protested amounts, which is obviously a typo – it incorrectly re-reported the FYE 12/31/2019 figure,[74] but there is an amount listed. The workpapers say the total Part A protested amounts are $432,674, but it clearly identifies the Area Wage Index issue and a specific dollar amount ($32,990) associated with its impact for its FYE 12/31/2020. The cost report does not break out the total protested amounts by issue and is only intended to be an estimate, which often changes as appeals progress. The amount claimed (although erroneous) exceeds the amount claimed for the Area Wage Index issue. When read together, the documents provide notice to the Medicare Contractor of protested amounts which capture all protested items.

ii. Case 20-0845GC, St. Charles Health System, Inc. (Prov. No. 38-0040, FYEs 12/31/2019 & 12/31/2020)

In Case 20-0845GC, the Medicare Contractor argues that St. Charles Health System, Inc. (Prov. No. 38-0040) did not protest the Area Wage Index issue for its FYEs 12/31/2019 & 12/31/2020).[75]

The Providers note, however, that St. Charles Health System, Inc. (Prov. No. 38-0040) is not actually a participant in this appeal.[76]

The Board Agrees – St. Charles is not included in this appeal and the Board hereby denies any Substantive Claim Challenge for this participant as irrelevant to this appeal.

iii. Case 20-0777GC, USC Verdugo Hills Hospital (Prov. No. 05-0124, FYE 12/31/2020)

[73] PRRB Case 20-0849GC, Provider's Response to MAC's July 3, 2023 Substantive Claim Letter, 5 (Aug. 1, 2023).
[74] PRRB Case 20-0849GC, Substantive Claim Letter, Ex. C-12 at 3.
[75] PRRB Case 20-0845GC, Medicare Administrative Contractor Substantive Claim Letter, 6 (Sept. 17, 2024).
[76] PRRB Case 22-0845GC, Providers' Response to MAC's September 17, 2024 Substantive Claim Letter, 2 n.3 (Sept. 19, 2024).

For Case 20-0777GC, the Medicare Contractor notes that, for FYE 12/31/2020, USC Verdugo Hills Hospital (Prov. No. 05-0124) identified $267,680 in Part A Protested amounts on its cost report, and a Summary of Protested Amounts with the same total, but that "A review of the Summary of Protested Amounts reveals that the Providers did not establish a self-disallowed item for the Area Wage Index Lowest Quartile IPPS Payment Reduction issue. Accordingly, there is nothing in the record to demonstrate that the Providers claimed an amount for the Area Wage Index Lowest Quartile IPPS Payment Reduction issue as a protested item in the applicable fiscal year Medicare cost reports."[77]

The Provider contends, however, that USC Verdugo Hills Hospital (Prov. No. 05-0124) did protest the AWI Payment Reduction Issue for its FYE 12/31/2020 cost report.[78]

The Board agrees with the Provider and specifically finds that this participant complied with the Substantive Claim requirements. The Provider listed $267,680 for Part A protested amounts on its FYE 12/31/2020 cost report; its workpapers attribute $21,983 to the Area Wage Index issue and a description of the issue reflecting the same amount.[79]

iv. Case 20-0782GC, Garfield Med Center (Prov. No. 05-0737, FYEs 6/30/2021)

For Case 20-0782GC, the Medicare Contractor notes that, for FYE 6/30/2021, Garfield Med Center (Prov. No. 05-0737) identified $2,523,108 in Part A Protested amounts on its cost report, and a Summary of Protested Amounts of $2,748,984, but that "A review of the Summary of Protested Amounts reveals that the Providers did not establish a self-disallowed item for the Area Wage Index Lowest Quartile IPPS Payment Reduction issue. Accordingly, there is nothing in the record to demonstrate that the Providers claimed an amount for the Area Wage Index Lowest Quartile IPPS Payment Reduction issue as a protested item in the applicable fiscal year Medicare cost reports."[80]

The Provider contends, however, that Garfield Med Center (Prov. No. 05-0737) did protest the AWI Payment Reduction Issue for its FYE 6/30/2021 cost report.[81]

The Board agrees with the Provider and specifically finds that this participant complied with the Substantive Claim requirements. The discrepancy between the amount on the cost report and the workpapers included with the Substantive Claim Challenge, as well as the absence of any description of the issue, appears to be because an Amended Cost report was filed, but those attachments and workpapers were not included in the Substantive Claim Challenge. They were, however, included by the Provider in its response. In fact, the Medicare Contractor

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[77] Consolidated Substantive Claim Letter for Twenty-Five Cases, 11, 36 (Sept. 17, 2024) (citing Ex. C-9 at 3-4).
[78] PRRB Case 20-0777GC, Providers' Response to MAC's September 17, 2024 Substantive Claim Letter, 5 (Sept. 19, 2024) (citing Exs. C-9 at 3-4 & P-2)..
[79] *Id.*
[80] Consolidated Substantive Claim Letter for Twenty-Five Cases, 13, 36 (Sept. 17, 2024) (citing Ex. C-11 at 22-24).
[81] PRRB Case 20-0782GC, Providers' Response to MAC's September 17, 2024 Substantive Claim Letter, 5-6 (Sept. 19, 2024) (citing Exs. C-11 at 22 & P-2).

acknowledged that this Provider protested the AWI Payment Reduction Issue for its FYE 6/30/2021 in an e-mail dated May 11, 2023.[82]

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[83] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."; and

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."[84]

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality

[82] *Id.* & Ex. P-3.
[83] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[84] *Id.* at 42326.

> proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[85]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but *uncodified* regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index."

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2020 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount by 0.2016 percent for FFY 2020. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board makes the following findings:

1) The Board has jurisdiction over the AWI Issue for the subject year in these cases and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenge[86]was filed in Case 20-0787GC pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered in the twenty-nine (29) Challenged Cases,[87] and

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[85] 84 Fed. Reg. at 42331.
[86] As the Board explained 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 more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[87] *See* Appendix A.

a the Board specifically finds that, for the Challenged Cases, it is undisputed that all the Challenged Participants failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1) *except for the following three Providers*, which ***did*** include an appropriate claim:
    i Case 20-0849GC, Northern Nevada Medical Center (Prov. No. 29-0032, FYE 12/31/2020);
    ii Case 20-0777GC, USC Verdugo Hills Hospital (Prov. No. 05-0124, FYE 12/31/2020); and
    iii Case 20-0782GC, Garfield Med Center (Prov. No. 05-0737, FYE 6/30/2021)
b the Board specifically finds that, in Case 20-0845GC, St. Charles Health System, Inc. (Prov. No. 38-0040, FYEs 12/31/2019 & 12/31/2020) is not a participant and denies the Substantive Claim challenge to that Provider;

4) Based upon the Providers' assertions regarding the FFY 2020 IPPS Final Rule, there are no findings of fact for resolution by the Board;

5) The Board is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

6) The Board is without the authority to decide the legal questions of:

    a Whether the Uncodified Regulation on Wage Index published in the FFY 2020 IPPS Final Rule is valid; and
    b Whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid for any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1).

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2020 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year. For any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1), the Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants their requests for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/27/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

Enclosure: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H) (J-L)

Appendix A

One Case where no Substantive Claim Challenge was Filed:

Case Number	Case Name	Final SOP Received	Nature of Substantive Claim Challenge
20-0787GC	MemorialCare FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group	03/26/2021	None filed

Twenty-nine (29) cases where Substantive Claim Challenges were filed (collectively the "Challenged Cases"):

Case Number	Case Name	Final SOP Received	Nature of Substantive Claim Challenge
20-0756GC	*Alameda Health System FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	08/04/2020	Consolidated
20-0763GC	*Alecto Healthcare FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0764GC	*Avanti FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0766GC	*Cedars-Sinai Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0769GC	*Community Med Ctrs FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0772GC	*Emanate Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0774GC	*Cottage Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0775GC	*John Muir Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0777GC	*Keck Medicine of USC FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated

20-0780GC	*Loma Linda University FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0782GC	*AHMC Healthcare FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0785GC	*KPC Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0788GC	*Palomar Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0789GC	*Scripps Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0790GC	*Sharp Healthcare FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0791GC	*Stanford Health Care FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0792GC	*Univ of California FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0797GC	*LA Downtown Medical Cente FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0799GC	*Sutter Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0826GC	*Prospect Medical Holdings FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Separate
20-0827GC	*PIH Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0831GC	*LA County FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0838GC	*Dignity Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0842GC	*Prime Healthcare FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated
20-0845GC	*Providence Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Separate
20-0846GC	*Kaiser Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated

20-0849GC	*UHS FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Separate
20-0851GC	*Tenet Healthcare FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Separate
20-0854GC	*Adventist Health FFY 2020 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*	03/26/2021	Consolidated

Appendix B

The following are the participants in each group for which a Substantive Claim Challenge was made by the Medicare Contractor (collectively the "Challenged Participants"):

Case 20-0849

- Palmdale Regional Medical Center (Prov. No. 05-0204, FYE 12/31/2019)
- Corona Regional Medical Center (Prov. No. 05-0329, FYE 12/31/2019)
- Southwest Healthcare System (Prov. No. 05-0701, FYE 12/31/2019)
- Temecula Valley Hospital (Prov. No. 05-0775, FYE 12/31/2019)
- George Washington University Hospital (Prov. No. 09-0001, FYE 12/31/2019)
- Manatee Memorial Hospital (Prov. No. 10-0035, FYE 12/31/2019)
- Wellington Regional Medical Center (Prov. No. 10-0275, FYE 12/31/2019)
- Lakewood Ranch Medical Center (Prov. No. 10-0299, FYE 12/31/2019)
- Valley Hospital Medical Center (Prov. No. 29-0021, FYE 12/31/2019)
- Desert Springs Hospital (Prov. No. 29-0022, FYE 12/31/2019)
- Northern Nevada Medical Center (Prov. No. 29-0032, FYE 12/31/2019)
- Summerlin Hospital Medical Center (Prov. No. 29-0041, FYE 12/31/2019)
- Spring Valley Hospital Medical Center (Prov. No. 29-0046, FYE 12/31/2019)
- Centennial Hills Hospital Medical Center (Prov. No. 29-0054, FYE 12/31/2019)
- Henderson Hospital (Prov. No. 29-0057, FYE 12/31/2019)
- St. Mary's Regional Medical Center (Prov. No. 37-0026, FYE 12/31/2019)
- Aiken Regional Medical Center (Prov. No. 42-0082, FYE 12/31/2019)
- South Texas Health System (Prov. No. 45-0119, FYE 12/31/2019)
- Northwest Texas Hospital (Prov. No. 45-0209, FYE 12/31/2019)
- Texoma Medical Center (Prov. No. 45-0324, FYE 12/31/2019)
- Cornerstone Regional Hospital (Prov. No. 45-0825, FYE 12/31/2019)
- Northern Nevada Medical Center (Prov. No. 29-0032, 12/31/2020)
- Cornerstone Regional Hospital (Prov. No. 45-0825, FYE 12/31/2020)

Case 20-0851GC

- Shelby Baptist Medical Center (Prov. No. 01-0016, FYEs 12/31/2019 & 12/31/2020)
- Walker Baptist Medical Center (Prov. No. 01-0089, FYEs 12/31/2019 & 12/31/2020)
- Citizens Baptist Medical Center (Prov. No. 01-0101, FYEs 12/31/2019 & 12/31/2020)
- Princeton Baptist Medical Center (Prov. No. 01-0103, FYEs 12/31/2019 & 12/31/2020)
- Brookwood Baptist Medical Center (Prov. No. 01-0139, FYEs 12/31/2019 & 12/31/2020)
- St. Mary's Hospital (Prov. No. 03-0010, FYE 9/30/2020)
- St. Joseph's Hospital (Prov. No. 03-011, FYE 9/30/2020)
- Abrazo Central Campus (Prov. No. 03-0030, FYEs 3/31/2020 & 3/31/2021)
- Abrazo Scottsdale Campus (Prov. No. 03-0083, FYEs 3/31/2020 & 3/31/2021)
- Abrazo Arrowhead Campus (Prov. No. 03-0094, FYEs 5/31/2020 & 5/31/2021)

- Abrazo West Campus (Prov. No.03-0110, FYEs 4/30/2020 & 4/30/2021)
- Doctors Hospital of Manteca (Prov. No. 05-0118, FYEs 5/31/2020 & 5/31/2021)
- Emanuel Medical Center (Prov. No. 05-0179, FYEs 12/31/2019 & 12/31/2020)
- Desert Regional Medical Center (Prov. No. 05-0423, FYEs 5/31/2020 & 5/31/2021)
- Hi Desert Medical Center (Prov. No. 05-0279, FYEs 5/31/2020 & 5/31/2021)
- Doctors Medical Center (Prov. No. 05-0464, FYEs 5/31/2020 & 5/31/2021)
- Sierra Vista Regional Medical Center (Prov. No. 05-0506, FYEs 5/31/2020 & 5/31/2021)
- John F Kennedy Memorial Hospital (Prov. No. 05-0534, FYEs 5/31/2020 & 5/31/2021)
- Los Alamitos Medical Center (Prov. No. 05-0551, FYEs 5/31/2020 & 5/31/2021)
- Fountain Falley Regional (Prov. No. 05-0570, FYEs 12/31/2019 & 12/31/2020)
- Lakewood Regional Medical Center (Prov. No. 05-0581, FYEs 5/31/2020 & 5/31/2021)
- Placentia Linda Hospital (Prov. No. 05-0589, FYEs 5/31/2020 & 5/31/2021)
- Twin Cities Community Hospital (Prov. No. 05-0633, FYEs 5/31/2020 & 5/31/2021)
- San Roman Regional Medical Center (Prov. No. 05-0689, FYEs 5/31/2020 & 5/31/2021)
- North Short Medical Center (Prov. No. 10-0029, FYEs 5/31/2020 & 5/31/2021)
- Hialeah Hospital (Prov. No. 10-0053, FYEs 5/31/2020 & 5/31/2021)
- Palm Beach Gardens (Prov. No. 10-0176, FYEs 12/31/2019 & 12/31/2020)
- Carol Cables Hospital (Prov. No. 10-0183, FYEs 12/31/2019 & 12/31/2020)
- Palmetto General Hospital (Prov. No. 10-0187, FYEs 12/31/2019 & 12/31/2020)
- Delray Medical Center (Prov. No. 10-0258, FYEs 12/31/2019 & 12/31/2020)
- West Boca Medical Center (Prov. No. 10-0268, FYEs 12/31/2019 & 12/31/2020)
- Good Samaritan Medical Center (Prov. No. 10-0287, FYEs 5/31/2020 & 5/31/2021)
- St. Mary's Medical Center (Prov. No. 10-0288, FYEs 5/31/2020 & 5/31/2021)
- Metrowest Medical Center (Prov. No. 22-0175, FYEs 1/31/2020 & 1/31/2021)
- St. Vincent Hospital (Prov. No. 22-0176, FYEs 1/31/2020 & 1/31/2021)
- Sinai Grace Hospital (Prov. No. 23-0024, FYEs 12/31/2019 & 12/31/2020)
- Harper Hutzel Hospital (Prov. No. 23-0104, FYEs 12/31/2019 & 12/31/2020)
- Detroit Receiving Hospital (Prov. No. 23-0273, FYEs 12/31/2019 & 12/31/2020)
- Huron Valley Sinai Hospital (Prov. No. 23-0277, FYEs 10/31/2020 & 10/31/2021)
- East Cooper Medical Center (Prov. No. 42-0089, FYEs 12/31/2019 & 12/31/2020)
- Coastal Carolina Hospital (Prov. No. 42-0101, FYEs 12/31/2019 & 12/31/2020)
- St. Francis Hospital (Prov. No. 44-0183, FYEs 5/31/2020 & 5/31/2021)
- St. Francis Bartless Medical Center (Prov. No. 44-0228, FYEs 5/31/2020 & 5/31/2021)
- The Hospitals of Providence (Prov. No. 45-0002, FYEs 5/31/2020 & 5/31/2021)
- Valley Baptist Brownsville (Prov. No. 45-0028, FYEs 4/30/2020 & 4/30/2021)
- VHS Harlingen Hospital (Prov. No. 45-0033, FYEs 8/31/2020 & 8/31/2021)
- Baptist Medical Center (Prov. No. 45-0058, FYEs 6/30/2020 & 6/30/2021)
- Nacogdoches Medical Center (Prov. No. 45-0656, FYEs 12/31/2019 & 12/31/2020)
- Sierra Medical Center (Prov. No. 45-0668, FYEs 5/31/2020 & 5/31/2021)
- Sierra Providence East (Prov. No. 67-0047, FYEs 12/31/2019 & 12/31/2020)
- Resolute Health Hospital (Prov. No. 67-0098, FYEs 5/31/2020 & 5/31/2021)
- The Hospitals of Providence Transmountain Campus (Prov. No. 67-0120, FYEs 12/31/2019 & 12/31/2020)

Case 20-0826GC

- Southern California Hospital at Hollywood (Prov. No. 05-0135, FYEs 12/31/2019 & 12/31/2020)
- Los Angeles Community Hospital (Prov. No. 05-0663, FYEs 12/31/2019 & 12/31/2020)
- Foothill Regional Medical Center (Prov. No. 05-0780, FYEs 12/31/2019 & 12/31/2020)
- Waterbury Hospital (Prov. No. 07-0005, FYEs 12/31/2019 & 12/31/2020)
- Rockville General Hospital (Prov. No. 07-0012, FYEs 12/31/2019 & 12/31/2020)
- Manchester Memorial Hospital (Prov. No. 07-0027, FYEs 12/31/2019 & 12/31/2020)
- CareWell Health Medical Center (Prov. No. 31-0083, FYEs 12/31/2019 & 12/31/2020)
- Delaware County Memorial Hospital (Prov. No. 39-0081, FYEs 12/31/2019 & 12/31/2020)
- Crozer Chester Medical Center (Prov. No. 39-0180, FYEs 12/31/2019 & 12/31/2020)
- Roger Williams Medical Center (Prov. No. 41-0004, FYE 12/31/2020)
- Our Lady of Fatima Hospital (Prov. No. 41-0005, FYEs 12/31/2019 & 12/31/2020)

Case 20-0845GC

- Providence Alaska Medical Center (Prov. No. 02-0001, FYEs 12/31/2019 & 12/31/2020)
- Providence St. Joseph Hospital (Prov. No. 05-0006, FYEs 6/30/2020 & 6/30/2021)
- Providence Queen of the Valley Medical Center (Prov. No. 05-0009, FYEs 6/30/2020 & 6/30/2021)
- Providence St. Joseph Hospital (Prov. No. 05-0069, FYE 6/30/2020)
- Providence Little Company of Mary Medical Center San Pedro (Prov. No. 05-0078, FYEs 12/31/2019 & 12/31/2020)
- Petaluma Valley Hospital (Prov. No. 05-0136, FYEs 6/30/2020 & 6/30/2021)
- Providence St. Jude Medical Center (Prov. No. 05-0168, FYE 6/30/2020)
- Providence Santa Rosa Memorial Hospital (Prov. No. 05-0174, FYEs 6/30/2020 & 6/30/2021)
- Hoag Memorial Hospital Presbyterian (Prov. No. 05-0024, FYEs 12/31/2019 & 12/31/2020)
- Providence Saint Joseph Medical Center (Prov. No. 05-0235, FYEs 12/31/2019 & 12/31/2020)
- Providence Holy Cross Medical Center (Prov. No. 05-0278, FYEs 12/31/2019 & 12/31/2020)
- St. Johns' Health Center (Prov. No. 05-0290, FYEs 12/31/2019 & 12/31/2020)
- Providence St. Mary Medical Center (Prov. No. 05-0300, FYE 6/30/2020)
- Providence Little Company of Mary Medical Center Torrance (Prov. No. 05-0353, FYEs 12/31/2019 & 12/31/2020)
- Providence Mission Hospital (Prov. No. 05-0567, FYE 6/30/2020)
- Providence Health System Southern California (Prov. No. 05-0761, FYEs 12/31/2019 & 12/31/2020)
- Hoag Orthopedic Institute (Prov. No. 05-0769, FYE 12/31/2019)
- Providence St. Patrick Hospital (Prov. No. 27-0014, FYEs 12/31/2019 & 12/31/2020)

- Providence Newberg Medical Center (Prov. No. 38-0037, FYEs 12/31/2019 & 12/31/2020)
- Providence Willamette Falls Medical Center (Prov. No. 38-0038, FYEs 12/31/2019 & 12/31/2020)
- St. Charles Health System, Inc. (Prov. No. 38-0040, FYEs 12/31/2019 & 12/31/2020)
- Providence Portland Medical Center (Prov. No. 38-0061, FYEs 12/31/2019 & 12/31/2020)
- Providence Medford Medical Center (Prov. No. 38-0075, FYEs 12/31/2019 & 12/31/2020)
- Providence Milwaukie Hospital (Prov. No. 38-0082, FYEs 12/31/2019 & 12/31/2020)
- Covenant Medical Center (Prov. No. 45-0040, FYEs 6/30/2020 & 6/30/2021)
- Grace Surgical Hospital (Prov. No. 45-0162, FYEs 12/31/2019 & 12/31/2020)
- Providence Regional Medical Center Everett (Prov. No. 50-0014, FYEs 12/31/2019 & 12/31/2020)
- Providence St. Peter Hospital (Prov. No. 50-0024, FYEs 12/31/2019 & 12/31/2020)
- Swedish Medical Center Cherry Hill (Prov. No. 50-0025, FYEs 12/31/2019 & 12/31/2020)
- Swedish Edmonds (Prov. No. 50-0026, FYEs 12/31/2019 & 12/31/2020)
- Swedish Medical Center (Prov. No. 50-0027, FYEs 12/31/2019 & 12/31/2020)
- Prov Sacred Hrt. Med. Ctr. & Children's Hospital (Prov. No. 50-0054, FYEs 12/31/2019 & 12/31/2020)
- Kadlec Regional Medical Center (Prov. No.50-0058, FYEs 12/31/2019 & 12/31/2020)
- Providence Holy Family Hospital (Prov. No. 50-0077, FYEs 12/31/2019 & 12/31/2020)
- Swedish Issaquah (Prov. No. 50-0152, FYEs 12/31/2019 & 12/31/2020)

Case 20-0756GC

- Alameda County Medical Center (Prov. No. 05-0320, FYE 06/30/2020)

Case 20-0763GC

- St. Rose Hospital (Prov. No. 05-0002, FYE 9/30/2020)
- Olympia Medical Center (Prov. No. 05-0742, FYEs 12/31/2019 & 12/31/2020)
- Wilson N. Jones (Prov. No. 45-0469, FYEs 12/31/2019 & 12/31/2020))

Case 20-0764GC

- Community Hospital of Huntington Park (Prov. No. 05-0091, FYEs 12/31/2019 & 12/31/2020)
- Memorial Hospital of Gardena (Prov. No. 05-0468, FYEs 12/31/2019 & 12/31/2020)
- East Los Angeles Doctors Hospital (Prov. No. 05-0641, FYEs 12/31/2019 & 12/31/2020)
- Coast Plaza Hospital (Prov. No. 05-0771, FYEs 12/31/2019 & 12/31/2020)

Case 20-0766GC

- Torrance Memorial Hospital (Prov. No. 05-0351, FYEs 6/30/2020 & 6/30/2021)
- Cedars-Sinai Medical Center (Prov. No. 05-0625, FYEs 6/30/2020 & 6/30/2021)

- Cedars-Sinai Marina Del Rey Hospital (Prov. No. 05-0740, FYEs 6/30/2020 & 6/30/2021)

Case 20-0769GC
- Community Regional Medical Center (Prov. No. 05-0060, FYEs 8/31/2020 & 8/31/2021)
- Clovis Community Medical Center (Prov. NO. 05-0492, FYEs 8/31/2020 & 8/31/2021)

Case 20-0772GC
- Emanate Health Inter-Community Hospital (Prov. No. 05-0382, FYEs 12/31/2019 & 12/31/2020)
- Emanate Health Foothill Presbyterian Hospital (Prov. No. 05-0597, FYEs 12/31/2019 & 12/31/2020)

Case 20-0774GC
- Goleta Valley Cottage Hospital (Prov. No. 05-0357, FYE 12/31/2019)
- Santa Barbara Cottage Hospital (Prov. No. 05-0396, FYE 12/31/2019)

Case 20-0775GC
- John Muir Med Ctr Walnut Creek Campus (Prov. No. 05-0180, FYEs 12/31/2019 & 12/31/2020)
- John Muir Med Ctr Concord Campus (Prov. No. 05-0496, FYEs 12/31/2019 & 12/31/2020)

Case 20-0777GC
- USC Verdugo Hills Hospital (Prov. No. 05-0124, FYEs 6/30/2020 & 12/31/2020)
- University of Southern California (Prov. No. 05-0696, FYE 9/30/2020)

Case 20-0780GC
- Loma Linda University Med Ctr (Prov. No. 05-0327, FYE 6/30/2020)
- Loma Linda University Med Ctr Murrieta (Prov. No. 05-0770, FYE 6/30/2020)[88]
- Loma Linda University Children's Hospital (Prov. No. 05-0778, FYE 6/30/2020)

Case 20-0782GC
- Parkview Community Hospital Med Center (Prov. No. 05-0102, FYE 6/30/2020)
- San Gabriel Valley Med Center (Prov. No. 05-0132, FYE 6/30/2020)
- Anaheim Regional Med Center (Prov. No. 05-0226, FYE 6/30/2020)
- Alhambra Hospital Med Center (Prov. No. 05-0281, FYE 6/30/2020)
- Whittier Hospital Med Center (Prov. No. 05-0735, FYE 6/30/2020)
- Monterey Park Hospital (Prov. No. 05-0736, FYE 6/30/2020)
- Garfield Med Center (Prov. No. 05-0737, FYEs 6/30/2020 & 06/31/2020)
- Greater El Monte Community Hospital (Prov. No. 05-0736, FYE 6/30/2020)

[88] In its September 5, 2024 filing, FSS indicated it would be filing a Jurisdictional Challenge over this Provider because it was appealing the same issue for the same fiscal year in Case Number 24-1998. That case was withdrawn in its entirety on September 11, 2024, making any challenge to a duplicate appeal moot.

Case 20-0785GC

- Hemet Global Med Ctr (Prov. No. 05-0390, FYEs 12/31/2019 & 12/31/2020)
- Victor Valley Global Med Ctr (Prov. No. 05-0517, FYEs 12/31/2019 & 12/31/2020)
- Menifee Global Med Ctr (Prov. No. 05-0684, FYEs 12/31/2019 & 12/31/2020)
- Anaheim Global Med Ctr (Prov. No. 05-0744, FYEs 8/31/2020 & 8/31/2021)
- Chapman Global Med Ctr (Prov. No. 05-0745, FYEs 8/31/2020 & 8/31/2021)
- Orange County Global Med Ctr (Prov. No. 05-0746, FYEs 8/31/2020 & 8/31/2021)
- South Coast Global Med Ctr (Prov. No. 05-0747, FYEs 8/31/2020 & 8/31/2021)

Case 20-0788GC

- Palomar Health Downtown Campus (Prov. No. 05-0115, FYEs 6/30/2020 & 6/30/2021)
- Palomar Med Ctr Poway (Prov. No. 05-0636, FYEs 6/30/2020 & 6/30/2021)

Case 20-0789GC

- Scripps Mercy Hospital (Prov. No. 05-0007, FYE 9/30/2020)
- Scripps Memorial Hospital La Jolla (Prov. No. 05-0324, FYE 9/30/2020)
- Scripps Green Hospital (Prov. No. 05-0424, FYE 9/30/2020)
- Scripps Memorial Hosp Encinitas (Prov. No. 05-0503, FYE 9/30/2020)

Case 20-0790GC

- Grossmont Hospital (Prov. No. 05-0026, FYE 9/30/2020)
- Sharp Memorial Hospital (Prov. No. 05-0100, FYE 9/30/2020)
- Sharp Chula Vista Medical Center (Prov. No. 05-0222, FYE 9/30/2020)
- Sharp Coronado Hospital (Prov. No. 05-0234, FYE 9/30/2020)

Case 20-0791GC

- Stanford Health Care – Valleycare (Prov. No. 05-0283, FYE 8/31/2020)
- Stanford Health Care (Prov. No. 05-441, FYE 8/31/2020

Case 20-0792GC

- UC San Diego-Hillcrest MC (Prov. No. 05-0025, FYE 6/30/2020)
- Santa Monica UCLA MC & Orthopaedic Hosp (Prov. No. 05-0112, FYEs 6/30/2020 & 6/30/2021)
- Ronald Reagan UCLA Med Ctr (Prov. No. 05-0262, FYEs 6/30/2020 & 6/30/2021)
- University of California Irvine Med Ctr (Prov. No. 05-0348, FYEs 6/30/2020 & 6/30/2021)
- UCSF Med Ctr (Prov. No. 05-0454, FYE 6/30/2020)
- University of California Davis Med Ctr (Prov. No. 05-059, FYE 6/30/2020)

Case 20-0797GC

- West Covina Med Ctr (Prov. No. 05-0096, FYEs 12/31/2019 & 12/31/2020)
- LA Downtown Med Ctr (Prov. No. 05-0763, FYEs 12/31/2019 & 12/31/2020)

Case 20-0799GC

- Peninsula Med Ctr (Prov. No. 05-0007, FYEs 12/31/2019 & 12/31/2020)
- CA Pacific- Davies Campus (Prov. No. 05-0008, FYE 12/31/2019)
- Alta Bates Summit Med Ctr (Prov. No. 05-0043, FYEs 12/31/2019 & 12/31/2020)
- California Pacific - Van Ness Campus (Prov. No. 05-0047, FYE 12/31/2019)
- California Pacific - Mission Bernal (Prov. No. 05-0055, FYEs 12/31/2019 & 12/31/2020)
- Sutter Solano Med Ctr (Prov. No. 05-0101, FYE 12/31/2019)
- Sutter Med Ctr – Sacramento (Prov. No. 05-0108, FYE 12/31/2019)
- Novato Community Hospital (Prov. No. 05-0131, FYE 12/31/2019)
- Sutter Santa Rosa Regional Hospital (Prov. No. 05-0291, FYE 12/31/2019)
- Alta Bates Summit Med Ctr-Alta Bates Camp (Prov. No. 05-0305, FYE 12/31/2019)
- Sutter Roseville Med Ctr (Prov. No. 05-0309, FYE 12/31/2019)
- Sutter Tracy Community Hospital (Prov. No. 05-0313, FYE 12/31/2019)
- Eden Med Ctr (Prov. No. 05-0488, FYE 12/31/2019)
- Sutter Auburn Faith Hospital (Prov. No. 05-0498, FYE 12/31/2019)
- Sutter Delta Med Ctr (Prov. No. 05-0523, FYEs 12/31/2019 & 12/31/2020)
- Sutter Davis Hospital (Prov. No. 05-0537, FYE 12/31/2019)
- Memorial Med Ctr (Prov. No. 05-0557, FYE 12/31/2019)
- Sutter Maternity & Surgery Center of Santa Cruz (Prov. No. 05-0714, FYE 12/31/2019)
- Sutter Surgical Hospital - North Valley (Prov. No. 05-0766, FYE 12/31/2019)[89]

Case 20-0827GC

- PIH Health Whittier Hospital (Prov. No. 05-0169, FYE 9/30/2020)
- PIH Health Downey Hospital (Prov. No. 05-0393, FYE 9/30/2020)
- PIH Health Good Samaritan Hospital (Prov. No. 05-0471 (FYEs 12/22/2019, 9/30/2020)

Case 20-0831GC

- LAC Olive View-UCLA Med Ctr (Prov. No. 05-0040, FYEs 6/30/2020 & 6/30/2021)
- Los Angeles General Med Ctr (Prov. No. 05-0373, FYEs 6/30/2020 & 6/30/2021)
- LAC Harbor UCLA Med Ctr (Prov. No. 05-0376, FYEs 6/30/2020 & 6/30/2021)
- LAC/Rancho Los Amigos National Rehab Ctr (Prov. No. 05-0717, FYEs 6/30/2020 & 6/30/2021)

Case 20-0838GC

- St. Joseph's Hospital & Med Ctr (Prov. No. 03-0024, FYE 06/20/2020)
- Chandler Regional Med Ctr (Prov. No. 03-0036, FYEs 12/31/2019 & 12/31/2020)
- Mercy Gilbert Med Ctr (Prov. No. 03-0119, FYE 06/20/2020)
- Mercy General Hospital (Prov. No. 05-0017, FYE 06/20/2020)
- Bakersfield Memorial Hospital (Prov. No. 05-0036, FYEs 12/31/2019 & 12/31/2020)
- Glendale Memorial Hospital & Health Center (Prov. No. 05-0058, FYEs 12/31/2019 & 12/31/2020)

[89] FSS also submitted a challenge for Menlo Park Surgical Hospital (Prov. No. 05-0754), but that Provider was withdrawn on September 19, 2024, so any challenge is now moot.

- St John's Hospital Camarillo (Prov. No. 05-0082, FYE 06/20/2020)
- St Joseph's Med Ctr of Stockton (Prov. No. 05-0084, FYE 06/20/2020)
- Community Hospital of San Bernardino (Prov. No. 05-0089, FYEs 12/31/2019 & 12/31/2020)
- Marian Med Ctr (Prov. No. 05-0107, FYE 06/20/2020)
- Northridge Hospital Med Ctr (Prov. No. 05-0116, FYEs 12/31/2019 & 12/31/2020)
- Woodland Memorial Hospital (Prov. No. 05-0127, FYEs 12/31/2019 & 12/31/2020)
- St. Bernardine Med Ctr (Prov. No. 05-0129, FYE 06/20/2020)
- California Hospital Med Ctr (Prov. No. 05-0149, FYEs 12/31/2019 & 12/31/2020)
- Sierra Nevada Memorial Hospital (Prov. No. 05-0150, FYEs 12/31/2019 & 12/31/2020)
- St Francis Memorial Hospital (Prov. No. 05-0152, FYEs 12/31/2019 & 12/31/2020)
- St. Mary Med Ctr (Prov. No. 05-0191, FYE 06/20/2020)
- Sequoia Hospital (Prov. No. 05-0197, FYEs 12/31/2019 & 12/31/2020)
- French Hospital Med Ctr (Prov. No. 05-0232, FYEs 12/31/2019 & 12/31/2020)
- Dominican Santa Cruz Hospital (Prov. No. 05-0242, FYE 06/20/2020)
- Mercy Med Ctr – Redding (Prov. No. 05-0280, FYE 06/20/2020)
- Mercy Hospital (Prov. No. 05-0295, FYE 06/20/2020)
- Mercy Hospital of Folsom (Prov. No. 05-0414, FYE 06/20/2020)
- Mercy Med Ctr (Prov. No. 05-0444, FYE 06/20/2020)
- St Mary's Med Ctr-SF (Prov. No. 05-0457, FYE 06/20/2020)
- Mercy San Juan Med Ctr (Prov. No. 05-0516, FYE 06/20/2020)
- Methodist Hospital of Sacramento (Prov. No. 05-0590, FYEs 12/31/2019 & 12/31/2020)
- St. Johns Pleasant Valley Hospital (Prov. No. 05-0616, FYEs 1/30/2020 & 1/30/2021)
- St. Rose Dominican Rose de Lima (Prov. No. 29-0012, FYE 06/20/2020)
- St. Rose Dominican Hospital – Siena (Prov. No. 29-0045, FYE 06/20/2020)
- St Rose Dominican Hospital - San Martin (Prov. No. 29-0053, FYE 06/20/2020)

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- Paradise Valley Hospital (Prov. No. 05-0024, FYEs 12/31/2019 & 12/31/2020)
- Encino Hospital Med Ctr (Prov. No. 05-0158, FYEs 12/31/2019 & 12/31/2020)
- East Valley Hospital Med Ctr (Prov. No. 05-0205, FYEs 12/31/2019 & 12/31/2020)
- Garden Grove Hospital & Med Ctr (Prov. No. 05-0230, FYEs 12/31/2019 & 12/31/2020)
- West Anaheim Med Ctr (Prov. No. 05-0426, FYEs 12/31/2019 & 12/31/2020)
- Huntington Beach Hospital (Prov. No. 05-0526, FYEs 12/31/2019 & 12/31/2020)
- La Palma Intercommunity Hospital (Prov. No. 05-0580, FYEs 12/31/2019 & 12/31/2020)
- Chino Valley Med Ctr (Prov. No. 05-0580, FYEs 12/31/2019 & 12/31/2020)
- San Dimas Community Hospital (Prov. No. 05-0586, FYE 12/31/2019
- Desert Valley Hospital (Prov. No. 05-0709, FYE 12/31/2019)
- Centinela Hospital Med Ctr (Prov. No. 05-0739, FYEs 12/31/2019 & 12/31/2020)
- Sherman Oaks Hospital (Prov. No. 05-0755, FYEs 12/31/2019 & 12/31/2020)
- Alvarado Hospital (Prov. No. 05-0757, FYEs 12/31/2019 & 12/31/2020)
- Montclair Hospital Med Ctr (Prov. No. 05-0758, FYEs 12/31/2019 & 12/31/2020)
- Shasta Regional Med Ctr (Prov. No. 05-0764, FYEs 12/31/2019 & 12/31/2020)

- Lehigh Regional Med Ctr (Prov. No. 10-0107, FYEs 12/31/2019 & 12/31/2020)
- Southern Regional Med Ctr (Prov. No. 11-0165, FYEs 12/31/2019 & 12/31/2020)
- Monroe Hospital (Prov. No. 15-0183, FYEs 12/31/2019 & 12/31/2020)
- Saint John Hospital (Prov. No. 17-0009, FYEs 12/31/2019 & 12/31/2020)
- Providence Med Ctr (Prov. No. 17-0146, FYEs 12/31/2019 & 12/31/2020)
- Lake Huron Med Ctr (Prov. No. 23-0031, FYEs 12/31/2019 & 12/31/2020)
- Garden City Hospital (Prov. No. 23-0244, FYEs 12/31/2019 & 12/31/2020)
- St Joseph's Med Ctr (Prov. No. 26-0085, FYEs 12/31/2019 & 12/31/2020)
- St Mary's Med Ctr (Prov. No. 26-0193, FYEs 12/31/2019 & 12/31/2020)
- North Vista Hospital (Prov. No. 29-0005, FYEs 12/31/2019 & 12/31/2020)
- St. Mary's Regional Med Ctr (Prov. No. 29-0009, FYEs 12/31/2019 & 12/31/2020)
- St. Mary's Hospital (Prov. No. 31-0006, FYEs 12/31/2019 & 12/31/2020)
- Saint Clare's Hospital (Prov. No. 31-0050, FYEs 12/31/2019 & 12/31/2020)
- Saint Michael's Med Ctr (Prov. No. 31-0096, FYEs 12/31/2019 & 12/31/2020)
- Lower Bucks Hospital (Prov. No. 39-0070, FYEs 12/31/2019 & 12/31/2020)
- Suburban Community Hospital (Prov. No. 39-0116, FYEs 12/31/2019 & 12/31/2020)
- Roxborough Memorial Hospital (Prov. No. 39-0304, FYEs 12/31/2019 & 12/31/2020)
- Landmark Med Ctr (Prov. No. 41-0011, FYEs 12/31/2019 & 12/31/2020)
- Dallas Med Ctr (Prov. No. 45-0379, FYEs 12/31/2019 & 12/31/2020)
- Dallas Regional Med Ctr (Prov. No. 45-0688, FYEs 12/31/2019 & 12/31/2020)
- Harlingen Med Ctr LP (Prov. No. 45-0855, FYEs 12/31/2019 & 12/31/2020)

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- Kaiser - South San Francisco (Prov. No. 05-0070, FYE 12/31/2020)
- Kaiser - Santa Clara (Prov. No. 05-0071, FYE 12/31/2020)
- Kaiser - Walnut Creek (Prov. No. 05-0072, FYE 12/31/2020)
- Kaiser – Vallejo (Prov. No. 05-0073, FYE 12/31/2020)
- Kaiser – Oakland (Prov. No. 05-0075, FYE 12/31/2020)
- Kaiser - San Francisco (Prov. No. 05-0076, FYE 12/31/2020)
- Kaiser - Panorama City (Prov. No. 05-0137, FYE 12/31/2020)
- Kaiser - Los Angeles (Prov. No. 05-0138, FYE 12/31/2020)
- Kaiser - Downey (Prov. No. 05-0139, FYE 12/31/2020)
- Kaiser - Fontana (Prov. No. 05-0140, FYE 12/31/2020)
- Kaiser - South Bay (Prov. No. 05-0411, FYE 12/31/2020)
- Kaiser – Sacramento (Prov. No. 05-0425, FYE 12/31/2020)
- Kaiser – San Rafael (Prov. No. 05-0510, FYE 12/31/2020)
- Kaiser – Fremont (Prov. No. 05-0512, FYE 12/31/2020)
- Kaiser – San Diego (Prov. No. 05-0515, FYE 12/31/2020)
- Kaiser – Redwood City (Prov. No. 05-0541, FYE 12/31/2020)
- Kaiser – West Los Angeles (Prov. No. 05-0561, FYE 12/31/2020)
- Kaiser – San Jose (Prov. No. 05-0604, FYE 12/31/2020)
- Kaiser –Orange County - Anaheim (Prov. No. 05-0609, FYE 12/31/2020)
- Kaiser – South Sacramento (Prov. No. 05-0674, FYE 12/31/2020)

- Kaiser – Woodland Hills (Prov. No. 05-0677, FYE 12/31/2020)
- Kaiser – Riverside (Prov. No. 05-0686, FYE 12/31/2020)
- Kaiser – Santa Rosa (Prov. No. 05-0690, FYE 12/31/2020)
- Kaiser – Fresno (Prov. No. 05-0710, FYE 12/31/2020)
- Kaiser – Baldwin Park (Prov. No. 05-0723, FYE 12/31/2020)
- Kaiser – Manteca (Prov. No. 05-0748, FYE 12/31/2020)
- Kaiser – Antioch (Prov. No. 05-0760, FYE 12/31/2020)
- Kaiser – Moreno Valley (Prov. No. 5-00765, FYE 12/31/2020)
- Kaiser – Vacaville (Prov. No. 05-0767, FYE 12/31/2020)
- Kaiser – Roseville (Prov. No. 05-0772, FYE 12/31/2020)
- Kaiser – San Leandro (Prov. No. 05-0777, FYE 12/31/2020)
- Kaiser – Hawaii (Prov. No. 12-0011, FYE 12/31/2020)
- Kaiser – Sunnyside Med Ctr (Prov. No. 38-0091, FYE 12/31/2020)
- Kaiser – Westside (Prov. No. 38-0103, FYE 12/31/2020)
- Kaiser – Washington (Prov. No.50-0052, FYE 12/31/2020)

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- St. Helena Hospital (Prov. No. 05-0013, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health White Memorial (Prov. No. 05-0103, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health Hanford (Prov. No. 05-0121, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health Reedley (Prov. No. 05-0192, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health Feather River (Prov. No. 05-0225, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health Simi Valley (Prov. No. 05-0236, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health Glendale (Prov. No. 05-0239, FYEs 12/31/2019 & 12/31/2020)
- Ukiah Valley Med Ctr (Prov. No. 05-0301, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health Lodi Memorial (Prov. No. 05-0336, FYE 12/31/2020)
- Adventist Health Bakersfield (Prov. No. 05-0455, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health Delano (Prov. No. 05-0608, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health Tulare (Prov. No. 05-0784, FYEs 12/31/2019 & 12/31/2020)
- Adventist Health Castle (Prov. No. 12-0006, FYEs 12/31/2019 & 12/31/2020)

Adventist Health Portland (Prov. No. 38-0060, FYEs 12/31/2019 & 12/31/2020

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
21-0828GC *et al* (31 cases) (*See* Appendix A)

Dear Mr. Vernon:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' consolidated request for expedited judicial review ("EJR") filed on August 28, 2024, in the thirty-one (31) above-referenced group appeals. The Board's decision on jurisdiction and EJR for the thirty-one (31) above-referenced group appeals is set forth below.

Issue:

The issue for which EJR has been requested is:

> [W]hether the [Providers'] [FFY 2021] standardized amount and hospital-specific operating [IPPS] [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.2030% for FFY 2021.[1]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[2] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals

[1] Consolidated request for Expedited Judicial Review at 3 (Aug. 28, 2024).
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[3] The standardized amount is 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 from the cost data the effects of 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. 27708, 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

located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[6]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[7]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[8] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[9] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[10] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by

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labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[4] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[5] of the Department of Health and Human Services.
[6] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited Sept. 27, 2024).
[7] 42 U.S.C. § 1395ww(d)(3)(E).
[8] 83 Fed. Reg. 20164 (May 7, 2018).
[9] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[10] *Id.* at 19162.

"reduc[ing] the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values for budget neutrality purposes, as well as changing the calculation of the rural floor . . . ."[11]

In the FY 2020 IPPS final rule, the Secretary summarized his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure. Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[12]

In the FFY 2020 IPPS Final Rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals, as proposed without modification. Based on the data for this final rule, for FY 2020, the 25th percentile wage index value across all hospitals is 0.8457."[13] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is then a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[14]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our

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[11] *Id.*
[12] 84 Fed. Reg. at 42326 (citations omitted).
[13] *Id.* at 42328.
[14] *Id.* at 42326.

approach is consistent with approaches used in other areas of the Medicare program."[15] The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[16] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[17]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[18] The Secretary also confirmed that he was "finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner" and asserted that his authority to do so "falls within the scope of the authority of section 1886(d)(3)(E) of the Act" and "even if [budget neutrality] were not required [under section 1886(d)(3)(E)], we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending."[19]

The Secretary announced that the low wage index policy would be *in effect* ***for at least*** *four years beginning in FFY 2020*, "in order to allow employee compensation increases implemented by [low wage index value] hospitals sufficient time to be reflected in the wage index calculation."[20] The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and "four years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index data."[21] The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[22]

In the FFY 2021 IPPS Final Rule, the Secretary stated he was continuing the low wage index hospital policy for FY 2021, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[23] Based on the data for this final rule, for FFY 2021, the 25th percentile wage index value across all hospitals was 0.8465, which was later corrected to 0.8469.[24]

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[15] *Id.*
[16] *Id.*
[17] *Id.*at 42328.
[18] *Id.*
[19] *Id.* at 42331.
[20] *Id.* at 42326.
[21] *Id.* at 42326-7.
[22] *Id.* at 42327.
[23] 85 Fed. Reg. 58432, 58436, 58767-68 (Sept. 18, 2020).
[24] *Id.* at 58768; 85 Fed. Reg. 78748, 78754 (Dec. 7, 2020) (Correction).

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that "while it would not be appropriate to create a wage index floor or a wage index ceiling", it would be appropriate to "provide a mechanism to increase the wage index of low wage index hospitals . . . while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals."[25] The Secretary maintained that this action had two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage index is not considered high or low, do not have their wage index values affected by this proposed policy."[26] Thus, the Secretary concluded that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . . it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[27]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[28] Based on this feedback, the Secretary decided to "finaliz[e] a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) "budget neutrality is required under [§ 1395ww(d)(3)(E)];" (2) "even if it were not required, [he believes that] it would be inappropriate to use the wage index to increase or decrease overall IPPS spending;" and (3) he "wish[ed] to consider further the policy arguments raised by commenters regarding [the] budget neutrality proposal."[29] Specifically, "consistent with [the Secretary's] current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in [the] rule, [was] implemented in a budget neutral manner."[30]

The Secretary has continued the low wage index hospital policy in the following four years, for FFYs 2021 to 2024, and continued to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[31]

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[25] 84 Fed. Reg. at 42329.
[26] *Id*.
[27] *Id*
[28] *Id.* at 42331.
[29] *Id*.
[30] *Id*.
[31] 85 Fed. Reg. at 58436 (Sept. 18, 2020); 86 Fed. Reg. at 44778 (Aug. 13, 2021); 87 Fed. Reg. at 49006 (Aug. 10, 2022); 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).

Providers' Position:

The Providers are challenging their IPPS payments for FFY 2021 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.[32]

The Providers explain that the Secretary continues to implement, without any changes, his policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") that he first adopted for FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that the Low Wage Index Redistribution increases the AWI values of hospitals with AWI values in the lowest quartile, nationally, by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values.[33]

The Providers note that in the FFY 2021 IPPS Final Rule, the Secretary reiterated his assertion that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E) despite acknowledging that the district court in *Bridgeport Hospital, et al. v. Becerra,* No. 1:20-cv-01574 (D.D.C.)[34] held that the Secretary did not have the legal authority under 42 U.S.C. §§ 1395ww(d)(3)(E) or 1395ww(d)(5)(I)(i) to adopt the FFY 2020 Low Wage Index Redistribution.[35] This section of the statute (42 U.S.C. § 1395ww(d)(3)(E)(i))authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) "reflect[ing] the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." The Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States."[36]

The Providers contend that the Secretary "again elected to implement his Low Wage Index [Redistribution] in a budget neutral manner" for FFY 2021. As a result, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.2030% to offset the AWI increases to those hospitals in the lowest AWI quartile.[37]

The Providers point out that the Secretary continues to assert that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E), however, he noted that even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke his statutory "exceptions and adjustments" authority in support of such a budget neutrality

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[32] Consolidated Request for EJR at 1 (Aug. 28, 2024).
[33] *Id.* at 3.
[34] 589 F. Supp. 3d 1 (2022), *aff'd in part and rev'd in part*, *Bridgeport Hospital, dba Yale New Haven Health, et al. v. Becerra,* 2024 WL 3504407 (D.C. Cir. 2024). The Providers note the same conclusions were made in the 9th Circuit in *Kaweah Delta Health Care District et al. v. Becerra*, 2022 WL 18278175 (C.D. Cal. 2022).
[35] Consolidated Request for EJR at 4.
[36] 42 U.S.C. § 1395ww(d)(3)(E)(i).
[37] Consolidated Request for EJR at 4.

adjustment.[38] This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." The Providers contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).[39]

The Providers argue that "the Secretary lacks the authority to (a) continue the Low Wage Index [Redistribution] in the manner set forth in the FFY 2021 IPPS Final Rule; and (b) continue to implement such policy in a budget neutral manner under the [AWI] statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, the [Providers are challenging] the adjustment to the standardized amount on several grounds, including, but not limited to, that it: exceeds statutory authority, contradicts the [AWI] congressional mandate, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively."[40]

The Providers note that "[t]he immediate detrimental effect will be a 0.2030% negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2021 for every IPPS hospital, resulting in a reduction in overall MS-DRG IPPS payments for all IPPS hospitals, including the [Providers]."[41] Further, as this is the second year of the implementation of the Low Wage Index Redistribution and the related budget neutrality adjustment, the Providers already suffered an unlawful negative adjustment in FFY 2020.[42]

The Providers summarize their request as follows:

> Based on the foregoing, the [Providers] are challenging the Low Wage Index [Redistribution] in this group appeal for several reasons, including but not limited to, whether the Secretary (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I)(i); and (2) improperly reduced FFY 2021 payments to IPPS hospitals, including the [Providers], as a result of the budget neutral implementation of the LowWage Index [Redistribution], which has been in effect since October 1, 2019, and continues through FFY 2021. The Providers seek their proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).[43]

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, but the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R.

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[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.* at 5.
[42] *Id.* at 4-5.
[43] *Id.*

§ 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.2030% reduction issued by the Secretary in the FFY 2021 IPPS Final Rule.[44]

Medicare Contractor's Position:

For twenty-nine (29) of the cases[45] in in the Consolidated Request for EJR, there has been no substantive claim or jurisdictional challenge filed. Following receipt of the Consolidated Request for EJR on August 28, 2024, the Medicare Contractor's representative, Federal Specialized Services ("FSS") filed a notice on September 5, 2024 certifying that that it would be filing Substantive Claim Challenges in twenty-one (21) cases, but failed to do so and the time for doing so has elapsed.[46] [47]

As detailed below, Substantive Claim Challenges were filed in two (2) cases prior to the filing of the Consolidated Request for EJR: 21-0909GC and 21-0910GC.[48] FSS' September 5, 2024 notice also advised the Board that these Substantive Claim Challenges were previously filed in the two Challenged Cases.

Substantive Claim Challenges:

A. Case 21-0909GC

1. Medicare Contractor's Challenge

Case 21-0909GC contains fifty-two (52) participants and, pursuant to Board Rule 20, was deemed fully formed by the Providers' Representative on April 20, 2022. FSS filed a Substantive Claim Challenge in this case on May 15, 2023. It notes that the relevant FFY 2021 covers the period of 10/01/2020 through 9/30/2021, and that the fifty-two participants have various cost reporting periods. As a result, the relevant FFY 2021 includes portions of two

[44] *Id.* at 6-8.
[45] *See* Appendix A (the "Unchallenged Cases").
[46] Board Rule 44.5.2 (2023) typically requires a party questioning whether a participant included an appropriate claim on the cost report at issue to file its Substantive Claim Challenge within 60 days of the group filing its Final Schedule of Providers ("SOP"). When an EJR Request is filed within 60 days of the Final SOP, the moving party must certify that it will be filing a challenge within five business days, and then must file the actual challenge within 20 days following the filing of the EJR Request. The Consolidated EJR Request in the case was filed on August 28, 2024. On September 5, 2024 (five business days after the EJR Request, noting that September 2 was a federal holiday), FSS certified that it would be filing substantive claim and/or jurisdictional challenges in twenty-one cases even though the EJR Request was not filed within 60 days of the Final SOPs in those cases. Twenty days from the date the Consolidated EJR Request was filed was Tuesday, September 17, 2024. As of the date of this decision, no substantive claim or jurisdictional challenges were filed in the twenty-one cases.
[47] FSS's September 5, 2024 certification also said that a Jurisdictional Challenge would be filed over Provider No. 05-0537 in Case 21-0864GC because it was pursuing the same issue in its individual appeal, Case 24-2270. No Jurisdictional Challenge was ever filed, and the AWI Payment issue was withdrawn from Case 24-2270 on September 9, 2024, so any potential challenge is now moot.
[48] Hereinafter collectively referred to as the "Challenged Cases."

separate cost reporting periods for these providers overlapping the 2020 and 2021 FYEs for a total of 107 appliable cost reporting periods.[49]

The Medicare Contractor claims that for all fifty-two participants, the Providers failed to include an appropriate cost report claim for the appealed item in dispute.[50] For all the fifty-two participants, the Medicare Contractor notes that the appeals were taken from the Federal Register, but that on the impacted cost reports, each Provider failed to submit any documentation to support they claimed reimbursement for the appealed issue. It also notes that, while the Providers may have filed their cost reports identifying certain amounts as Part A Protested amounts, "[t]he breakdown of the costs included in this amount exclude a component for Area Wage Index (AWI). Accordingly, there is nothing in the as filed cost report to demonstrate that the Provider properly established a self-disallowed item for the AWI issue in its FYE 12/31/2020 cost report as described at 42 C.F.R. § 413.24(j)(2)."[51]

2. Providers' Response

The Providers filed a response to the Substantive Claim Challenge on June 14, 2023. First, they argue that the Board should not consider the challenge because it was untimely. Citing Board Rule 44.5.2, the Providers note that the challenge was filed more than 60 days after the Providers certified that the group was complete pursuant to Board Rule 20, and also more than 60 days after the Board resumed normal operations following the issuance of Board Alert 3.[52]

Second, the Providers also argue that the substantive claim requirement at 42 C.F.R. § 413.24(j) is substantively and procedurally invalid pursuant to the holdings in *Bethesda Hospital Ass'n. v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*") and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) ("*Banner Heart Hospital*").[53]

Third, the Providers note they have exercised their statutory right to appeal from a Federal Register publication, namely the FFY 2021 IPPS Final Rule, which was published on September 18, 2020. Thus, their appeals from this final determination were due by mid-March, 2021, while the first cost reports for the Providers in this appeal were not due until the end of March, 2021. For this reason, it would have been factually impossible to protest the issue on their cost reports prior to filing the group appeal.[54] They also claim that by filing the group appeal, the Providers gave notice that they were all protesting their IPPS payments based on the reasons set forth in the appeal.[55]

The Providers also argue that a challenge to the policy being appealed is not a "specific item" of reimbursement that could be claimed because it arises from IPPS claims and cuts across all IPPS payments. They also believe that all of the participants in this appeal satisfied the substantive

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[49] Medicare Administrative Contractor's Substantive Claim Letter at 1 (May 15, 2023).
[50] *Id*.
[51] *E.g.*, *id.* at 6 (citing Ex. C-2, Page 2).
[52] Case 21-0909GC, Provider's Response to MAC's May 15, 2023 Substantive Claim Letter, 1-2, 8 (June 14, 2023).
[53] *Id.* at 2, 9-11, 15-16.
[54] *Id.* at 2, 4 & n.1.
[55] *Id.* at 2-3, 13.

claim requirements by submitting claims on their cost reports for all operating IPPS payments, that their cost report claims sought reimbursement for all amounts due under the law, and that the AWI payment reduction issue seeks payment of amounts that would have been paid if the law had been properly applied.[56] Similarly, the Providers believe it is unreasonable to require cost-reporting protests on the AWI Payment Reduction Issue because "the Secretary has long been aware of the AWI Payment Reduction Issue, because it was presented more than two years ago in the *Bridgeport* and *Kaweah Delta* Board appeals and federal court litigation, and in subsequent board appeals every year since."[57]

With one exception, the Providers concede that the "MAC is correct that the Hospitals did not explicitly repeat their protest of the AWI Payment Reduction Issue on the identified as-filed Medicare cost reports."[58] They do claim that Doctors Medical Center of Modesto (Provider No. 05-0464) explicitly protested the appealed issued on its 5/31/2022 Medicare cost report.[59]

B. Case 21-0910GC

1. Medicare Contractor's Challenge

Case 21-0910GC contains twenty-one (21) participants and, pursuant to Board Rule 20, was deemed fully formed by the Providers' Representative on April 20, 2022. FSS filed a Substantive Claim Challenge in this case on April 21, 2023. It notes that the relevant FFY 2021 covers the period of 10/01/2020 through 9/30/2021, and that the participants all have a cost reporting periods ending December 31. As a result, the relevant FFY 2021 includes portions of two separate cost reporting periods for these providers overlapping the 2020 and 2021 FYEs for a total of forty-two (42) appliable cost reporting periods.[60]

The Medicare Contractor argues that a single participant, namely Doctors Hospital of Laredo (Provider No. 45-0643, FYE 12/31/2020) ("Laredo") did not submit an appropriate cost report claim in accordance with 42 C.F.R. § 413.24(j).[61] The Medicare Contractor notes that the appeal for Laredo was taken from the Federal Register, but that on the impacted cost report, it failed to submit any documentation to support they claimed reimbursement for the appealed issue. It also notes that, while it identified $836,792 in Part A Protested Amounts on its cost report, $0 relates to the wage index issue.[62]

2. Providers' Response

The Providers filed a response to the Substantive Claim Challenge on May 19, 2023. The response makes all of the same arguments as the response in case 21-2909GC. Likewise, they

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[56] *Id.* at 3.
[57] *Id.* at 13-14.
[58] *Id.* at 5.
[59] *Id.* at n.3 (citing Ex. C-33 at 2).
[60] Case 21-0910GC, Medicare Administrative Contractor Substantive Claim Letter, 1 (Apr. 21, 2023).
[61] *Id.* at 4.
[62] *Id.* (citing Ex.s C-2 and C-3).

also concede that "[t]he MAC is correct that Laredo did not explicitly repeat its protest of the AWI Payment Reduction Issue on its identified as-filed Medicare cost report."[63]

Decision of the Board:

A. Jurisdiction and Request for EJR

Each of the participants in these thirty-one (31) group cases appealed from the FFY 2021 IPPS Final Rule.[64] The Board has determined that: (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[65] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy ("AiC") calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.2030 percent (*i.e.,* the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j) are applicable. The regulation 42 C.F.R. § 413.24(j) requires that:

> (1) *General Requirement*. 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

[63] Case 21-0910GC, Provider's Response to MAC's April 21, 2023 Substantive Claim Letter, 5 (May 19, 2023).
[64] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*), rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[65] *See* 42 C.F.R. § 405.1837.

> 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
>
> (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.[66]

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.
> (b) *Summary of Procedures*.
> ****
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .

[66] (Bold and underline emphasis added.)

> ****
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
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> ****
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section*—(1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[67]

These regulations are applicable to the cost reporting periods in these group cases.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

a. Unchallenged Cases

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[68] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[69] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires

[67] (Bold and underline emphasis added.)
[68] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[69] (Emphasis added.)

the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included *if review under subsection (b)(1) has been triggered by a party raising a question under subsection (a) of whether a provider made an appropriate claim for the specific item under appeal on the relevant as-filed cost report*.

Accordingly, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[70] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made on the relevant as-filed cost report.[71] The Board further notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[72] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on the Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these type of instances, any Substantive Claim Challenge would be premature. That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position.

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[70] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

[71] *See* 42 C.F.R. § 405.1873(a),

[72] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

Here, for some of the twenty-nine (29) Unchallenged Cases, while FSS indicated that it would be filing Substantive Claim Challenges, it failed to do so within the time required by the Board's Rules. In this regard, all of the participants in the Unchallenged Cases are appealing the FFY 2021 Federal Register Notice and FSS has not challenged whether the as-filed cost reports included an appropriate claim for the appealed issue. Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings of fact on substantive claim requirements in the Unchallenged Cases for any of the participants.

b. Challenged Cases and Challenged Participants

Substantive Claim Challenges have been filed in Cases 21-0909GC and 21-0910GC. In response, the Providers make several arguments.

First, the Providers argue that the two Substantive Claim Challenges filed by FSS should be disregarded because they are not timely. The Board rejects this argument based on the timing of the challenges and Board Alert 19.

Board Rule 44.5.2 (2021) generally requires Substantive Claim Challenges be filed within sixty (60) days after the group files its final Schedule of Providers ("SOP") unless the moving party's filing demonstrates good cause. In both of the Challenged Cases, the Providers' Representative filed its Rule 20 Certification (in lieu of a hard copy SOP) on April 20, 2022. Thus, any Substantive Claim Challenges would have been due no later than June 20, 2022.

These deadlines, however, were indefinitely stayed via Board Alert 19 due to the public health emergency created by the COVID-19 pandemic.[73] This indefinite stay was lifted effective December 7, 2022, via Board Alert 23, which stated:

> ***Effective Wednesday, December 7, 2022***, Board Order No. 3 ceases suspension of deadlines and will hold parties to the deadline specified in: (1) *any* Board rule or instruction; and/or (2) *any* Board notice or correspondence issued ***on or after that date***.[74]

There was no correspondence in these two cases, or general notice applicable to these cases, which re-established deadlines for Substantive Claim Challenges.

The Providers posit that that the challenges should have been filed, at the latest, within 60 days of the Alert 19-stay being lifted (*i.e.*, within 60 days of December 7, 2022). When Alert 19 was lifted, however, the Board did not automatically reimpose deadlines that had passed through the application of Board Rules. Instead, Alert 23 informed the Provider community that the Board would be reissuing Notices of Hearing on a rolling basis to re-establish certain deadlines. Alert 23 intended to notify the Provider community that the deadlines set forth in Board Rules would be applicable on a prospective basis. Indeed, while responses to motions are generally due

[73] Available at https://www.cms.gov/files/document/prrb-alerts.pdf.
[74] Available at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/current-prrb-alerts. (Emphasis in original).

within 30 days of the motion's filing,[75] it is not realistic to think that every single motion filed while Alert 19 was active (a period of nearly three years) would be due within 30 days (*i.e.*, no later than January 6, 2023). Based on the foregoing, the Board rejects the argument to not consider the Substantive Claim Challenges because they were not timely filed.

The Providers also suggest they have complied with the 42 C.F.R. §§ 413.24(j) and 405.1873 because (1) they submitted claims on their cost reports for all operating IPPS payments, that their cost report claims sought reimbursement for all amounts due under the law, and that the AWI payment reduction issue seeks payment of amounts that would have been paid if the law had been properly applied;[76] (2) by filing the group appeal, the Providers gave notice that they were all protesting their IPPS payments based on AWI payment issue;[77] and (3) the Secretary is aware of the AWI payment issue because it has been litigated several times.[78] The Board rejects these arguments. The Providers cannot satisfy the requirements to make an appropriate cost report claim by implication. 42 C.F.R. § 413.24(j) requires a Provider to make a ***specific*** claim on its cost report, or to actually self-disallow the claim, and the Board is bound by this regulation.[79] And with one exception, the Providers in the Challenged Cases concede that they did not explicitly make a claim for, or self-disallow, the issue under appeal.[80]

In case 21-0909GC, the Providers do claim that Doctors Medical Center of Modesto (Provider No. 05-0464) explicitly protested the appealed issued on its 5/31/2022 Medicare cost report.[81] After reviewing the record, the Board concurs with this finding.[82] The Board also finds that two other Providers in Case 21-0909GC have protested the AWI Payment Issue and made an appropriate cost report claim:

- Doctors Medical Center of Manteca (Provider No. 05-0118)[83]
- Desert Regional Medical Center (Provider No. 05-0243)[84]

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[85] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

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[75] Board Rule 44.3.
[76] *E.g.*, Case 21-0909GC, Provider's Response to MAC's May 15, 2023 Substantive Claim Letter, 3 (June 14, 2023).
[77] *Id.* at 2-3, 13.
[78] *Id.* at 13-14.
[79] 42 C.F.R. § 405.1867.
[80] *Supra* n. 58-59 & 63 and accompanying text.
[81] *Supra* n.61 and accompanying text.
[82] Case 21-0909GC, Medicare Administrative Contractor Substantive Claim Letter, Ex. C-33 at 2 (May 15, 2023).
[83] *Id.* at Ex. C-25 at 5.
[84] *Id.* at Ex. C-29 at 5.
[85] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."; and

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."[86]

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[87]

[86] *Id.* at 42326.
[87] 84 Fed. Reg. at 42331.

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but *uncodified* regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index."

While this appeal involves the FFY 2021 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[88] The proposed rule did not propose any changes to this policy. The Final Rule for FFY 2021 refers to the responses to comments provided in the FFY 2020 Final Rule, and applied the policy in the same manner as it was applied in FFY 2020.[89] Therefore, the Board finds that this policy continues to be a binding but *uncodified* regulation for FFY 2021.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2021 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount by 0.2030 percent for FFY 2021. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board makes the following findings:

1) The Board has jurisdiction over the AWI Issue for the subject year in these cases and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[90] have been filed for the twenty-nine (29) Unchallenged Cases pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered in the Cases 21-0909GC and 21-0910GC, and

    a the Board specifically finds that, for Case 21-0909GC, it is undisputed that all the participants failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1) *except for the following three Providers*, which ***did*** include an appropriate claim:

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[88] 85 Fed. Reg. 58432, 58766-68 (Sept. 18, 2020)..
[89] *Id.* at 58768.
[90] As the Board explained 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 more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

i Doctors Medical Center of Modesto (Provider No. 05-0464, FYE 5/31/2022);
ii Doctors Medical Center of Manteca (Provider No. 05-0118, FYE 5/31/2022)
iii Desert Regional Medical Center (Provider No. 05-0243, FYE 5/31/2022)

b the Board specifically finds that, in Case 21-0910GC, it is undisputed that Doctors Hospital of Laredo (Provider No. 45-0642, FYE 12/31/2020) failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1);

4) Based upon the Providers' assertions regarding the FFY 2021 IPPS Final Rule, there are no findings of fact for resolution by the Board;

5) The Board is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

6) The Board is without the authority to decide the legal questions of:

a Whether the Uncodified Regulation on Wage Index published in the FFY 2021 IPPS Final Rule is valid; and
b Whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid for any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1).

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2021 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year. For any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1), the Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants their requests for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/27/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

Enclosure: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H) (J-L)

Appendix A

Twenty-Nine Cases where no Substantive Claim Challenge was Filed (the "Unchallenged Cases")

21-0828GC	*AHMC Healthcare FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0829GC	*Alecto Healthcare FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0831GC	*Avanti FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0838GC	*Cedars-Sinai Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0839GC	*Community Med Ctrs FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0840GC	*Cottage Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0841GC	*Dignity Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0842GC	*Emanate Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0843GC	*John Muir Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0844GC	*Keck Medicine of USC FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0845GC	*KPC Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0846GC	*LA Downtown Med. Ctr. LLC FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0848GC	*Loma Linda University FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0849GC	*MemorialCare FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0850GC	*Palomar Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0851GC	*PIH Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0853GC	*Prospect Medical Holdings FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0854GC	*Scripps Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0855GC	*Sharp Healthcare FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0857GC	*Stanford Health Care FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*

21-0864GC	*Sutter Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0865GC	*Univ of California FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0868GC	*Adventist Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0892GC	*Kaiser Health FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0903GC	*Prime Healthcare FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0906GC	*Providence St. Joseph FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0911G	*Toyon Associates FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction Group*
21-0914GC	*Alameda Health System FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0928GC	*LA County FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*

Two cases where Substantive Claim Challenges were filed (the "Challenged Cases")

21-0909GC	*Tenet Healthcare FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
21-0910GC	*UHS FFY 2021 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
22-0523GC *et al* (31 cases) (*See* Appendix A)

Dear Mr. Vernon:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' consolidated request for expedited judicial review ("EJR") filed on August 28, 2024, in the thirty-one (31) above-referenced group appeals. The Board's decision on jurisdiction and EJR for the thirty-one (31) above-referenced group appeals is set forth below.

Issue:

The issue for which EJR has been requested is:

> [W]hether the Providers' FFY 2022 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.1971% for FFY 2022.[1]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[2] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals

[1] Consolidated request for Expedited Judicial Review at 3 (Aug. 28, 2024).
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[3] The standardized amount is 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 from the cost data the effects of 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. 27708, 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

located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[6]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[7]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[8] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[9] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[10] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by

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labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[4] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[5] of the Department of Health and Human Services.
[6] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited Sept. 27, 2024).
[7] 42 U.S.C. § 1395ww(d)(3)(E).
[8] 83 Fed. Reg. 20164 (May 7, 2018).
[9] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[10] *Id.* at 19162.

"reduc[ing] the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values for budget neutrality purposes, as well as changing the calculation of the rural floor . . . ."[11]

In the FY 2020 IPPS final rule, the Secretary summarized his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure. Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[12]

In the FFY 2020 IPPS Final Rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals, as proposed without modification. Based on the data for this final rule, for FY 2020, the 25th percentile wage index value across all hospitals is 0.8457."[13] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is then a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[14]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our

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[11] *Id.*
[12] 84 Fed. Reg. at 42326 (citations omitted).
[13] *Id.* at 42328.
[14] *Id.* at 42326.

approach is consistent with approaches used in other areas of the Medicare program."[15] The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[16] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[17]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[18] The Secretary also confirmed that he was "finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner" and asserted that his authority to do so "falls within the scope of the authority of section 1886(d)(3)(E) of the Act" and "even if [budget neutrality] were not required [under section 1886(d)(3)(E)], we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending."[19]

The Secretary announced that the low wage index policy would be *in effect* ***for at least*** *four years beginning in FFY 2020*, "in order to allow employee compensation increases implemented by [low wage index value] hospitals sufficient time to be reflected in the wage index calculation."[20] The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and "four years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index data."[21] The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[22]

In the FFY 2021 IPPS Final Rule, the Secretary stated he was continuing the low wage index hospital policy for FY 2021, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[23] Based on the data for this final rule, for FFY 2021, the 25th percentile wage index value across all hospitals was 0.8465, which was later corrected to 0.8469.[24]

Thereafter, in the FY 2022 IPPS Final Rule, the Secretary again stated he was continuing the low wage index hospital policy for FY 2022, and also applying this policy in a budget neutral manner

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[15] *Id.*
[16] *Id.*
[17] *Id.* at 42328.
[18] *Id.*
[19] *Id.* at 42331.
[20] *Id.* at 42326.
[21] *Id.* at 42326-7.
[22] *Id.* at 42327.
[23] 85 Fed. Reg. 58432, 58436, 58767-68 (Sept. 18, 2020).
[24] *Id.* at 58768; 85 Fed. Reg. 78748, 78754 (Dec. 7, 2020) (Correction).

by applying an adjustment to the standardized amounts.[25] Based on the data for this final rule, for FY 2022, the 25th percentile wage index value across all hospitals was 0.8437.[26]

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that "while it would not be appropriate to create a wage index floor or a wage index ceiling", it would be appropriate to "provide a mechanism to increase the wage index of low wage index hospitals . . . while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals."[27] The Secretary maintained that this action had two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage index is not considered high or low, do not have their wage index values affected by this proposed policy."[28] Thus, the Secretary concluded that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . . it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[29]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[30] Based on this feedback, the Secretary decided to "finaliz[e] a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) "budget neutrality is required under [§ 1395ww(d)(3)(E)];" (2) "even if it were not required, [he believes that] it would be inappropriate to use the wage index to increase or decrease overall IPPS spending;" and (3) he "wish[ed] to consider further the policy arguments raised by commenters regarding [the] budget neutrality proposal."[31] Specifically, "consistent with [the Secretary's] current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in [the] rule, [was] implemented in a budget neutral manner."[32]

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[25] 86 Fed. Reg. 44774, 44778 (Aug. 13, 2021).
[26] *Id.* at 45178.
[27] 84 Fed. Reg. at 42329.
[28] *Id.*
[29] *Id.*
[30] *Id.* at 42331.
[31] *Id*.
[32] *Id*.

The Secretary has continued the low wage index hospital policy in the following four years, for FFYs 2021 to 2024, and continued to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[33]

Providers' Position:

The Providers are challenging their IPPS payments for FFY 2022 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.[34]

The Providers explain that the Secretary continues to implement, without any changes, his policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") that he first adopted for FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that the Low Wage Index Redistribution increases the AWI values of hospitals with AWI values in the lowest quartile, nationally, by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values.[35]

The Providers note that in the FFY 2022 IPPS Final Rule, the Secretary reiterated his assertion that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E) despite acknowledging that the district court in *Bridgeport Hospital, et al. v. Becerra,* No. 1:20-cv-01574 (D.D.C.)[36] held that the Secretary did not have the legal authority under 42 U.S.C. §§ 1395ww(d)(3)(E) or 1395ww(d)(5)(I)(i) to adopt the FFY 2020 Low Wage Index Redistribution.[37] This section of the statute (42 U.S.C. § 1395ww(d)(3)(E)(i)) authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) "reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." The Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States."[38]

The Providers contend that the Secretary "again elected to implement his Low Wage Index Redistribution in a budget neutral manner" for FFY 2022. As a result, the Providers allege, the

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[33] 85 Fed. Reg. at 58436 (Sept. 18, 2020); 86 Fed. Reg. at 44778 (Aug. 13, 2021); 87 Fed. Reg. at 49006 (Aug. 10, 2022); 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[34] Consolidated Request for EJR at 1 (Aug. 28, 2024).
[35] *Id.* at 3.
[36] 589 F. Supp. 3d 1 (2022), *aff'd in part and rev'd in part*, *Bridgeport Hospital, dba Yale New Haven Health, et al. v. Becerra,* 2024 WL 3504407 (D.C. Cir. 2024). The Providers note the same conclusions were made in the 9th Circuit in *Kaweah Delta Health Care District et al. v. Becerra*, 2022 WL 18278175 (C.D. Cal. 2022).
[37] Consolidated Request for EJR at 4.
[38] 42 U.S.C. § 1395ww(d)(3)(E)(i).

Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.1971% to offset the AWI increases to those hospitals in the lowest AWI quartile.[39]

The Providers point out that the Secretary continues to assert that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E), however, he noted that even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke is statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment.[40] This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." The Providers contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).[41]

The Providers argue that "the Secretary lacks the authority to (a) continue the Low Wage Index [Redistribution] in the manner set forth in the FFY 2022 Final IPPS Rule; and, (b) continue to implement such policy in a budget neutral manner under the [AWI] statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, the [Providers are challenging] the adjustment to the standardized amount on several grounds, including, but not limited to, that it: exceeds statutory authority, contradicts the [AWI] congressional mandate, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively."[42]

The Providers note that "[t]he immediate detrimental effect will be a 0.1971% negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2022 for every IPPS hospital, resulting in a reduction in overall MS-DRG IPPS payments for all IPPS hospitals, including the [Providers]." Further, as this is the second year of the implementation of the Low Wage Index Redistribution and the related budget neutrality adjustment, the Providers already suffered an unlawful negative adjustment in FFYs 2020 and 2021.[43]

The Providers summarize their request as follows:

> Based on the foregoing, the [Providers] are challenging the Low Wage Index [Redistribution] in this group appeal for several reasons, including but not limited to, whether the Secretary (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I)(i); and (2) improperly reduced FFY 2022 payments to IPPS hospitals, including the [Providers], as a result of the budget neutral implementation of the Low Wage Index [Redistribution], which has been

[39] Consolidated Request for EJR at 4.
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.* at 4-5.

> in effect since October 1, 2019, and continues through FFY 2022. The [Providers] seek their proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).[44]

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, but the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.1971% reduction issued by the Secretary in the FFY 2022 IPPS Final Rule.[45]

Medicare Contractor's Position:

As further detailed below, for seventeen (17) of the cases[46] in the Consolidated Request for EJR, there has been no substantive claim or jurisdictional challenge filed. In in the remaining fourteen (14) cases, substantive claim challenges were filed prior to the Consolidated Request for EJR. In thirteen (13) cases, there was a timely substantive claim challenge. In one case, there was a second, untimely challenge, but the provider being challenged was withdrawn from the case so it is moot. In one other case, there was a substantive claim challenge that was not timely, and, as such, the Board declines to consider it.

Following receipt of the Consolidated Request for EJR on August 28, 2024, the Medicare Contractor's representative, Federal Specialized Services ("FSS") filed a notice on September 5, 2024 certifying that that it would be filing Substantive Claim Challenges in thirteen (13) cases, and also noted that a substantive claim challenge had previously been filed in one (1) case. FSS did not acknowledge the other thirteen cases where substantive claim challenges had already been filed but, nevertheless, failed to file any new challenges within the time required by the Board's Rules.[47]

Substantive Claim Challenges:

A. Medicare Contractor's Challenges

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[44] *Id.* at 5.
[45] *Id.* at 6-8.
[46] *See* Appendix A (the "Unchallenged Cases").
[47] Board Rule 44.5.2 (2023) typically requires a party questioning whether a participant included an appropriate claim on the cost report at issue to file its Substantive Claim Challenge within 60 days of the group filing its Final Schedule of Providers ("SOP"). When an EJR Request is filed within 60 days of the Final SOP, the moving party must certify that it will be filing a challenge within five business days, and then must file the actual challenge within 20 days following the filing of the EJR Request. The Consolidated EJR Request in the case was filed on August 28, 2024. On September 5, 2024 (five business days after the EJR Request, noting that September 2 was a federal holiday), FSS certified that it would be filing substantive claim and/or jurisdictional challenges in thirteen cases even though the EJR Request was not filed within 60 days of the Final SOPs in those cases. Twenty days from the date the Consolidated EJR Request was filed was Tuesday, September 17, 2024. As of the date of this decision, no additional substantive claim or jurisdictional challenges were filed in the cases noted by FSS.

As detailed below, Substantive Claim Challenges have been filed in fourteen (14) cases.[48] FSS notes throughout the Substantive Claim Challenges that the FFY 2022 overlaps with portions of two separate cost reporting periods for most the Providers,[49] and that many cost reports for the latter periods were not due at the time the challenges were filed. As such, it claims this is "good cause" to supplement those challenges once the cost reports were filed as envisioned by Board Rule 44.5.2.[50]

The Arguments raised in all of the Substantive Claim Challenges are materially identical. The specific Participants and FYEs being challenged in each case (the "Challenged Participants") are set forth in Appendix B to this decision. The Medicare Contractor generally notes that the appeals were taken from the Federal Register, but that on the impacted cost reports, each Challenged Participant failed to submit any documentation to support they claimed reimbursement for the appealed issue. It also notes that, while the Challenged Participants may have filed their cost reports identifying certain amounts as Part A Protested amounts, "A review of the Summary of Protested Amounts reveals that the Provider did not establish a self-disallowed item for the Area Wage Index Lowest Quartile IPPS Payment Reduction issue. Accordingly, there is nothing in the record to demonstrate that the Provider claimed an amount for the Area Wage Index Lowest Quartile IPPS Payment Reduction issue as a protested item in its FYE 12/31/2021 Medicare cost report. Thus, the Provider did not properly establish a self-disallowed item for the specific item in dispute as described at 42 C.F.R. § 413.24(j)(2)."[51]

B. Providers' Responses to Substantive Claim Challenges

The Providers filed responses to each Substantive Claim Challenge, which are all materially identical, except where noted in the Board's discussion, below.

First, the Providers argue that the substantive claim requirement at 42 C.F.R. § 413.24(j) is substantively and procedurally invalid pursuant to the holdings in *Bethesda Hospital Ass'n. v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*") and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) ("*Banner Heart Hospital*").[52]

Second, the Providers note they have exercised their statutory right to appeal from a Federal Register publication, namely the FFY 2022 IPPS Final Rule, which was published on August 13, 2021. Thus, their appeals from this final determination were due by mid-February, 2022, while the first cost reports for the Providers in this appeal were not due until after this date. For this reason, it would have been factually impossible to protest the issue on their cost reports prior to filing the group appeal.[53] They also claim that by filing the group appeal, the Providers gave

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[48] *See* Appendix A (the "Challenged Cases").
[49] *But see, e.g.*, PRRB Case 22-0554GC, where all participants have an FYE 09/30/2022.
[50] *E.g.*, PRRB Case 22-0523GC, Medicare Administrative Contractor Substantive Claim Letter, 4 (Apr. 27, 2023).
[51] *E.g.*, *id.* at 4-5 (citing Exs. C-3 and C-4).
[52] *E.g.,* PRRB Case 22-0523GC, Providers' Response to MAC's April 27, 2023 Substantive Claim Letter, 2 (May 26, 2023).
[53] *Id.* at 2 & n.1.

notice that they were all protesting their IPPS payments based on the reasons set forth in the appeal.[54]

The Providers also argue that a challenge to the policy being appealed is not a "specific item" of reimbursement that could be claimed because it arises from IPPS claims and cuts across all IPPS payments. They also believe that all of the participants in this appeal satisfied the substantive claim requirements by submitting claims on their cost reports for all operating IPPS payments, that their cost report claims sought reimbursement for all amounts due under the law, and that the AWI payment reduction issue seeks payment of amounts that would have been paid if the law had been properly applied.[55] Similarly, the Providers believe it is unreasonable to require cost-reporting protests on the AWI Payment Reduction Issue because "the Secretary has long been aware of the AWI Payment Reduction Issue, because it was presented more than two years ago in the *Bridgeport* and *Kaweah Delta* Board appeals and federal court litigation, and in subsequent board appeals every year since."[56]

For the vast majority of the Challenged Participants, the Providers concede that the "MAC is correct that the [challenged] Hospitals did not explicitly repeat their protest of the AWI Payment Reduction Issue on their identified as-filed Medicare cost reports."[57] Arguments related to specific Challenged Participants for which the Providers argue that they *did* comply with the substantive claim requirements are outlined, below.

Decision of the Board:

A. Jurisdiction and Request for EJR

Each of the participants in these thirty-one (31) group cases appealed from the FFY 2022 IPPS Final Rule.[58] The Board has determined that: (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[59] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy ("AiC") calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.1971 percent (*i.e.,* the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has

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[54] *Id.* at 2-3.
[55] *Id.*
[56] *Id.* at 13-14.
[57] *Id.* at 5.
[58] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[59] *See* 42 C.F.R. § 405.1837.

jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j) are applicable. The regulation 42 C.F.R. § 413.24(j) requires that:

> (1) *General Requirement*. 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
>
> (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.[60]

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.
> (b) *Summary of Procedures*.
> ****
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ****
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
> ****
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section*—(1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether

[60] (Bold and underline emphasis added.)

> the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[61]

These regulations are applicable to the cost reporting periods in these group cases.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

a. Unchallenged Cases and Providers with no Cost Reports

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[62] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[63] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included *if review under subsection (b)(1) has been triggered by a party raising a question under subsection (a) of whether a provider made an appropriate claim for the specific item under appeal on the relevant as-filed cost report*.

Accordingly, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[64] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made on the relevant as-filed cost report.[65] The Board further notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[66] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

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[61] (Bold and underline emphasis added.)
[62] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[63] (Emphasis added.)
[64] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[65] *See* 42 C.F.R. § 405.1873(a),
[66] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on the Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these type of instances, any Substantive Claim Challenge would be premature. That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position.

Here, for some of the seventeen (17) Unchallenged Cases, while FSS indicated that it would be filing Substantive Claim Challenges, it failed to do so within the time required by the Board's Rules. Additionally, FSS indicated for some participants in the Unchallenged Cases, cost reports have not been filed. As previously noted, the fact that cost reports have not yet been filed does not trigger § 405.1873(a). In this regard, all of the participants in the Unchallenged Cases are appealing the FFY 2022 Federal Register Notice and either (1) FSS has not challenged whether the as-filed cost reports included an appropriate claim for the appealed issue, or (2) the cost reports impacted by the FFY 2022 Federal Register Notice appear to have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[67] Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings of fact on substantive claim requirements in the Unchallenged Cases for any of the participants.

b. Challenged Cases and Challenged Participants

As previously noted, for the vast majority of the Challenged Participants, the Providers concede that the "MAC is correct that the [challenged] Hospitals did not explicitly repeat their protest of the AWI Payment Reduction Issue on their identified as-filed Medicare cost reports."[68] Except as noted below, the Board specifically finds that it is undisputed that these participants failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1).

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[67] *See* 80 Fed. Reg. at 70556, 70569-70.
[68] *E.g.,* PRRB Case 22-0523GC, Providers' Response to MAC's April 27, 2023 Substantive Claim Letter, 5 (May 26, 2023).

For two Challenged Participants, however, the Providers raise different arguments.

i. Case 22-0557GC, Rockville General Hospital (Prov. No. 07-0012; FYE 12/31/2021)

In Case 22-0557GC, the Medicare Contractor claims that for the FYE 12/31/2021, Rockville General Hospital (Prov. No. 07-0012; FYE 12/31/2021) ("Rockville") failed to include an appropriate cost report claim for the appealed item in dispute .[69] It notes that the Providers identified $10,487 in Part A Protested amounts on its cost report, and a Summary of Protested Amounts with the same total. The Summary of Protested Amounts, however, does not have an actual amount for the wage index issue.[70]

The Providers filed a response to the Substantive Claim Challenge on June 14, 2023. The legal arguments are materially identical to those made in the response in Case 22-0523GC, except that they disagree with the factual assertions in the Medicare Contractor's Substantive Claim Challenge. Specifically, the Providers state that Rockville explicitly protested the AWI Payment Reduction Issue.[71] They also note that Rockville had no inpatient discharges during the period from October 1, 2021 through December 31, 2021 (for its FYE 12/31/2021), so there is no estimated impact for the appealed issue during this time period, but that it *did* have Medicare inpatient discharges during its FYE December 31, 2022 (for its FYE 12/31/2022).[72] Rockville's FYE December 31, 2022 cost report was not, however, due until May 31, 2022 – fifteen (15) months after the deadline for appealing the applicable Federal Register.[73]

The Board disagrees with the Provider and finds that Rockville failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1) for its FYE 12/31/2021.

42 C.F.R. §§ 413.24(j) can be satisfied if a provider (1) claims full reimbursement for a specific item on its cost report, or (2) self-disallows the specific item. To properly self-disallow an item, a provider must (i) ***include an estimated reimbursement amount for each item in the protested amount line on its cost report***, and (ii) attach a separate worksheet to the cost report for each specific self-disallowed item.

For its FYE 12/31/2021, Rockville did, in fact, list the Area Wage Index Reduction issue in its summary of protested amounts, but did not associate a dollar amount (estimated reimbursement amount) with it.[74] This is a fatal deficiency under the requirements of 42 C.F.R. § 413.24(j). Indeed, Rockville explained that it did not have a reimbursement impact for its FYE 12/31/2021 for this issue because it did not have any inpatient discharges for that time period. In fact, its

[69] PRRB Case 22-0557GC, Medicare Administrative Contractor Substantive Claim Letter, 1 (May 16, 2023).
[70] *Id.* at Ex. C-2 at 4.
[71] PRRB Case 22-0557GC, Providers' Response to MAC's May 16, 2023 Substantive Claim Letter, 4-5 and Ex. C-2 at 4 (June 14, 2023).
[72] *Id.* at 5 & n.2.
[73] *Id.* at 4.
[74] PRRB Case 22-0557GC, Medicare Administrative Contractor Substantive Claim Letter, Ex. C-2 at 4 (May 16, 2023).

reimbursement impact for this issue was limited to its FYE 12/31/2022, which overlaps with the FFY 2022 at issue, but the cost report for its FY 2022 was not due before the deadline for appealing the FFY 2022 Final Rule in this case.[75]

The Medicare Contractor only challenged Rockville's cost reporting period for FYE 12/31/2021. Rockville did not include an estimated reimbursement impact for this time period and conceded that it did not have any reimbursement impact for that time period.

As previously noted, the cost report for Rockville's FYE 12/31/2022 had not been filed at the time of the appeal, and it would have been impossible to demonstrate compliance with the requirements of 42 C.F.R. § 413.24(j) at the time of the appeal and are thus inapplicable, but the Medicare Contractor did not challenge that cost reporting period and the Board's obligation to make findings of fact under 42 C.F.R. § 405.1873 has not been triggered for that time period.

ii. Case 22-0572GC, St. Mary's Regional Medical Center (Prov. No. 37-0026; FYE 12/31/2022)

Case 22-05572GC contains twenty-one (21) participants and, pursuant to Board Rule 20, was deemed fully formed by the Providers' Representative on March 22, 2023. FSS filed a Substantive Claim Challenge in this case on September 12, 2023. The Medicare Contractor claims that for the FYE 12/31/2022, St. Mary's Regional Medical Center (Prov. No. 37-0026) ("St. Mary's") failed to include an appropriate cost report claim for the appealed item in dispute.[76] It notes that St. Mary's filed its FYE 12/31/2022 cost report and indicated $0 in Part A Protested Amounts.[77] Accordingly, there is nothing in the as filed cost report to demonstrate that the Provider properly established a self-disallowed item for the understated Wage Index Payment Amount issue in its FYE 12/31/2022 cost report as described at 42 C.F.R. § 413.24(j)(2).

The Providers filed a response to the Substantive Claim Challenge on October 3, 2023. They make two arguments in addition to the general arguments made in all of the Challenged Cases noted, *supra.*

First, the Providers argue that the Substantive Claim Challenge should be denied as untimely pursuant to Board Rule 44.5.2 because it was filed more than 60 days after the Providers certified that the group was fully formed, and that there was no effort to demonstrate good cause for the untimely filing.[78]

Second, the Providers disagree with the factual assertions in the Medicare Contractor's Substantive Claim Challenge. Specifically, the Providers state that St. Mary's explicitly protested

[75] PRRB Case 22-0557GC, Providers' Response to MAC's May 16, 2023 Substantive Claim Letter, 4-5 & n.2 (June 14, 2023).
[76] PRRB Case 22-0572GC, Medicare Administrative Contractor Substantive Claim Letter, 1 (Sept. 12, 2023).
[77] *Id.* at 4 (citing Ex. C-2).
[78] PRRB Case 22-0572GC, Providers' Response to MAC's September 12, 2023 Substantive Claim Letter, 2 (Oct. 3, 2023).

the AWI Payment Reduction Issue on its cover letter to the cost report and accompanying workpapers.[79]

Board Rule 44.5.2 (2021) generally requires Substantive Claim Challenges be filed within sixty (60) days after the group files its final Schedule of Providers ("SOP") unless the moving party's filing demonstrates good cause. In this case, the Providers' Representative filed its Rule 20 Certification (in lieu of a hard copy SOP) on March 22, 2023. Thus, any Substantive Claim Challenges would have been due no later than May 22, 2023. The Substantive Claim Challenge was filed on September 12, 2023 and fails to make any argument to demonstrate good cause for the belated filing.

Failure to comply with the Board's rules can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. ***The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules*** and orders or for inappropriate conduct during proceedings in the appeal.
>
> *****
>
> (c) ***f a contractor fails to meet a filing deadline or other requirement established by the Board, the Board may——***
>
> (1) Take other actions that it considers appropriate, such as—
>
> (i) Issuing a decision based on the written record submitted to that point; or
>
> (ii) Issuing a written notice to CMS describing the contractor's actions and requesting that CMS take appropriate action, such as review of the contractor's compliance with the contractual requirements of §§ 421.120, 421.122, and 421.124 of this chapter; . . .[80]

Absent good cause for the belated filing of the Medicare Contractor's Substantive Claim Challenge, the Board finds that it is appropriate to issue its decision on St. Mary's in Case 22-0572GC based on the record submitted up to that point with regard to any review of the Final Schedule of Providers and related Substantive Claim issues. Since the Medicare Contractor did not issue a ***timely*** challenge to St. Mary's for its FYE 12/31/2022 in Case 22-0572GC, The Board finds that its obligation to make findings of fact under 42 C.F.R. § 405.1873 has not been triggered for that time period and declines to consider any arguments raised in the belated challenge or make any related findings of fact.

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[79] *Id.* at 4-5 and Ex. P-1 at 2-3.
[80] (Emphasis added).

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[81] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."; and

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."[82]

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to

[81] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[82] *Id.* at 42326.

> target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[83]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but *uncodified* regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index."

While this appeal involves the FFY 2022 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[84] The proposed rule did not propose any changes to this policy. The Final Rule for FFY 2022 refers to the responses to comments provided in the FFY 2020 Final Rule, and applied the policy in the same manner as it was applied in FFY 2020.[85] Therefore, the Board finds that this policy continues to be a binding but *uncodified* regulation for FFY 2022.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2022 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount by 0.1971 percent for FFY 2022. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board makes the following findings:

1) The Board has jurisdiction over the AWI Issue for the subject year in these cases and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[86] have been filed for the seventeen (17) Unchallenged Cases, or for the Unchallenged Participants in the fourteen (14) Challenged Cases, listed in

[83] 84 Fed. Reg. at 42331.
[84] 86 Fed. Reg. 44774, 45180 (Aug. 13, 2021).
[85] *Id.*
[86] As the Board explained 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 more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

Appendix A pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) While the Providers appealed cost reporting periods beginning after January 1, 2016, no ***timely*** substantive claim challenges have been filed for Case 22-0572GC pursuant to Board Rule 44.5.2 (2021) and 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

4) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered in the Challenged Cases (***except for Case 22-0572GC***) for the Challenged Participants and FYEs listed in Appendix B, and

    a the Board specifically finds that, except for Case 22-0557GC, Rockville General Hospital (Prov. No. 07-0012; FYE 12/31/2021), it is undisputed that these participants failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1); and
    b the Board specifically finds that, in Case 22-0557GC, Rockville General Hospital (Prov. No. 07-0012; FYE 12/31/2021) also failed to include "an appropriate claim for the specific item" that is the subject of its group appeal as required under 42 C.F.R. § 413.24(j)(1).

5) Based upon the Providers' assertions regarding the FFY 2022 IPPS Final Rule, there are no findings of fact for resolution by the Board;

6) The Board is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

7) The Board is without the authority to decide the legal questions of:

    a Whether the Uncodified Regulation on Wage Index published in the FFY 2022 IPPS Final Rule is valid; and
    b Whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid for any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1).

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2022 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year. For any Providers which the Board has specifically found failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1), the Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants their requests for EJR for the issue and the subject

years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/27/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

Enclosure: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H) (J-L)

Appendix A

Seventeen Cases where no Substantive Claim Challenge was Filed (collectively the "Unchallenged Cases")

22-0524GC	*AHMC Healthcare FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0525GC	*Alameda Health System FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0527GC	*Community Med Ctrs FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0528GC	*Cottage Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0529GC	*Dignity Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0544GC	*Keck Medicine of USC FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0550GC	*Loma Linda University FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0552GC	*MemorialCare FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0558GC	*Providence St. Joseph FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0559GC	*Scripps Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0560GC	*Sharp Healthcare FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0561GC	*Stanford Health Care FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0567GC	*Sutter Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0570GC	*Tenet Healthcare FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0571GC	*Univ of California FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0575GC	*Pipeline FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0576GC	*Cedars-Sinai Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*

Fourteen cases where Substantive Claim Challenges were filed (collectively the "Challenged Cases")

22-0523GC	*Adventist Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0526GC	*Alecto Healthcare FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0530GC	*Emanate Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0531GC	*John Muir Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0539GC	*Kaiser Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0546GC	*KPC Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0547GC	*LA County FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0548GC	*LA Downtown Med. Ctr. LLC FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0553GC	*Palomar Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0554GC	*PIH Health FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0556GC	*Prime Healthcare FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0557GC	*Prospect Medical Holdings FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0572GC	*UHS FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
22-0574G	*Toyon Associates FFY 2022 Area Wage Index Lowest Quartile IPPS Payment Reduction Group*

Appendix B

The following are the participants in each group for which a Substantive Claim Challenge was made by the Medicare Contractor (collectively the "Challenged Participants"). Any Participants not listed below are collectively the "Unchallenged Participants".

Case 22-0523GC
- Adventist Health Hanford (Prov. No. 05-0121, FYE 12/31/2021)
- Adventist Health Reedley (Prov. No. 05-0192, FYE 12/31/2021)
- Ukiah Valley Medical Center (Prov. No. 05-0301, FYE 12/31/2021)
- Adventist Health Tulare (Prov. No. 05-0784, FYE 12/31/2021)

Case 22-0526GC
- Wilson N Jones (Prov. No. 45-0469, FYE 12/31/2021)

Case 22-0530GC
- Emanate Health Intercommunity Hospital (Prov. 05-0382, FYE 12/31/2021)
- Foothill Presbyterian Hospital (Prov. NO. 05-0597, FYE 12/31/2021)

Case 22-0531GC
- John Muir Medical Center – Walnut Creek Campus (Prov. No. 05-0180, FYE 12/31/2021)
- John Muir Medical Center – Concord Campus (Prov. No. 05-0496, FYE 12/31/2021)

Case 22-0539GC
- Kaiser Foundation Hospital - South San Francisco (Prov. 05-0070, FYE 12/31/2021)
- Kaiser Foundation Hospital - Santa Clara (Prov. No. 05-0071, FYE 12/31/2021)
- Kaiser Foundation Hospital - Walnut Creek (Prov. 05-0072, FYE 12/31/2021)
- Kaiser Foundation Hospital - Vallejo (Prov. 05-0073, FYE 12/31/2021)
- Kaiser Foundation Hospital – Oakland/Richmond (Prov. 05-0075, FYE 12/31/2021)
- Kaiser Foundation Hospital - San Francisco (Prov. 05-0076, FYE 12/31/2021)
- Kaiser Foundation Hospital - Panorama City (Prov. 05-0137, FYE 12/31/2021)
- Kaiser Foundation Hospital - Los Angeles (Prov. 05-0138, FYE 12/31/2021)
- Kaiser Foundation Hospital - Downey (Prov. 05-0139, FYE 12/31/2021)
- Kaiser Foundation Hospital - Fontana Medical Center (Prov. 05-0140, FYE 12/31/2021)
- Kaiser Foundation Hospital - Sacramento (Prov. 05-0425, FYE 12/31/2021)
- Kaiser Foundation Hospital – San Rafael (Prov. 05-0510, FYE 12/31/2021)
- Kaiser Foundation Hospital - Fremont (Prov. 05-0512, FYE 12/31/2021)
- Kaiser Foundation Hospital - Zion (Prov. 05-0515, FYE 12/31/2021)
- Kaiser Foundation Hospital - Redwood City (Prov. 05-0541, FYE 12/31/2021)
- Kaiser Foundation Hospital - San Jose (Prov. 05-0604, FYE 12/31/2021)
- Kaiser Foundation Hospital - Anaheim (Prov. 05-0609, FYE 12/31/2021)
- Kaiser Foundation Hospital - So. Sacramento (Prov. 05-0674, FYE 12/31/2021)
- Kaiser Foundation Hospital - Woodland Hills (Prov. 05-0677, FYE 12/31/2021)

- Kaiser Foundation Hospital - Riverside (Prov. 05-0686, FYE 12/31/2021)
- Kaiser Foundation Hospital - Fresno (Prov. 05-0710, FYE 12/31/2021)
- Kaiser Foundation Hospital - Baldwin Park (Prov. 05-0723, FYE 12/31/2021)
- Kaiser Foundation Hospital - Manteca (Prov. 05-0748, FYE 12/31/2021)
- Kaiser Foundation Hospital - Antioch (Prov. 05-0760, FYE 12/31/2021)
- Kaiser Foundation Hospital - Moreno Valley (Prov. 05-0765, FYE 12/31/2021)
- Kaiser Foundation Hospital - Vacaville (Prov. 05-0767, FYE 12/31/2021)
- Kaiser Foundation Hospital - Roseville (Prov. 05-0772, FYE 12/31/2021)
- Kaiser Foundation Hospital - San Leandro (Prov. 05-0777, FYE 12/31/2021)
- Kaiser Foundation Hospital - Hawaii (Prov. 12-0011, FYE 12/31/2021)
- Kaiser Sunnyside Medical Center (Prov. 38-0091, FYE 12/31/2021)
- Kaiser Foundation Hospital - Westside (Prov. 38-0103, FYE 12/31/2021)
- Kaiser Permanente Central Hospital (Prov. 50-0052, FYE 12/31/2021)

Case 22-0546GC

- Hemet Valley Medical Center (Prov. No. 05-0390, FYE 12/31/2021)
- Victor Valley Global Medical Center (Prov. No. 05-0517, FYE 12/31/2021)
- Menifee Valley Medical Center (Prov. No. 05-0684, FYE 12/31/2021)
- Anaheim Global Medical Center (Prov. No. 05-0744, FYE 8/31/2022)
- Chapman Global Medical Center (Prov. No. 05-0745, FYE 8/31/2022)
- Orange County Global Medical Center (Prov. No. 05-0746, FYE 8/31/2022)
- South Coast Global Medical Center (Prov. No. 05-0747, FYE 8/31/2022)

Case 22-0547GC

- LAC Olive View – UCLA Medical Center (Prov. No. 05-0040, FYE 6/30/2022)
- LAC+USC Medical Center (Prov. No. 05-0373, FYE 6/30/2022)
- LAC Harbor UCLA Medical Center (Prov. No. 05-0376, FYE 6/30/2022)
- LAC/Rancho Los Amigos National Rehab Center (Prov. No. 05-0717, FYE 6/30/2022)

Case 22-0548GC

- West Covina Medical Center Inc. (Prov. No. 05-0096, FYE 12/31/2021)
- LA Downtown Medical Center LLC (Prov. No. 05-0763, FYE 12/31/2021)

Case 22-0553GC

- Palomar Medical Center (Prov. No. 05-0115, FYE 06/30/2022)
- Palomar Medical Center Poway (Prov. No. 05-0636, FYE 06/30/2022)

Case 22-0554GC

- PIH Health Whittier Hospital (Prov. No. 05-0169, FYE 09/30/2022)
- PIH Hospital - Downey (Prov. No. 05-0393, FYE 09/30/2022)

Case 22-0556GC

- Paradise Valley Hospital (Prov. No. 05-0025, FYE 12/31/2021)
- Saint Francis Medical Center (Prov. No. 05-0104, FYE 12/31/2021)

- Encino Hospital Medical Center (Prov. No. 05-0185, FYE 12/31/2021)
- Garden Grove Hospital & Med Center (Prov. No. 05-0230, FYE 12/31/2021)
- West Anaheim Medical Center (Prov. No. 05-0426, FYE 12/31/2021)
- Huntington Beach Hospital (Prov. No. 05-0526, FYE 12/31/2021)
- La Palma Intercommunity Hospital (Prov. No. 05-0580, FYE 12/31/2021)
- Chino Valley Medical Center (Prov. No. 05-0586, FYE 12/31/2021)
- San Dimas Community Hospital (Prov. No. 05-0588, FYE 12/31/2021)
- Desert Valley Hospital (Prov. No. 05-0709, FYE 12/31/2021)
- Centinela Hospital Med Center (Prov. No. 05-0739, FYE 12/31/2021)
- Sherman Oaks Hospital (Prov. No. 05-0755, FYE 12/31/2021)
- Alvarado Hospital Med Center (Prov. No. 05-0757, FYE 12/31/2021)
- Montclair Hospital Med Center (Prov. No. 05-0758, FYE 12/31/2021)
- Shasta Regional Med Center (Prov. No. 05-0764, FYE 12/31/2021)
- Lehigh Regional Med Center (Prov. No. 10-0107, FYE 12/31/2021)
- Southern Regional Med Center (Prov. No. 11-0165, FYE 12/31/2021)
- Monroe Hospital (Prov. No. 15-0813, FYE 12/31/2021)
- Saint John Hospital (Prov. No. 17-0009, FYE 12/31/2021)
- Providence Medical Center (Prov. No. 17-0146, FYE 12/31/2021)
- Lake Huron Medical Center (Prov. No. 23-0031, FYE 12/31/2021)
- Garden City Hospital (Prov. No. 23-0244, FYE 12/31/2021)
- St. Joseph Medical Center (Prov. No. 26-0086, FYE 12/31/2021)
- St. Mary's Medical Center (Prov. No. 26-0193, FYE 12/31/2021)
- North Vista Hospital (Prov. No. 29-0005, FYE 12/31/2021)
- St. Mary's Regional Med Center (Prov. No. 29-0009, FYE 12/31/2021)
- St. Mary's General Hospital (Prov. No. 31-0006, FYE 12/31/2021)
- St. Clare's Hospital Denville (Prov. No. 31-0060, FYE 12/31/2021)
- St. Michael's Medical Center (Prov. No. 31-0096, FYE 12/31/2021)
- Lower Bucks Hospital (Prov. No. 39-0070, FYE 12/31/2021)
- Suburban Community Hospital (Prov. No. 39-0116, FYE 12/31/2021)
- Roxborough Memorial Hospital (Prov. No. 39-0304, FYE 12/31/2021)
- Landmark Medical Center (Prov. No. 41-0011, FYE 12/31/2021)
- Pampa Regional Med Center (Prov. No. 45-0099, FYE 12/31/2021)
- Dallas Medical Center (Prov. No. 45-0379, FYE 12/31/2021)
- Dallas Regional Med Center (Prov. No. 45-0688, FYE 12/31/2021)
- Harlingen Medical Center (Prov. No. 45-0855, FYE 12/31/2021)

Case 22-0557GC

- Rockville General Hospital (Prov. No. 07-0012; FYE 12/31/2021) (“Rockville”)

Case 22-0572GC

- St. Mary’s Regional Medical Center (Prov. No. 37-0026; FYE 12/31/2022) (“St. Mary’s”)

Case 22-0574G

- Antelope Valley Hospital (Prov. No. 05-0056, FYE 06/30/2022)
- Bakersfield Heart Hospital (Prov. No. 05-0724, FYE 12/31/2021)
- Beverly Hospital (Prov. No. 05-0350, FYE 12/31/2021)
- Casa Colina Hospital (Prov. No. 05-0782, FYE 3/31/2022)
- Comm Mem Hosp San Buenaventura (Prov. No. 05-0394, FYE 12/31/2021)
- Dameron Hospital (Prov. No. 05-0122, FYE 12/31/2021)
- El Centro Regional Medical Center (Prov. No. 05-0045, FYE 06/30/2022)
- Good Samaritan Hospital (Prov. No. 05-0257, FYE 12/31/2021)
- Hollywood Presbyterian Medical Center (Prov. No. 05-0063, FYE 12/31/2021)
- Lompoc Valley Medical Center (Prov. No. 05-0110, FYE 06/30/2022)
- Mad River Community Hospital (Prov. No. 05-0028, FYE 06/30/2022)
- Madera Community Hospital (Prov. No. 05-0568, FYE 06/30/2022)
- Marin General Hospital (Prov. No. 05-0360, FYE 12/31/2021)
- Mission Community Hospital (Prov. No. 05-0704, FYE 12/31/2021)
- Oak Valley Hospital District (Prov. No. 05-0067, FYE 06/30/2022)
- Oroville Hospital (Prov. No. 05-0030, FYE 11/30/2021)
- Pacifica Hospital of the Valley (Prov. No. 05-0378, FYE 12/31/2021)
- Pioneers Memorial Healthcare District (Prov. No. 05-0342, FYE 06/30/2022)
- Pomona Valley Hospital Med Center (Prov. No. 05-0231, FYE 12/31/2021)
- Redlands Community Hospital (Prov. No. 05-0272, FYE 9/30/2022)
- Riverside County Reg Med Center (Prov. No. 05-0292, FYE 06/30/2022)
- Saint Agnes Medical Center (Prov. No. 05-0093, FYE 06/30/2022)
- San Gorgonio Memorial Hospital (Prov. No. 05-0054, FYE 06/30/2022)
- San Mateo Medical Center (Prov. No. 05-0113, FYE 06/30/2022)
- Sierra View Medical Center (Prov. No. 05-0261, FYE 06/30/2022)
- Sonoma Valley Hospital (Prov. No. 05-0090, FYE 06/30/2022)
- Tri-City Medical Center (Prov. No. 05-0128, FYE 06/30/2022)
- Valley Presbyterian Hospital (Prov. No. 05-0126, FYE 12/31/2021)
- Ventura County Medical Center (Prov. No. 05-0159, FYE 06/30/2022)
- Watsonville Community Hospital (Prov. No. 05-0194, FYE 7/31/2022)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
23-0611GC *et al.* (32 Cases) (*See* Appendix A)

Dear Mr. Vernon:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' consolidated request for expedited judicial review ("EJR") filed on August 28, 2024, in the thirty-two (32) above-referenced group appeals. The Board's decision on jurisdiction and EJR for the thirty-two (32) above-referenced group appeals is set forth below.

Issue:

The issue for which EJR has been requested is:

> [W]hether the Providers' FFY 2023 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.1854% for FFY 2023.[1]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[2] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[3] for all subsection (d) hospitals

[1] Consolidated request for Expedited Judicial Review at 3 (Aug. 28, 2024).
[2] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[3] The standardized amount is 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 from the cost data the effects of 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. 27708, 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

located in an "urban" or "rural" area.[4]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[5] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[6]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[7]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[8] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[9] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[10] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by

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labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[4] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[5] of the Department of Health and Human Services.
[6] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited Sept. 27, 2024).
[7] 42 U.S.C. § 1395ww(d)(3)(E)..
[8] 83 Fed. Reg. 20164 (May 7, 2018).
[9] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[10] *Id.* at 19162.

"reduc[ing] the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values for budget neutrality purposes, as well as changing the calculation of the rural floor . . . ."[11]

In the FY 2020 IPPS final rule, the Secretary summarized his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure. Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[12]

In the FFY 2020 IPPS Final Rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals, as proposed without modification. Based on the data for this final rule, for FY 2020, the 25th percentile wage index value across all hospitals is 0.8457."[13] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is then a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[14]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our

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[11] *Id.*
[12] 84 Fed. Reg. at 42326 (citations omitted).
[13] *Id.* at 42328.
[14] *Id.* at 42326.

approach is consistent with approaches used in other areas of the Medicare program."[15] The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[16] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[17]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[18] The Secretary also confirmed that he was "finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner" and asserted that his authority to do so "falls within the scope of the authority of section 1886(d)(3)(E) of the Act" and "even if [budget neutrality] were not required [under section 1886(d)(3)(E)], we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending."[19]

The Secretary announced that the low wage index policy would be *in effect* ***for at least*** *four years beginning in FFY 2020*, "in order to allow employee compensation increases implemented by [low wage index value] hospitals sufficient time to be reflected in the wage index calculation."[20] The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and "four years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index data."[21] The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[22]

In the FFY 2021 IPPS Final Rule, the Secretary stated he was continuing the low wage index hospital policy for FY 2021, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[23] Based on the data for this final rule, for FFY 2021, the 25th percentile wage index value across all hospitals was 0.8465, which was later corrected to 0.8469.[24]

Thereafter, in the FY 2022 IPPS Final Rule, the Secretary again stated he was continuing the low wage index hospital policy for FY 2022, and also applying this policy in a budget neutral manner

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[15] *Id.*
[16] *Id.*
[17] *Id.*at 42328.
[18] *Id.*
[19] *Id.* at 42331.
[20] *Id.* at 42326.
[21] *Id.* at42326-7.
[22] *Id.* at 42327.
[23] 85 Fed. Reg. 58432, 58436, 58767-68 (Sept. 18, 2020).
[24] *Id.* at 58768; 85 Fed. Reg. 78748, 78754 (Dec. 7, 2020) (Correction).

by applying an adjustment to the standardized amounts.[25] Based on the data for this final rule, for FY 2022, the 25th percentile wage index value across all hospitals was 0.8437.[26]

Again, in the FY 2023 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2023, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[27] Based on the data for this final rule, for FY 2023, the 25th percentile wage index value across all hospitals was 0.8427.[28]

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that "while it would not be appropriate to create a wage index floor or a wage index ceiling", it would be appropriate to "provide a mechanism to increase the wage index of low wage index hospitals . . . while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals."[29] The Secretary maintained that this action had two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage index is not considered high or low, do not have their wage index values affected by this proposed policy."[30] Thus, the Secretary concluded that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . . it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[31]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[32] Based on this feedback, the Secretary decided to "finaliz[e] a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) "budget neutrality is required under [§ 1395ww(d)(3)(E)];" (2) "even if it were not required, [he believes that] it would be inappropriate to use the wage index to increase or decrease overall IPPS spending;" and (3) he "wish[ed] to consider further the policy arguments raised by commenters regarding [the] budget neutrality proposal."[33] Specifically, "consistent with [the Secretary's] current methodology for implementing wage index budget neutrality under

[25] 86 Fed. Reg. 44774, 44778 (Aug. 13, 2021).
[26] *Id.* at 45178.
[27] 87 Fed. Reg. 48780, 49006 (Aug. 10, 2022).
[28] *Id.*
[29] 84 Fed. Reg. at 42329.
[30] *Id.*
[31] *Id.*
[32] *Id.* at 42331.
[33] *Id*.

[§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in [the] rule, [was] implemented in a budget neutral manner."[34]

The Secretary has continued the low wage index hospital policy in the following four years, for FFYs 2021 to 2024, and continued to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[35]

Providers' Position:

The Providers are challenging their IPPS payments for FFY 2023 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.[36]

The Providers explain that the Secretary continues to implement, without any changes, his policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") that he first adopted for FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that the Low Wage Index Redistribution increases the AWI values of hospitals with AWI values in the lowest quartile, nationally, by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values.[37]

The Providers note that in the FFY 2023 IPPS Final Rule, the Secretary reiterated his assertion that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E) despite acknowledging that the district court in *Bridgeport Hospital, et al. v. Becerra,* No. 1:20-cv-01574 (D.D.C.)[38] held that the Secretary did not have the legal authority under 42 U.S.C. §§ 1395ww(d)(3)(E) or 1395ww(d)(5)(I)(i) to adopt the FFY 2020 Low Wage Index Redistribution.[39] This section of the statute (42 U.S.C. § 1395ww(d)(3)(E)(i)) authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) "reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level."

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[34] *Id*.
[35] 85 Fed. Reg. at 58436 (Sept. 18, 2020); 86 Fed. Reg. at 44778 (Aug. 13, 2021); 87 Fed. Reg. at 49006 (Aug. 10, 2022); 88 Fed. Reg 58640, 58978-58979 (Aug. 28, 2023).
[36] Consolidated Request for EJR at 1 (Aug. 28, 2024).
[37] *Id.* at 3.
[38] 589 F. Supp. 3d 1 (2022), *aff'd in part and rev'd in part*, *Bridgeport Hospital, dba Yale New Haven Health, et al. v. Becerra,* 2024 WL 3504407 (D.C. Cir. 2024). The Providers note the same conclusions were made in the 9th Circuit in *Kaweah Delta Health Care District et al. v. Becerra*, 2022 WL 18278175 (C.D. Cal. 2022).
[39] Consolidated Request for EJR at 4.

The Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States."[40]

The Providers contend that the Secretary "again elected to implement his Low Wage Index Redistribution in a budget neutral manner" for FFY 2023. As a result, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.1854% to offset the AWI increases to those hospitals in the lowest AWI quartile.[41]

The Providers point out that the Secretary continues to assert that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E), however, he noted that even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke is statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment.[42] This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." The Providers contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).[43]

The Providers argue that "the Secretary lacks the authority to (a) continue the Low Wage Index [Redistribution] in the manner set forth in the FFY 2023 Final IPPS Rule; and, (b) continue to implement such policy in a budget neutral manner under the [AWI] statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, the [Providers are challenging] the adjustment to the standardized amount on several grounds, including, but not limited to, that it: exceeds statutory authority, contradicts the [AWI] congressional mandate, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively."[44]

The Providers note that "[t]he immediate detrimental effect will be a 0.1854% negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2023 for every IPPS hospital, resulting in a reduction in overall MS-DRG IPPS payments for all IPPS hospitals, including the [Providers]." Further, as this is the fourth year of the implementation of the Low Wage Index Redistribution and the related budget neutrality adjustment, the Providers already suffered an unlawful negative adjustment in FFYs 2020 to 2022.[45]

The Providers summarize their request as follows:

> Based on the foregoing, the [Providers] are challenging the Low Wage Index [Redistribution] in this group appeal for several reasons, including

[40] 42 U.S.C. § 1395(ww)(d)(3)(E)(i).
[41] Consolidated Request for EJR at 4.
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.* at 4-5.

> but not limited to, whether the Secretary (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I)(i); and (2) improperly reduced FFY 2023 payments to IPPS hospitals, including the [Providers], as a result of the budget neutral implementation of the Low Wage Index [Redistribution], which has been in effect since October 1, 2019, and continues through FFY 2023. The [Providers] seek their proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, but the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.1854% reduction issued by the Secretary in the FFY 2023 IPPS Final Rule.[46]

Medicare Contractor's Position:

Following receipt of the Consolidated Request for EJR on August 28, 2024, the Medicare Contractor's representative, Federal Specialized Services ("FSS") filed a notice on September 5, 2024 certifying that that it would be filing Substantive Claim Challenges in nine (9) cases. FSS, however, failed to file of these challenges within the time required by the Board's Rules.[47] FSS also noted that in seventeen (17) cases, cost reports have not been filed and, as a result, the Medicare Contractor cannot determine whether a substantive claim challenge is appropriate.[48]

Decision of the Board:

A. Jurisdiction and Request for EJR

Each of the participants in these thirty-two (32) group cases appealed from the FFY 2023 IPPS Final Rule.[49] The Board has determined that: (1) the participants' documentation in each of the

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[46] *Id.* at 6-8.

[47] Board Rule 44.5.2 (2023) typically requires a party questioning whether a participant included an appropriate claim on the cost report at issue to file its Substantive Claim Challenge within 60 days of the group filing its Final Schedule of Providers ("SOP"). When an EJR Request is filed within 60 days of the Final SOP, the moving party must certify that it will be filing a challenge within five business days, and then must file the actual challenge within 20 days following the filing of the EJR Request. The Consolidated EJR Request in the case was filed on August 28, 2024. On September 5, 2024 (five business days after the EJR Request, noting that September 2 was a federal holiday), FSS certified that it would be filing substantive claim and/or jurisdictional challenges in nine cases even though the EJR Request was not filed within 60 days of the Final SOPs in those cases. Twenty days from the date the Consolidated EJR Request was filed was Tuesday, September 17, 2024. As the date of this decision, no substantive claim or jurisdictional challenges were filed in the cases noted by FSS.

[48] FSS EJR Response at 1-2 (Sept. 5, 2024).

[49] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination

group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[50] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy ("AiC") calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.1854 percent (*i.e.,* the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j) are applicable. The regulation 42 C.F.R. § 413.24(j) requires that:

> (1) *General Requirement*. 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.

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from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.

[50] *See* 42 C.F.R. § 405.1837.

> (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
>
> (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.[51]

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.
> (b) *Summary of Procedures*.
> ****
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ****
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ****
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether

[51] (Bold and underline emphasis added.)

> the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section*—(1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[52]

These regulations are applicable to the cost reporting periods in these group cases.

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[53] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[54] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included *if review under subsection (b)(1) has been triggered by a party raising a question under subsection (a) of whether a provider made an appropriate claim for the specific item under appeal on the relevant as-filed cost report*.

Accordingly, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[55] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made on the relevant as-filed cost report.[56] The Board further notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether

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[52] (Bold and underline emphasis added.)
[53] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[54] (Emphasis added.)
[55] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[56] *See* 42 C.F.R. § 405.1873(a),

the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[57] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on the Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these type of instances, any Substantive Claim Challenge would be premature. That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position.

Here, for the above-captioned appeals, while FSS indicated that it would be filing Substantive Claim Challenges in nine (9) cases, it failed to do so within the time required by the Board's Rules. Additionally, FSS indicated that in seventeen (17) cases, cost reports have not been filed. As previously noted, the fact that cost reports have not yet been filed does not trigger § 405.1873(a). In this regard, all of the participants in the above-referenced group cases are appealing the FFY 2023 Federal Register Notice and the cost reports impacted by such notice appear to have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[58] Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in these cases for any of the participants.

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in

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[57] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.
[58] *See* 80 Fed. Reg. at 70556, 70569-70.

the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[59] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."; and

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."[60]

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality

[59] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[60] *Id.* at 42326.

> adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[61]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but *uncodified* regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index."

While this appeal involves the FFY 2023 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[62] The proposed rule did not propose any changes to this policy. The Final Rule for FFY 2023 refers to the responses to comments provided in the FFY 2020 Final Rule, and applied the policy in the same manner as it was applied in FFY 2020.[63] Therefore, the Board finds that this policy continues to be a binding but *uncodified* regulation for FFY 2023.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2023 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount by 0.1854 percent for FFY 2023. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board makes the following findings:

1) The Board has jurisdiction over the AWI Issue for the subject year in these cases and that the Providers in these group appeals are entitled to a hearing before the Board;

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[64] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger either Board review under § 405.1873(b) or reporting under § 405.1873(d)(2);

3) Based upon the Providers' assertions regarding the FFY 2023 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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[61] 84 Fed. Reg. at 42331.
[62] 87 Fed. Reg. 48780, 49007-49008 (Aug. 10, 2022).
[63] *Id.*
[64] As the Board explained 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 more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

4) The Board is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

5) The Board is without the authority to decide the legal question of whether the Uncodified Regulation on Wage Index published in the FFY 2023 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2023 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

For the Board:

9/27/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

Enclosure: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H) (J-L)

Appendix A

Thirty-two cases encompassed in the Consolidated Request for Expedited Judicial Review

23-0611GC	*Alameda Health System FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0614GC	*Adventist Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0615GC	*AHMC Healthcare FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0616GC	*Alecto Healthcare FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0617GC	*Cedars-Sinai Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0625GC	*CommonSpirit Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0626GC	*Community Med Ctrs FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0627GC	*Cottage Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0628GC	*Emanate Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0629GC	*Hoag FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0631GC	*John Muir Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0632GC	*Kaiser Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0633GC	*Keck Medicine of USC FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0634GC	*LA County FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0635GC	*LA Downtown Med. Ctr. LLC FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0636GC	*Loma Linda University FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0637GC	*MemorialCare FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0638GC	*Palomar Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0639GC	*PIH Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0640GC	*Pipeline FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*

23-0641GC	*Prime Healthcare FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0656GC	*Prospect Medical Holdings FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0657GC	*Providence Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0658GC	*Scripps Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0659GC	*Sharp Healthcare FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0660GC	*Stanford Health Care FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0661GC	*Sutter Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0667GC	*Tenet Healthcare FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0669GC	*Univ of California FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0670GC	*UHS FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0671GC	*KPC Health FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction CIRP Group*
23-0676G	*Toyon Associates FFY 2023 Area Wage Index Lowest Quartile IPPS Payment Reduction Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

J.C. Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave., Ste. 570A
Arcadia, CA 91006

RE: ***Consolidated Motion for Reinstatement of 4 Cases***
Carolinas Medical Center (Prov. No. 34-0113)
FYEs 12/31/2008, 12/31/2009, 12/31/2010, 12/31/2011
Case Nos. 14-1203, 14-2767, 15-2294, 15-2462

Dear Mr. Ravindran,

In connection with the four (4) above-captioned cases involving Carolinas Medical Center ("Provider"), the Provider Reimbursement Review Board ("Board") has reviewed the June 16, 2023 *Consolidated* Motion for Reinstatement filed by the Provider's Representative, Quality Reimbursement Services, Inc. ("QRS"). The Provider is commonly owned by the Carolinas HealthCare System ("Carolinas HealthCare") and, as a result, is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). The decision of the Board on the *Consolidated* Motion for Reinstatement is set forth below.

Pertinent Facts:

The Provider filed a *Consolidated* Motion for Reinstatement of 4 different cases for FYs 2008 through 2011. In each case, the Board issued a decision to dismiss the sole remaining issue in the case relating to Medicaid eligible days. While the procedural stance of each case was similar when it was dismissed, there are differences. Accordingly, the Board gives a summary of the procedural history of each case leading up to the dismissal of the relevant case.

A. Case No. 14-1203 – Provider's Appeal of FY 2008

On **December 3, 2013**, QRS established Case No. 14-1203 by timely filing the Provider's appeal request appealing its FY 2008 Notice of Program Reimbursement ("NPR") dated June 5, 2013. The hearing request included only the following single issue:

- Issue 1: Outlier Payments – Fixed Loss Threshold

On **February 3, 2014**, the Provider timely added the following issues to Case No. 14-1203:

- Issue 2: Disproportionate Share Hospital (DSH) Medicaid Eligible Days
- Issue 3: DSH Medicare Part C Days – Medicare/Medicaid Fraction
- Issue 4: DSH Medicaid Labor & Delivery Days
- Issue 5: DSH Dual Eligible Days Exhausted Part A – Medicare/Medicaid Fraction

- Issue 6: DSH Medicaid Eligible Observation Days
- Issue 7[1]: Medicare Charity Bad Debts

On **December 19, 2014**, the Provider withdrew Issue 6. On **May 22, 2017**, the Provider transferred Issues 1, 3, 4, and 5 to CIRP group appeal for Carolinas HealthCare as required by 42 C.F.R. § 405.1837(b)(1). On **March 6, 2021**, the Provider withdrew Issue 7. As a result of the transfers and withdrawals, the *only* remaining issue in Case No. 14-1203 is Issue 2 – DSH Medicaid Eligible Days.

On **August 1, 2014**, QRS timely filed the Provider's' preliminary position paper. Similarly, on **November 26, 2014**, the Medicare Contractor timely filed its preliminary position paper.

On **September 28, 2020**, the Board issued notice to the parties that the Provider must file its final position paper by March 6, 2021 and that the Medicare Contractor must file its final position paper by April 5, 2021. This notice gave the following instruction regarding the content of the Provider's final position paper:

> Provider's Final Position Paper – For each remaining issue, the position paper **must state the material facts that support the appealed claim**, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. **This filing must also include any exhibits the Provider will use to support its position**. ***See*** **Board Rule 27 for more specific content requirements**. If the Provider misses its due date, the Board will dismiss the cases.[2]

On **March 6, 2021**, QRS timely filed the Provider's final position paper. Significantly, for Issue 2, the Provider did not include a list of Medicaid eligible days in dispute but rather stated that such a listing was "NOT INCLUDED – BEING SENT UNDER SEPATE COVER." The Provider did not comply with Board Rule 25.2.2 and include an explanation of: (1) why the listing and supporting documentation was not included *consistent with its burden of proof under 42 C.F.R. § 412.106(b)(4)(iii)*; (2) what efforts had been made of the past 7+ years since the appeal was filed to obtain such listing and supporting documentation; or (3) when such listing and supporting documentation was expected to be filed. Instead, the Provider attached as Exhibit P-2 to the final position paper the same exact "Estimated Impact" for Issue 2 that was in the appeal request filed 7+ years ago that showed the "Estimated Impact" as $19,243 based on an estimated 50 additional "Medicaid Secondary Payor Days."

On **April 1, 2021**, the Medicare Contractor timely filed its final position paper. For Issue 2, the Medicare Contractor noted that the Provider had failed to provide a listing of additional Medicaid eligible days with its final position papers but instead said one was being submitted under separate cover. As no such listing was ever provided and the NPR at issue based payment on documented and audited Medicaid days, the Medicare Contractor requested the Board to dismiss Issue 2. In requesting dismissal, the Medicare Contractor noted that the NPR was ***based on the provider's amended cost report submitted on September 22, 2011*** (with a copy included as Exhibit C-3) and that the Medicare Contractor accepted the

[1] The Provider listed the issues as 1 through 6 on the February 3, 2014 letter.
[2] (Bold emphasis added and footnote omitted.)

Medicaid eligible days claimed by the Provider on that amended cost report without adjustment (specifically 41,498 Medicaid eligible days and 1,028 Medicaid HMO days).

On **May 20, 2021**, QRS filed a request for postponement of the hearing for 180 days stating that it "is finalizing a listing [of Medicaid eligible days] for submission to the MAC." On **May 25, 2021**, the Board rescheduled the hearing for January 5, 2022.

On **December 29, 2021**, QRS filed a request for postponement of the hearing for another 180 days stating that it "is finalizing a listing for submission to the MAC but is experiencing a delay in receiving an eligibility listing by the State." On **January 3, 2022**, the Board rescheduled the hearing for July 6, 2022.

On **May 23, 2022**, the Medicare Contractor filed a Motion to Dismiss the Issue 2, Medicaid Eligible Days issue, arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that *both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover*. However, no listing has ever been provided in the 79 months since the appeal was filed.

QRS did ***not*** file any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days. Instead, on **June 3, 2022**, QRS requested a postponement and included its response therein. Specifically, QRS acknowledged that it had not submitted a listing of additional Medicaid eligible days being claims in this appeal; however, ***for the first time in this appeal,*** QRS asserted that the Provider had not abandoned the appeal because it was having difficulty in obtaining documentation from the state of North Carolina. QRS maintains that the Provider's difficulties in obtaining information from North Carolina warranted a postponement of this case.

Specifically, QRS describes these difficulties as follows:

> *QRS **has made** the following efforts with the State*:
>
> ***On July 28, 2020**, QRS requested for the eligibility listing to be sent directly to the MAC* from the respective state contact in the Business System Analyst department at the Information NC Department of Health and Human Services to see if the database used to process eligibility had been fixed. That same day, the contact in the Business System Analyst department informed QRS that, at that time, they did not foresee any updates *to those **older voided** segments* in the immediate future.
>
> ***On May 11, 2021**, QRS *reached out* to the State contact *for an update* to see if the database had been fixed and if the providers could obtain direct access to the match system. The analyst stated there is *now a workable*

> *database* but doubts the Providers have direct access to it. These match issues are system-wide and do not relate to any specific provider. Please see the attached email correspondence related to the State match issues.
>
> QRS continues to work with the State to develop an alternative method to fix the deficiencies. *The last discussions took place in May and June of 2022*. Once the system issues at the State are addressed, the match will be processed, and a listing prepared. QRS believes that the State system issues will ultimately be solved, and this appeal will be finalized through an administrative resolution. As such, QRS respectively requests for a postponement.
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> 1. One final point is that on December 23, 2020 FSS was instructed not to implement Administrative Resolutions that impact DPP/DSH for cost reports prior to fiscal year end 2013. As already noted, the MAC has challenged this appeal by taking the position that has not moved forward with the review process. Based on this challenge, the MAC does not agree with this postponement request. However, this challenge appears to be somewhat disingenuous as the MAC clearly does not have the authority to finalize an AR at this time.
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> For the reasons discussed above, the Provider hereby requests a 180-day postponement of case number 14-1203.[3]

QRS included one exhibit in support of its postponement request. This exhibit is 2 pages consisting of 3 emails between QRS and North Carolina dated July 28, 2020, May 11, 2021, and May 13, 2021. It is unclear if 3 emails are a chain (*i.e*., no intervening emails) or are separate emails that were spliced together in one document/exhibit.

On **April 14, 2023**, the Board dismissed Issue 2 in its entirety based on its finding that: (1) the Provider had failed to provide a Medicaid eligible days listing or other supporting documentation for the Medicaid Eligible days issue as required by the controlling regulations at 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 (as applicable via Board Rule 27.2); and (2) the Provider failed to provide any *timely* explanation to the Board, as to why the documentation was absent or what is being done to obtain it, *notwithstanding the facts that: (1) this case had been pending for over 9 years; and (2) it had more than 14 years since FY 2008 had closed*. Accordingly, due to the Provider's failure to diligently and properly develop the merits of its position (including but not limited to the material facts in the case), the Board concluded that there are no days at issue and that the amount in controversy is $0.

B. Case No. 14-2767 – Provider's Appeal of FY 2009

On **March 4, 2014**, QRS established Case No. 14-2767 by timely filing the Provider's appeal request appealing its FY 2009 NPR dated September 4, 2013. The hearing request included the following issues:

[3] (Emphasis added.)

- Issue 1: DSH Medicaid Eligible Days
- Issue 2: DSH Medicare Part C Days – Medicare/Medicaid Fraction
- Issue 3: DSH Medicaid Labor & Delivery Days
- Issue 4: DSH Dual Eligible Days Exhausted Part A – Medicare/Medicaid Fraction
- Issue 5: DSH Medicaid Eligible Observation Days
- Issue 6: Outlier Payments-Fixed Loss Threshold

On **October 9, 2014**, the Provider transferred Issues 2, 4, and 6 to Carolinas HealthCare CIRP group appeals. On **October 31, 2014**, the Provider withdrew Issue 3. Similarly, on **May 20, 2015**, the Provider withdrew Issue 5. As a result of these transfers and withdrawals, the *only* issue remaining in Case No. 14-2767 is Issue 1 – DSH Medicaid Eligible Days.

On **October 31, 2014**, the Provider filed its preliminary position paper. Similarly, on **April 29, 2015**, the Medicare Contractor filed its preliminary position paper.

On **September 28, 2020**, the Board issued a Notice of Hearing and Critical Due Dates setting a hearing for June 4, 2021 and set due dates for final position papers. Significantly, this Notice gave the following instructions for the Provider's final position paper:

> Provider's Final Position Paper – For each remaining issue, the position paper **must state the material facts that support the appealed claim**, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. **This filing must also include any exhibits the Provider will use to support its position**. ***See*** **Board Rule 27 for more specific content requirements**. If the Provider misses its due date, the Board will dismiss the cases.[4]

On **March 6, 2021**, the Provider timely filed its final position paper. Significantly, for Issue 1, the Provider did not include a list of Medicaid eligible days in dispute but rather stated that such a listing was "NOT INCLUDED – BEING SENT UNDER SEPATE COVER." The Provider did not comply with Board Rule 25.2.2 and include an explanation of: (1) why the listing and supporting documentation was not included *consistent with its burden of proof under 42 C.F.R. § 412.106(b)(4)(iii)*; (2) what efforts had been made of the past 7 years since the appeal was filed to obtain such listing and supporting documentation; or (3) when such listing and supporting documentation was expected to be filed. Instead, the Provider attached as Exhibit P-2 to the final position paper the same exact "Estimated Impact" for Issue 2 that was in the appeal request filed 7 years ago that showed the "Estimated Impact" as $33,152 based on an estimated 50 additional "Medicaid Secondary Payor Days."

Similarly, on **April 1, 2021**, the Medicare Contractor timely filed its final position paper. For Issue 1, the Medicare Contractor noted that the Provider had failed to provide a listing of additional Medicaid eligible days in either the appeal request, the preliminary position paper or the final position papers. Accordingly, due to these failures, the Medicare Contractor requested the Board to deny the inclusion of any additional days.

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[4] (Bold emphasis added and footnote omitted.)

On **May 20, 2021**, QRS filed a request for postponement of the hearing for 180 days stating that it "is finalizing a listing [of Medicaid eligible days] for submission to the MAC." On **May 25, 2021**, the Board rescheduled the hearing for January 5, 2022.

On **December 29, 2021**, QRS filed a second request for postponement for 180 days stating that it "is finalizing a listing for submission to the MAC but is experiencing a delay in receiving eligibility listing by the State." On **January 5, 2022**, the Board rescheduled the hearing for July 6, 2022.

On **May 23, 2022**, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 79[5] months since the appeal was filed.

QRS did ***not*** file any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days. Instead, on **June 3, 2022**, QRS requested a postponement and included its response therein. Specifically, QRS states that its failure to submit a listing of additional Medicaid eligible days is not due to the Provider abandoning the case. Rather, ***for the first time in this appeal,*** QRS claimed that the delay was due "a significant issue with the State of North Carolina matching process and, more specifically, the voiding of certain Medicaid patient records from the State system." QRS represented that "[t]he Provider has been actively trying to work with the state to process eligibility" In this regard, QRS states:

> QRS has made the following efforts with the State:
>
> ***On July 28, 2020***, QRS requested for the eligibility listing to be sent directly to the MAC from the respective state contact in the Business System Analyst department at the Information NC Department of Health and Human Services to see [*sic*] if the database used to process eligibility had been fixed. That same day, the contact in the Business System Analyst department informed QRS that, at that time, they did not foresee any updates to those older voided segments in the immediate future.
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> ***On May 11, 2021***, QRS reached out to the State contact for an update to see if the database had been fixed and if the providers could obtain direct access to the match system. The analyst stated there is now a workable database but doubts the Providers have direct access to it. These match issues are system-

[5] The correct time frame is 99 months since the appeal was filed.

wide and do not relate to any specific provider. Please see the attached email correspondence related to the State match issues.

QRS continues to work with the State to develop an alternative method to fix the deficiencies. ***The last discussions took place in May and June of 2022.*** Once the system issues at the State are addressed, the match will be processed, and a listing prepared. QRS believes that the State system issues will ultimately be solved, and this appeal will be finalized through an administrative resolution. As such, QRS respectively requests for a postponement.

1. One final point is that on December 23, 2020 FSS was instructed not to implement Administrative Resolutions that impact DPP/DSH for cost reports prior to fiscal year end 2013. As already noted, the MAC has challenged this appeal by taking the position that has not moved forward with the review process. Based on this challenge, the MAC does not agree with this postponement request. However, this challenge appears to be somewhat disingenuous as the MAC clearly does not have the authority to finalize an AR at this time.

For the reasons discussed above, the Provider hereby request a 180-day postponement of case number 14-2767.

On **April 14, 2023**, the Board dismissed Issue 1 in its entirety finding that: (1) the Provider had failed to provide a Medicaid eligible days listing or other supporting documentation for the Medicaid Eligible days issue as required by the controlling regulations at 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 (as applicable via Board Rule 27.2); and (2) the Provider had failed to provide any *timely* explanation to the Board as to why the documentation was absent or what is being done to obtain it, *notwithstanding the facts that: (1) this case had been pending for over 9 years and (2) it had more than 13 years since FY 2009 had closed*. Accordingly, due to the Provider's failure to develop the merits of its position (including but not limited to the material facts in the case), the Board concluded that there are no days at issue and that the amount in controversy is $0.

C. Case No. 15-2294 – Provider's Appeal of FY 2010

On **April 20, 2015**, QRS established Case No. 15-2294 by filing the Provider's appeal request appealing its FY 2010 NPR dated October 22, 2014. The hearing request included the following issues:

- Issue 1: (DSH Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH SSI Fraction Medicare Part C Days
- Issue 4: DSH SSI Fraction/Dual Eligible Days
- Issue 5: DSH Medicaid Eligible Days
- Issue 6: DSH Medicaid Fraction Medicare Part C Days
- Issue 7: DSH Medicaid Fraction/Dual Eligible Days

- Issue 8: Outlier Payments-Fixed Loss Threshold

On **November 18, 2015**, the Provider transferred Issues 3, 6, 7 and 8 to Carolinas HealthCare CIRP groups. On **December 30, 2015**, the Provider made similar transfers of Issues 2 and 4 to Carolinas HealthCare CIPR groups. On **June 28, 2022**, the Board dismissed issue 1. As a result of these transfers, withdrawal, and dismissal, the *only* remaining issue remaining in Case No. 15-2294 is Issue 5 – DSH Medicaid Eligible Days.

On **December 23, 2015**, the Provider filed its preliminary position paper. Similarly, on **April 4, 2016**, the Medicare Contractor filed its preliminary position paper.

On **June, 1, 2018**, the Medicare Contractor filed a jurisdictional challenge requesting that the Board dismiss Issue 5 because the Provider did not have a right to appeal the issue pursuant to 42 C.F.R. § 405.1835(a)(i)-(ii) (as amended in 2008) due to the failure of the Provider to claim or protest the Medicaid eligible days in dispute on its FY 2010 cost report (both the original and amended as-filed cost reports for FY 2010).

On **June 28, 2018**, QRS timely filed its response to the jurisdictional challenge asserting that: (1) the Audit Adjustment No. 17 made to its FY 2010 cost report was sufficient for the Board to generally have jurisdiction over any DSH-related issue such as Medicaid eligible days; (2) the presentment requirement as codified at 42 C.F.R. § 405.1835(a)(i)-(ii) (as amended in 2008) because DSH is not an item that has to be adjusted or claimed on a cost report; and (3) consistent with CMS Ruling 1727-R, the Provider had a good faith belief that claiming reimbursement on its FY 2010 cost report would be futile because it could not claim as-yet unidentified additional Medicaid eligible days that had not already been identified in the State matching process.

On **September 28, 2020**, the Board issued a Notice of Hearing and Critical Due Dates setting a hearing for June 4, 2021 and set due dates for final position papers. Significantly, this Notice gave the following instructions for the Provider's final position paper:

> Provider's Final Position Paper – For each remaining issue, the position paper **must state the material facts that support the appealed claim**, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. **This filing must also include any exhibits the Provider will use to support its position**. ***See*** **Board Rule 27 for more specific content requirements**. If the Provider misses its due date, the Board will dismiss the cases.[6]

On **March 4, 2021**, QRS filed the Provider's final position paper. Significantly, for Issue 5, the Provider did not include a list of Medicaid eligible days in dispute but rather stated that such a listing was "NOT INCLUDED – BEING SENT UNDER SEPATE COVER." The Provider did not comply with Board Rule 25.2.2 and include an explanation of: (1) why the listing and supporting documentation was not included *consistent with its burden of proof under 42 C.F.R. § 412.106(b)(4)(iii)*; (2) what

[6] (Bold emphasis added and footnote omitted.)

efforts had been made of the past 5+ years since the appeal was filed to obtain such listing and supporting documentation; or (3) when such listing and supporting documentation was expected to be filed. Instead, the Provider attached as Exhibit P-2 to the final position paper the same exact "Estimated Impact" for Issue 2 that was in the appeal request filed 5+ years ago that showed the "Estimated Impact" as $19,584 based on an estimated 50 additional "Medicaid Secondary Payor Days."

On **April 1, 2021**, the Medicare Contractor filed its final position paper. For Issue 5, the Medicare Contractor notes that the Provider submitted an amended cost report received on February 23, 2013 and the amended cost report increased the original 17,822 Medicaid HMO days by 4600 resulting in an aggregate 22,477 Medicaid HMO days being claimed and significantly all other Medicaid days remained the same as the original as-filed cost report to the amended cost report. Accordingly, the Medicare Contractor contends that the inclusion of any additional days is excessive and unwarranted, particularly since the Provider has had all opportunity to include any additional Medicaid eligible days and even failed to include any listing of additional Medicaid eligible days with its final position paper. Accordingly, the Medicare Contractor requested that the Board deny the inclusion of any additional Medicaid eligible days.

On **May 20, 2021**, QRS filed a request for postponement of the hearing for 180 days stating that it "is finalizing a listing [of Medicaid eligible days] for submission to the MAC." On **May 25, 2021**, the Board rescheduled the hearing for January 5, 2022.

On **December 29, 2021**, QRS filed a second request for postponement for 180 days stating that it "is finalizing a listing for submission to the MAC but is experiencing a delay in receiving eligibility listing by the State." On **January 5, 2022**, the Board rescheduled the hearing for July 6, 2022.

On **May 23, 2022**, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that *both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover*. However, no listing has ever been provided in the 79[7] months since the appeal was filed.

QRS did ***not*** file any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days. Instead, on **June 3, 2022**, QRS requested a postponement and included its response therein. Specifically, QRS states that its failure to submit a listing of additional Medicaid eligible days is not due to the Provider abandoning the case. Rather, ***for the first time in this appeal,*** QRS claimed that the delay was due "a significant issue with the State of North Carolina matching process and, more specifically, the voiding of certain Medicaid patient records from the State system." QRS represented that "[t]he Provider has been actively trying to work with the state to process eligibility" In this regard, QRS states:

[7] The correct time frame is 99 months since the appeal was filed.

QRS has made the following efforts with the State:

On July 28, 2020, QRS requested for the eligibility listing to be sent directly to the MAC from the respective state contact in the Business System Analyst department at the Information NC Department of Health and Human Services to see [*sic*] if the database used to process eligibility had been fixed. That same day, the contact in the Business System Analyst department informed QRS that, at that time, they did not foresee any updates to those older voided segments in the immediate future.

On May 11, 2021, QRS reached out to the State contact for an update to see if the database had been fixed and if the providers could obtain direct access to the match system. The analyst stated there is now a workable database but doubts the Providers have direct access to it. These match issues are system-wide and do not relate to any specific provider. Please see the attached email correspondence related to the State match issues.

QRS continues to work with the State to develop an alternative method to fix the deficiencies. ***The last discussions took place in May and June of 2022.*** Once the system issues at the State are addressed, the match will be processed, and a listing prepared. QRS believes that the State system issues will ultimately be solved, and this appeal will be finalized through an administrative resolution. As such, QRS respectively requests for a postponement.

1. One final point is that on December 23, 2020 FSS was instructed not to implement Administrative Resolutions that impact DPP/DSH for cost reports prior to fiscal year end 2013. As already noted, the MAC has challenged this appeal by taking the position that has not moved forward with the review process. Based on this challenge, the MAC does not agree with this postponement request. However, this challenge appears to be somewhat disingenuous as the MAC clearly does not have the authority to finalize an AR at this time.

For the reasons discussed above, the Provider hereby request a 180-day postponement of case number 14-2767.

On **December 20, 2022**, the Board dismissed Issue 1 in its entirety finding that: (1) the Provider had failed to provide a Medicaid eligible days listing or other supporting documentation for the Medicaid Eligible days issue as required by the controlling regulations at 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 (as applicable via Board Rule 27.2); and (2) the Provider had failed to provide any *timely* explanation to the Board as to why the documentation was absent or what is being done to obtain it, *notwithstanding the facts that: (1) this case had been pending for over 7½ years and (2) it had almost 12 years since FY 2010 had closed*. Accordingly, due to the Provider's failure to

develop the merits of its position (including but not limited to the material facts in the case), the Board concluded that there are no days at issue and that the amount in controversy is $0.

D. <u>Case No. 15-2462</u> – Provider's Appeal of FY 20111

On **April 27, 2015**, QRS established Case No. 15-2462 by timely appealing its FY 2011 NPR dated October 29, 2014. The hearing request included the following issues:

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH Medicare Part C Days – SSI Fraction
- Issue 4: DSH Dual Eligible Days Exhausted Part A – SSI Fraction
- Issue 5: DSH Medicaid Eligible Days
- Issue 6: DSH Medicare Part C Days – Medicaid Fraction
- Issue 7: DSH Dual Eligible Days Exhausted Part A – Medicaid Fraction
- Issue 8: Outlier Payments – Fixed Loss Threshold

On **December 30, 2015**, the Provider transferred Issues 2, 3, 4, 6, 7, and 8 to Carolinas HealthCare CIRP groups. On **June 10, 2022**, the Board dismissed Issue 1. As a result of these transfers and dismissal, the *only* issue remaining in Case No. 15-2462 is Issue 5 – DSH Medicaid Eligible Days.

On **December 23, 2015**, the Provider filed its preliminary position paper. Similarly, **on April 11, 2016**, the Medicare Contractor filed its preliminary position paper.

On **June, 5, 2018**, the Medicare Contractor filed a jurisdictional challenge requesting that the Board dismiss Issue 5 because the Provider did not have a right to appeal the issue pursuant to 42 C.F.R. § 405.1835(a)(i)-(ii) (as amended in 2008) due to the failure of the Provider to claim or protest the Medicaid eligible days in dispute on its FY 2011 cost report (both the original and amended as-filed cost reports for FY 2010).

On **July 2, 2018**, QRS timely filed its response to the jurisdictional challenge asserting that: (1) the Audit Adjustment No. 17 made to its FY 2010 cost report was sufficient for the Board to generally have jurisdiction over any DSH-related issue such as Medicaid eligible days; (2) the presentment requirement as codified at 42 C.F.R. § 405.1835(a)(i)-(ii) (as amended in 2008) because DSH is not an item that has to be adjusted or claimed on a cost report; and (3) consistent with CMS Ruling 1727-R, the Provider had a good faith belief that claiming reimbursement on its FY 2011 cost report would be futile because it could not claim as-yet unidentified additional Medicaid eligible days that had not already been identified in the State matching process.

On **September 28, 2020**, the Board issued a Notice of Hearing and Critical Due Dates setting a hearing for June 4, 2021 and set due dates for final position papers. Significantly, this Notice gave the following instructions for the Provider's final position paper:

> Provider's Final Position Paper – For each remaining issue, the position paper **must state the material facts that support the appealed claim**,

> identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. **This filing must also include any exhibits the Provider will use to support its position**. ***See*** **Board Rule 27 for more specific content requirements**. If the Provider misses its due date, the Board will dismiss the cases.[8]

On **March 4, 2021**, QRS filed the Provider's final position paper. Significantly, for Issue 5, the Provider did not include a list of Medicaid eligible days in dispute but rather stated that such a listing was "NOT INCLUDED – BEING SENT UNDER SEPATE COVER." The Provider did not comply with Board Rule 25.2.2 and include an explanation of: (1) why the listing and supporting documentation was not included *consistent with its burden of proof under 42 C.F.R. § 412.106(b)(4)(iii)*; (2) what efforts had been made of the past 5+ years since the appeal was filed to obtain such listing and supporting documentation; or (3) when such listing and supporting documentation was expected to be filed. Instead, the Provider attached as Exhibit P-2 to the final position paper the same exact "Estimated Impact" for Issue 2 that was in the appeal request filed 5+ years ago that showed the "Estimated Impact" as $19,077 based on an estimated 50 additional "Medicaid Secondary Payor Days."

On **April 1, 2021**, the Medicare Contractor filed its final position paper.

On **May 20, 2021**, QRS filed a request for postponement of the hearing for 180 days stating that it "is finalizing a listing [of Medicaid eligible days] for submission to the MAC." On **May 25, 2021**, the Board rescheduled the hearing for January 5, 2022.

On **December 29, 2021**, QRS filed a second request for postponement for 180 days stating that it "is finalizing a listing for submission to the MAC but is experiencing a delay in receiving eligibility listing by the State." On **January 5, 2022**, the Board rescheduled the hearing for July 6, 2022.

On **May 23, 2022**, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that *both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover*. However, no listing has ever been provided in the 79[9] months since the appeal was filed.

QRS did ***not*** file any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days. Instead, on **June 3, 2022**, QRS requested a postponement and included its response therein. Specifically, QRS states that its failure to submit a listing of additional Medicaid eligible days is not due to the Provider abandoning the case. Rather, ***for the first time in this appeal,***

[8] (Bold emphasis added and footnote omitted.)
[9] The correct time frame is 96 months since the appeal was filed.

QRS claimed that the delay was due "a significant issue with the State of North Carolina matching process and, more specifically, the voiding of certain Medicaid patient records from the State system." QRS represented that "[t]he Provider has been actively trying to work with the state to process eligibility" In this regard, QRS states:

> QRS has made the following efforts with the State:
>
> ***On July 28, 2020***, QRS requested for the eligibility listing to be sent directly to the MAC from the respective state contact in the Business System Analyst department at the Information NC Department of Health and Human Services to see [*sic*] if the database used to process eligibility had been fixed. That same day, the contact in the Business System Analyst department informed QRS that, at that time, they did not foresee any updates to those older voided segments in the immediate future.
>
> ***On May 11, 2021***, QRS reached out to the State contact for an update to see if the database had been fixed and if the providers could obtain direct access to the match system. The analyst stated there is now a workable database but doubts the Providers have direct access to it. These match issues are system-wide and do not relate to any specific provider. Please see the attached email correspondence related to the State match issues.
>
> QRS continues to work with the State to develop an alternative method to fix the deficiencies. ***The last discussions took place in May and June of 2022*.** Once the system issues at the State are addressed, the match will be processed, and a listing prepared. QRS believes that the State system issues will ultimately be solved, and this appeal will be finalized through an administrative resolution. As such, QRS respectively requests for a postponement.
>
> 1. One final point is that on December 23, 2020 FSS was instructed not to implement Administrative Resolutions that impact DPP/DSH for cost reports prior to fiscal year end 2013. As already noted, the MAC has challenged this appeal by taking the position that has not moved forward with the review process. Based on this challenge, the MAC does not agree with this postponement request. However, this challenge appears to be somewhat disingenuous as the MAC clearly does not have the authority to finalize an AR at this time.
>
> For the reasons discussed above, the Provider hereby request a 180-day postponement of case number 14-2767.

On **December 20, 2022**, the Board dismissed Issue 1 in its entirety finding that: (1) the Provider had failed to provide a Medicaid eligible days listing or other supporting documentation for the Medicaid Eligible days issue as required by the controlling regulations at 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 (as applicable via Board Rule 27.2); and (2) the Provider had

failed to provide any *timely* explanation to the Board as to why the documentation was absent or what is being done to obtain it, *notwithstanding the facts that: (1) this case had been pending for over 7 years and (2) it had almost 11 years since FY 2010 had closed*.[10] Accordingly, due to the Provider's failure to develop the merits of its position (including but not limited to the material facts in the case), the Board concluded that there are no days at issue and that the amount in controversy is $0.

On **June 16, 2023**, the Provider filed a Motion for Reinstatement. The Provider also simultaneously filed in U.S. District Court, appealing the Board's April 14, 2023 dismissals.

Provider's Motion for Reinstatement:

The Provider through its representative, Quality Reimbursement Services, Inc. (QRS), request the Board to reinstate their appeal because they have expressed no intention to abandon their appeal on the Medicaid Eligible day issue. The Provider states a "two-fold" argument regarding the difficulties in matching their patients to the State's Medicaid eligibility files. First, it is well-established that North Carolina does not match on the basis of a single unique identifier and attached the Declaration of Janahan Ramanathan. Second, the State has been purging records from its database, which is similar to the "stale records" issue in Baystate Medical Center. The Provider believes it is about a month away from finalizing Medicaid eligible days for FY 2009 even though the matching is not complete. It anticipates that it will finish the matching for 2008, 2010, and 2011 by October 31, 2024.

QRS admits that there are "some missing details that, otherwise, would have been included" from its Position Papers and requests this letter to supplement its final position paper. The Provider "recognizes that the [final position paper] for the above-referenced appeals did not contain an explanation of the efforts QRS was making on behalf of the Providers or the impossibility of submitting a Medicaid eligible days list due to the deficiencies in the State's matching process. The [final position papers] were all filed in early March of 2021, at the height of Covid. Just as the entire Country, and in fact the Board itself, experienced severe operational challenges due to Covid, QRS also faced significant challenges such as maintaining staffing and performing tasks such as filing [final position papers]."[11]

Additionally, the Provider also indicates that "in order to protect its rights, QRS has filed a complaint in district court seeking to overturn the dismissals in Case Nos. 14-1203, 14-2767, and 15-2462."[12]

Board's Decision:

As set forth below, the Board denies the Consolidated Motion for Reinstatement and declines to exercise its discretion to reinstate these appeals. In addressing the Consolidate Motion for Reinstatement, the Board is only addressing new arguments presented by QRS in that Motion and affirms its original decision to dismiss these cases (incorporating it herein by reference).

[10] In case 15-2294, the Board dismissed the Medicaid Eligible Days issue from the appeal and subsequently, closing the appeal on December 20, 2022.
[11] Provider's Motion for Reinstatement (June 16, 2023).
[12] *Id.*

Pursuant to Board Rule 47.1. "A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case… The Board will not reinstate an issue(s)/case if the provider was at fault."

The Provider explains that "First, North Carolina does not match on the basis of a single unique identifier… Second, … the State has been purging records from its database, which is similar to the 'stale records' issue in Baystate Medical Center."[13] However, QRS does not explain *their* particular process in obtaining a listing rather generally states what *may* cause delays in receiving a listing. This generic information and the Provider has not clarified what steps were taken, what results were received or what steps are still needed to produce a final eligible days listing. Indeed, at this late date, the relevant state records being sought are ***now*** well over 10 years old and it should not be surprising that a state would have recently purged these records.

In an apparent effort to demonstrate its diligence, QRS attached 3 affidavits. QRS asserts that these affidavits explain why the Provider has not produced an eligible day listing sooner. Two of those affidavits are not specific to these cases and only provide general information. Accordingly, the Board focuses on the third affidavit which was issued by Niranjan Thambythurai. In his affidavit, he states: "Since I took over responsibility for the [4] appeals in June 2015, I have worked diligently to identify Medicaid eligible days" & "concentrated on FYE 2009 before I sent in matches for other years ... as there were problems with matching". However, neither the affidavit of Janahan Ramanathan or Niranjan Thambythurai provide a timeline of their efforts to obtain an eligible days listing and do not demonstrate their diligence in identifying any days in dispute for these 4 cases. It is unclear what, if any, work was done prior to 2015. Indeed, it is not clear what work was done after the Provider assigned the cases in June 2015 to Mr. Thambythurai for development as there is no description or timeline of his efforts. Regardless, *it is clear that. for the FY 2008 and 2009 cases the Provider was* ***not diligent*** since in both of those cases the Provider had already filed its preliminary position paper (specifically filed on August 1, 2014 and October 31, 2014 respectively).

Further, the Providers filed their preliminary position papers in the FY 2010 and 2011 cases on December 23, 2015, *i.e*., shortly after the Provider allegedly began working these appeals. It is troubling that there is no information to demonstrate the Provider's diligence in working these cases. Rather the only information we have is that, more than 8 years after starting work on these cases in June 2015: "[w]e are about a month away from finalizing Medicaid eligible days for FY 2009 even though the matching is not complete." All of the information provided at this late date should have been included with their preliminary position paper as made clear by Board Rule 25.2 (2013):

> **25.2 – Preliminary Documents:**
>
> **A. General:** With the preliminary position papers, the parties *must exchange all available documentation* as preliminary exhibits to fully support your position. The Intermediary must also give the Provider all evidence the Intermediary considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Intermediary believes is necessary for resolution which has not been submitted by the Provider.

[13] *Id*.

> **B. Unavailable and Omitted Preliminary Documents:** If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.

Here, in its preliminary position papers for FYs 2008, 2009, 2010, and 2011, the Provider failed to explain why the documents were not available, describe its efforts to obtain them, and explain when they would become available. The Provider even failed to do this in its final position papers. The explanation provided is essentially too little, too late and does not demonstrate the Provider's diligence.

Lastly, QRS states it faced significant challenges due to Covid "such as maintaining staffing and performing tasks such as filing [final position papers]."[14] QRS admits that it did not contain an explanation of the efforts it was taking on behalf of the Providers or the difficulties with the State's matching process in its Final Position Paper. In connection with this contention, Mr. Thambythurai's affidavit states that, prior to the COVID-19 onset, a seasoned staff attorney was responsible for Final Position Paper filings but quit March 2020 due to COVID. A "junior staffer" who was originally an admin assistant took over preparing and filing the Final Position Paper, but "was unable to be given sufficient guidance as to the req'ts for [final position papers]...." The Board's issuance of Alert 19, in response to COVID challenges, dealt with *filing deadlines*; Board Alert 19 does ***not*** apply to the content or exhibit requirements of any filings made. The Board finds that, indeed, notwithstanding Alert 19, the Provider took it upon themselves to file their final position paper and, in so doing, they are responsible for the omission of any content and exhibits errors in its final position paper. In this respect, their position paper filings do not mention challenges related to the COVID-19 pandemic. Again, at a minimum, they should have complied with Board Rule 25.2 and identified the missing documentation, explained why it was unavailable, described the efforts to obtain that documentation and explained when it would become available.

Finally, the Board notes that the Secretary has stated that 17 months following the close of a fiscal year is ample time to identify any additional days missed in the as-filed cost report[15] (which here the 17-month mark would have been ***well before*** *any of these appeals were even filed*).[16] As noted above, the Provider

---

[14] *Id.*

[15] In this regard, the Board notes that the Secretary stated in the final rule published on November 13, 2015 that generally 17 months after the close of a provider's fiscal year (the filing of the cost report is due the last day of the 5th month after the close of the fiscal year) is *sufficient time* for the provider to identify any additional Medicaid eligible days missed in the as-filed cost report:

> In our experience, we believe an additional 12 months [after the filing of the cost report on the last day of the 5th month following the end of the fiscal year] is sufficient time for States to make Medicaid eligibility determinations and for hospitals to revise its number of Medicaid-eligible patient days in order to make an appropriate cost report claim for a DSH payment adjustment.

80 Fed. Reg. 70298, 70564 (Nov. 13, 2015).

[16] The following is a break out, for each case, of the 17-month mark following the fiscal year end and when the appeal was filed.

FY	17-month mark	Appeal Date
FY 2008	June 2010	Dec. 3, 2013
FY 2009	June 2011	Mar. 4, 2014
FY 2010	June 2012	Apr. 20, 2015
FY 2011	June 2013	Apr. 27, 2015

has not established its diligence in working these cases and, as described in detail in the Board's dismissal decisions, the Provider failed to comply with the Board's position paper requirements and failed to develop the merits of its cases on the Medicaid eligible days issue.

In summary, the Board finds that nothing about the Request for Reinstatement or affidavits provide the Board with a detailed explanation as to why the listing has not been produced since the 8 years the appeal was filed. The Board determines the Provider is at fault and has not demonstrated a "good cause" as to why the cases should be reinstated. After review, pursuant to Board Rule 47.1, the Board **denies** the request to reinstate PRRB Case Nos. 14-1203, 14-2767, 15-2294, and 15-2462.

Board Members Participating:

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

For the Board:

9/30/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Dana Johnson, Palmetto GBA (J-M)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Board Determination on Duplicative CIRP Groups
CHS CY 2021 412.103 Wage Index CIRP Group, Case Number: 24-2453GC
CHS CY 2021 Wage Index CIRP Group, Case Number: 24-0272GC

Dear Mr. Hettich and Ms. Williams:

The Provider Reimbursement Review Board (Board) has reviewed the Common Issue Related Party ("CIRP") group filed by King & Spalding, LLP ("King & Spalding") on September 9, 2024, to which the Board assigned Case No. 24-2453GC. This group was formed with a single provider, North Okaloosa Medical Center (10-0122) based on its Notice of Program Reimbursement ("NPR") dated March 11, 2024. A second provider, Tyler Memorial Hospital (39-0192) was subsequently added to the group on September 23, 2024, based on its NPR dated March 27, 2024.

Upon review, however, the Board notes that Case No. 24-0272GC, filed on November 27, 2023, is already pending for the same issue, calendar year ("CY"), and parent organization. This group, which is not yet fully formed, currently includes 11 providers, including both North Okaloosa Medical Center (10-0122) and Tyler Memorial Hospital (39-0192).

Both CIRP group appeals include Representative letters signed by the Senior Vice President of Revenue Management at Community Health Systems, Nathaniel K. Summar. Mr. Summar appointed Powers, Pyles, Sutter & Verville to be the representative for the providers in Case No. 24-0272GC and appointed King & Spalding to be the representative for the providers in Case No. 24-2453GC.

Board Determination:

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination.

The Board is bound by the statutes and regulations, including those governing CIRPs, specifically 42 C.F.R. §405.1837(b)(1) which requires that commonly owned or controlled providers file a single group for the same issue occurring in the same year. Accordingly, for the Community Health System chain and its CY 2021 Wage Index issue, the providers can pursue the issue in only one group. In addition, pursuant to Board Rule 5.1., there may be only one representative for the appeal.

After reviewing the facts in these cases, the Board has determined the CY 2021 appeal of the "412.103 Wage Index" issue filed by King & Spalding under Case No. 24-2453GC is duplicative of the "Wage

Index" issue under appeal in the Powers, Pyles, Sutter & Verville CIRP group, Case No. 24-0272GC. Consequently, the Board is using its discretion and hereby closes Case No. 24-2453GC as a duplicate of Case No. 24-0272GC. Because the two providers in Case No. 24-2453GC are already included in the surviving appeal, Case No. 24-0272GC, no further action is required to transfer or consolidate the providers. Case No. 24-2453GC is hereby closed and removed from the Board's docket.

With regard to representation, Powers, Pyles, Sutter & Verville, PC will remain the group representative of the surviving group, Case No. 24-0272GC. If CHS wishes to appoint a different representative, it must submit an updated letter of authorization to the Board.[1]

Finally, the Board once again directs CHS' attention to *Board Rule 4.6, which specifically prohibits "Duplicate Filings":*

> **4.6 No Duplicate Filings**
>
> **4.6.1 Same Issue from One Determination**
> A provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group).
>
> **4.6.2 Same Issue from Multiple Determinations**
> Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR covering the same time period in separate appeals. See Rule 6.3 for instruction on how to add a new determination to a pending individual appeal covering the same time period.
>
> **4.6.3 Issue Previously Dismissed or Withdrawn**
> Once an issue is dismissed or withdrawn, the provider may not appeal or pursue that in any other case.

In that regard, the Board admonishes CHS for appointing multiple representatives to handle the same issue in multiple group appeals. *Specifically, the Board notes that CHS authorized improper duplicate filings of the same issues. CHS should be on notice that the Board may consider taking additional remedial actions as authorized by 42 C.F.R. § 405.1868(b).*[2]

Board Members:
Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

9/30/2024

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)
Nathaniel Summar, Community Health System

[1] Because the subject appeal is a CIRP Group, only one letter is required for all the CIRP providers within the group.
[2] CHS is advised that it is not appropriate to appoint multiple representatives to handle the same issue in separate appeals, nor is it appropriate to appeal common issues in an individual appeal after it has authorized a different representative to include the issue in a CIRP group for that provider.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Notice of Dismissal – Updated Rationale***
Moss Adams Standardized Amount Group and Individual Provider Cases
Case Nos. 21-0980GC, *et al.* (*see* **Appendix A** listing 5 group and 12 individual cases)

Dear Mr. Bunting:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the seventeen (17) above-referenced group and individual provider cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board Majority has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all seventeen (17) cases in their entirety.[1] This issue is not new to the Board and this determination is consistent with its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[2] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board Majority finds that it lacks substantive jurisdiction over the issue raised in these group appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment ("BNA") made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using*

[1] For the twelve (12) individual provider appeals, the standardized amount was either the sole issue or is the sole remaining issue following withdrawal of another issue.

[2] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

1981 data.[3] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable BNAs.[4] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the BNAs applied to those years reduced the standardized amounts (by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[5] Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs, the Board Majority finds that it may not review the standardized amount used for the FFYs appealed as it relates to the common issues in these appeals. In this regard, the Board Majority again notes that the rates for FFY 1986 *and subsequent years* are based on the FFY 1985 budget-neutrality-adjusted rates. Accordingly, the Providers assertion that the initial FFY 1984 standardized amount continues to serve as the base for all future calculations is incorrect as causal link is broken. Specifically, they may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*,[6] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[7]

PROCEDURAL BACKGROUND:

A. Group Issue – Limited to Alleged Error in the Initial Calculation of the Standardized Amount for the Initial Year of IPPS

Moss Adams LLP ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed a Jurisdictional Challenge covering seventeen (17) cases.[8] The Providers' Representative filed responses to this challenge. The group issue statements, jurisdictional challenge, and responses thereto for all seventeen (17) cases are materially identical and can be considered together.

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[3] The Board Majority has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 BNAs. These intervening adjustments for FFYs 1986 and other FFYs include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[4] *See infra* note 58 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[5] *See infra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 BNA).

[6] *See also supra* note 3 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[7] *See also supra* note 3 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[8] *See* **Appendix A**.

The group issue statement presented is:

> In 1983 CMS established the Inpatient Prospective Payment System (IPPS) and created DRG payments that originate from 1981 cost reporting data. The 1981 cost reporting data is considered a base year from which the calculation of every DRG payment since 1983 has originated, including the DRG payments applicable to this year.
>
> A recent decision by the United States Court of Appeals for the District of Columbia . . . in *St. Francis Medical Center v. Azar* allows hospitals the opportunity to correct their Medicare reimbursement due to erroneous 1981 cost reporting data that CMS (acting through its predecessor agency (HCFA) used to calculate the IPPS standardized amounts in 1983. Specifically, the 1981 cost reporting data that CMS used to calculate the IPPS standardized amounts for 1983 erroneously characterized transfers of patients from one hospital to another as "patient discharges." This caused an overstatement of the number of discharges and understatement in the allowable operating costs, which were calculated on a "per discharge" basis. **This, in turn, led to an understatement of the standardized payment amounts for 1983. These understated standardized amounts from 1983, as updated annually, have been used to determine IPPS payments for every year thereafter, <u>meaning those Medicare payments were also understated</u>**. The applicable regulation governing this issue is 42 C.F.R. 413.9.
>
> **The Providers have included a calculation of underpayment** that utilizes an updated labor, non-labor and capital base rate based upon a presumption CMS has understated these national rates by -0.9.[9]

CMS opted to use 1981 as a "base year" to calculate these initial FFY 1984 rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but

[9] *E.g.*, Case 21-0980GC, Providers' Group Issue Statement (bold and underline emphasis added).

in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges.[10]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[11] They claim that the average cost per discharge should not include transfers. They also argue that hospitals have not been permitted to appeal the rate under CMS' improper interpretation of 42 C.F.R. 405.1885(a)(1). They go on to argue:

> A recent decision by the United States Court of Appeals for the District of Columbia Circuit (D.C. Circuit) in *St. Francis Medical Center v. Azar* allows hospitals the opportunity to correct their Medicare reimbursement due to alleged erroneous 1981 cost reporting data that CMS (acting through its predecessor agency HCFA) used to calculate IPPS standardized amounts in 1983.[12]

A. Jurisdictional Challenges

The Medicare Contractor filed a challenge in seventeen (17) different cases, and the Providers filed responses in each case.[13] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responded they are "not challenging CMS' development of the budget neutrality fact utilized in the development of the 1984 and 1985 Federal IPPS rates" that are precluded from administrative and judicial review.[14] Rather, they claim their challenge of the standardized amount is "a separate variable component utilized in the FFY 1984 and 1985 Federal IPPS rate calculations" and this component of prospective payment rate is not precluded from administrative or judicial review.[15]

---

[10] *See id*.
[11] *See e.g.,* Case 21-0980GC, Group Issue Statement ("These understated standardized amounts from 1983, as updated annually, have been used to determine IPPS payments for every year thereafter, meaning those Medicare payments were also understated.")
[12] *Id.* (Citing *St. Francis Medical Center v. Azar*, 894 F. 3d 290 (D.C. Cir. 2018)).
[13] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.
[14] *See e.g.,* Case 21-0980GC Response to MAC Jurisdictional Challenge at 2 (May 3, 2024).
[15] *Id*. at 2-3.

The Providers state that unlike the budget neutrality adjustments, Congress had an opportunity "to exercise a preclusion of administrative and judicial review on other components of the 1984 and 1985 IPPS payment calculations but Congress declined. Therefore, if errors exist in other payment components, including the standardized amount, Congress permits interested parties the right to challenge."[16]

Finally, the Provider argue that "[a]ny notion that CMS only pays claims up to a fixed amount (*i.e.*, fixed pie) is incorrect. CMS paid all allowable claims in FYs 1984 and 1985 (and future years) without consideration of a fixed payment cap (pie)."[17] The Provider contends that in prior decisions on this issue, the Board "placed great reliance upon the fixed pie concept for FFYs 1984 and 1985 payment rate development" and that this runs contrary to how CMS operates "like an actuary, utilizes estimations and projections to future payments" and "differences in projected payment versus actual payment over the course of time must be incorporated in any fix pie rationale."[18] The Provider posits that the Board's decision that one variable component is precluded from review, and therefore all other variable components must remain permanent, is "unsupported by the Medicare regulation."[19]

BOARD DECISION:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 17 cases because: (1) the initial IPPS standardized amounts set for FFY 1984[20] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[21]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; [22] and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[23] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

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[16] *Id*. at 3.
[17] *Id*.
[18] *Id*.
[19] *Id*. at 4.
[20] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[21] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[22] *But see* **Appendix B**. The Board has not traced the standardized amount after FFY 1986 all the way up to the each of the years in question. **Appendix B** highlights how, in addition to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and forward, there could be other intervening statutory or regulatory events (whether discretionary or mandatory) that could break the Providers' alleged causal link between the alleged error in the initial FFY 1984 rates and the standardize amounts used in the years at issue.
[23] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[24] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[25]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[26] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[27] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1981 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount and then *updated* by an inflationary factor to bring it forward to FFY 1984.[28] The Providers dispute how the Secretary determined

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[24] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[25] *Id.*
[26] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[27] *Id.* (emphasis added).
[28] *Id*. at 39763-64. The Board Majority notes that the 1981 data appears to have been available to the public close in time to when the initial IPPS was established, as explained in the proposed rule issued on May 27, 1988:

> *B. Public Requests for Data*
> In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format and are listed below with the cost of each tape. Anyone wishing to purchase data tapes should submit a written request along with a check to cover the cost of the tapes to the following address: HCFA Office of Statistics and Data Management, Bureau of Data Management and Strategy, Room l-F-2 Oak Meadows Building, 6325 Security Boulevard, Baltimore, MD 21207.
> ****
> 4. H180 **Extract, Cost Reporting Periods Ending January 1, 1981 through December 31, 1981**
> This file contains selected data items from cost reports. **These data were used in computing the initial Federal prospective payment rate**.
> Price: $530.00

"discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[29] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary (*see also* **Appendix B**). In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the BNA for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—

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53 Fed. Reg. 19498, 19526 (May 27, 1988). Apparently, the Secretary made the data available in this manner due to demand, as previously the Secretary made this information available through FOIA as discussed in the following excerpt from the January 3, 1984 Final Rule:

> *We agree hospitals should have access to the data used in connection with the development of the prospective payment system*. We would like to point out that public access to disclosable information is provided under the Freedom of Information Act (5 U.S.C. 552). While we cannot guarantee that all requested information will be disclosed in the format desired by the requester, we will continue to respond promptly to all information requests and provide all available data to assist the hospital industry and other interested parties in the evaluation of the prospective payment system.
>
> In fact, much of the applicable data has already been made available to requesters. For example, the cost report file used as a basis for determining the budget neutrality adjustment factor and other factors had already been made available for public use before publication of the interim rule. This data, together with our descriptions of the budget neutrality determination published in section VIII of the Addendum to the interim rule, should allow our budget neutrality determination to be replicated. 49 Fed. Reg. at 251.

(Emphasis added.) It is unclear to what extent any of this 1981 information continues to be available to the public at this late date and, if not, to what extent CMS is obligated to continue to make it available to the public at this late date.

[29] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[30]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[31]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required

[30] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[31] (Italics emphasis in original and bold and underline emphasis added.)

> for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[32]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[33] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the BNA).

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[32] (Italics emphasis in original and bold and underline emphasis added.)

[33] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board Majority's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1⁄2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,
>
> (VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,
>
> (VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 [percentage point] for hospitals located in a rural area,
>
> (IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban

> or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,
>
> (X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[34]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average

[34] (Emphasis added.)

standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage

> increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 BNAs (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
>
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.
>
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—
>
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[35]

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[35] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the* ***initial*** *FFY 1984 standardized amount*.[36]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the BNAs for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In

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(i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
(ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
(iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
(iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
(3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
(i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
(ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
(iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

[36] *See e.g.,* 21-0980GC, Issue Statement at 1.

addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[37] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***roughly 20 to 35 years*** to increase the ***initial*** FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward by the relevant 20 to 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue[38] *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[39]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 BNAs which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the BNAs had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[40] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 BNA (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those BNAs). Thus, in the Board Majority's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 BNAs. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of

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[37] *See* **Appendix B.**
[38] *See supra* note 20 accompanying text.
[39] *See id.*
[40] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

> the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[41]

Accordingly, the Board Majority finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the BNAs made for FFY 1984 and 1985.[42]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 BNAs. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[43]

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[41] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the BNAs would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[42] The Board Majority notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 BNAs given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[43] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs.

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 BNAs are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board Majority finds that the FFYs 1984 and 1985 BNAs effectively fixed the standardized amounts from that point forward for use in the IPPS system.[44]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 BNAs confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 BNA as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 BNA to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of

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Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[44] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.

The adjustment of the Federal portion was determined as follows:

- *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
- *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
- *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
- *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
- *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.

The resulting adjustment factor for the fiscal year 1984 Federal portion is .969. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[45]

[45] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).

In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970 using the same methodology.[46] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the BNA factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[47]

Accordingly, while the Providers did not appeal the BNAs, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the BNA for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the BNA for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a

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[46] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

[47] *Id.* at 255 (emphasis added.) *See also id.* at 331 (stating as part of the discussion on the BNAs: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

> result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[48]

Regardless, the Secretary's application of a 0.970 BNA factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 BNA. Moreover, as previously noted, since the FFY 1984 BNA is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 BNA effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 BNA also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a BNA of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1, 1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[49]
>
> ****

[48] *Id.* at 255.
[49] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

By finalizing an adjustment factor less than one (1), the Secretary confirmed that the standardized amounts were too high. Thus, like her BNA made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[50]

3. The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget-neutrality-adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[51]

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[50] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

[51] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[52] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[53]

A glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board Majority has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

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the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

[52] *Id.* (emphasis added).

[53] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

Accordingly, the Board Majority finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments and the alleged causal link between the initial standardized amounts set for FFY 1984 and those in dispute is broken.[54]

* * * * *

In summary, the Providers confirm that they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 BNAs, but rather they are contesting the base rate calculation of the *initial* standardized amount used for FFY 1984.[55] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[56]

The Board Majority disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the BNA made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[57] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable BNAs.[58] Indeed, the Secretary applied a BNA to those years to reduce the standardized

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[54] *See supra* note 22.
[55] *E.g.*, Case 21-0980GC, Providers' Preliminary Position Paper at 5.
[56] *See e.g.,* Case 21-0980GC, Response to MAC Jurisdictional Challenge at 2-3.
[57] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts
[58] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive

amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[59] Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates and the Providers may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board Majority finds that: (1) the appealed issue is *inextricably* tied with the FFY 1984 and 1985 BNAs to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[60]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board Majority concludes that it does not have substantive jurisdiction over the issue in the seventeen (17) group and individual provider cases listed in **Appendix A**, and hereby closes these seventeen (17) group and individual provider cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[59] *See supra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[60] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (dissenting)

For the Board:

9/30/2024

X Clayton J. Nix

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

Appendices A – Listing of Cases Covered by this Notice of Dismissal
B – Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue
C – Additional Excepts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

Dissenting

For the reasons explained below, I dissent from the Board Majority's decision regarding the issue of whether CMS' failure to remove transfer cases from its discharge data decreased the Standardized Amount, and would find that the Board has substantive jurisdiction in this case.

The Providers' issue statement is essentially the same as that in *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023) ("St. Mary's")*[61], an appeal from the Board's "Dismissal Based on Lack of Substantive Jurisdiction" dated April 6, 2023,[62] the Board's first decision on the topic of "Understated IPPS Standardized Amount" after the D.C. Circuit ruled in *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) ruling that the reopening regulation – and thus its predicate facts position – does not apply to appeals made to the Board.

In these "Understated IPPS Standardized Amount" cases, the providers consistently argue that a computational error at the inception of the IPPS has not been corrected,[63] that "the Secretary failed to properly distinguish between patient transfers and discharges in establishing the PPS1983 base year amounts,[64] and that "the resulting understated initial base year amounts were carried forward across 35 years resulting in the alleged understated standardized amount used for setting the FFY 2019 IPPS payment rates."[65]

The Board Majority finds that the Board has no jurisdiction based on the presupposition that the final FFY 1984 and 1985 standardized amounts (which were based on 1981 discharge data) were adjusted for budget neutrality, thus, the final rates in those years are *inextricably tied* with budget neutrality adjustments for which administrative and judicial review is prohibited by 42 U.S.C. § 1395ww(d)(7). The Board Majority rationalizes its conclusion by stating that the initial 1983 standardized amount was overstated, so therefore the initial base rate that was set using 1981 data could not have been erroneous. I respectfully disagree.

The Providers have presented several arguments as to why the standardized amount is understated; that is not for me to decide today. My dissent over the majority's conclusion that the Board has no

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[61] "The Hospitals challenge their Medicare inpatient hospital payments for Federal Fiscal Year ("FFY") 2019 as being unlawfully understated because the Secretary calculated them using a "standardized amount" that was invalidly low because of an embedded error from the Secretary's original implementation of the Medicare Hospital Inpatient Prospective Payment System ("IPPS") in FFY 1984." *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023), Complaint at 25.*

[62] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024); *see also*, *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023),* Complaint at 28 ("on April 6, 2023, the Board dismissed the Hospitals' administrative appeals, holding *for the first time* in any administrative appeal raising this substantive issue that the Budget Neutrality Preclusion Provisions strip it of jurisdiction over the Hospitals' claims.")

[63] See Saint Francis Med. Ctr. v. Azar, 894 F.3d 290 (D.C. Cir. 2018).

[64] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), at 3, available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024);

[65] *Id*.

substantive jurisdiction over this appeal solely because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. To reach their conclusion, my colleagues have skipped ahead to an analysis of the budget neutrality adjustments, and passed over the Providers' challenge to the accuracy of the 1981 discharge data.[66] The Providers are not challenging the "determination of the requirement, or the proportional amount, of any budget neutrality adjustment" in IPPS rates, which is what the plain language of 42 U.S.C. § 1395ww(d)(7) prohibits. Rather than consider the issue to be that CMS did not properly calculate the average cost per discharge, my colleagues prejudicate that the data cannot be reviewed because a subsequent calculation utilizing that data was later incorporated into an adjustment which was deemed sacrosanct by a Congress that readily admitted the data was flawed.[67]

In reaching my decision, I am persuaded by the concurring opinion in *St. Francis* asserting "it is not reasonable for HHS to 'cement misclassified' costs into 'future reimbursements, thus perpetuating literally million-dollar mistakes.'"[68] Additionally, I note the rulemaking for the Capital PPS Final Rule, whereby CMS applied a correction factor for capital-related costs in the Capital PPS Final Rule in 1991, thus setting a possible precent for making such a change.[69] Finally, I believe that the Board jurisdictional statute, 42 U.S.C. § 1395oo, should be read broadly to support the "strong presumption that Congress intends judicial review of administrative action."[70]

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[66] *See* Providers' Statement of Disputed Issue.

[67] "The case mix index values used in the PPS model were based on billing information reported in 1981. At that time, the patient diagnostic information necessary for DRG assignment was completely unrelated to payment. ***As a result, the 1981 bills contain a variety of errors which tend to cause the hospital case mix values to be understated.*** Hospital PPS payments, however, are based on the diagnostic information reported on the current bills, under very different incentives. Therefore, an increase in overall hospital case mix under PPS was anticipated." Adjustments in Medicare's Prospective Payment System, S. Hrg. 98-1122, Hearing before the Subcommittee on Health of the Committee on Finance, United States Senate, Ninety-Eighth Congress, Second Session, August 8, 1984, available at https://www.finance.senate.gov/imo/media/doc/HRG98-1122.pdf, page 14 of 147 (accessed July 11, 2024) (***emphasis added***). *See also* 56 Fed. Reg. 43358 at 43387 (Aug. 30, 1991) (Prospective Payment System for Inpatient Hospital Capital-Related Costs – Final Rule). ("*Comment*: Several commenters questioned the treatment of transfers in determining the hospital-specific rate. Some commenters suggested that transfer should not be included in the discharge count because payment is not made for all transfers on a per discharge basis. One commenter suggested that each transfer case should be counted as a fraction based on the amount paid for the transfer case as a portion of the full case payment. Others believed that including transfers in the case-mix index would distort the hospital-specific rate because transfer cases tend to have a higher DRG weight. *Response*: We agree with the commenters that the treatment of transfers in the discharge count is problematic. To the extent a transfer is paid on a per diem basis, including the transfer in the discharge count will understate the hospital-specific rate. If the transfer were not counted at all, as suggested by some commenters, the hospital-specific rate would be overstated. In contrast, there is no distortion in the hospital-specific rate if the transfer is paid at the full DRG rate. Since some transfers are paid on a per diem basis and other transfers are paid at the full DRG amount, either the total include or the total exclusion of transfers will distort the hospital-specific rate unless the costs of all transfer cases are removed from the base period costs. We do not believe that it is administratively feasible to remove the costs associated with transfer cases. Instead, to account for transfers, as recommended by one commenter, we are adopting and adjustment to the discharge count used to calculation the hospital-specific rate. [. . . .].")

[68] *St. Francis* at 298, citing *Regions Hospital v. Shalala*, 522 U.S. 448, 462, 118 S.Ct. 909, 139 L.Ed.2d 895 (1998).

[69] 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991).

[70] *Bowen v. Academy of Family Physicians*, 476 U.S. 667, 670 (1986).

In conclusion, the Providers should be afforded the due process of proving to the Board that the 1981 discharge data were indeed flawed, leading to understated amounts in the Federal Fiscal Years at issue.

9/30/2024

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

APPENDIX A

Jurisdictional Challenges and Responses; Cases at Issue

On April 24, 2024, the Medicare Contractor filed a challenge to the following two (2) group cases and four (4) individual appeals, which all share a common lead Medicare Contractor, Noridian Healthcare Solutions, LLC (J-F):

21-0980GC	Confluence Health FFY 2021 MCARE PYMT DISPUTE CMS DRG BASE RATE CALCULATION ERRORS CIRP Group
24-0617G	Moss Adams CY 2015 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors Group
19-0546	Overlake Hospital Medical Center (50-0051), FYE 06/30/2016
21-0964	St. Charles Bend (38-0047), FFY 2021
21-0985	Virginia Mason Memorial Hospital (50-0036), FFY 2021
21-1016	Salem Hospital (38-0051), FFY 2021

The same April 24, 2024 Jurisdictional Challenge contained three (3) group cases and eight (8) individual appeals which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

24-0624GC	Hawaii Pacific Health CY 2015 MCARE Payment Dispute DRG Base Rate Calculation Errors CIRP Group
24-0626GC	PHH CY 2014 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors CIRP Group
24-1714GC	John Muir Health CY 2018 MCARE Payment Dispute CMS DRG Base Rate Calculation Errors CIRP Group
20-1302	Menifee Valley Medical Center (05-0684), FYE 12/31/2015
21-0913	Menifee Valley Medical Center (05-0684), FYE 12/31/2016
21-0987	Valley Presbyterian Hospital (05-0126), FFY 2021
21-1017	El Centro Regional Medical Center (05-0045), FFY 2021
21-1018	Pioneers Memorial Healthcare District (05-0342), FFY 2021
21-1019	Sierra View Medical Center (05-0261), FFY 2021
21-1021	San Mateo Medical Center (05-0113), FFY 2021
21-1022	Victor Valley Global Medical Center (05-0517), FFY 2021

APPENDIX B

Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue

Set forth below are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments ("BNAs") and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). These other example raise questions about the causal link between the standardized amount rates at issue and the initial standardize amounts set for FFY 1984. Curiously, the Providers stopped their analysis at 1986 and did not carry forward their analysis for years 1987 through the particular year at issue (*e.g.*, for the lead case under Case No. 18-1646G, there are an additional 28 intervening years since the standardize amount issue is the FFY 2015 standard amount rate).

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[71] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[72]

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[71] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[72] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs,

c. BNAs made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[73]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[74] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[75]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[76]

> inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

[73] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[74] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 20.

[75] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[76] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[77] and 1997[78] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[79]

To illustrate the complex nature of these issues, the Board Majority points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[80] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[81] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that

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> percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

[77] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[78] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[79] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[80] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[81] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law **to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more **nor** less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

*Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were **higher** than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the **overstatement** of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into **a proposed composite correction factor** for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically

appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[82]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed

[82] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

> We received no comments on this issue.
>
> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[83] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[84] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[85]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[86] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for

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[83] *Id.* at 35703-04 (bold and underline emphasis added).
[84] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[85] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[86] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).

discharges on or after May 1,1986"[87] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

[87] 51 Fed. Reg. at 16773.

APPENDIX C

Additional Excerpts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

In its decision, the Board Majority has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 BNA accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[88]

[88] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). The Board Majority notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 BNA accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her BNAs for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

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basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.
For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 BNA to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[89]

[89] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Lisa Ellis
Toyon Associates, Inc.
1800 Sutter St., Ste. 600
Concord, CA 94520

RE: ***Notice of Dismissal – Updated Rationale***
Toyon Associates Standardized Amount CIRP Group Cases
Case Nos. 19-0354GC, *et al.* (*see* **Appendix A** listing 11 group cases)

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the eleven (11) above-referenced common issue related party ("CIRP") and optional group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all eleven (11) CIRP and optional group cases in their entirety. This issue is not new to the Board and this determination is consistent with the its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget-neutrality-adjusted federal rates.

In summary, the Board Majority finds that it lacks substantive jurisdiction over the issue raised in these group appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment ("BNA") made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board Majority has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 BNAs. These intervening adjustments for FFYs 1986 and 2018 include

intertwined with those applicable BNAs.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the BNAs applied to those years reduced the standardized amounts (by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs, the Board Majority finds that it may not review the standardized amount used for the FFYs appealed as it relates to the common issues in these appeals. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget -neutrality-adjusted rates. Accordingly, the Providers assertion that the initial FFY 1984 standardized amount continues to serve as the base for all future calculations is incorrect as causal link is broken. Specifically, they may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

The Board Majority also notes that the Providers appear to raise a new legal issue that is beyond the scope of the original group issue statement in these group cases. Per their group issue statements, these group appeals challenge the standardized amount "first calculated" for the ***initial*** year of IPPS, namely FFY 1984 running from October 1, 1983 to September 30, 1984.[7] Pursuant to 42 C.F.R. §§ 405.1837(a)(2) and (f)(1), a group may contain only one issue and no issues may be added to the group appeal. In their Response to the Medicare Contractors' Jurisdictional Challenge, the Providers appear to have ***improperly*** raised a new legal issue that is not part of this appeal. Specifically, the Providers appear to challenge the FFY 1986 standardized amount rates and subsequent years as being *improperly* based on the FFY 1985 budget-neutrality adjusted rates. The Board confirms that, *if so*, this is a newly-added issue and hereby ***dismisses*** it from these appeals pursuant to 42 C.F.R. §§ 405.1837(a)(2), (c) and (f)(1).

---

both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 59 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 43 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 BNA).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *E.g.,* Case No. 24-1601G, Providers' Group Issue Statement.

PROCEDURAL BACKGROUND:

A. Group Issue – Limited to Alleged Error in the Initial Calculation of the Standardized Amount for the Initial Year of IPPS

Toyon Associates, Inc. ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed two (2) Jurisdictional Challenges covering eleven (11) group cases.[8] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all eleven (11) cases are materially identical and can be considered together.

The group issue statement presented is:

> The provider disputes the accuracy of IPPS payments, as well as any add-on payments determined by the IPPS payments, due to the Standard Dollar Amount (SDA) or "Standardized Amount" being erroneous.
>
> The provider contends that CMS improperly determined the number of discharges in the original calculation, and overstated the denominator. *The provider argues this error resulted in an understatement of the average allowable operating costs per case, and understated the SDA* ***in the original calculation***.
>
> On June 29, 2018, the United States Court of Appeals for the District of Columbia Circuit ("U.S. Court of Appeals") rendered a decision on Case No. 17-5098 (the "Predicate Fact Appeal Decision"), due to the "Error Carried Forward" impact from how the 1983 standardized amounts were determined, the following types of Medicare reimbursement are impacted: Federal/Hospital Specific Payments/ (Operating); Federal/Hospital Specific Payments (Capital); and GME/IME Payments. The "Predicate Fact" of the 1983 standardized amounts has a material "Error Carried Forward" ("ECF") effect in other areas impacted by the allowable operating costs by discharge, most notable of which are the MAC's Medicare PS&R reconciliation adjustments performed as part of the Medicare cost report desk review process.[9]

The Providers restate the issue in their preliminary position paper:

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[8] *See* **Appendix A**.
[9] *E.g.*, Case 19-0354GC, Providers' Group Issue Statement in Appeal Request (emphasis added).

> [W]hether it was proper for CMS to establish a standardized amount for a 1983 "base year" using a cost calculation that did not differentiate the transfer of a patient from true "discharges," *and to perpetuate that standardized rate year after year without correction*, despite acknowledging including transfers in the calculation was problematic.[10]

Their preliminary position papers further explains that:

> Since 1983, the amount of Medicare reimbursement provided to hospitals for inpatient services has been based on fixed and prospectively determined rates, and CMS' calculation begins with a figure called the "standardized amount," or average cost incurred by hospitals nationwide for each patient they treat and discharge. 42 U.S.C. §1395ww(d)(2).[11]

CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[12]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[13]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[14] They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers. They also argue that hospitals have not been permitted to appeal the rate under CMS' improper interpretation of 42 C.F.R. 405.1885(a)(1).[15] They go on to argue:

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[10] *E.g.*, Case 19-0354GC, Providers' Preliminary Position Paper at 1 (Feb. 14, 2022) (emphasis added).
[11] *Id*. at 2.
[12] *See id*. at 3.
[13] *Id.* (citing 56 Fed. Reg. 43358, 43387 (Aug. 30, 1991) (related to capital PPS).
[14] *See id*. at 3 ("[B]ecause the standardized rate is simply carried forward year after year and only updated for inflation, CMS has wrongfully perpetuated that arbitrary and flawed calculation of the 1983 IPPS standardized rate year after year.")
[15] *Id*.

> The *St. Francis* Court's reversal of CMS' interpretation of the predicate fact rule establishes Providers' rights to appeal the IPPS Standardized Rate, a flawed calculation which has negatively impacted Providers year after year. Providers now seek that the rate be corrected through this appeal.[16]

B. Jurisdictional Challenges

The Medicare Contractor filed challenges in eleven (11) different group cases, and the Providers filed responses in each case.[17] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responded "that the MAC has not met its "heavy burden" in showing that the Providers challenge to the 1983 standardized amount is precluded from review by a preclusion provision governing budget neutrality adjustments applied in 1984 and 1985."[18] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. They ask the Board to deny the Jurisdictional Challenges.

The Providers counter the Medicare Contractor by arguing that budget neutrality adjustments are not applicable to these appeals. The Providers acknowledge that they are not challenging the budget neutrality adjustments for FYs 1984 or 1985, rather "CMS's calculation of the "costs per discharge" in the first step of the methodology prescribed by statute for calculating the original, 1983 standardized amounts."[19] They argue that there is a strong presumption in favor of judicial review,[20] and that such a presumption may only be overcome by clear and convincing evidence of a specific legislative intent to preclude review of the matter at issue.[21]

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[16] *Id*. (Citing *St. Francis Medical Center v. Azar*, 894 F. 3d 290 (D.C. Cir. 2018)).
[17] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.
[18] *See e.g.*, PRRB Case No. 19-1153G, *et al.*, Response to Jurisdictional Challenge at 1 (Apr. 29, 2024).
[19] *Id.* at 2.
[20] *Id*. at 1. (Citing *Am. Clinical Lab. Ass'n v. Azar*, 931 F.3d 1195, 1204 (D.C. Cir. 2019)).
[21] *Id.* (Citing *Abbot Labs. v. Gardner*, 387 U.S. 136, 141 (1967)).

BOARD DECISION:

As described more fully below, the Board Majority finds that it lacks substantive jurisdiction over each of the 11 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[22] are ***inextricably*** tied to the FFY 1984 and 1985 BNAs to the "applicable percentage increases" for IPPS[23]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs;[24] and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs. Further, the fact that the Secretary's BNA to the FY 1984 Federal Rates was 0.970[25] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[26] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[27]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[28] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[29] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

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[22] The Board Majority notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).

[23] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 BNAs are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).

[24] *But see* **Appendix B**. The Board has not traced the standardized amount after FFY 1986 all the way up to the each of the years in question. **Appendix B** highlights how, in addition to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and forward, there could be other intervening statutory or regulatory events (whether discretionary or mandatory) that could break the Providers' alleged causal link between the alleged error in the initial FFY 1984 rates and the standardize amounts used in the years at issue.

[25] In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

[26] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.

[27] *Id.*

[28] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).

[29] *Id.* (emphasis added).

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1981 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount and then *updated* by an inflationary factor to bring it forward to FFY 1984.[30] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed

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[30] *Id*. at 39763-64. The Board Majority notes that the 1981 data appears to have been available to the public close in time to when the initial IPPS was established, as explained in the proposed rule issued on May 27, 1988:

> *B. Public Requests for Data*
> In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format and are listed below with the cost of each tape. Anyone wishing to purchase data tapes should submit a written request along with a check to cover the cost of the tapes to the following address: HCFA Office of Statistics and Data Management, Bureau of Data Management and Strategy, Room l-F-2 Oak Meadows Building, 6325 Security Boulevard, Baltimore, MD 21207.
>
> ****
>
> 4. H180 **Extract, Cost Reporting Periods Ending January 1, 1981 through December 31, 1981**
> This file contains selected data items from cost reports. **<u>These data were used in computing the initial Federal prospective payment rate</u>**.
> Price: $530.00

53 Fed. Reg. 19498, 19526 (May 27, 1988). Apparently, the Secretary made the data available in this manner due to demand, as previously the Secretary made this information available through FOIA as discussed in the following excerpt from the January 3, 1984 Final Rule:

> *We agree hospitals should have access to the data used in connection with the development of the prospective payment system*. We would like to point out that public access to disclosable information is provided under the Freedom of Information Act (5 U.S.C. 552). While we cannot guarantee that all requested information will be disclosed in the format desired by the requester, we will continue to respond promptly to all information requests and provide all available data to assist the hospital industry and other interested parties in the evaluation of the prospective payment system.
> In fact, much of the applicable data has already been made available to requesters. For example, the cost report file used as a basis for determining the budget neutrality adjustment factor and other factors had already been made available for public use before publication of the interim rule. This data, together with our descriptions of the budget neutrality determination published in section VIII of the Addendum to the interim rule, should allow our budget neutrality determination to be replicated. 49 Fed. Reg. at 251.

(Emphasis added.) It is unclear to what extent any of this 1981 information continues to be available to the public at this late date and, if not, to what extent CMS is obligated to continue to make it available to the public at this late date.

the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[31] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary (*see also* **Appendix B**). In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the BNA for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> > (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[32]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

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[31] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[32] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[33]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[34]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average

[33] (Italics emphasis in original and bold and underline emphasis added.)
[34] (Italics emphasis in original and bold and underline emphasis added.)

payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[35] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the BNA).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1⁄2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points

[35] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board Majority's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 [percentage point] for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year ***1998***, 0 percent,

(XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[36]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the

[36] (Emphasis added.)

> Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 BNAs (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used

in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
>
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.
>
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—
>
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.

> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[37]

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[37] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the* ***initial*** *FFY 1984 standardized amount*.[38]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the BNAs for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[39] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***roughly 20 to 35 years*** to increase the ***initial*** FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward by the relevant 20 to 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue[40] *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[41]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 BNAs which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the BNAs had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to

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[38] *E.g.*, PRRB Case 19-1153G *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 2.
[39] *See* **Appendix B.**
[40] *See supra* note 24 accompanying text.
[41] *See id.*

(*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[42] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 BNA (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those BNAs). Thus, in the Board Majority's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 BNAs. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[43]

Accordingly, the Board Majority finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the BNAs made for FFY 1984 and 1985.[44]

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[42] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[43] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the BNAs would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[44] The Board Majority notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 BNAs given the statutory provision precluding administrative and judicial review of those adjustments. Further,

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 BNAs. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[45]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 BNAs are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board Majority finds that the FFYs 1984 and 1985 BNAs effectively fixed the standardized amounts from that point forward for use in the IPPS system.[46]

Saint Francis did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[45] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[46] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 BNAs confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 BNA as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 BNA to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.

> • *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
>
> • *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
>
> • *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[47]

In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970 using the same methodology.[48] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the BNA factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[49]

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[47] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[48] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[49] *Id.* at 255 (emphasis added.) *See also id.* at 331 (stating as part of the discussion on the BNAs: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing

Accordingly, while the Providers did not appeal the BNAs, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the BNA for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the BNA for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[50]

Regardless, the Secretary's application of a 0.970 BNA factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 BNA. Moreover, as previously noted, since the FFY 1984 BNA is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 BNA effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 BNA also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a BNA of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable

reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[50] *Id.* at 255.

> cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1, 1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[51]
>
> ****

By finalizing an adjustment factor less than one (1), the Secretary confirmed that the standardized amounts were too high. Thus, like her BNA made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[52]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget-neutrality-adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical

[51] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[52] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

> explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[53]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[54] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a

[53] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").
[54] *Id.* (emphasis added).

> zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[55]

A glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 BNA and then used the FFY 1985 budget-neutrality-adjusted rates to set those for FFY 1986 and subsequent years.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board Majority finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

4. *Any issues the Providers have regarding the use of the FFY 1985 budget-neutrality-adjusted rates to set the standardized amounts for FFY 1986 and subsequent years is beyond the scope of these appeals.*

As discussed above, the Providers admit that the Secretary used the FFY 1985-budget-neutrality adjusted rates to set the standardized amounts for FFY 1986 and subsequent years and that they do not challenge the FFY 1985 BNA.[56] However, in their response to the Medicare Contractors' Jurisdictional Challenge, the Providers appear to potentially challenge the Secretary's use of the 1985-budget-neutrality adjusted rates to set the standardize amount rates for FFY 1986 and subsequent years by claiming the Secretary failed to follow the statutory directives of Congress in calculating the standardized amount rates for FFY 1986 and subsequent years. If so, this challenge would be a new issue that is not part of the groups' original appeal.

Pursuant to 42 C.F.R. § 405.1837(a)(2), a group must *only* "involve[] a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Consistent with this requirement, 42 C.F.R. § 405.1837(c)(3) specifies that a group appeal request must include "a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group

[55] 87 Fed. Reg. 16772, 16773 (May 6, 1986).
[56] Providers' Response to Medicare Contractors' Jurisdictional Challenge at 1.

appeal." Further, the group appeal request must explain "why the provider[s] believe[] Medicare payment is incorrect for each disputed item" and "[h]ow and why the provider[s] believe[] Medicare payment must be determined differently for each disputed item." Consistent with these two (2) regulatory provisions, 42 C.F.R. § 405.1837(f)(1) specifies that, after a group appeal request is filed, "a provider *may* ***not*** *add* other questions of fact or law to the appeal, *regardless of whether the question is common to other members of the appeal*."

Here, the Providers only challenged the ***initial*** federal standardized amounts "first calculated" under the IPPS for FFY 1984 as improper by asserting that the Secretary failed to exclude transfers when determining the base cost per discharge rate mandated in 42 U.S.C. § 1395ww(d)(2)(A) as demonstrated in the excerpts taken from the group issue statements quoted above.[57] The Providers *belated* focus on the Secretary's use of the 1985-budget-neutrality adjusted rates in the FFY 1986 rates and subsequent years illustrates the underlying problem with these appeals, namely the failure to trace the causality of the alleged error in setting the original FFY 1984 standardize amount rates and those at issue as used over 30 years later.[58]

The Providers stance on this discovery suggests that the real issue with the standardized amounts used in the years at issue may now be potentially shifting to a new allegation that the Secretary improperly used the FFY 1985 budget neutrality-adjusted rates in setting their current rates:

> An argument that the 1984 and 1985 budget neutrality adjustments would obviate any damages associated with an understated 1983 standardized amount is also wrong for a second reason. *It is based on* ***a false premise*** *that those budget neutrality adjustments were properly rolled forward into subsequent fiscal years*. . . . By specifying that these adjustments only apply "[f]or discharges occurring in fiscal year 1984 or fiscal year 1985," and that payment amounts "for [those] fiscal year[s]" may not exceed what they would have been under the system that preceded the IPPS, Congress made its intent clear that the budget neutrality adjustments required by section 1395ww(e)(1)(B) only apply to FYs 1984 and 1985, and cannot be carried forward to future years. [59]

Further, the Providers further conclude that Congress did not intend the FY 1985 budget-neutrality-adjusted rates to apply in FFY 1986 and subsequent years:

> The MAC's argument that the Board lacks jurisdiction over these appeals is also based on the premise that *Congress intended* the budget neutrality adjustments required by § 1395ww(e)(1)(B) to

[57] *E.g.*, Case No. 24-1601G Group Issue Statement.
[58] *See* **Appendix B** (providing examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue).
[59] Provider's Response to the Medicare Contractors' Jurisdictional Challenge at 3-4 (emphasis added).

> apply in FFYs 1986 and onward but, as explained above, *that premise if **false***.[60]

The Providers' group issue statements do not challenge the use of the FFY 1985 budget neutrality-adjusted rates in setting the rates for FFY 1986 and subsequent years and the Providers may not now add that issue to their appeal. Accordingly, to the extent the Provers are attempting to add this new issue to their appeal at this late date, the Board Majority ***dismisses*** that new issue, (*i.e.*, dismisses the challenge to the Secretary's use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and subsequent years), pursuant to 42 C.F.R. §§ 405.1837(a)(2), (c), and (f)(1).[61]

* * * * *

In summary, the Providers confirm that they are not challenging the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 BNAs, but rather they are contesting the base rate calculation of the standardized amount.[62] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[63]

The Board Majority disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the BNA made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[64]

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[60] *Id.* at 5 n.2 (emphasis added).

[61] *See also* Board Rule 8. Consistent with these regulations, Board Rule 8.1 (July 2015) specifies: "Some issues may have multiple components. To comply with the regulatory requirement to ***specifically** identify* the items in dispute, ***each*** contested component must be appealed as a ***separate** issue **and** described as **narrowly** as possible* using the applicable format outlined in Rule 7." (Emphasis added.) *See also Evangelical Comty. Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[62] *E.g.*, PRRB Case Nos. 19-1311G, *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 1-2.

[63] *Id.* at 2.

[64] The Board Majority has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 BNAs. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not

Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable BNAs.[65] Indeed, the Secretary applied a BNA to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[66] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board Majority finds that it may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals.[67] In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates and the Providers may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would

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revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[65] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board Majority notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board Majority's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing BNAs made for FFYs 1984 and 1985.

[66] *See supra* note 43 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 BNA).

[67] *But see supra* note 24.

have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board Majority finds that: (1) the appealed issue is *inextricably* tied with the FFY 1984 and 1985 BNAs to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[68]) prohibit administrative and judicial review of those BNAs. Based on these findings, the Board Majority concludes that it does not have substantive jurisdiction[69] over the issue in the eleven (11) group cases listed in **Appendix A**, and hereby closes these eleven (11) group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (concurring in part, dissenting in part)

For the Board:

9/30/2024

X Clayton J. Nix

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

Appendices A – Listing of Cases Covered by this Notice of Dismissal
B – Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue
C – Additional Excepts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

[68] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).
[69] The Board has not formally reviewed these cases for other aspects of jurisdiction, including claims filing requirements (*e.g.*, timeliness) or whether any revised NPRs were appeal and, if so, whether the relevant Provider(s) properly appealed the revised NPR(s).

Concurring in part, dissenting in part

I concur with the majority's dismissal of the Providers' challenge to the FFY 1986 standardized amount rates and subsequent years as being improperly based on the FFY 1985 budget-neutrality adjusted rates. However, for the reasons explained below, I dissent from the Board Majority's decision regarding the issue of whether CMS' failure to remove transfer cases from its discharge data decreased the Standardized Amount, and would find that the Board has substantive jurisdiction in this case.

The Providers' issue statement is essentially the same as that in *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023) ("St. Mary's")*[70], an appeal from the Board's "Dismissal Based on Lack of Substantive Jurisdiction" dated April 6, 2023,[71] the Board's first decision on the topic of "Understated IPPS Standardized Amount" after the D.C. Circuit ruled in *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) ruling that the reopening regulation – and thus its predicate facts position – does not apply to appeals made to the Board.

In these "Understated IPPS Standardized Amount" cases, the providers consistently argue that a computational error at the inception of the IPPS has not been corrected,[72] that "the Secretary failed to properly distinguish between patient transfers and discharges in establishing the PPS1983 base year amounts,[73] and that "the resulting understated initial base year amounts were carried forward across 35 years resulting in the alleged understated standardized amount used for setting the FFY 2019 IPPS payment rates."[74]

The majority finds that the Board has no jurisdiction based on the presupposition that the final FFY 1984 and 1985 standardized amounts (which were based on 1981 discharge data) were adjusted for budget neutrality, thus, the final rates in those years are *inextricably tied* with budget neutrality adjustments for which administrative and judicial review is prohibited by 42 U.S.C. § 1395ww(d)(7). The Board Majority rationalizes its conclusion by stating that the initial 1983 standardized amount was overstated, so therefore the initial base rate that was set using 1981 data could not have been erroneous. I respectfully disagree.

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[70] "The Hospitals challenge their Medicare inpatient hospital payments for Federal Fiscal Year ("FFY") 2019 as being unlawfully understated because the Secretary calculated them using a "standardized amount" that was invalidly low because of an embedded error from the Secretary's original implementation of the Medicare Hospital Inpatient Prospective Payment System ("IPPS") in FFY 1984." *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023), Complaint at 25.*

[71] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024); *see also*, *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023),* Complaint at 28 ("on April 6, 2023, the Board dismissed the Hospitals' administrative appeals, holding *for the first time* in any administrative appeal raising this substantive issue that the Budget Neutrality Preclusion Provisions strip it of jurisdiction over the Hospitals' claims.")

[72] See Saint Francis Med. Ctr. v. Azar, 894 F.3d 290 (D.C. Cir. 2018).

[73] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), at 3, available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024);

[74] *Id*.

The Providers have presented several arguments as to why the standardized amount is understated; that is not for me to decide today. My dissent over the majority's conclusion that the Board has no substantive jurisdiction over this appeal solely because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. To reach their conclusion, my colleagues have skipped ahead to an analysis of the budget neutrality adjustments, and passed over the Providers' challenge to the accuracy of the 1981 discharge data.[75] The Providers are not challenging the "determination of the requirement, or the proportional amount, of any budget neutrality adjustment" in IPPS rates, which is what the plain language of 42 U.S.C. § 1395ww(d)(7) prohibits. Rather than consider the issue to be that CMS did not properly calculate the average cost per discharge, my colleagues prejudicate that the data cannot be reviewed because a subsequent calculation utilizing that data was later incorporated into an adjustment which was deemed sacrosanct by a Congress that readily admitted the data was flawed.[76]

In reaching my decision, I am persuaded by the concurring opinion in *St. Francis* asserting "it is not reasonable for HHS to 'cement misclassified' costs into 'future reimbursements, thus perpetuating literally million-dollar mistakes.'"[77] Additionally, I note the rulemaking for the Capital PPS Final Rule, whereby CMS applied a correction factor for capital-related costs in the Capital PPS Final Rule in 1991, thus setting a possible precent for making such a change.[78] Finally,

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[75] *See* Providers' Issue Statement.

[76] "The case mix index values used in the PPS model were based on billing information reported in 1981. At that time, the patient diagnostic information necessary for DRG assignment was completely unrelated to payment. ***As a result, the 1981 bills contain a variety of errors which tend to cause the hospital case mix values to be understated.*** Hospital PPS payments, however, are based on the diagnostic information reported on the current bills, under very different incentives. Therefore, an increase in overall hospital case mix under PPS was anticipated." Adjustments in Medicare's Prospective Payment System, S. Hrg. 98-1122, Hearing before the Subcommittee on Health of the Committee on Finance, United States Senate, Ninety-Eighth Congress, Second Session, August 8, 1984, available at https://www.finance.senate.gov/imo/media/doc/HRG98-1122.pdf, page 14 of 147 (accessed July 11, 2024) (***emphasis added***). *See also* 56 Fed. Reg. 43358 at 43387 (Aug. 30, 1991) (Prospective Payment System for Inpatient Hospital Capital-Related Costs – Final Rule). ("*Comment*: Several commenters questioned the treatment of transfers in determining the hospital-specific rate. Some commenters suggested that transfer should not be included in the discharge count because payment is not made for all transfers on a per discharge basis. One commenter suggested that each transfer case should be counted as a fraction based on the amount paid for the transfer case as a portion of the full case payment. Others believed that including transfers in the case-mix index would distort the hospital-specific rate because transfer cases tend to have a higher DRG weight. *Response*: We agree with the commenters that the treatment of transfers in the discharge count is problematic. To the extent a transfer is paid on a per diem basis, including the transfer in the discharge count will understate the hospital-specific rate. If the transfer were not counted at all, as suggested by some commenters, the hospital-specific rate would be overstated. In contrast, there is no distortion in the hospital-specific rate if the transfer is paid at the full DRG rate. Since some transfers are paid on a per diem basis and other transfers are paid at the full DRG amount, either the total include or the total exclusion of transfers will distort the hospital-specific rate unless the costs of all transfer cases are removed from the base period costs. We do not believe that it is administratively feasible to remove the costs associated with transfer cases. Instead, to account for transfers, as recommended by one commenter, we are adopting and adjustment to the discharge count used to calculation the hospital-specific rate. [. . . .].")

[77] *St. Francis* at 298, citing *Regions Hospital v. Shalala*, 522 U.S. 448, 462, 118 S.Ct. 909, 139 L.Ed.2d 895 (1998).

[78] 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991).

I believe that the Board jurisdictional statute, 42 U.S.C. § 1395oo, should be read broadly to support the "strong presumption that Congress intends judicial review of administrative action."[79]

In conclusion, the Providers should be afforded the due process of proving to the Board that the 1981 discharge data were indeed flawed, leading to understated amounts in the Federal Fiscal Years at issue.

9/30/2024

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

[79] *Bowen v. Academy of Family Physicians*, 476 U.S. 667, 670 (1986).

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On April 3, 2024, the Medicare Contractor filed a challenge to the following three (3) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions, LLC (J-F):

19-0354GC	Providence Health CY 2016 PHS Providence Predicate Fact SDA Group CIRP Group
19-0356GC	Providence Health CY 2014 PHS Providence Predicate Fact SDA Group CIRP Group
19-1153G	Toyon Associates FFY 2019 IPPS Standardized Rate Group

On April 15, 2024, the Medicare Contractor filed a challenge to the following eight (8) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

23-1687GC	Univ of California CY 2016 IPPS Standardized Payment Rate CIRP Group
24-1255GC	Alameda Health System FFY 2024 IPPS Standardized Payment Rate CIRP Group
24-1259GC	Sutter Health FFY 2024 IPPS Standardized Payment Rate CIRP Group
24-1260GC	Stanford Health Care FFY 2024 IPPS Standardized Payment Rate CIRP Group
24-1261GC	Palomar Health FFY 2024 IPPS Standardized Payment Rate CIRP Group
24-1262GC	Univ of California FFY 2024 IPPS Standardized Payment Rate CIRP Group
24-1263G	Toyon Associates FFY 2024 IPPS Standardized Payment Rate Group
24-1739G	Toyon Associates CY 2016 IPPS Standardized Payment Rate Group

APPENDIX B
Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue

Set forth below are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments ("BNAs") and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). These other example raise questions about the causal link between the standardized amount rates at issue and the initial standardize amounts set for FFY 1984. Curiously, the Providers stopped their analysis at 1986 and did not carry forward their analysis for years 1987 through the particular year at issue (*e.g.*, for the lead case under Case No. 18-1646G, there are an additional 28 intervening years since the standardize amount issue is the FFY 2015 standard amount rate).

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[80] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[81]

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[80] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[81] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.

c. BNAs made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[82]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[83] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[84]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[85]

> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

[82] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[83] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 22.

[84] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[85] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[86] and 1997[87] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[88]

To illustrate the complex nature of these issues, the Board Majority points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[89] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[90] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous*

[86] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[87] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[88] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[89] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[90] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have***

***been demonstrated to be overstated**, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[91]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[91] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[92] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[93] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[94]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[95] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[96] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

---

[92] *Id.* at 35703-04 (bold and underline emphasis added).
[93] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[94] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[95] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[96] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C
Additional Excerpts from FFY 1985 IPPS Final Rule
Affirming Application of FFY 1985 budget-neutrality-adjusted rates to
FFY 1986 and subsequent years.

In its decision, the Board Majority has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 BNA accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[97]

[97] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). The Board Majority notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 BNA accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her BNAs for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**
>
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized.

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 BNA to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[98]

[98] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Corinna Goron
Healthcare Reimbursement Services, Inc.
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RE: ***Notice of Dismissal – Updated Rationale***
HRS Standardized Amount CIRP Group Cases
Case Nos. 19-1143GC, *et al.* (*see* **Appendix A** listing 13 CIRP group cases)

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the thirteen (13) above-referenced common issue related party ("CIRP") group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative failed to file timely responses to these challenges. As set forth below, the Board Majority has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and, therefore, is dismissing these group cases in their entirety. This issue is not new to the Board and this determination is consistent with the its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget-neutrality-adjusted federal rates.

In summary, the Board Majority finds that it lacks substantive jurisdiction over the issue raised in these group appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment ("BNA") made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board Majority has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 BNAs. These intervening adjustments for FFYs 1986 and 2018 include

intertwined with those applicable BNAs.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the BNAs applied to those years reduced the standardized amounts (by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs, the Board Majority finds that it may not review the standardized amount used for the FFYs appealed as it relates to the common issues in these appeals. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget -neutrality-adjusted rates. Accordingly, the Providers assertion that the initial FFY 1984 standardized amount continues to serve as the base for all future calculations is incorrect as causal link is broken. Specifically, they may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

PROCEDURAL BACKGROUND:

A. Group Issue – Limited to Alleged Error in the Initial Calculation of the Standardized Amount for the Initial Year of IPPS

Healthcare Reimbursement Services, Inc. ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") groups which are challenging the IPPS standardized amount. The Medicare Contractor filed a Jurisdictional Challenge covering thirteen (13) group cases.[7] On February 9, 2024, HRS filed a request to postpone the deadline to respond to this challenge. On February 12, 2024, the Board granted an extension to the Jurisdictional Challenge response deadline by May 20, 2024. However, no response was filed by that deadline. The group issue statements are materially identical and can be considered together.

The group issue statement presented is:

---

both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 53 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 38 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 BNA).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *See* **Appendix A**.

> Whether the Secretary properly calculated the Providers' Standardized Payment Amount.
>
> *****
>
> The standardized amount was initially computed in 1983 system using 1981 hospital cost report data. The standardized amount was developed on the basis of an average cost per discharge computation. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-counted discharges, by including both discharges and transfers in the base year data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to an initial computation of the standardized amount that was lower than it would have been had the total number of patient discharges been accurately computed.
>
> This initial computational error at the inception of the PPS has never been corrected. As each year's standardized amount is updated based on the previous year's amount, the standardized amount has been lower than it should have been in every year since the inception of PPS in 1984. See Saint Francis Med. Ctr. v. Azar, 894 F.3d 290 (D.C. Cir. 2018). Providers contend that it was arbitrary, capricious and inconsistent with law for the Secretary to fail to adjust the 1981 cost report data to reflect the correct number of Medicare discharges, and to provide appropriate revisions to the PPS standardized amount. 5 U.S.C. § 706(2)(A).[8]

In their preliminary position paper, they restate the group issue as follows:

> The Providers in this group appeal contend that the standardized amount is understated due to an error made ***when it was first calculated***. Since this error has not been corrected, the Providers are entitled to additional Medicare reimbursement so that they are paid as if the error had not occurred in the first instance.[9]

In their preliminary position papers, the Providers further explain that:

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[8] *E.g.*, Case 19-1143GC, Providers' group issue statement.
[9] *E.g.*, Case 19-1143GC, Providers' Preliminary Position Paper at 3 (Aug. 7, 2020).

> [T]he Secretary's calculation [of the standardized amount] was flawed because he failed to correctly identify the number Medicare inpatient discharges. . . [T]he Secretary used the FY 1981 cost report data and the 1981 Medicare Discharge File to identify the number of Medicare inpatient discharges.[10] However, neither of those data sources distinguished between true "discharges," where the patient's acute care treatment is complete, and "transfers," where a patient is sent to another department or hospital because the patient requires further treatment beyond the capabilities of the original admitting facility.[11] As a result, the number of discharges used in the calculation of the standardized amount was overstated.[12]

CMS opted to use 1981 as a "base year" to calculate these initial FFY 1984 rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[13]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges.[14]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[15] They claim that the average cost per discharge should not include transfers. They also argue that hospitals have not been permitted to appeal the rate under CMS' improper interpretation of 42 C.F.R. 405.1885(a)(1). They go on to argue:

> The Secretary has repeatedly acknowledged . . . that the inclusion of transfers in the calculation of the standardized amount had the effect [of] diluting the calculation. Yet to this day, the Secretary has declined to correct the standardized amount on a prospective basis. The Secretary's continued refusal to correct the standardized amount despite acknowledging the errors in its

[10] (Citation omitted).
[11] (Citation omitted).
[12] *Id*. at 5.
[13] *Id.*
[14] *See id* at 5-6.
[15] *See e.g.,* Case 19-1143GC, Appeal at Submission.

> calculation constitutes arbitrary and capricious action which is not entitled to deference under *Chevron*.[16]

B. Jurisdictional Challenges

The Medicare Contractor filed a challenge in the thirteen (13) different group cases, and the Providers failed to file a timely response in each.[17] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers failed to file a timely response, despite requesting and receiving an extension to the Board's deadline. Board Rule 44.4.3 specifies, in relevant part: "Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Therefore, the Board will move forward a determination absent a response from the Providers.

BOARD DECISION:

As described more fully below, the Board Majority finds that it lacks substantive jurisdiction over each of the 13 CIRP groups because: (1) the initial IPPS standardized amounts set for FFY 1984[18] are ***inextricably*** tied to the FFY 1984 and 1985 BNAs to the "applicable percentage increases" for IPPS[19]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs;[20] and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs. Further, the fact that the Secretary's BNA to the FY 1984 Federal Rates was 0.970[21]

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[16] *Id.* at 9.
[17] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.
[18] The Board Majority notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[19] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 BNAs are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[20] *But see* **Appendix B**. The Board has not traced the standardized amount after FFY 1986 all the way up to the each of the years in question. **Appendix B** highlights how, in addition to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and forward, there could be other intervening statutory or regulatory events (whether discretionary or mandatory) that could break the Providers' alleged causal link between the alleged error in the initial FFY 1984 rates and the standardize amounts used in the years at issue.
[21] In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[22] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[23]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[24] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[25] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1981 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount and then *updated* by an inflationary factor to bring it forward to FFY 1984.[26] The Providers dispute how the Secretary determined

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[22] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[23] *Id.*
[24] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[25] *Id.* (emphasis added).
[26] *Id*. at 39763-64. The Board Majority notes that the 1981 data appears to have been available to the public close in time to when the initial IPPS was established, as explained in the proposed rule issued on May 27, 1988:

> *B. Public Requests for Data*
> In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format and are listed below with the cost of each tape. Anyone wishing to purchase data tapes should submit a written request along with a check to cover the cost of the tapes to the following address: HCFA Office of Statistics and Data Management, Bureau of Data Management and Strategy, Room l-F-2 Oak Meadows Building, 6325 Security Boulevard, Baltimore, MD 21207.
> ****

"discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[27] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary (*see also* **Appendix B**). In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the BNA for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and

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> 4. H180 **Extract, Cost Reporting Periods Ending January 1, 1981 through December 31, 1981**
> This file contains selected data items from cost reports. **These data were used in computing the initial Federal prospective payment rate**.
> Price: $530.00

53 Fed. Reg. 19498, 19526 (May 27, 1988). Apparently, the Secretary made the data available in this manner due to demand, as previously the Secretary made this information available through FOIA as discussed in the following excerpt from the January 3, 1984 Final Rule:

> *We agree hospitals should have access to the data used in connection with the development of the prospective payment system*. We would like to point out that public access to disclosable information is provided under the Freedom of Information Act (5 U.S.C. 552). While we cannot guarantee that all requested information will be disclosed in the format desired by the requester, we will continue to respond promptly to all information requests and provide all available data to assist the hospital industry and other interested parties in the evaluation of the prospective payment system.
> In fact, much of the applicable data has already been made available to requesters. For example, the cost report file used as a basis for determining the budget neutrality adjustment factor and other factors had already been made available for public use before publication of the interim rule. This data, together with our descriptions of the budget neutrality determination published in section VIII of the Addendum to the interim rule, should allow our budget neutrality determination to be replicated. 49 Fed. Reg. at 251.

(Emphasis added.) It is unclear to what extent any of this 1981 information continues to be available to the public at this late date and, if not, to what extent CMS is obligated to continue to make it available to the public at this late date.

[27] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> > (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[28]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[29]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

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[28] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[29] (Italics emphasis in original and bold and underline emphasis added.)

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[30]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[31] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the BNA).

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[30] (Italics emphasis in original and bold and underline emphasis added.)

[31] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board Majority's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1/2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,
>
> (VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

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required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

> (VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 [percentage point] for hospitals located in a rural area,
>
> (IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,
>
> (X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[32]

[32] (Emphasis added.)

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 BNAs (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and

(D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.

(ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—

(A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.

(3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making

> this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[33]

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the* ***initial*** *FFY 1984 standardized amount*.[34]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential*

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[33] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

[34] *See e.g.,* Case 24-0998GC, Issue Statement at 1.

adjustments. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the BNAs for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[35] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***roughly 20 to 35 years*** to increase the ***initial*** FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward by the relevant 20 to 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue[36] *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[37]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 BNAs which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the BNAs had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[38] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 BNA (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those BNAs). Thus, in the Board Majority's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 BNAs. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

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[35] *See* **Appendix B.**
[36] *See supra* note 20 accompanying text.
[37] *See id.*
[38] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[39]

Accordingly, the Board Majority finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the BNAs made for FFY 1984 and 1985.[40]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 BNAs. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[41]

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[39] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the BNAs would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[40] The Board Majority notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 BNAs given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[41] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 BNAs are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board Majority finds that the FFYs 1984 and 1985 BNAs effectively fixed the standardized amounts from that point forward for use in the IPPS system.[42]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 BNAs confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 BNA as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 BNA to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[42] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.

The adjustment of the Federal portion was determined as follows:

- *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
- *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
- *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
- *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
- *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.

The resulting adjustment factor for the fiscal year 1984 Federal portion is .969. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment

> because of their participation in demonstrations and studies were not included in the calculations above.[43]

In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970 using the same methodology.[44] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the BNA factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[45]

Accordingly, while the Providers did not appeal the BNAs, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the BNA for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the BNA for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the

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[43] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[44] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[45] *Id.* at 255 (emphasis added.) *See also id.* at 331 (stating as part of the discussion on the BNAs: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

> level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[46]

Regardless, the Secretary's application of a 0.970 BNA factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 BNA. Moreover, as previously noted, since the FFY 1984 BNA is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 BNA effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 BNA also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a BNA of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1, 1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950

[46] *Id.* at 255.

National—.954[47]

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By finalizing an adjustment factor less than one (1), the Secretary confirmed that the standardized amounts were too high. Thus, like her BNA made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[48]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget-neutrality-adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and

[47] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[48] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

> have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[49]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[50] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[51]

Significantly, *the Providers did not file a response to the jurisdictional challenge and a glaring gap in the Providers' preliminary position paper* is their failure to discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment and used the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and subsequent years.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

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[49] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

[50] *Id.* (emphasis added).

[51] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

* * * * *

The Board majority finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the BNA made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[52] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable BNAs.[53] Indeed, the Secretary applied a BNA to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these BNAs appear to have

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[52] The Board Majority has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 BNAs. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[53] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board Majority notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board Majority's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing BNAs made for FFYs 1984 and 1985.

already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[54] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board Majority finds that it may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals.[55] In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates and the Providers may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board Majority finds that: (1) the appealed issue is *inextricably* tied with the FFY 1984 and 1985 BNAs to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[56]) prohibit administrative and judicial review of those BNAs. Based on these findings, the Board Majority concludes that it does not have substantive jurisdiction[57] over the issue in the thirteen (13) CIRP group cases listed in **Appendix A**, and hereby closes these thirteen (13) CIRP group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (dissenting)

For the Board:

9/30/2024

X Clayton J. Nix

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

[54] *See supra* note 38 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 BNA).
[55] *But see supra* note 20.
[56] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).
[57] The Board has not formally reviewed these cases for other aspects of jurisdiction, including claims filing requirements (*e.g.*, timeliness) or whether any revised NPRs were appeal and, if so, whether the relevant Provider(s) properly appealed the revised NPR(s).

Appendices A – Listing of Cases Covered by this Notice of Dismissal
B – Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue
C – Additional Excepts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

Dissenting

For the reasons explained below, I dissent from the Board Majority's decision regarding the issue of whether CMS' failure to remove transfer cases from its discharge data decreased the Standardized Amount, and would find that the Board has substantive jurisdiction in this case.

The Providers' issue statement is essentially the same as that in *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023) ("St. Mary's")*[58], an appeal from the Board's "Dismissal Based on Lack of Substantive Jurisdiction" dated April 6, 2023,[59] the Board's first decision on the topic of "Understated IPPS Standardized Amount" after the D.C. Circuit ruled in *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) ruling that the reopening regulation – and thus its predicate facts position – does not apply to appeals made to the Board.

In these "Understated IPPS Standardized Amount" cases, the providers consistently argue that a computational error at the inception of the IPPS has not been corrected,[60] that "the Secretary failed to properly distinguish between patient transfers and discharges in establishing the PPS1983 base year amounts,[61] and that "the resulting understated initial base year amounts were carried forward across 35 years resulting in the alleged understated standardized amount used for setting the FFY 2019 IPPS payment rates."[62]

The Board Majority finds that the Board has no jurisdiction based on the presupposition that the final FFY 1984 and 1985 standardized amounts (which were based on 1981 discharge data) were adjusted for budget neutrality, thus, the final rates in those years are *inextricably tied* with budget neutrality adjustments for which administrative and judicial review is prohibited by 42 U.S.C. § 1395ww(d)(7). The Board Majority rationalizes its conclusion by stating that the initial 1983 standardized amount was overstated, so therefore the initial base rate that was set using 1981 data could not have been erroneous. I respectfully disagree.

The Providers have presented several arguments as to why the standardized amount is understated; that is not for me to decide today. My dissent over the majority's conclusion that the Board has no

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[58] "The Hospitals challenge their Medicare inpatient hospital payments for Federal Fiscal Year ("FFY") 2019 as being unlawfully understated because the Secretary calculated them using a "standardized amount" that was invalidly low because of an embedded error from the Secretary's original implementation of the Medicare Hospital Inpatient Prospective Payment System ("IPPS") in FFY 1984." *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023), Complaint at 25.*

[59] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024); *see also*, *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023),* Complaint at 28 ("on April 6, 2023, the Board dismissed the Hospitals' administrative appeals, holding *for the first time* in any administrative appeal raising this substantive issue that the Budget Neutrality Preclusion Provisions strip it of jurisdiction over the Hospitals' claims.")

[60] See Saint Francis Med. Ctr. v. Azar, 894 F.3d 290 (D.C. Cir. 2018).

[61] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), at 3, available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024);

[62] *Id*.

substantive jurisdiction over this appeal solely because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. To reach their conclusion, my colleagues have skipped ahead to an analysis of the budget neutrality adjustments, and passed over the Providers' challenge to the accuracy of the 1981 discharge data.[63] The Providers are not challenging the "determination of the requirement, or the proportional amount, of any budget neutrality adjustment" in IPPS rates, which is what the plain language of 42 U.S.C. § 1395ww(d)(7) prohibits. Rather than consider the issue to be that CMS did not properly calculate the average cost per discharge, my colleagues prejudicate that the data cannot be reviewed because a subsequent calculation utilizing that data was later incorporated into an adjustment which was deemed sacrosanct by a Congress that readily admitted the data was flawed.[64]

In reaching my decision, I am persuaded by the concurring opinion in *St. Francis* asserting "it is not reasonable for HHS to 'cement misclassified' costs into 'future reimbursements, thus perpetuating literally million-dollar mistakes.'"[65] Additionally, I note the rulemaking for the Capital PPS Final Rule, whereby CMS applied a correction factor for capital-related costs in the Capital PPS Final Rule in 1991, thus setting a possible precent for making such a change.[66] Finally, I believe that the Board jurisdictional statute, 42 U.S.C. § 1395oo, should be read broadly to support the "strong presumption that Congress intends judicial review of administrative action."[67]

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[63] *See* Case 19-1143GC, Providers' group issue statement.

[64] "The case mix index values used in the PPS model were based on billing information reported in 1981. At that time, the patient diagnostic information necessary for DRG assignment was completely unrelated to payment. ***As a result, the 1981 bills contain a variety of errors which tend to cause the hospital case mix values to be understated.*** Hospital PPS payments, however, are based on the diagnostic information reported on the current bills, under very different incentives. Therefore, an increase in overall hospital case mix under PPS was anticipated." Adjustments in Medicare's Prospective Payment System, S. Hrg. 98-1122, Hearing before the Subcommittee on Health of the Committee on Finance, United States Senate, Ninety-Eighth Congress, Second Session, August 8, 1984, available at https://www.finance.senate.gov/imo/media/doc/HRG98-1122.pdf, page 14 of 147 (accessed July 11, 2024) (***emphasis added***). *See also* 56 Fed. Reg. 43358 at 43387 (Aug. 30, 1991) (Prospective Payment System for Inpatient Hospital Capital-Related Costs – Final Rule). ("*Comment*: Several commenters questioned the treatment of transfers in determining the hospital-specific rate. Some commenters suggested that transfer should not be included in the discharge count because payment is not made for all transfers on a per discharge basis. One commenter suggested that each transfer case should be counted as a fraction based on the amount paid for the transfer case as a portion of the full case payment. Others believed that including transfers in the case-mix index would distort the hospital-specific rate because transfer cases tend to have a higher DRG weight. *Response*: We agree with the commenters that the treatment of transfers in the discharge count is problematic. To the extent a transfer is paid on a per diem basis, including the transfer in the discharge count will understate the hospital-specific rate. If the transfer were not counted at all, as suggested by some commenters, the hospital-specific rate would be overstated. In contrast, there is no distortion in the hospital-specific rate if the transfer is paid at the full DRG rate. Since some transfers are paid on a per diem basis and other transfers are paid at the full DRG amount, either the total include or the total exclusion of transfers will distort the hospital-specific rate unless the costs of all transfer cases are removed from the base period costs. We do not believe that it is administratively feasible to remove the costs associated with transfer cases. Instead, to account for transfers, as recommended by one commenter, we are adopting and adjustment to the discharge count used to calculation the hospital-specific rate. [. . . .].")

[65] *St. Francis* at 298, citing *Regions Hospital v. Shalala*, 522 U.S. 448, 462, 118 S.Ct. 909, 139 L.Ed.2d 895 (1998).

[66] 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991).

[67] *Bowen v. Academy of Family Physicians*, 476 U.S. 667, 670 (1986).

In conclusion, the Providers should be afforded the due process of proving to the Board that the 1981 discharge data were indeed flawed, leading to understated amounts in the Federal Fiscal Years at issue.

9/30/2024

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On February 8, 2024, the Medicare Contractor filed a challenge to the following thirteen (13) cases which all share a common lead Medicare Contractor, Novitas Solutions, Inc. c/o GuideWell Source (J-L):

19-1143GC	RWJ Barnabas FFY 2019 IPPS Understated Standardized Payment Amount CIRP Group
19-1241GC	RWJ Barnabas CY 2015 Standardized Payment Amount CIRP Group
19-1764GC	RWJ Barnabas CY 2016 Standardized Payment Amount CIRP Group
19-1819GC	RWJ Barnabas CY 2011 Standardized Payment Amount CIRP Group
19-1820GC	RWJ Barnabas CY 2012 Standardized Payment Amount CIRP Group
19-1876GC	RWJ Barnabas CY 2010 Standardized Payment Amount CIRP Group
20-0284GC	RWJ Barnabas CY 2017 Standardized Payment Amount CIRP Group
20-0928GC	RWJ Barnabas CY 2020 IPPS Understated Standardized Payment Amount CIRP Group
21-0390GC	RWJ Barnabas FFY 2021 IPPS Understated Standardized Payment Amount CIRP Group
22-0455GC	RWJ Barnabas FFY 2022 IPPS Understated Standardized Payment Amount CIRP Group
23-0432GC	RWJ Barnabas CY 2018 Standardized Payment Amount CIRP Group
23-0783GC	RWJ Barnabas FFY 2023 IPPS Understated Standardized Payment Amount CIRP Group
24-1080GC	RWJ Barnabas FFY 2024 IPPS Understated Standardized Payment Amount CIRP Group

APPENDIX B
Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue

Set forth below are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments ("BNAs") and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). These other example raise questions about the causal link between the standardized amount rates at issue and the initial standardize amounts set for FFY 1984. Curiously, the Providers stopped their analysis at 1986 and did not carry forward their analysis for years 1987 through the particular year at issue (*e.g.*, for the lead case under Case No. 18-1646G, there are an additional 28 intervening years since the standardize amount issue is the FFY 2015 standard amount rate).

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[68] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[69]

---

[68] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[69] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.

c. BNAs made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[70]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[71] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[72]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[73]

> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

[70] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[71] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 18.

[72] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[73] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[74] and 1997[75] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[76]

To illustrate the complex nature of these issues, the Board Majority points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[77] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[78] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous*

[74] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[75] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[76] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[77] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[78] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have***

***been demonstrated to be overstated**, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[79]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[79] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[80] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[81] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[82]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[83] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[84] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

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[80] *Id.* at 35703-04 (bold and underline emphasis added).
[81] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[82] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[83] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[84] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C
Additional Excerpts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

In its decision, the Board Majority has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 BNA accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[85]

[85] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). The Board Majority notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 BNA accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her BNAs for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**
>
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized.

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 BNA to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[86]

[86] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Elmhurst, IL 60126

RE: ***Notice of Dismissal – Updated Rationale***
SRG Standardized Amount CIRP Group Cases
Case Nos. 20-2104GC, *et al.* (*see* **Appendix A** listing 10 CIRP group cases)

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the ten (10) above-referenced common issue related party ("CIRP") group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all ten (10) CIRP group cases in their entirety. This issue is not new to the Board and this determination is consistent with the its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget-neutrality-adjusted federal rates.

In summary, the Board Majority finds that it lacks substantive jurisdiction over the issue raised in these group appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment ("BNA") made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board Majority has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 BNAs. These intervening adjustments for FFYs 1986 and 2018 include

intertwined with those applicable BNAs.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the BNAs applied to those years reduced the standardized amounts (by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs, the Board Majority finds that it may not review the standardized amount used for the FFYs appealed as it relates to the common issues in these appeals. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget -neutrality-adjusted rates. Accordingly, the Providers assertion that the initial FFY 1984 standardized amount continues to serve as the base for all future calculations is incorrect as causal link is broken. Specifically, they may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

The Board Majority also notes that the Providers appear to raise a new legal issue that is beyond the scope of the original group issue statement in these group cases. Per their group issue statements, these group appeals challenge the "original" standardized amount established for the ***initial*** year of IPPS, namely FFY 1984 running from October 1, 1983 to September 30, 1984.[7] Pursuant to 42 C.F.R. §§ 405.1837(a)(2) and (f)(1), a group may contain only one issue and no issues may be added to the group appeal. In their Response to the Medicare Contractors' Jurisdictional Challenge, the Providers appear to have ***improperly*** raised a new legal issue that is not part of this appeal. Specifically, the Providers appear to challenge the FFY 1986 standardized amount rates and subsequent years as being *improperly* based on the FFY 1985 budget-neutrality adjusted rates. The Board confirms that, *if so*, this is a newly-added issue and hereby ***dismisses*** it from these appeals pursuant to 42 C.F.R. §§ 405.1837(a)(2), (c) and (f)(1).

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both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 62 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 BNA).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *E.g.,* Case No. 20-2104GC, Providers' Group Issue Statement.

PROCEDURAL BACKGROUND:

A. Group Issue – Limited to Alleged Error in the Initial Calculation of the Standardized Amount for the Initial Year of IPPS

Strategic Reimbursement Group, LLC ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") groups which are challenging the IPPS standardized amount. The Medicare Contractor filed three (3) Jurisdictional Challenges covering ten (10) group cases.[8] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all ten (10) cases are materially identical and can be considered together.

The group issue statement presented is:

> Whether the Secretary's failure to distinguish between patient discharges and transfers and / or the Secretary's inconsistent treatment of transfers during the development of the standardized amount used by the Secretary to calculate reimbursement for diagnosis related groups ("DRG's") during the implementation of the inpatient prospective payment system ("IPPS"), resulted in an understatement of the Federal DRG Prospective Payment Amounts paid to the Providers in the fiscal year at issue, and an understatement of all IPPS reimbursement elements derived from calculations based on the standardized amount, including but not limited to indirect medical education ("IME") payment and disproportionate share hospital ("DSH") payments paid to the Providers in the fiscal year at issue.
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> The core issue under dispute pertains to the correctness of the **original** standardized amount computed in 1983 by the Secretary and requires some historical context. In accordance with Congress's instructions, the Secretary submitted his proposal for the development of IPPS to Congress in December 1982. . . . Under the prospective payment methodology proposed by the Secretary, and ultimately adopted by Congress, it was concluded that providers would be paid a "flat rate for each type of discharge." *Id.* at 36. Accordingly, the development of IPPS required first the categorization of different types of discharges, and once categorized, a determination of the payment rate applicable to each category of discharge.

[8] *See* **Appendix A**.

> The *categorization* of different types of discharges was accomplished through the use of diagnostic related groups ("DRGs") and is not challenged by Providers. Rather, the focus of this appeal is on the Secretary's calculation of the "flat rate" payable per discharge for each DRG, referred to herein as the "DRG Payment Amounts." The DRG Payment Amounts are the product of two figures (1) the applicable adjusted standardized amount (the "Standardized Amount"), and (2) the applicable "DRG Weight."
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> The Secretary's **original** calculation of the Standardized Amount in 1983 still directly impacts Medicare reimbursement under IPPS for the fiscal year at issue in this appeal. Unlike the DRG Weights, which since at least 1988 have been annually recalibrated utilizing relatively recent MedPar data,4 the Standardized Amount for the current fiscal year is still based upon the Secretary's original calculation of the Standardized Amount utilizing 1981 data. *See* Social Security Act § 1886(d)(3)(A)(i)-(iv); *Saint Francis Medical Center, et al. v. Azar*, 894 F.3d 290, 294 (D.C. Cir. 2018)("To this day, therefore, Medicare payments for inpatient services depend in part on factual determinations derived from 1981 data and embedded in 1983 calculations…") . Thus, any erroneous understatement of the original standardized amount calculation has been perpetuated because the standardized amount has been updated annually for inflation and not recalculated each year, thus compounding into the current standardized amount for each facility nationally and impacting the computation on the Provider's DRG and related payments used in the as-filed cost report.
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> The Secretary's original error was compounded further when the Secretary adopted a transfer payment methodology because he deemed it necessary "to distinguish between discharges where the patient has received complete treatment and discharges where the patient is transferred to another institution for related care. The prospective payment system was intended to provide full payment, less deductibles and coinsurance, for all inpatient services associated with a particular diagnosis." 48 Fed. Reg. 39,759 (Jan. 3, 1983). Obviously, this failed to consider the error made by the Secretary in including transfer patients in the 1981 initial discharge data.
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> The underlying data and computation used in the determination of this standardized amount were compiled and performed by the Secretary and are unavailable to the Provider. The Secretary has acknowledged this error, but, to the Provider's knowledge, has not

> furnished data to permit a calculation as to the extent or amount of such error. See 56 Fed. Reg. at 43358 (Aug. 30, 1991).
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> The Provider is dissatisfied with, and challenges the calculations performed by the Secretary in computing the standardized amounts used in determination of the Provider's DRG payments and all other payments impacted by this calculation and incorporated into this as-filed cost report. The Provider appeals the payment methodology required for filing the as-filed cost report which incorporates the understated DRG payment for IPPS cases.[9]

The preliminary position paper restates the issue:

> Whether the Secretary's failure to distinguish between patient discharges and transfers during the implementation of the inpatient prospective payment system resulted in an understatement of the Federal DRG Prospective Payment Amounts paid to the Providers in the fiscal year at issue.[10]

Their preliminary position papers further explain that:

> Providers assert that the Secretary understated the Federal DRG Prospective Payment Amounts (the "DRG Payment Amounts") during the development of the [IPPS]. The understatement of DRG Payment Amounts results from limitations inherent in the source data utilized by the Secretary during the development of IPPS, namely, such data's failure to distinguish patients truly *discharged* from the hospital from patients who were merely *transferred* to another hospital.[11]

CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[12]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but

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[99] *E.g.*, Case 20-2104GC, Providers' Group Issue Statement.
[10] *E.g.*, Case 20-2104GC, Providers' Preliminary Position Paper at 4 (Mar. 14, 2022).
[11] *Id*.
[12] *See id*. at 11.

in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges.[13]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[14] They claim that the average cost per discharge should not include transfers. They also argue that hospitals have not been permitted to appeal the rate under CMS' improper interpretation of 42 C.F.R. 405.1885(a)(1). They go on to argue:

> To this day, therefore, Medicare payments for inpatient services depend in part on factual determinations derived from 1981 data and embedded in 1983 calculations, including the calculation of "allowable operating costs per discharge." See *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290, 291 (D.C. Cir. 20180. Accordingly, any error made by the Secretary in the calculation of the original Standardized Amount continues to impact the updated Standardized Amount, and thus, the DRG Payment Rates.[15]

B. Jurisdictional Challenges

The Medicare Contractor filed three (3) challenges in ten (10) different group cases, and the Providers filed responses in each case.[16] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responded they are "***not*** challenging the methodology of the 1984-1985 Budget Neutrality Adjustments" that are precluded from administrative and judicial review.[17] Rather, they claim their challenge is of "an entirely separate factor in the calculation of the DRG Payment Amounts (*i.e.*, the base rate calculation of the standardized amount" and this component of prospective payment rate is not precluded from administrative or judicial review.[18]

The Providers state that unlike the budget neutrality adjustments, "[t]here is a strong presumption that Congress does not mean to prohibit all judicial review of agency action when it may direct

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[13] *See id*.
[14] *See id.* at 2.
[15] *Id.* at 9.
[16] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.
[17] *See e.g.,* Case 20-2104GC, Providers' Response to MAC Jurisdictional Challenge at 20 (May 3, 2024).
[18] *Id*.

preclusion in some circumstances" and "there must be a showing of "clear and convincing evidence" that Congress intended to exclude a matter from administrative and judicial review."[19]

BOARD DECISION:

As described more fully below, the Board Majority finds that it lacks substantive jurisdiction over each of the 10 CIRP groups because: (1) the initial IPPS standardized amounts set for FFY 1984[20] are ***inextricably*** tied to the FFY 1984 and 1985 BNAs to the "applicable percentage increases" for IPPS[21]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs;[22] and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs. Further, the fact that the Secretary's BNA to the FY 1984 Federal Rates was 0.970[23] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[24] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[25]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[26] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and

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[19] *Id.* at 21.
[20] The Board Majority notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[21] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 BNAs are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[22] *But see* **Appendix B**. The Board has not traced the standardized amount after FFY 1986 all the way up to the each of the years in question. **Appendix B** highlights how, in addition to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and forward, there could be other intervening statutory or regulatory events (whether discretionary or mandatory) that could break the Providers' alleged causal link between the alleged error in the initial FFY 1984 rates and the standardize amounts used in the years at issue.
[23] In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[24] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[25] *Id.*
[26] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).

adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[27] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1981 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount and then *updated* by an inflationary factor to bring it forward to FFY 1984.[28] The Providers dispute how the Secretary determined

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[27] *Id.* (emphasis added).

[28] *Id*. at 39763-64. The Board Majority notes that the 1981 data appears to have been available to the public close in time to when the initial IPPS was established, as explained in the proposed rule issued on May 27, 1988:

> *B. Public Requests for Data*
> In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format and are listed below with the cost of each tape. Anyone wishing to purchase data tapes should submit a written request along with a check to cover the cost of the tapes to the following address: HCFA Office of Statistics and Data Management, Bureau of Data Management and Strategy, Room l-F-2 Oak Meadows Building, 6325 Security Boulevard, Baltimore, MD 21207.
> ****
> 4. H180 **Extract, Cost Reporting Periods Ending January 1, 1981 through December 31, 1981**
> This file contains selected data items from cost reports. **These data were used in computing the initial Federal prospective payment rate**.
> Price: $530.00

53 Fed. Reg. 19498, 19526 (May 27, 1988). Apparently, the Secretary made the data available in this manner due to demand, as previously the Secretary made this information available through FOIA as discussed in the following excerpt from the January 3, 1984 Final Rule:

> *We agree hospitals should have access to the data used in connection with the development of the prospective payment system*. We would like to point out that public access to disclosable information is provided under the Freedom of Information Act (5 U.S.C. 552). While we cannot guarantee that all requested information will be disclosed in the format desired by the requester, we will continue to respond promptly to all information requests and provide all available data to assist the hospital industry and other interested parties in the evaluation of the prospective payment system.
> In fact, much of the applicable data has already been made available to requesters. For example, the cost report file used as a basis for determining the budget neutrality adjustment factor and other factors had already been made available for public use before publication of the interim rule. This data, together with our descriptions of the budget neutrality determination published in section VIII of the Addendum to the interim rule, should allow our budget neutrality determination to be replicated. 49 Fed. Reg. at 251.

"discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[29] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary (*see also* **Appendix B**). In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the BNA for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
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> (1) . . . .
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> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
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> (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
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> *are not greater or less than*—
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> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983*

(Emphasis added.) It is unclear to what extent any of this 1981 information continues to be available to the public at this late date and, if not, to what extent CMS is obligated to continue to make it available to the public at this late date.

[28] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[29] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (excluding payments made under section 1395cc(a)(1)(F) of this title).[30]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
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> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[31]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
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> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality

[30] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[31] (Italics emphasis in original and bold and underline emphasis added.)

> control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[32]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[33] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the BNA).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
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> (I) ***for fiscal year 1986***, 1⁄2 percent,

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[32] (Italics emphasis in original and bold and underline emphasis added.)

[33] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board Majority's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
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> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

(II) for fiscal year ***1987***, 1.15 percent,

(III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 [percentage point] for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
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> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
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> (XIII) for fiscal year ***1998***, 0 percent,
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> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
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> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[34]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital

[34] (Emphasis added.)

> weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 BNAs (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
>
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.
>
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—

> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[35]

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[35] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[36]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the BNAs for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[37] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***roughly 20 to 35 years*** to increase the ***initial*** FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate

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(ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
(iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

[36] *See e.g.,* Case 20-2104GC, Providers' Preliminary Position Paper at 9.

[37] *See* **Appendix B.**

the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward by the relevant 20 to 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue[38] *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[39]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 BNAs which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the BNAs had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[40] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 BNA (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those BNAs). Thus, in the Board Majority's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 BNAs. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[41]

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[38] *See supra* note 22 accompanying text.
[39] *See id.*
[40] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").
[41] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the BNAs would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

Accordingly, the Board Majority finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the BNAs made for FFY 1984 and 1985.[42]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 BNAs. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[43]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

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50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality*** *adjustment* (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[42] The Board Majority notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 BNAs given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[43] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

Since the FFY 1984 and 1985 BNAs are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board Majority finds that the FFYs 1984 and 1985 BNAs effectively fixed the standardized amounts from that point forward for use in the IPPS system.[44]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 BNAs confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 BNA as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 BNA to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.

[44] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
> - *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[45]

In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970 using the same methodology.[46] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the BNA factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt*

[45] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[46] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> *to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[47]

Accordingly, while the Providers did not appeal the BNAs, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the BNA for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the BNA for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[48]

Regardless, the Secretary's application of a 0.970 BNA factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 BNA. Moreover, as previously noted, since the FFY 1984 BNA is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 BNA effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

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[47] *Id.* at 255 (emphasis added.) *See also id.* at 331 (stating as part of the discussion on the BNAs: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[48] *Id.* at 255.

2. *The FFY 1985 BNA also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a BNA of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1, 1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[49]
>
> ****

By finalizing an adjustment factor less than one (1), the Secretary confirmed that the standardized amounts were too high. Thus, like her BNA made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[50]

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[49] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[50] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

3. The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget-neutrality-adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[51]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[52] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

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[51] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

[52] *Id.* (emphasis added).

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[53]

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board Majority finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

4. Any issues the Providers have regarding the use of the FFY 1985 budget-neutrality-adjusted rates to set the standardized amounts for FFY 1986 and subsequent years is beyond the scope of these appeals.

As discussed above, the Providers admit that the Secretary used the FFY 1985-budget-neutrality adjusted rates to set the standardized amounts for FFY 1986 and subsequent years and that they do not challenge the FFY 1985 BNA.[54] However, in their response to the Medicare Contractors' Jurisdictional Challenge, the Providers appear to potentially challenge the Secretary's use of the 1985-budget-neutrality adjusted rates to set the standardize amount rates for FFY 1986 and subsequent years by claiming the Secretary failed to follow the statutory directives of Congress in calculating the standardized amount rates for FFY 1986 and subsequent years. If so, this challenge would be a new issue that is not part of the groups' original appeal.

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[53] 87 Fed. Reg. 16772, 16773 (May 6, 1986).
[54] Providers' Response to Medicare Contractors' Jurisdictional Challenge at 20.

Pursuant to 42 C.F.R. § 405.1837(a)(2), a group must *only* "involve[] a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Consistent with this requirement, 42 C.F.R. § 405.1837(c)(3) specifies that a group appeal request must include "a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal." Further, the group appeal request must explain "why the provider[s] believe[] Medicare payment is incorrect for each disputed item" and "[h]ow and why the provider[s] believe[] Medicare payment must be determined differently for each disputed item." Consistent with these two (2) regulatory provisions, 42 C.F.R. § 405.1837(f)(1) specifies that, after a group appeal request is filed, "a provider *may* ***not*** *add* other questions of fact or law to the appeal, *regardless of whether the question is common to other members of the appeal*."

Here, the Providers only challenged the ***initial*** federal standardized amounts established under the IPPS for FFY 1984 as improper by asserting that the Secretary failed to exclude transfers when determining the base cost per discharge rate mandated in 42 U.S.C. § 1395ww(d)(2)(A) as demonstrated in the excerpts taken from the group issue statements quoted above. The Providers *belated* focus on the Secretary's use of the 1985-budget-neutrality adjusted rates in the FFY 1986 rates and subsequent years illustrates the underlying problem with these appeals, namely the failure to trace the causality of the alleged error in setting the original FFY 1984 standardize amount rates and those at issue as used over 30 years later.[55]

The Providers stance on this discovery suggests that the real issue with the standardized amounts used in the years at issue may now be potentially shifting to a new allegation that the Secretary improperly used the FFY 1985 budget neutrality-adjusted rates in setting their current rates:

> The non-residual impact of the 1984-1985 Budget Neutrality Adjustments can be further observed by following the Congressional directives for calculating the DRG Payment Amounts for fiscal year 1986, which was complicated by the Secretary's actions at the time. For the fiscal year October 1, 1985 through September 30, 1986, the Secretary was directed to again "compute an average standardized amount…equal to the amount computed for the previous fiscal year under **paragraph (2)(D)** or under this subparagraph, increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)." 42 U.S.C. § 1395ww(d)(3)(A)(i) (emphasis added). The calculation of the fiscal year 1986 standardized amount, by its express reference to the standardized amount calculation in paragraph (2)(D) (used in the previous year calculation), ***excludes*** the 1984-1985 Budget Neutrality Adjustments from the computation

[55] *See* **Appendix B** (providing examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue).

because such adjustments were applied through the operation of paragraphs (2)(F) and (3)(C), respectively. *See* 42 U.S.C. § 1395ww(d)(2)(F), (3)(C).

The original standardized amount is not cleansed of the Discharge Calculation Error for all future periods by virtue of its "passage through" the portal of the 1984-1985 Budget Neutrality Adjustments as the MAC would argue. *In fact, the plain language of the statute and its history highlights the temporary 1984-1985 impact of those adjustments and their express exclusion from future calculations of the standardized amount*. The fiscal year 1986 computation of the average standardized amount is the same paragraph (2)(A)-(D) calculation, Discharge Calculation Error included, as it was during the original computation in 1984. *See* 42 U.S.C. § 1395ww(d)(3)(A)(i).

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There were, however certain complications impacting the determination of the DRG Payment Rates for fiscal year 1986 that disrupted the "statutory flow" of the calculation of the standardized amounts. . . . In this limited respect, and for this limited period, Congress did recognize the incorporation of the 1985 Budget Neutrality Adjustment in the amount of payment for hospitals, "[n]otwithstanding any other provision of law…under section 1886 of the Social Security Act [§ 1395ww] for inpatient hospital services for discharges occurring…during the extension period…" Emergency Extension Act of 1985, Pub. L. 99-107, § 5(a) 99 Stat. 479 (1985). However, the "extension period" for the payment freeze enacted by the Emergency Extension Act of 1985 ended on May 1, 1986, and the governing provisions of § 1395ww(d)(3)(A) resumed for standardized amount calculations for the remainder of fiscal year 1986, ***without the 1985 Budget Neutrality Adjustment incorporated***, and with an ***increase*** to the expected applicable percentage increase from ¼ percent to ½ percent.

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As described above, the fiscal year 1986 statutory computation of the average standardized amount ***did not*** include any incorporation of the 1984-1985 Budget Neutrality Adjustments.

****

Congress could not have been clearer in rejecting the Secretary's attempt to imbed the 1985 Budget Neutrality Adjustment into the 1986 standardized rates as it required that, "for discharges occurring on or after October 1, 1986, the applicable percentage increase

> (described in section 1886(b)(3)(B)) ***for discharges occurring during fiscal year 1986 shall be deemed to have been ½ percent***." Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(e)(B), 100 Stat. 154 (1986). In other words, for the 1987 calculations relying on "the prior year's" standardized amount under § 1395ww(d)(3)(A), the effect of the temporary freeze of standardized rates incorporating the 1985 Budget Neutrality Adjustment was eliminated as if it did not occur. *See Id.* Whatever "inextricable tie" was associated with the 1984-1985 Budget Neutrality Adjustments that the MAC attempts to argue, it is clear from Congress's instruction for the calculation of the standardized amount effective October 1, 1986, that it was "untied" after 1985 without further impact. *See Id.*
>
> ****
>
> Thus, from October 1, 1986 through the present date, the average standardized rate has contained the Discharge Calculation Error made by CMS when failing to follow the directive of subsection (d)(2)(A). . . . The 1984-1985 Budget Neutrality Adjustments were temporary to those specific fiscal years and did not represent a "curative portal" through which the Discharge Calculation Error passes for correction.[56]

The Providers' group issue statements do not challenge the use of the FFY 1985 budget neutrality-adjusted rates in setting the rates for FFY 1986 and subsequent years and the Providers may not now add that issue to their appeal. Indeed, to the extent it could have been considered part of the group issue statement, it was not briefed in their preliminary position papers and, as such, would be considered withdrawn/abandoned as position papers are required to fully develop the merits of the Providers' position on the claim(s) in their appeal.[57] Accordingly, to the extent the Provers are attempting to add this new issue to their appeal at this late date, the Board Majority ***dismisses*** that new issue, (*i.e.*, dismisses the challenge to the Secretary's use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and subsequent years), pursuant to 42 C.F.R. §§ 405.1837(a)(2), (c), and (f)(1).[58]

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[56] Provider's Response to the Medicare Contractors' Jurisdictional Challenge at 12-13, 14-15 (some footnotes and citations omitted and emphasis in original except italics added to second paragraph quoted).

[57] *See* 42 C.F.R. § 405.1853(b); Board Rule 25. *See also* Board Rule 25.3 (stating "The Board requires the parties file a complete preliminary position paper that includes a fully developed narrative…, all exhibits…, a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn*." (emphasis added)).

[58] *See also* Board Rule 8. Consistent with these regulations, Board Rule 8.1 (July 2015) specifies: "Some issues may have multiple components. To comply with the regulatory requirement to ***specifically*** *identify* the items in dispute, ***each*** contested component must be appealed as a ***separate*** *issue* ***and*** *described as* ***narrowly*** *as possible* using the applicable format outlined in Rule 7." (Emphasis added.) *See also Evangelical Comty. Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

* * * * *

In summary, the Providers confirm that they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather they are contesting the base rate calculation of the standardized amount.[59] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[60]

The Board Majority disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the BNA made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[61] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable BNAs.[62] Indeed, the Secretary applied a BNA to those years to reduce the standardized

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The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[59] Providers' Response to Medicare Contractors' Jurisdictional Challenge at 20.

[60] *Supra* note 16.

[61] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[62] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board

amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[63] Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board Majority finds that it may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFU 1985 budget-neutrality-adjusted rates and the Providers may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board Majority finds that: (1) the appealed issue is *inextricably* tied with the FFY 1984 and 1985 BNAs to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[64]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board Majority concludes that it does not have substantive jurisdiction over the issue in the ten (10) CIRP group cases listed in **Appendix A**, and hereby closes these ten (10) group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[63] *See supra* note 41 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[64] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (concurring, in part, & dissenting, in part)

For the Board:

9/30/2024

X Clayton J. Nix

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

Appendices A – Listing of Cases Covered by this Notice of Dismissal
B – Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue
C – Additional Excepts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

Concurring in part, dissenting in part

I concur with the majority's dismissal of the Providers' challenge to the FFY 1986 standardized amount rates and subsequent years as being improperly based on the FFY 1985 budget-neutrality adjusted rates. However, for the reasons explained below, I dissent from the Board Majority's decision regarding the issue of whether CMS' failure to remove transfer cases from its discharge data decreased the Standardized Amount, and would find that the Board has substantive jurisdiction in this case.

The Providers' issue statement is essentially the same as that in *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023) ("St. Mary's")*[65], an appeal from the Board's "Dismissal Based on Lack of Substantive Jurisdiction" dated April 6, 2023,[66] the Board's first decision on the topic of "Understated IPPS Standardized Amount" after the D.C. Circuit ruled in *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) ruling that the reopening regulation – and thus its predicate facts position – does not apply to appeals made to the Board.

In these "Understated IPPS Standardized Amount" cases, the providers consistently argue that a computational error at the inception of the IPPS has not been corrected,[67] that "the Secretary failed to properly distinguish between patient transfers and discharges in establishing the PPS1983 base year amounts,[68] and that "the resulting understated initial base year amounts were carried forward across 35 years resulting in the alleged understated standardized amount used for setting the FFY 2019 IPPS payment rates."[69]

The majority finds that the Board has no jurisdiction based on the presupposition that the final FFY 1984 and 1985 standardized amounts (which were based on 1981 discharge data) were adjusted for budget neutrality, thus, the final rates in those years are *inextricably tied* with budget neutrality adjustments for which administrative and judicial review is prohibited by 42 U.S.C. § 1395ww(d)(7). The Board Majority rationalizes its conclusion by stating that the initial 1983 standardized amount was overstated, so therefore the initial base rate that was set using 1981 data could not have been erroneous. I respectfully disagree.

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[65] "The Hospitals challenge their Medicare inpatient hospital payments for Federal Fiscal Year ("FFY") 2019 as being unlawfully understated because the Secretary calculated them using a "standardized amount" that was invalidly low because of an embedded error from the Secretary's original implementation of the Medicare Hospital Inpatient Prospective Payment System ("IPPS") in FFY 1984." *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023), Complaint at 25.*

[66] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024); *see also*, *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023),* Complaint at 28 ("on April 6, 2023, the Board dismissed the Hospitals' administrative appeals, holding *for the first time* in any administrative appeal raising this substantive issue that the Budget Neutrality Preclusion Provisions strip it of jurisdiction over the Hospitals' claims.")

[67] See Saint Francis Med. Ctr. v. Azar, 894 F.3d 290 (D.C. Cir. 2018).

[68] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), at 3, available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024);

[69] *Id*.

The Providers have presented several arguments as to why the standardized amount is understated; that is not for me to decide today. My dissent over the majority's conclusion that the Board has no substantive jurisdiction over this appeal solely because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. To reach their conclusion, my colleagues have skipped ahead to an analysis of the budget neutrality adjustments, and passed over the Providers' challenge to the accuracy of the 1981 discharge data.[70] The Providers are not challenging the "determination of the requirement, or the proportional amount, of any budget neutrality adjustment" in IPPS rates, which is what the plain language of 42 U.S.C. § 1395ww(d)(7) prohibits. Rather than consider the issue to be that CMS did not properly calculate the average cost per discharge, my colleagues prejudicate that the data cannot be reviewed because a subsequent calculation utilizing that data was later incorporated into an adjustment which was deemed sacrosanct by a Congress that readily admitted the data was flawed.[71]

In reaching my decision, I am persuaded by the concurring opinion in *St. Francis* asserting "it is not reasonable for HHS to 'cement misclassified' costs into 'future reimbursements, thus perpetuating literally million-dollar mistakes.'"[72] Additionally, I note the rulemaking for the Capital PPS Final Rule, whereby CMS applied a correction factor for capital-related costs in the Capital PPS Final Rule in 1991, thus setting a possible precent for making such a change.[73] Finally,

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[70] *See* Providers' PPP at 4.

[71] "The case mix index values used in the PPS model were based on billing information reported in 1981. At that time, the patient diagnostic information necessary for DRG assignment was completely unrelated to payment. ***As a result, the 1981 bills contain a variety of errors which tend to cause the hospital case mix values to be understated.*** Hospital PPS payments, however, are based on the diagnostic information reported on the current bills, under very different incentives. Therefore, an increase in overall hospital case mix under PPS was anticipated." Adjustments in Medicare's Prospective Payment System, S. Hrg. 98-1122, Hearing before the Subcommittee on Health of the Committee on Finance, United States Senate, Ninety-Eighth Congress, Second Session, August 8, 1984, available at https://www.finance.senate.gov/imo/media/doc/HRG98-1122.pdf, page 14 of 147 (accessed July 11, 2024) (***emphasis added***). *See also* 56 Fed. Reg. 43358 at 43387 (Aug. 30, 1991) (Prospective Payment System for Inpatient Hospital Capital-Related Costs – Final Rule). ("*Comment*: Several commenters questioned the treatment of transfers in determining the hospital-specific rate. Some commenters suggested that transfer should not be included in the discharge count because payment is not made for all transfers on a per discharge basis. One commenter suggested that each transfer case should be counted as a fraction based on the amount paid for the transfer case as a portion of the full case payment. Others believed that including transfers in the case-mix index would distort the hospital-specific rate because transfer cases tend to have a higher DRG weight. *Response*: We agree with the commenters that the treatment of transfers in the discharge count is problematic. To the extent a transfer is paid on a per diem basis, including the transfer in the discharge count will understate the hospital-specific rate. If the transfer were not counted at all, as suggested by some commenters, the hospital-specific rate would be overstated. In contrast, there is no distortion in the hospital-specific rate if the transfer is paid at the full DRG rate. Since some transfers are paid on a per diem basis and other transfers are paid at the full DRG amount, either the total include or the total exclusion of transfers will distort the hospital-specific rate unless the costs of all transfer cases are removed from the base period costs. We do not believe that it is administratively feasible to remove the costs associated with transfer cases. Instead, to account for transfers, as recommended by one commenter, we are adopting and adjustment to the discharge count used to calculation the hospital-specific rate. [. . . .].")

[72] *St. Francis* at 298, citing *Regions Hospital v. Shalala*, 522 U.S. 448, 462, 118 S.Ct. 909, 139 L.Ed.2d 895 (1998).

[73] 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991).

I believe that the Board jurisdictional statute, 42 U.S.C. § 1395oo, should be read broadly to support the "strong presumption that Congress intends judicial review of administrative action."[74]

In conclusion, the Providers should be afforded the due process of proving to the Board that the 1981 discharge data were indeed flawed, leading to understated amounts in the Federal Fiscal Years at issue.

9/30/2024

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

[74] *Bowen v. Academy of Family Physicians*, 476 U.S. 667, 670 (1986).

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On April 3, 2024, the Medicare Contractor filed a challenge to the following four (4) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions, LLC (J-F):

20-2104GC	EvergreenHealth FFY 2020 Understatement of PPS Standardized Amount CIRP Group
21-0994GC	EvergreenHealth FFY 2021 Understatement of PPS Standardized Amount CIRP Group
22-0585GC	EvergreenHealth FFY 2022 Understatement of PPS Standardized Amount CIRP Group
23-0549GC	EvergreenHealth FFY 2023 Understatement of PPS Standardized Amount CIRP Group

The April 23, 2024 Jurisdictional Challenge contained four (4) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

24-0032GC	Renown Health CY 2019 Understatement of PPS Standardized Amount CIRP Group
24-0066GC	Adventist Health CY 2019 Understatement of PPS Standardized Amount CIRP Group
24-1281GC	Renown Health FFY 2024 Understatement of PPS Standardized Amount CIRP Group
24-1555GC	Adventist Health FFY 2024 Understatement of PPS Standardized Amount CIRP Group

The May 1, 2024 Jurisdictional Challenge contained two (2) cases which all share a common lead Medicare Contractor, Novitas Solutions, Inc. c/o GuideWell Source (J-H):

24-1232GC	CHRISTUS Health FFY 2024 Understatement of PPS Standardized Amount CIRP Group
24-1486GC	Presbyterian Healthcare FFY 2024 Understatement of PPS Standardized Amount CIRP Group

APPENDIX B

Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue

Set forth below are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments ("BNAs") and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). These other example raise questions about the causal link between the standardized amount rates at issue and the initial standardize amounts set for FFY 1984. Curiously, the Providers stopped their analysis at 1986 and did not carry forward their analysis for years 1987 through the particular year at issue (*e.g.*, for the lead case under Case No. 18-1646G, there are an additional 28 intervening years since the standardize amount issue is the FFY 2015 standard amount rate).

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[75] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[76]

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[75] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[76] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs,

c. BNAs made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[77]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[78] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[79]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[80]

> inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

[77] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[78] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 20.

[79] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[80] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[81] and 1997[82] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[83]

To illustrate the complex nature of these issues, the Board Majority points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[84] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[85] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that

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percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

[81] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[82] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[83] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[84] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[85] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law **to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more **nor** less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

*Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were **higher** than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the **overstatement** of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into **a proposed composite correction factor** for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically

> appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.
>
> Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:
>
> | | Percent |
> |---|---|
> | Forecasted market basket increase.. | +4.27 |
> | Part B costs and FICA taxes..... | +.31 |
> | Composite correction factor..... | –7.5 |
> | Composite policy target adjustment factor..... | –1.5 |
>
> However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[86]
>
> ****
>
> (3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.
>
> When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed

[86] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

> We received no comments on this issue.
>
> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[87] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[88] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[89]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[90] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for

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[87] *Id.* at 35703-04 (bold and underline emphasis added).
[88] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[89] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[90] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).

discharges on or after May 1,1986"[91] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

[91] 51 Fed. Reg. at 16773.

APPENDIX C

**Additional Excerpts from FFY 1985 IPPS Final Rule
Affirming Application of FFY 1985 budget-neutrality-adjusted rates to
FFY 1986 and subsequent years.**

In its decision, the Board Majority has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 BNA accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[92]

[92] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). The Board Majority notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 BNA accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her BNAs for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

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basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.
For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 BNA to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[93]

[93] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Daniel Hettich, Esq.
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RE: ***Notice of Dismissal – Updated Rationale***
King & Spalding Standardized Amount CIRP Group Cases
Case Nos. 24-1601G & 24-1634GC (*see* **Appendix A** listing 2 CIRP group cases)

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the two (2) above-referenced group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in each of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board Majority has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing both group cases in their entirety. This issue is not new to the Board and this determination is consistent with the its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget-neutrality-adjusted federal rates.

In summary, the Board Majority finds that it lacks substantive jurisdiction over the issue raised in these group appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment ("BNA") made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board Majority has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 BNAs. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or

intertwined with those applicable BNAs.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the BNAs applied to those years reduced the standardized amounts (by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs, the Board Majority finds that it may not review the standardized amount used for the FFYs appealed as it relates to the common issues in these appeals. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget -neutrality-adjusted rates. Accordingly, the Providers assertion that the initial FFY 1984 standardized amount continues to serve as the base for all future calculations is incorrect as causal link is broken. Specifically, they may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

The Board Majority also notes that the Providers appear to raise a new legal issue that is beyond the scope of the original group issue statement in these group cases. Per their group issue statements, these group appeals challenge the standardized amount "first calculated" for the ***initial*** year of IPPS, namely FFY 1984 running from October 1, 1983 to September 30, 1984.[7] Pursuant to 42 C.F.R. §§ 405.1837(a)(2) and (f)(1), a group may contain only one issue and no issues may be added to the group appeal. In their Response to the Medicare Contractors' Jurisdictional Challenge, the Providers appear to have ***improperly*** raised a new legal issue that is not part of this appeal. Specifically, the Providers appear to challenge the FFY 1986 standardized amount rates and subsequent years as being *improperly* based on the FFY 1985 budget-neutrality adjusted rates. The Board confirms that, *if so*, this is a newly-added issue and hereby ***dismisses*** it from these appeals pursuant to 42 C.F.R. §§ 405.1837(a)(2), (c) and (f)(1).

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not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 61 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 40 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 BNA).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *E.g.,* Case No. 24-1601G, Providers' Group Issue Statement.

PROCEDURAL BACKGROUND:

A. Group Issue – Limited to Alleged Error in the Initial Calculation of the Standardized Amount for the Initial Year of IPPS

King & Spalding, LLP ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") groups which are challenging the IPPS standardized amount. The Medicare Contractor filed a Jurisdictional Challenge covering two (2) group cases.[8] The Providers' Representative filed a response to this challenge. The group issue statements are materially identical and can be considered together.

The group issue statement presented is:

> The Providers contend that the standardized amount for the fiscal year under appeal is understated *due to errors made when the standardized amount was **first calculated** that have not since been corrected*. Medicare's inpatient prospective payment system ("IPPS") pays acute care hospitals for inpatient services based on national standardized payment amount. 42 U.S.C. § 1395ww(d)(2)(C). *The standardized amount was **first calculated** when the IPPS was established in 1983*. Each year, the standardized amount is updated for inflation and adjusted for certain factors to capture cost variances. For each Medicare inpatient that a hospital treats in a given year, the adjusted standardized amount is multiplied by the diagnosis related group ("DRG") weight for the patient, which reflects the severity of the patient's condition, to calculate the payment due to the hospital for the patient admission. 42 U.S.C. § 1395ww(d). In other words, the standardized amount is the building block for payment of each admission under the IPPS.[9]

In the Providers' group issue statement further explains that:

> The Medicare statute states that the standardized amount must reflect the allowable operating costs per discharge incurred by hospitals nationwide for the base year in which it is calculated. See 42 U.S.C. § 1395ww(d)(2). The Secretary attempted to comply with this directive by dividing hospitals' standardized allowable-Medicare costs as reported in their 1981 cost reports by their number of Medicare discharges during the same period.[10] However, the 1981 cost report data did not distinguish between true "discharges," where the patient's acute care treatment is complete,

[8] *See* **Appendix A**.
[9] *E.g.*, Case 24-1601GC, Group Issue Statement at 1 (Jul. 10, 2020).
[10] (Citation omitted).

> and "transfers," where a patient is sent to another department or hospital because the patient requires further treatment beyond the capabilities of the original admitting facility.[11]

CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[12]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges.[13]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[14] They claim that the average cost per discharge should not include transfers.

B. Jurisdictional Challenges

The Medicare Contractor filed a challenge in the two (2) different group cases, and the Providers filed a timely response in each.[15] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responses to these challenges reiterated that the group appeal rests on the fact that each appeal's IPPS payments for the applicable FFY is "CMS's calculation of the "costs per discharge" in the first step of the methodology prescribed by statute for calculating the original, 1983 standardized amounts."[16] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. The ask the Board to deny the Jurisdictional Challenges.

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[11] *Id*. (Citation omitted).
[12] *Id.*
[13] *Id*.
[14] *See e.g.,* Case 24-1601G, Appeal at Submission.
[15] *See* **Appendix A**.
[16] *E.g.*, PRRB Case 24-1601G, Response to Jurisdictional Challenge at 2 (May 31, 2024).

The Providers counter the Medicare Contractor by arguing that budget neutrality adjustments are not applicable to these appeals. They go on to state that "[b]y its explicit and unambiguous terms, the budget neutrality preclusion provision invoked by the MAC bars administrative and judicial review only of challenges to the budget neutrality adjustments made pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985."[17] They argue that there is a strong presumption in favor of judicial review, and that in this instance there is not clear indication that Congress intended to preclude review of more recent FFY Standardized Amounts or the predicate facts related to the methodology for calculating the 1983 Standardized Amount.[18]

BOARD DECISION:

As described more fully below, the Board Majority finds that it lacks substantive jurisdiction over each of the 2 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[19] are ***inextricably*** tied to the FFY 1984 and 1985 BNAs to the "applicable percentage increases" for IPPS[20]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs;[21] and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs. Further, the fact that the Secretary's BNA to the FY 1984 Federal Rates was 0.970[22] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[23] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[24]

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[17] *Id*.
[18] *See id.* at 1 and 3-4.
[19] The Board Majority notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[20] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 BNAs are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[21] *But see* **Appendix B**. The Board has not traced the standardized amount after FFY 1986 all the way up to the each of the years in question. **Appendix B** highlights how, in addition to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and forward, there could be other intervening statutory or regulatory events (whether discretionary or mandatory) that could break the Providers' alleged causal link between the alleged error in the initial FFY 1984 rates and the standardize amounts used in the years at issue.
[22] In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[23] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[24] *Id.*

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[25] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[26] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1981 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount and then *updated* by an inflationary factor to bring it forward to FFY 1984.[27] The Providers dispute how the Secretary determined

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[25] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).

[26] *Id.* (emphasis added).

[27] *Id*. at 39763-64. The Board Majority notes that the 1981 data appears to have been available to the public close in time to when the initial IPPS was established, as explained in the proposed rule issued on May 27, 1988:

> *B. Public Requests for Data*
> In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format and are listed below with the cost of each tape. Anyone wishing to purchase data tapes should submit a written request along with a check to cover the cost of the tapes to the following address: HCFA Office of Statistics and Data Management, Bureau of Data Management and Strategy, Room l-F-2 Oak Meadows Building, 6325 Security Boulevard, Baltimore, MD 21207.
>
> ****
>
> 4. H180 **Extract, Cost Reporting Periods Ending January 1, 1981 through December 31, 1981**
> This file contains selected data items from cost reports. **These data were used in computing the initial Federal prospective payment rate**.
> Price: $530.00

53 Fed. Reg. 19498, 19526 (May 27, 1988). Apparently, the Secretary made the data available in this manner due to demand, as previously the Secretary made this information available through FOIA as discussed in the following excerpt from the January 3, 1984 Final Rule:

> *We agree hospitals should have access to the data used in connection with the development of the prospective payment system*. We would like to point out that public access to disclosable information is provided under the Freedom of Information Act (5 U.S.C. 552). While we cannot guarantee that all requested information will be disclosed in the format desired by the requester, we will continue to respond promptly to all information requests and provide all available data to

"discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[28] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary (*see also* **Appendix B**). In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the BNA for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—

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assist the hospital industry and other interested parties in the evaluation of the prospective payment system.
In fact, much of the applicable data has already been made available to requesters. For example, the cost report file used as a basis for determining the budget neutrality adjustment factor and other factors had already been made available for public use before publication of the interim rule. This data, together with our descriptions of the budget neutrality determination published in section VIII of the Addendum to the interim rule, should allow our budget neutrality determination to be replicated. 49 Fed. Reg. at 251.

(Emphasis added.) It is unclear to what extent any of this 1981 information continues to be available to the public at this late date and, if not, to what extent CMS is obligated to continue to make it available to the public at this late date.

[28] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[29]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[30]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient

[29] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[30] (Italics emphasis in original and bold and underline emphasis added.)

> operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[31]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[32] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the BNA).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

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[31] (Italics emphasis in original and bold and underline emphasis added.)

[32] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board Majority's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) ***for fiscal year 1986***, 1/2 percent,

(II) for fiscal year ***1987***, 1.15 percent,

(III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 [percentage point] for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located

> in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[33]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the***

[33] (Emphasis added.)

fiscal year involved by the applicable percentage increase under subsection (b)(3)(B). With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous

> fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 BNAs (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
>
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.

> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective <u>adjusted</u> average standardized amounts <u>computed for the previous fiscal year</u>**—
>
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[34]

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[34] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **<u>Adjusted for budget neutrality under paragraph (h) of this section</u>**.

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the* ***initial*** *FFY 1984 standardized amount*.[35]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the BNAs for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[36] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

[35] *See e.g.,* Case 24-1601GC, Group Issue Statement at 1.
[36] *See* **Appendix B.**

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***roughly 20 to 35 years*** to increase the ***initial*** FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward by the relevant 20 to 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue[37] *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[38]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 BNAs which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the BNAs had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[39] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 BNA (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those BNAs). Thus, in the Board Majority's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 BNAs. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[40]

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[37] *See supra* note 21 accompanying text.
[38] *See id.*
[39] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").
[40] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the BNAs would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since***

Accordingly, the Board Majority finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the BNAs made for FFY 1984 and 1985.[41]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 BNAs. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[42]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

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the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987. 50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[41] The Board Majority notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 BNAs given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[42] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 BNAs are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board Majority finds that the FFYs 1984 and 1985 BNAs effectively fixed the standardized amounts from that point forward for use in the IPPS system.[43]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 BNAs confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 BNA as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 BNA to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment

[43] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
> - *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[44]

In the final rule published on January 3, 1984, the Secretary revised the Federal BNA factor to 0.970 using the same methodology.[45] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the BNA factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made

[44] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[45] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[46]

Accordingly, while the Providers did not appeal the BNAs, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the BNA for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the BNA for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[47]

Regardless, the Secretary's application of a 0.970 BNA factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 BNA. Moreover, as previously noted, since the FFY 1984 BNA is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 BNA effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

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[46] *Id.* at 255 (emphasis added.) *See also id.* at 331 (stating as part of the discussion on the BNAs: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[47] *Id.* at 255.

2. *The FFY 1985 BNA also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a BNA of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1, 1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[48]
>
> ****

By finalizing an adjustment factor less than one (1), the Secretary confirmed that the standardized amounts were too high. Thus, like her BNA made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[49]

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[48] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[49] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

3. The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget-neutrality-adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[50]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[51] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

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[50] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

[51] *Id.* (emphasis added).

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[52]

The Board Majority has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that:

- The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

- The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Indeed, the Providers acknowledge that they are not challenging the FFY 1985 BNA and acknowledge that the Secretary used.[53] Accordingly, given the incorporation of the FFY 1985 budget-neutrality-adjusted rates into subsequent years, the Board Majority finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 BNA.

4. *Any issues the Providers have regarding the use of the FFY 1985 budget-neutrality-adjusted rates to set the standardized amounts for FFY 1986 and subsequent years is beyond the scope of these appeals.*

As discussed above, the Providers admit that the Secretary used the FFY 1985-budget-neutrality adjusted rates to set the standardized amounts for FFY 1986 and subsequent years and that they do not challenge the FFY 1985 BNA.[54] However, in their response to the Medicare Contractors' Jurisdictional Challenge, the Providers appear to potentially challenge the Secretary's use of the 1985-budget-neutrality adjusted rates to set the standardize amount rates for FFY 1986 and subsequent years by claiming the Secretary failed to follow the statutory directives of Congress

[52] 87 Fed. Reg. 16772, 16773 (May 6, 1986).
[53] Providers' Response to Medicare Contractors' Jurisdictional Challenge at 2.
[54] Providers' Response to Medicare Contractors' Jurisdictional Challenge at 2.

in calculating the standardized amount rates for FFY 1986 and subsequent years. If so, this challenge would be a new issue that is not part of the groups' original appeal.

Pursuant to 42 C.F.R. § 405.1837(a)(2), a group must *only* "involve[] a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Consistent with this requirement, 42 C.F.R. § 405.1837(c)(3) specifies that a group appeal request must include "a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal." Further, the group appeal request must explain "why the provider[s] believe[] Medicare payment is incorrect for each disputed item" and "[h]ow and why the provider[s] believe[] Medicare payment must be determined differently for each disputed item." Consistent with these two (2) regulatory provisions, 42 C.F.R. § 405.1837(f)(1) specifies that, after a group appeal request is filed, "a provider *may* ***not*** *add* other questions of fact or law to the appeal, *regardless of whether the question is common to other members of the appeal*."

Here, the Providers only challenged the ***initial*** federal standardized amounts "first calculated" under the IPPS for FFY 1984 as improper by asserting that the Secretary failed to exclude transfers when determining the base cost per discharge rate mandated in 42 U.S.C. § 1395ww(d)(2)(A) as demonstrated in the excerpts taken from the group issue statements quoted above.[55] The Providers *belated* focus on the Secretary's use of the 1985-budget-neutrality adjusted rates in the FFY 1986 rates and subsequent years illustrates the underlying problem with these appeals, namely the failure to trace the causality of the alleged error in setting the original FFY 1984 standardize amount rates and those at issue as used over 30 years later.[56]

The Providers stance on this discovery suggests that the real issue with the standardized amounts used in the years at issue may now be potentially shifting to a new allegation that the Secretary improperly used the FFY 1985 budget neutrality-adjusted rates in setting their current rates:

> Sections 1395ww(d)(3)(B)(C)(i) and (e)(1)(B) required the Secretary to calculate a new budget neutrality adjustment for FY 1985. But just as the statute foreclosed carrying forward the FY 1984 budget neutrality adjustment to FY 1985, *so too does it* ***foreclose carrying forward*** *the FY 1985 budget neutrality adjustment to FY 1986*. Under Section 1395ww(d)(3)(A), the starting point for FY 1986 is the "respective average standardized amount computed for the previous fiscal year under…this subparagraph." In other words, the baseline for FY 1986 should have been the FY 1985 standardized amount before it was adjusted for outliers under (3)(B), budget neutrality under (3)(C) and (e)(1)(B), the weighting factors under (3)(D) or area wages under

[55] *E.g.*, Case No. 24-1601G Group Issue Statement.
[56] *See* **Appendix B** (providing examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue).

> (3)(E). Moreover, neither section 1395ww(d)(3)(B)(C)(i) nor (e)(1)(B) required calculating a new budget neutrality adjustment for FY 1986.[57]

Further, the Providers further conclude that Congress did not intend the FY 1985 budget-neutrality-adjusted rates to apply in FFY 1986 and subsequent years:

> The MAC's argument that the Board lacks jurisdiction over these appeals is also based on the premise that *Congress intended* the budget neutrality adjustments required by § 1395ww(e)(1)(B) to apply in FFYs 1986 and onward but, as explained above, *that premise if [sic]* ***false***.[58]

The Providers' group issue statements do not challenge the use of the FFY 1985 budget neutrality-adjusted rates in setting the rates for FFY 1986 and subsequent years and the Providers may not now add that issue to their appeal. Accordingly, to the extent the Provers are attempting to add this new issue to their appeal at this late date, the Board Majority ***dismisses*** that new issue, (*i.e.*, dismisses the challenge to the Secretary's use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and subsequent years), pursuant to 42 C.F.R. §§ 405.1837(a)(2), (c), and (f)(1).[59]

* * * * *

In summary, the Providers confirm that they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather they are contesting the base rate calculation of the standardized amount.[60]

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[57] Provider's Response to the Medicare Contractors' Jurisdictional Challenge at 4 (emphasis added).
[58] *Id.* at 5 n.2 (emphasis added).
[59] *See also* Board Rule 8. Consistent with these regulations, Board Rule 8.1 (July 2015) specifies: "Some issues may have multiple components. To comply with the regulatory requirement to ***specifically*** *identify* the items in dispute, ***each*** contested component must be appealed as a ***separate*** *issue* ***and*** *described as* ***narrowly*** *as possible* using the applicable format outlined in Rule 7." (Emphasis added.) *See also Evangelical Cmty. Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[60] Providers' Response to the Medicare Contractors' Jurisdictional Challenge at 2.

The Majority Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the BNA made for that FFY and the 1984 and 1985 BNAs are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[61] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable BNAs.[62] Indeed, the Secretary applied a BNA to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these BNAs appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[63] Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board Majority finds that it may not review the standardized amount used for the FFYs

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[61] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[62] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[63] *See supra* note 40 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

being appealed as it relates to the common issue in these appeals. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates and the Providers may not simply pass through, or over, the BNAs for FFYs 1984 and 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board Majority finds that: (1) the appealed issue is *inextricably* tied with the FFY 1984 and 1985 BNAs to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[64]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board Majority concludes that it does not have substantive jurisdiction over the issue in the two (2) group cases listed in **Appendix A**, and hereby closes these two (2) group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (concurring, in part, & dissenting, in part)

For the Board:

9/30/2024

X Clayton J. Nix

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

Appendices A – Listing of Cases Covered by this Notice of Dismissal
B – Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue
C – Additional Excepts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

[64] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

Concurring in part, dissenting in part

I concur with the majority's dismissal of the Providers' challenge to the FFY 1986 standardized amount rates and subsequent years as being improperly based on the FFY 1985 budget-neutrality adjusted rates. However, for the reasons explained below, I dissent from the Board Majority's decision regarding the issue of whether CMS' failure to remove transfer cases from its discharge data decreased the Standardized Amount, and would find that the Board has substantive jurisdiction in this case.

The Providers' issue statement is essentially the same as that in *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023) ("St. Mary's")*[65], an appeal from the Board's "Dismissal Based on Lack of Substantive Jurisdiction" dated April 6, 2023,[66] the Board's first decision on the topic of "Understated IPPS Standardized Amount" after the D.C. Circuit ruled in *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) ruling that the reopening regulation – and thus its predicate facts position – does not apply to appeals made to the Board.

In these "Understated IPPS Standardized Amount" cases, the providers consistently argue that a computational error at the inception of the IPPS has not been corrected,[67] that "the Secretary failed to properly distinguish between patient transfers and discharges in establishing the PPS1983 base year amounts,[68] and that "the resulting understated initial base year amounts were carried forward across 35 years resulting in the alleged understated standardized amount used for setting the FFY 2019 IPPS payment rates."[69]

The Board Majority finds that the Board has no jurisdiction based on the presupposition that the final FFY 1984 and 1985 standardized amounts (which were based on 1981 discharge data) were adjusted for budget neutrality, thus, the final rates in those years are *inextricably tied* with budget neutrality adjustments for which administrative and judicial review is prohibited by 42 U.S.C. § 1395ww(d)(7). The Board Majority rationalizes its conclusion by stating that the initial 1983 standardized amount was overstated, so therefore the initial base rate that was set using 1981 data could not have been erroneous. I respectfully disagree.

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[65] "The Hospitals challenge their Medicare inpatient hospital payments for Federal Fiscal Year ("FFY") 2019 as being unlawfully understated because the Secretary calculated them using a "standardized amount" that was invalidly low because of an embedded error from the Secretary's original implementation of the Medicare Hospital Inpatient Prospective Payment System ("IPPS") in FFY 1984." *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023), Complaint at 25.*

[66] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024); *see also*, *St. Mary's Reg'l Med. Ctr., et al. v. Becerra, No. 1:23-cv-01594 (D.D.C. filed June 2, 2023),* Complaint at 28 ("on April 6, 2023, the Board dismissed the Hospitals' administrative appeals, holding *for the first time* in any administrative appeal raising this substantive issue that the Budget Neutrality Preclusion Provisions strip it of jurisdiction over the Hospitals' claims.")

[67] See Saint Francis Med. Ctr. v. Azar, 894 F.3d 290 (D.C. Cir. 2018).

[68] Dismissal Based on Lack of Substantive Jurisdiction, Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC (Apr. 6, 2023), at 3, available at https://www.cms.gov/files/document/prrb-jurisdictional-decisions-4-1-2023-through-4-30-2023.pdf (last accessed Sept. 23, 2024);

[69] *Id*.

The Providers have presented several arguments as to why the standardized amount is understated; that is not for me to decide today. My dissent over the majority's conclusion that the Board has no substantive jurisdiction over this appeal solely because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. To reach their conclusion, my colleagues have skipped ahead to an analysis of the budget neutrality adjustments, and passed over the Providers' challenge to the accuracy of the 1981 discharge data.[70] The Providers are not challenging the "determination of the requirement, or the proportional amount, of any budget neutrality adjustment" in IPPS rates, which is what the plain language of 42 U.S.C. § 1395ww(d)(7) prohibits. Rather than consider the issue to be that CMS did not properly calculate the average cost per discharge, my colleagues prejudicate that the data cannot be reviewed because a subsequent calculation utilizing that data was later incorporated into an adjustment which was deemed sacrosanct by a Congress that readily admitted the data was flawed.[71]

In reaching my decision, I am persuaded by the concurring opinion in *St. Francis* asserting "it is not reasonable for HHS to 'cement misclassified' costs into 'future reimbursements, thus perpetuating literally million-dollar mistakes.'"[72] Additionally, I note the rulemaking for the Capital PPS Final Rule, whereby CMS applied a correction factor for capital-related costs in the Capital PPS Final Rule in 1991, thus setting a possible precent for making such a change.[73] Finally,

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[70] *See* Case 24-1601GC, Group Issue Statement at 1 (Jul. 10, 2020)..

[71] "The case mix index values used in the PPS model were based on billing information reported in 1981. At that time, the patient diagnostic information necessary for DRG assignment was completely unrelated to payment. ***As a result, the 1981 bills contain a variety of errors which tend to cause the hospital case mix values to be understated.*** Hospital PPS payments, however, are based on the diagnostic information reported on the current bills, under very different incentives. Therefore, an increase in overall hospital case mix under PPS was anticipated." Adjustments in Medicare's Prospective Payment System, S. Hrg. 98-1122, Hearing before the Subcommittee on Health of the Committee on Finance, United States Senate, Ninety-Eighth Congress, Second Session, August 8, 1984, available at https://www.finance.senate.gov/imo/media/doc/HRG98-1122.pdf, page 14 of 147 (accessed July 11, 2024) (***emphasis added***). *See also* 56 Fed. Reg. 43358 at 43387 (Aug. 30, 1991) (Prospective Payment System for Inpatient Hospital Capital-Related Costs – Final Rule). ("*Comment*: Several commenters questioned the treatment of transfers in determining the hospital-specific rate. Some commenters suggested that transfer should not be included in the discharge count because payment is not made for all transfers on a per discharge basis. One commenter suggested that each transfer case should be counted as a fraction based on the amount paid for the transfer case as a portion of the full case payment. Others believed that including transfers in the case-mix index would distort the hospital-specific rate because transfer cases tend to have a higher DRG weight. *Response*: We agree with the commenters that the treatment of transfers in the discharge count is problematic. To the extent a transfer is paid on a per diem basis, including the transfer in the discharge count will understate the hospital-specific rate. If the transfer were not counted at all, as suggested by some commenters, the hospital-specific rate would be overstated. In contrast, there is no distortion in the hospital-specific rate if the transfer is paid at the full DRG rate. Since some transfers are paid on a per diem basis and other transfers are paid at the full DRG amount, either the total include or the total exclusion of transfers will distort the hospital-specific rate unless the costs of all transfer cases are removed from the base period costs. We do not believe that it is administratively feasible to remove the costs associated with transfer cases. Instead, to account for transfers, as recommended by one commenter, we are adopting and adjustment to the discharge count used to calculation the hospital-specific rate. [. . . .].")

[72] *St. Francis* at 298, citing *Regions Hospital v. Shalala*, 522 U.S. 448, 462, 118 S.Ct. 909, 139 L.Ed.2d 895 (1998).

[73] 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991).

I believe that the Board jurisdictional statute, 42 U.S.C. § 1395oo, should be read broadly to support the "strong presumption that Congress intends judicial review of administrative action."[74]

In conclusion, the Providers should be afforded the due process of proving to the Board that the 1981 discharge data were indeed flawed, leading to understated amounts in the Federal Fiscal Years at issue.

9/30/2024

X Nicole E. Musgrave

Nicole E. Musgrave, Esq.
Board Member
Signed by: Nicole Musgrave-burdette -A

[74] *Bowen v. Academy of Family Physicians*, 476 U.S. 667, 670 (1986).

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On May 1, 2024, the Medicare Contractor filed a challenge to the following two (2) cases which all share a common lead Medicare Contractor, Novitas Solutions, Inc. c/o GuideWell Source (J-H):

24-1601G	King & Spalding FFY 2024 Understated Standardized Amount Group
24-1634GC	Ochsner Health System FFY 2024 Understated Standardized Amount CIRP Group

APPENDIX B

Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue

Set forth below are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments ("BNAs") and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). These other example raise questions about the causal link between the standardized amount rates at issue and the initial standardize amounts set for FFY 1984. Curiously, the Providers stopped their analysis at 1986 and did not carry forward their analysis for years 1987 through the particular year at issue (*e.g.*, for the lead case under Case No. 18-1646G, there are an additional 28 intervening years since the standardize amount issue is the FFY 2015 standard amount rate).

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[75] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[76]

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[75] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[76] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs,

c. BNAs made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[77]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[78] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[79]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[80]

> inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

[77] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[78] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 19.

[79] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[80] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[81] and 1997[82] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[83]

To illustrate the complex nature of these issues, the Board Majority points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[84] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[85] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that

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percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

[81] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[82] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[83] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[84] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[85] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law **to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more **nor** less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

*Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were **higher** than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the **overstatement** of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into **a proposed composite correction factor** for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically

appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[86]

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(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed

[86] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

> We received no comments on this issue.
>
> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[87] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[88] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[89]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[90] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for

---

[87] *Id.* at 35703-04 (bold and underline emphasis added).
[88] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[89] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[90] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).

discharges on or after May 1,1986"[91] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

[91] 51 Fed. Reg. at 16773.

APPENDIX C

**Additional Excerpts from FFY 1985 IPPS Final Rule
Affirming Application of FFY 1985 budget-neutrality-adjusted rates to
FFY 1986 and subsequent years.**

In its decision, the Board Majority has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 BNA accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[92]

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[92] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). The Board Majority notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 BNA accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her BNAs for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

---

basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.
For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 BNA to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[93]

[93] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

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RE: ***Request to Rescind Remand and Bifurcate DSH Part C Days Issue***
Blumberg Ribner 2004 Dual Eligible Days
Case No. 08-0693G

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 23, 2016 request for Rescission of Remand and Bifurcation regarding DSH Part C Days for the Blumberg Ribner 2004 Dual Eligible Days group.

Background:

On **January 24, 2008**, the Board received the group appeal request. The entire description for the Medicare/Medicaid Dual Eligible Patient Days issue reads:

> [DSH] Adjustment – The Providers contend that their respective DSH adjustments are understated due to **the exclusion** from the Medicaid proxy calculation of **certain** days relating to patients dually eligible for both Medicaid and Medicare. Further, the Providers assert that the HCFA Administrator's decision pertaining to **said days** in *Edgewater Medical Center v. Blue Cross and Blue Shield of Illinois* (June 19, 2000) is inconsistent with applicable Medicare Regulations.

On **September 1, 2009**, the Provider submitted its preliminary position paper.[1]

On **October 17, 2014**, the Board issued a decision "determine[ing] that the case must be bifurcated for compliance with [CMS] Ruling 1498-R." Specifically, the Board bifurcated from this case the period from 10/1/2004 – 12/31/2004 from the appeal, as *that period was **not** subject to CMS Ruling 1498-R*. This period was transferred to Case No. 08-0694G, Blumberg Ribner

[1] In accordance with the Board rules in place at the time the Providers filed their preliminary position paper, the Board received the cover page, preliminary documentation list; a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Board Rule 25.3 (July 1, 2009).

10/1/2004-2005 Dual Eligible Days. The Group representative withdrew Case No. 08-0694G on July 9, 2015.

As the Board's decision make clear, the remaining period in the group left in the group was subject to CMS Ruling 1498-R Accordingly, also on **October 17, 2014**, the Board remanded the Providers and applicable FYEs pursuant to CMS Ruling 1498-R and closed the appeal.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On May 23, 2016 (*more than 1½ years after the Board had remanded the case*), the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next reference an Affidavit of Isaac Blumberg, a representative of the Providers, who affirms that the Providers' use of the term "dual eligible days" as used in that case was intended to refer to both Medicare Part A and Medicare Part C days.

Last, the Providers argue that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must**

[2] Bifurcation Request Letter at 1 (May 23, 2016).
[3] *Id.* at 2.

> **precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the reconsideration request was filed, addresses how the Board handles a Motion for Reinstatement: "[a] Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case . . . if an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the Provider must address whether the CMS ruling permits reinstatement of such issue(s)/case."

> **46.1 – Motion for Reinstatement**
> A Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the Provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will *not* reinstate an issue(s)/case *if the Provider was at fault*. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the Provider *must* address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the Provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rules 46.2 and 46.3 below.[4]

Here, if the CIRP group was filed with the intention that it include Part C days issue, it is unclear why the Provider took 1½ years to file a request for reinstatement in this case after the Board had closed this case pursuant to a standard 1498-R remand. Indeed, the Board finds that there was no such intention and that the group appeal request does not encompass the dual eligible Part C days issue. T The group appeal request pertains to "certain days" involving dual eligible and then limits "***said*** days" to *Edgewater Medical Center v. Blue Cross and Blue Shield/Blue Cross and Blue Shield of Illinois* (June 19, 2000); however, the *Edgewater* decision addresses the issue of dual eligible Medicare Part A days in DSH, ***not*** Part C days. Further, Consistent with 42 C.F.R. § 405.1837(a)(2) and (f)(1), a group representative may *not* later add issues to a group appeal once the group appeal request is filed. Accordingly, it is clear that the group does not encompass

[4] (Emphasis added.)

the separate and distinct Part C days issue and the Providers have not established good cause to reinstate/reopen Case No. 08-0693G.[5]

Regarding the Board's decision in Case No. 08-2624GC, the issue statement in that case is clearly different that that filed in this CIRP group. Moreover, the record of that case is not before the Board. As such, the Board declines to give it any weight. Similarly, the Affidavit filed with the request for reconsideration pertained to another case and for different group issue statement and, as such, the Board declines to give it any weight in this case. Moreover, the additional independent reasons stated below reinforce the Board's decision to deny the request for reinstatement.

Consistent with 42 C.F.R. § 405.1853(b)(2)-(3) (2009), Board Rule 25 (July 1, 2009), in effect at the time the group appeal filed its position paper, addresses the Content Standards for Position Papers:

Rule 25 – Preliminary Position Papers

COMMENTARY: Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

To address complaints under the previous Rules that the parties have not had sufficient time to develop meaningful position papers, upon publication of these Rules, the Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the Provider, twelve months for the Intermediary and fifteen months for the Provider's response. The Board may modify these timelines as appropriate for the particular matter appealed (e.g. see Rule 50 Children's GME appeals. As the Board and the parties gain more experience with this process, the timeframes may be modified.

[5] This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*, 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022). In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ." *Id*. at 11. The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[5] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal. *Id.* Here, the Board makes the same finding based on similarly overly generalized language.

> **25.1 - Content**: The text of the Preliminary Position Papers must include the following:
>
> **A. Provider's Preliminary Position Paper**:
>
> 1. for each issue, state the material facts that support your claim.
> 2. identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position.
> 3. provide a conclusion applying the material facts to the controlling authorities.
>
> ****
>
> **25.2 – Preliminary Documents:**
>
> **A. General:** With the preliminary position papers, the parties must exchange all available documentation as preliminary exhibits to fully support your position. . . .
>
> **B. Unavailable and Omitted Preliminary Documents:** If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts you made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.
>
> **C. Preliminary Documentation List:** Parties must attach a list of the exhibits exchanged with the preliminary position paper.
>
> **25.3. - Filing Requirements to Board**
>
> Parties should only file with the Board 1) the cover page of the preliminary position paper 2) the preliminary documentation list and 3) a statement indicating how a good faith effort to confer was made in accordance with 42 CFR §405.1853. Do not file any other documents with the Board.[6]

In this respect, the commentary to Board Rule 23.3, noted:

> The Regulations [at 42 C.F.R. § 405.1853(b)] and these Rules impose preliminary position paper requirements that are more stringent than in the past. *Full development of the parties' position* fosters efficient use of the administrative review process and due process. The due dates have been extended to give the parties a

[6] (Underline emphasis added and all other emphasis in original.)

> better opportunity to develop their case. Because the date for adding issues will have expired and transfers are severely limited, *the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position*. **CAUTION: Unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the documents), new arguments and documents not included in your preliminary position paper may be excluded at hearing.**[7]

Therefore, had the Providers intended to appeal the Part C days issue as part of this appeal, that issue would have needed to be included in the Providers' preliminary position paper, and there is no indication that the Providers did brief the issue. The Provider did not include a complete copy of the preliminary position paper with its request for reinstatement to document its briefing and pursuit of the Part C days issue. Thus, to the extent it was ever part of this appeal, the Board presumes it was not briefed and abandoned, particularly since a group may contain only a single issue.

Indeed, Board Alert 7 issued on May 25, 2010 directed providers with appeals that included both an issue subject to 1498-R and another issue(s) not subject to 1498-R to ensure the position paper briefed the issues *not subject to 1498-R*:

> On or before the position paper deadline:
>
> (1) Submit a letter to the Board and Intermediary
>
> • identifying those issue(s) in your case that are governed by CMS-1498-R and therefore will not be briefed, and
>
> • to assist the Board in prioritizing, we would appreciate your advising us which remand procedure you prefer.
>
> (2) Brief the remaining issues, if any, in accordance with the Board's rules. If in doubt about whether your issue is governed by the Ruling, brief it and include your position as to why it is or is not covered.
>
> At least 30 days prior to the hearing date: Advise the Board and Intermediary in writing of issues or cases that will not require a hearing because they are governed by the Ruling. If you have not already received or requested a remand for the issues governed by the Ruling, state which remand procedure you select.

[7] (Italics and underline emphasis added and bold emphasis in original.)

The Board also notes that the Providers did not include a separate amount in controversy for the Part C days issue in the ***final*** schedule of Providers, which was submitted to the Board on July 15, 2010. 42 C.F.R. § 405.1839(b)(2) explains that providers cannot aggregate claims in order to meet amount in controversy requirements:

> (2) *Aggregation of claims.* (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).
>
> (B) The single issue that is common to each provider may exist over different cost reporting periods.

The regulation is clear that a group appeal can only include one single common issue, which in this case was the dual eligible Part A issue. The Providers did not include a calculation for the Part C days issue with the final Schedule of Providers, therefore the Board finds that the issue was not included in this group appeal and evidence that the group would meet the $50,000 amount in controversy requirement for the *alleged* DSH Part C issue.

Last, as discussed above, on October 17, 2014, the Board issued a decision in which it bifurcated the period from 10/1/2004 – 12/31/2004 from the appeal, as that period was not subject to CMS Ruling 1498-R. This period was transferred to Case No. 08-0694G, Blumberg Ribner 10/1/2004-2005 Dual Eligible Days. The Group representative did not pursue the Part C days issue in that group, as it withdrew Case No. 08-0694G on July 9, 2015. Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 08-0693G.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 08-0693G and thus **denies** the request for Rule 41.1 Reinstatement and Bifurcation. Case No. 08-0693G remains closed.[8]

Board Members Participating:

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

For the Board:

9/30/2024

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[8] *See supra* note 5.

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RE: ***Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue***
Blumberg-Ribner 2002 Dual Eligible Days Group
Case No. 08-2012G

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 23, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Blumberg Ribner 2002 Group.

Background:

On **May 27, 2008**, the Board received the group appeal request. The issue statement in the group appeal reads:

> [DSH] Adjustment – The Provider contend that their respective DSH adjustments are understated due to the exclusion from the Medicaid proxy calculation of **certain days** relating to patients dually eligible for both Medicaid and Medicare. Further, the Providers assert that the HCFA Administrator's decision pertaining to **said days** in *Edgewater Medical Center v. Blue Cross and Blue Shield/Blue Cross and Blue Shield of Illinois* (June 19, 2000) is inconsistent with applicable Medicare Regulations.[1]

On **December 1, 2009**, the Group representative filed the Providers' preliminary position paper with the Board.[2]

On **January 24, 2013,** the Board issued a letter to the parties indicating that it had begun a review of the appeal as it is "***subject to CMS Ruling 1498-R***"[3] and requesting additional information related to one of the Providers in the appeal.

[1] (Underline emphasis added.)
[2] In accordance with the Board rules in place at the time the Providers filed their preliminary position paper, the Board received the cover page, preliminary documentation list; a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Board Rule 25.3 (July 1, 2009).
[3] Emphasis added.

On **February 22, 2013**, the Group representative responded to the Board's request by submitting the requested additional documentation. Significantly, the Group representative's response did not include any claim or notification that there was another issue in the group that needed to be bifurcated prior to the Board executing a 1498-R remand.

On **April 30, 2014**, the Board issued a jurisdictional decision.

On **May 8, 2014**, the Board remanded the appeal pursuant to CMS Ruling 1498-R and closed the appeal.

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On May 23, 2016, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argue that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[4]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[5]

The Providers next reference an Affidavit of Isaac Blumberg, a representative of the Providers, who affirms that the Providers' use of the term "dual eligible days" was intended to refer to both Medicare Part A and Medicare Part C days.

Last, the Providers argue that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

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[4] Bifurcation Request Letter at 1 (May 23, 2016).
[5] *Id.* at 2.

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the reconsideration request was filed, addresses how the Board handles a Motion for Reinstatement: "[a] Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case . . . if an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the Provider must address whether the CMS ruling permits reinstatement of such issue(s)/case."

> **46.1 – Motion for Reinstatement**
> A Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the Provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will *not* reinstate an issue(s)/case *if the Provider was at fault*. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the Provider *must* address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the Provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rules 46.2 and 46.3 below.[6]

The Board finds that the group appeal request does not encompass the dual eligible Part C days issue. The group appeal request pertains to "certain days" involving dual eligible and then limits "***said*** days" to *Edgewater Medical Center v. Blue Cross and Blue Shield/Blue Cross and Blue Shield of Illinois* (June 19, 2000); however, the *Edgewater* decision addresses the issue of dual eligible Medicare Part A days in DSH, ***not*** Part C days. Accordingly, it is clear that the group does not encompass Part C days and the Providers have not established good cause to reinstate/reopen Case No. 08-2012G.[7]

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[6] (Emphasis added.)

[7] This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*, 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022). In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he

Regarding the Board's decision in Case No. 08-2624GC, the issue statement in that case is clearly different that that filed in this CIRP group. Moreover, the record of that case is not before the Board. As such, the Board declines to give it any weight. Similarly, the Affidavit filed with the request for reconsideration pertained to another case and for different group issue statement and, as such, the Board declines to give it any weight in this case. Moreover, the additional independent reasons stated below reinforce the Board's decision to deny the request for reinstatement.

Consistent with 42 C.F.R. § 405.1853(b)(2)-(3) (2009), Board Rule 25 (July 1, 2009), in effect at the time the group appeal filed its position paper, addresses the Content Standards for Position Papers:

Rule 25 – Preliminary Position Papers

COMMENTARY: Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

To address complaints under the previous Rules that the parties have not had sufficient time to develop meaningful position papers, upon publication of these Rules, the Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the Provider, twelve months for the Intermediary and fifteen months for the Provider's response. The Board may modify these timelines as appropriate for the particular matter appealed (e.g. see Rule 50 Children's GME appeals. As the Board and the parties gain more experience with this process, the timeframes may be modified.

25.1 - Content: The text of the Preliminary Position Papers must include the following:

A. Provider's Preliminary Position Paper:

1. for each issue, state the material facts that support your claim.

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intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ." *Id*. at 11. The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[7] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal. *Id.* Here, the Board makes the same finding based on similarly overly generalized language.

> 2. identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position.
> 3. provide a conclusion applying the material facts to the controlling authorities.
>
> ****
>
> **25.2 – Preliminary Documents:**
>
> **A. General:** With the preliminary position papers, the parties must exchange all available documentation as preliminary exhibits to fully support your position. . . .
>
> **B. Unavailable and Omitted Preliminary Documents:** If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts you made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.
>
> **C. Preliminary Documentation List:** Parties must attach a list of the exhibits exchanged with the preliminary position paper.
>
> **25.3. - Filing Requirements to Board**
>
> Parties should only file with the Board 1) the cover page of the preliminary position paper 2) the preliminary documentation list and 3) a statement indicating how a good faith effort to confer was made in accordance with 42 CFR §405.1853. Do not file any other documents with the Board.[8]

In this respect, the commentary to Board Rule 23.3, noted:

> The Regulations [at 42 C.F.R. § 405.1853(b)] and these Rules impose preliminary position paper requirements that are more stringent than in the past. *Full development of the parties' position* fosters efficient use of the administrative review process and due process. The due dates have been extended to give the parties a better opportunity to develop their case. Because the date for adding issues will have expired and transfers are severely limited, *the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position.* **CAUTION: Unless the parties demonstrate good cause (e.g.,**

[8] (Underline emphasis added and all other emphasis in original.)

> **subsequent case law or documents were unavailable through no fault of the party offering the documents), new arguments and documents not included in your preliminary position paper may be excluded at hearing.**[9]

Therefore, had the Providers intended to appeal the Part C days issue as part of this appeal, that issue would have needed to be included in the Providers' preliminary position paper, and there is no indication that the Providers did brief the issue. The Provider did not include a complete copy of the preliminary position paper with its request for reinstatement to document its briefing and pursuit of the Part C days issue. Thus, to the extent it was ever part of this appeal, the Board presumes it was not briefed and abandoned, particularly since a group may contain only a single issue.

Indeed, Board Alert 7 issued on May 25, 2010 directed providers with appeals that included both an issue subject to 1498-R and another issue(s) not subject to 1498-R to ensure the position paper briefed the issues *not subject to 1498-R*:

> On or before the position paper deadline:
>
> (1) Submit a letter to the Board and Intermediary
>
> • identifying those issue(s) in your case that are governed by CMS-1498-R and therefore will not be briefed, and
>
> • to assist the Board in prioritizing, we would appreciate your advising us which remand procedure you prefer.
>
> (2) Brief the remaining issues, if any, in accordance with the Board's rules. If in doubt about whether your issue is governed by the Ruling, brief it and include your position as to why it is or is not covered.
>
> At least 30 days prior to the hearing date: Advise the Board and Intermediary in writing of issues or cases that will not require a hearing because they are governed by the Ruling. If you have not already received or requested a remand for the issues governed by the Ruling, state which remand procedure you select.

The Board also notes that the Providers did not include a separate amount in controversy for the Part C days issue in the ***final*** schedule of Providers, which was submitted to the Board on July 15, 2010. 42 C.F.R. § 405.1839(b)(2) explains that providers cannot aggregate claims in order to meet amount in controversy requirements:

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[9] (Italics and underline emphasis added and bold emphasis in original.)

> (2) *Aggregation of claims.* (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).
>
> (B) The single issue that is common to each provider may exist over different cost reporting periods.

The regulation is clear that a group appeal can only include one single common issue, which in this case was the dual eligible Part A issue. The Providers did not include a calculation for the Part C days issue with the final Schedule of Providers, therefore the Board finds that the issue was not included in this group appeal and evidence that the group would meet the $50,000 amount in controversy requirement for the *alleged* DSH Part C issue.

Last, as discussed above, on January 24, 2013, the Board notified the Providers' representative that it was reviewing the group as it was subject to CMS Ruling 1498-R, and requested additional information. The Providers' representative responded to that request on February 22, 2013, and did not raise any objection to the referenced 1498-R remand. Had the Providers intended to pursue the Part C days issue, they should have notified the Board at that time, if not sooner. Accordingly, an independent basis to deny reinstatement/reopening request is that, to the extent the alleged Part C issue was ever part of Case No. 08-2012G, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when the Board notified the Providers it was reviewing the appeal as it was subject to remand and needed additional information for one of the Providers. Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 08-2012G.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 08-2012G and thus **denies** the request for Rule 41.1 Reinstatement and Bifurcation.[10] Case No. 08-2012G remains closed.

Board Members Participating:

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

For the Board:

9/30/2024

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[10] *See supra* note 7.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal Regarding DSH Part C Days Issue***
Blumberg-Ribner 2003 Dual Eligible Days Group
Case No. 08-2013G

Dear Mr. Blumberg and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 23, 2016 request for Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days for the Blumberg Ribner 2003 Group.

Background:

On **May 27, 2008**, the Board received the group appeal request. The issue statement in the group appeal reads:

> [DSH] Adjustment – The Provider contend that their respective DSH adjustments are understated due to the exclusion from the Medicaid proxy calculation of certain days relating to patients dually eligible for both Medicaid and Medicare. Further, the Providers assert that the HCFA Administrator's decision pertaining to said days in *Edgewater Medical Center v. Blue Cross and Blue Shield/Blue Cross and Blue Shield of Illinois* (June 19, 2000) is inconsistent with applicable Medicare Regulations.

On **December 1, 2009**, the Group representative filed the Providers' preliminary position paper with the Board.[1]

On **December 30, 2015**, the Provider Reimbursement Review Board (the "Board") remanded the group issue of DSH dual eligible days pursuant to CMS Ruling 1498-R, and the appeal was closed.

[1] In accordance with the Board rules in place at the time the Providers filed their preliminary position paper, the Board received the cover page, preliminary documentation list; a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Board Rule 25.3 (July 1, 2009).

Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days Issue

On May 23, 2016, the Board received a letter from Blumberg Ribner requesting Rule 41.1 Reinstatement and Bifurcation of Group Appeal regarding DSH Part C Days issue. The Providers argue that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

The Providers refer to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

The Providers next reference an Affidavit of Isaac Blumberg, a representative of the Providers, who affirms that the Providers' use of the term "dual eligible days" was intended to refer to both Medicare Part A and Medicare Part C days.

Last, the Providers argue that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

> Your hearing request must include an identification and statement of the issue(S) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

The Providers argue that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

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[2] Bifurcation Request Letter at 1 (May 23, 2016).
[3] *Id.* at 2.

Decision of the Board

Board Rule 46.1 (July 1, 2015), in effect at the time the reconsideration request was filed, addresses how the Board handles a Motion for Reinstatement: "[a] Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case . . . if an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the Provider must address whether the CMS ruling permits reinstatement of such issue(s)/case."

> **46.1 – Motion for Reinstatement**
> A Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the Provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will *not* reinstate an issue(s)/case *if the Provider was at fault*. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the Provider *must* address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the Provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rules 46.2 and 46.3 below.[4]

The Board finds that the group appeal request does not encompass the dual eligible Part C days issue. The group appeal request pertains to "certain days" involving dual eligible and then limits "***said*** days" to *Edgewater Medical Center v. Blue Cross and Blue Shield/Blue Cross and Blue Shield of Illinois* (June 19, 2000); however, the *Edgewater* decision addresses the issue of dual eligible Medicare Part A days in DSH, ***not*** Part C days. Accordingly, it is clear that the group does not encompass Part C days and the Providers have not established good cause to reinstate/reopen Case No. 08-2013G.[5]

Regarding the Board's decision in Case No. 08-2624GC, the issue statement in that case is clearly different that that filed in this CIRP group. Moreover, the record of that case is not before the

[4] (Emphasis added.)

[5] This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*, 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022). In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ." *Id*. at 11. The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[5] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal. *Id.* Here, the Board makes the same finding based on similarly overly generalized language.

Board. As such, the Board declines to give it any weight. Similarly, the Affidavit filed with the request for reconsideration pertained to another case and for different group issue statement and, as such, the Board declines to give it any weight in this case. Moreover, the additional independent reasons stated below reinforce the Board's decision to deny the request for reinstatement.

Consistent with 42 C.F.R. § 405.1853(b)(2)-(3) (2009), Board Rule 25 (July 1, 2009), in effect at the time the group appeal filed its position paper, addresses the Content Standards for Position Papers:

Rule 25 – Preliminary Position Papers

COMMENTARY: Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

To address complaints under the previous Rules that the parties have not had sufficient time to develop meaningful position papers, upon publication of these Rules, the Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the Provider, twelve months for the Intermediary and fifteen months for the Provider's response. The Board may modify these timelines as appropriate for the particular matter appealed (e.g. see Rule 50 Children's GME appeals. As the Board and the parties gain more experience with this process, the timeframes may be modified.

25.1 - Content: The text of the Preliminary Position Papers must include the following:

A. Provider's Preliminary Position Paper:

1. for each issue, state the material facts that support your claim.
2. identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position.
3. provide a conclusion applying the material facts to the controlling authorities.

****

25.2 – Preliminary Documents:

> **A. General:** With the preliminary position papers, the parties must exchange all available documentation as preliminary exhibits to fully support your position. . . .
>
> **B. Unavailable and Omitted Preliminary Documents:** If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts you made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.
>
> **C. Preliminary Documentation List:** Parties must attach a list of the exhibits exchanged with the preliminary position paper.
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> **25.3. - Filing Requirements to Board**
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> Parties should only file with the Board 1) the cover page of the preliminary position paper 2) the preliminary documentation list and 3) a statement indicating how a good faith effort to confer was made in accordance with 42 CFR §405.1853. Do not file any other documents with the Board.[6]

In this respect, the commentary to Board Rule 23.3, noted:

> The Regulations [at 42 C.F.R. § 405.1853(b)] and these Rules impose preliminary position paper requirements that are more stringent than in the past. *Full development of the parties' position* fosters efficient use of the administrative review process and due process. The due dates have been extended to give the parties a better opportunity to develop their case. Because the date for adding issues will have expired and transfers are severely limited, *the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position*. **CAUTION: Unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the documents), new arguments and documents not included in your preliminary position paper may be excluded at hearing.**[7]

[6] (Underline emphasis added and all other emphasis in original.)
[7] (Italics and underline emphasis added and bold emphasis in original.)

Therefore, had the Providers intended to appeal the Part C days issue as part of this appeal, that issue would have needed to be included in the Providers' preliminary position paper, and there is no indication that the Providers did brief the issue. The Provider did not include a complete copy of the preliminary position paper with its request for reinstatement to document its briefing and pursuit of the Part C days issue. Thus, to the extent it was ever part of this appeal, the Board presumes it was not briefed and abandoned, particularly since a group may contain only a single issue.

Indeed, Board Alert 7 issued on May 25, 2010 directed providers with appeals that included both an issue subject to 1498-R and another issue(s) not subject to 1498-R to ensure the position paper briefed the issues *not subject to 1498-R*:

> On or before the position paper deadline:
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> (1) Submit a letter to the Board and Intermediary
>
> • identifying those issue(s) in your case that are governed by CMS-1498-R and therefore will not be briefed, and
>
> • to assist the Board in prioritizing, we would appreciate your advising us which remand procedure you prefer.
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> (2) Brief the remaining issues, if any, in accordance with the Board's rules. If in doubt about whether your issue is governed by the Ruling, brief it and include your position as to why it is or is not covered.
>
> At least 30 days prior to the hearing date: Advise the Board and Intermediary in writing of issues or cases that will not require a hearing because they are governed by the Ruling. If you have not already received or requested a remand for the issues governed by the Ruling, state which remand procedure you select.

The Board also notes that the Providers did not include a separate amount in controversy for the Part C days issue in the ***final*** schedule of Providers, which was submitted to the Board on July 15, 2010. 42 C.F.R. § 405.1839(b)(2) explains that providers cannot aggregate claims in order to meet amount in controversy requirements:

> (2) *Aggregation of claims.* (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

> (B) The single issue that is common to each provider may exist over different cost reporting periods.

The regulation is clear that a group appeal can only include one single common issue, which in this case was the dual eligible Part A issue. The Providers did not include a calculation for the Part C days issue with the final Schedule of Providers, therefore the Board finds that the issue was not included in this group appeal and evidence that the group would meet the $50,000 amount in controversy requirement for the *alleged* DSH Part C issue.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopn and rinstate Case No. 08-2013G and thus **denies** the request for Rule 41.1 Reinstatement and Bifurcation.[8] Case No. 08-2013G remains closed.

Board Members Participating:

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

For the Board:

9/30/2024

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[8] *See supra* note 5.