CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
The Mary Imogene Bassett Hospital	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 2007-2012**
Provider	
vs.	
National Government Services, Inc.	**Review of: PRRB Dec. No. 2018-D25 Dated: February 27, 2018**
Medicare Administrative Contractor	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). CMS' Center for Medicare (CM) and the Medicare Administrative Contractor (MAC) submitted comments, requesting reversal of the Board's decision. The Provider requested that the Administrator not review the Board decision. The parties were notified of the Administrator's intention to review the Board's decision. Comments were subsequently received from the Provider requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether, the Provider, as a Sole Community Hospital (SCH), was properly reimbursed for Indirect Medical Education (IME) costs for services provided to Medicare Advantage (MA or Part C) patients for the cost reporting periods in dispute. In particular, the issue was whether the interim IME payments received for MA patients, as reported on the Provider Statistical Reimbursement (PS&R) Report 118, should be included in the total interim payments on Worksheet E-1 when determining the final settlement amounts owed to the Provider when paid under the Hospital Specific Rate (HSR) methodology.

The Board held that the MAC's disallowance of interim IME payments for MA patients on Worksheet E-1 of the Medicare cost report for the purpose of determining the final settlement

amounts owed to the Provider was improper. The Board concluded that the MAC failed to pay the Provider for IME payments related to services provided to Part C patients. The Board remanded the matter to the MAC to pay the Provider for IME payments related to its Part C services by either removing the Part C IME payments reported on the PS&R Report 118 from the interim payments on Worksheet E-1, or by adding the Part C IME payments to the hospital-specific rate (HSR) calculation. In reaching this determination the Board agreed with the Provider that the statute and regulations in effect during the cost report years under appeal entitled section 1886(d) Hospitals, including SCHs, to IME payments for Medicare Part C patients. The Board found that the Federal fiscal year (FFY) 2015 Inpatient Prospective payment (IPPS) Final Rule, dated August 22, 2014, simply established the methodology to calculate IME for Part C services for SCHs paid by the HSR in order to correct the previous erroneous cost report instructions which did not comport with the statute.

SUMMARY OF COMMENTS

The CM submitted comments requesting that the Administrator reverse the Board's decision and affirm that, for the cost reporting periods ending 2007 through 2012 under appeal, the MAC properly excluded Part C IME payments from the Provider's HSR. The CM disagreed with the Board's conclusion that the statute and regulations in effect during the cost report years under appeal allowed a SCH, such as the Provider, to be paid IME for its Part C patients even when the SCH was paid based on the HSR. The CM strongly disagreed with the Board that the FFY 2015 IPPS Final rule simply established the methodology to calculate IME for Part C services for SCHs paid by the HSR. The fiscal year 2015 IPPS proposed and final rule clearly state that CMS made a prospective change in policy, effective for discharges occurring in cost reporting periods beginning on or after October 1 2014. There is no indication anywhere in the preamble, regulations, or cost reporting instructions that CMS was making clarification in policy which would apply retroactively.

The MAC submitted comments requesting that the Administrator reverse the Board decision. The MAC's position was that it followed the precise steps specified in the regulations and reimbursed the Provider at the highest level of the five reimbursement methods allowed, which in this case was the HSR was based upon the 1982 base period.

In initial filings, requesting that the Administrator not review the Board Decision, the Provider stated that the MAC is quite clear that its actions denying the Hospital any IME reimbursement for Part C patients was grounded in the cost reporting instructions., The MAC concedes that the Hospital did not receive and retain any IME reimbursement for Part C patients - that is the whole case, right there. CMS policy, even if one was actually adopted, cannot override the statute.

The Provider also argued that the Director Memorandum, which states that "In the case of Medicare Part C patients, historically, there was no component of the HSR that already accounts for the additional costs for their Medicare Part C patients, and there was historically no payment mechanism for SCH is paid based on their hospital specific rate to receive the IME add-on payment for Medicare Pap: C patients." That statement is correct and explains why the Hospital appealed, since the absence of such a mechanism violated the Balanced Budget Act of 1997.

Notably the Director Memorandum does not point to any Federal Register publication or other material to show that this historic practice was the result of a conscious, well thought-out decision rather than simply a mistake due to the complexity of the issue and the extremely limited impact. Even more notably, the Director Memorandum, like the MAC Request, makes no effort to show that the historic "policy," if it even be a policy complied with the very clear mandate of the Balanced Budget Act. The Provider also stated that the issue decided by the PRRB raises no larger concerns with respect to precedent or policy as the Hospital is one of only a handful of SCHs in the country which are also teaching hospitals, and, as among those, it is one of the very few, if any, that is paid for Medicare Part A on a hospital specific rate (base year trended forward).

In its subsequent comments, the Provider pointed to the hierarchy of legal authority which illustrates the divide between the Hospital and the Board on one hand, and the MAC and CMS staff on the other side. The Hospital's view, with which the Board agreed, is that the statute controls if it is on point, that the regulations are the next place to look, and more inferior sources of authority, e.g., manuals, worksheets, instructions etc. cannot override legislation, or validly adopted regulations. See National Medical Enterprises v. Bowen, 851 F.2d 291, 292 (9th Cir. 1988) ("The Manual is a guide for intermediaries in applying the Medicare statute and reimbursement regulations and does not have the binding effect of law or regulation"}. Moreover, the court noted that Part II of the Provider Reimbursement Manual "" which is the portion relied upon by the MAC here-" is "only an instruction form [which] requires no particular deference ... " Id. The Balanced Budget Act of 1997 could not be clearer that all "subsection (d)" hospitals are entitled to an increment to their reimbursement to compensate them for IME and that such entitlement extends to the portion of IME allocable to MA or Part C patients. The provider contended that neither the MAC, nor CMS staff, have explained how the original outcome at final settlement complied with the legislation, for the simple reason that it did not.

The next highest source of law in the hierarchy of authority are regulations promulgated c-0nsistent with the Administrative Procedure Act. There is a regulation on point, at 42 C.F.R. §412.l05(g). It, too, mandates IME reimbursement for MA patients. The MAC, in its position paper, cited a different regulation, at 42 C.F.R. § 412.92, dealing with SCHs. The MAC noted that SCHs are paid for Part A patients at the highest of five different potential reimbursement rates, and that in the case of the Hospital the highest such rate was "the hospital specific rate determined under 42 C.F.R. § 412.73", i.e., 1982 base year trended forward. What the MAC did in substance, however, did not comply with that regulation. Instead, the MAC determined the Hospital's Part A reimbursement by (a) "the hospital-specific rate as determined under§ 412.73" minus (b) the interim IME payments the Hospital had received for Part C patients. There is nothing in the regulation relied upon by the MAC which authorized this subtraction liability it was reducing was for Part A inpatient services, but the previous payments by which it reduced such liability included a slice of IME payments for Part C patients. None of this is disputed, and the Stipulations trace through in granular detail the intersection of the calculation of Part A reimbursement with Part C payments, with specific, line item references to the cost report worksheets. The Stipulations confirm that the MAC reduced the Hospital's Part A reimbursement entitled by the interim IME Part C payments, based on the MAC's application of the cost reporting instructions. The Provider stated that the cost reporting instructions, however,

were not enacted by Congress, nor were they promulgated in a formal rulemaking under the Administrative Procedure Act. Consequently, the instructions represent the lowest form of authority, and must yield when, as is the case here, higher forms of authority are explicitly on point. National Medical Enterprises v. Bowen, 851 F.2d 291. No one, not the MAC, CMS staff, the Hospital, or the Board have identified any formal rule-making process supporting the cost reporting instructions, in particular the aspect that results in IME Part C reimbursement payments being forfeited by crediting them against Part A obligations. Rather, the Provider stated that the only material anyone has identified is a pair of excerpts from Federal Register in 2014. The Federal Register passage from May 15~ 2014 at 28092 and 28363-6414 acknowledges there was no express payment mechanism for SCHs, which are paid based on their hospital specific rate to receive the IME add-on for Part C patients:

The Provider stated that, while the *Federal Register* announcement stated that prospectively an add-on would be paid for Part C patients where a SCH receives a hospital specific rate, it was completely silent as to whether prior practice (which the MAC followed) complied with controlling legislation. It is emphatically not the case that prior to 2014 there was any carefully thought-out regulatory activity consistent with the Administrative Procedure Act that justified no IME reimbursement in respect of Part C patients where a SCH was receiving a hospital specific rate. The proposed conclusion of the MAC and CMS staff is that program instructions override legislation, but no one has offered an explanation of how doing so is anything other than an outright violation of law. Such a conclusion is not entitled to any deference. *See Chevron U.S.A. v. N.R.D.C.*, 467 U.S. 837, 843~44 (1984). The proposed conclusion is further flawed because there was no administrative analysis published contemporaneously with the worksheet instructions on which ·the MAC relies. *See Council v. Urological Interests v. Burwell*, 790 F.3d 212, 222 {D.C. Cir. 2015). Post hoc analysis and interpretation are not entitled to deference.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Pursuant to the Social Security Amendments of 1983,[1] Congress established the inpatient prospective payment system (IPPS) for inpatient operating costs (PPS) as reflected in section 1886(d) of the Social Security Act. Under IPPS, hospitals receive certain add-on payments such as disproportionate share adjustment and, relevant to this case, the indirect medical education (IME) adjustment under section 1886(d)(5)(B) of the Social Security Act. [2]

[1] Social Security Amendments of 1983, §601, Pub. L. No. 98-21, 97 Stat. 65, 149-163 (1983).

[2] 48 Fed. Reg. 39752 (September 1, 1983 ((“5. Indirect Medical Education - Section 1886(d)(5)(B) of the Act provides for additional payments to be made to hospitals under the prospective payment system for the indirect costs of medical education. This payment is computed in the same manner as the indirect teaching adjustment under the notice of hospital cost limits published September 30, 1982 (47 FR 43310), except that the educational adjustment factor is to equal twice the factor computed under that method…..

Section 1886(d)(11) of the Act provides for an additional amount to a subsection (d) teaching hospital that has an approved teaching training program for each applicable discharge of any individual who is enrolled under Medicare managed care under Part C. In particular, section 1886(d)(11) of the Act states:

> ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—
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> (A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.
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> (B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term "applicable discharge" means the discharge of any individual who is enrolled under a risk–sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare+Choice organization under part C.
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> (C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

Further, section 1886(d)(5)(D) of the Act specifies payment for hospitals that meet the criteria for a sole community hospitals. Under section 1886(d)(5)(D), SCHs are paid based on their hospital specific rate from a specified base year or the IPPS Federal rate, whichever yields the highest aggregate payment for hospitals cost reporting period. Specifically, section 1886(d)(5)(D) states that:

> For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—
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> (I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(C), or
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> (II) the amount determined under paragraph (1)(A)(iii), whichever results in greater payment to the hospital.

Regarding the hospital specific rate to be paid to a SCH, section 1886(b)(3)(C) explains:

The teaching adjustment *does not apply to any hospital not paid under the prospective payment system*, such as those hospitals or distinct part psychiatric and rehabilitation units that are paid on a reasonable cost basis, since the payments to those facilities already include the indirect costs of medical education.")

> (C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), subject to subparagraphs (I) and (L) the term "target amount" means—
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> (i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—
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> (I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—
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> (II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period,
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> ***
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> (iv) with respect to discharges occurring in fiscal year 1995 and each subsequent fiscal year, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).
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> There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.[3]

These various provisions are set forth in the regulations at 42 CFR Part 412. The scope of 42 CFR Part 412 as explained at 42 CFR § 412.1,(a)(1), states:

> (a) Purpose.
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> (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis.

In addition, under the IPPS payments, hospitals that incur the indirect costs for graduate medical education programs are paid pursuant to 42 CFR 412.105:

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[3] *See also* section 1886(d)(3)(I) of the Act.

> § 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.
> CMS makes an additional payment to hospitals for indirect medical education costs using the following procedures:
> (a) Basic data. CMS determines the following for each hospital:
> (1) The hospital's ratio of full-time equivalent residents (except as limited under paragraph (f) of this section) to the number of beds (as determined under paragraph (b) of this section).
> ***
> (2) The hospital's DRG revenue for inpatient operating costs based on DRG–adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made under the provisions of § 412.106.

Further, section 1886(d)(11) was implemented pursuant to final notice and comment rulemaking at 62 Fed. Reg.45966 (August 29, 1997),[4] by adding a new paragraph (g) to §412.105 to implement this provision: stating that:

> g) Indirect medical education payment for managed care enrollees. For portions of cost reporting periods occurring on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare+Choice organization under title XVIII, Part C of the Act during the period, according to the applicable payment percentages described in §§ 413.76(c)(1) through (c)(5) of this subchapter.

The general rules for SCHs are set forth at 42 CFR § 412.90 and state that:

> (a) Sole community hospitals. CMS may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel

[4] 62 Fed. Reg.45966 (August 29, 1997) (Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates) ("Section 4622 of Public Law 105-33 added a new section 1886(d)(11) to the Act to provide for IME payments to teaching hospitals for discharges associated with Medicare managed care beneficiaries for portions of cost reporting periods occurring on or after January 1, 1998. The additional payment is equal to an "applicable percentage" of the estimated average per discharge amount that would have been made for that discharge if the beneficiary were not enrolled in managed care. The applicable percentage is set forth in section 1886(h)(3)(D)(ii) of the Act and is equal to 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and subsequent years. We are adding a new paragraph (g) to §412.105 to implement this provision.")

> conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under § 412.92(a), its prospective payment rates for inpatient operating costs are determined under § 412.92(d).

Regarding the payment for SCHs, 42 CFR 412.92(d) states that:

> (d) Determining prospective payment rates for inpatient operating costs for sole community hospitals -
> (1) General rule. For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:
> (i) The Federal payment rate applicable to the hospitals as determined under subpart D of this part.
> (ii) The hospital-specific rate as determined under § 412.73.
> (iii) The hospital-specific rate as determined under § 412.75.
> (iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under § 412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section).
> (v) For cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate as determined under § 412.78.[5]

Notably, 42 CFR 412.73, 412.75. 412.77 and 412.78, do not provide for an IME payment with respect to the HSR methodology.consistent with the general prescription that the IME adjustment is an IPPS payment.

For the cost years at issue, section 3601.1 Provider Reimbursement Manual (PRM) 15-2 or PRM-15-2 section 4030 for worksheet E Part A applied. Historically, when payments to SCHs are based on the HSR[6] they do not include IME add-on payments[7] The Secretary, after further

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[5] For a more detailed discussion of the original calculation of the FY 1982 hospital-specific rate and the FY 1987 hospital-specific rate, see the September 1, 1983 interim final rule (48 Fed. Reg. 39772); the April 20, 1990 final rule with comment (55 Fed. Reg. 15150); and the September 4, 1990 final rule (55 Fed. Reg. 35994).

[6] *See* 79 Fed. Reg. 27978, 28092-28093 (May 15, 2014); *See also* 79 Fed. Reg. 49853, 50002-50004 (Aug. 22, 2014).

[7] *See* 79 Fed. Reg. 27978, 28092-28093 (2014); *See also, e.g.,* 62 FR 45966, 46122 (Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates) (August 29, 1997) ("Because hospitals receiving their hospital-specific rate do not receive outliers, IME, or DSH, they are unaffected by the policy changes related to these additional payments."); 73 FR 48434, *48630*- (August 19, 2008)(Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates) ("For each cost reporting period, the fiscal intermediary/MAC determines which of the payment options will yield the highest aggregate payment. Interim payments are automatically made at the highest rate

review of the language in §1886(d)(11) of the Act and effective for discharges on or after October 1, 2014, proposed to provide all teaching SCHs an IME add-on payment for discharges of Medicare Part C patients, regardless of whether the SCH is paid under the Federal rate or HSR. The Secretary determined that the language at section 1886(d)(11) of the Act, did not directly address the matter and, likewise, did not prohibit the inclusion of this payment in the HSR for SCH. The Secretary stated:

> Under CMS' current payment system, both the IME add-on payment for Medicare Part A patients discharges under section 1886(d)(5)(B) of the Act and the IME add-on payment for Medicare Part C patient discharges under section 1886(d)(11) of the Act are included as part of the Federal rate payment, whereas neither of these add-on payments are included as part of the hospital-specific rate payment. We note that SCH that are paid based on their hospital-specific rate do not receive an IME add-on payment for Medicare Part A patient discharges because, generally, the hospital-specific rate already reflects the additional costs that a teaching hospital incurs for its Medicare Part A patients, but they also do not receive the IME add-on payment for Medicare Part C patients discharges under section 1886(d)(11) of the Act. Therefore, in the case of Medicare Part C patients, there is no component of the hospital-specific rate that already accounts for the their Medicare Part C patients, and there is currently no payment mechanism for SCHs paid based on their hospital-specific rate to receive the IME add-on payment for Medicare Part C patients.
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> For the reasons specified below, effective for discharges occurring in cost reporting periods beginning on or after October 1, 2014, we are proposing: (1) to provide all SCHs that are subsection (d) teaching hospitals IME add-on payments for applicable discharges of Medicare Part C patients in accordance with section 1886(d)(11) of the Act, regardless of whether the SCH is paid based on the Federal rate or its hospital-specific rate; and (2) that, for purposes of the comparison of payments based on the Federal rate and payments based on the hospital-specific rate under section 1886(d)(5)(D) of the Act, IME payments under section 1886(d)(11) of the Act for Medicare Part C patients will no longer be included as part of the Federal rate payment. After the higher of the Federal rate payment amount or the hospital-specific rate payment amount is determined,

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using the best data available at the time the fiscal intermediary/MAC makes the determination. However, it may not be possible for the fiscal intermediary/MAC to determine in advance precisely which of the rates will yield the highest aggregate payment by year's end. *In many instances, it is not possible to forecast the outlier payments, or the amount of the DSH adjustment or the IME adjustment, all of which are applicable only to payments based on the Federal rate and not to payments based on the hospital-specific rate.* The fiscal intermediary/MAC makes a final adjustment at the close of the cost reporting period after it determines precisely which of the payment rates would yield the highest aggregate payment to the hospital.")

> any IME add-on payments would be added to that payment for purposes of determining the hospital's total payment amount.
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> As noted above, under section 1886(d)(5)(D) of the Act, SCHs are paid based on their hospital-specific rate or the IPPS Federal rate, whichever yields the higher payment for the hospital's cost reporting period. For each cost reporting period, the MAC determines which of the payment options will yield the higher aggregate payment. Interim payments are automatically made on a claim-by-claim basis at the higher rate using the best data available at the time the MAC makes the payment determination for each discharge. However, it may not be possible for the MAC to determine in advance precisely which of the rates will yield the higher aggregate payment by year's end. In many cases, it is not possible to forecast outlier payments or the final amount of the DSH payment adjustment or the IME adjustment until cost report settlement. As noted above, these adjustments amounts are applicable only to payments based on the Federal rate and not to payments based on the hospital-specific rate. The MAC makes a final adjustment at cost report settlement after it determines precisely which of the two payment rates would yield the higher aggregate payment to the hospital for its cost reporting period. This payment methodology makes SCHs unique because SCH payments can change on a yearly basis from payments based on the hospital-specific rate to payments based on the Federal rate, or vice versa.[8]

In this case, the Provider argued that it should have received IME payments for its services rendered to the Medicare Part C patients pursuant to the language of section 1886(d)(11) of the Act. The Provider also argued and pointed to legal authority that the PRM Instructions could not override the statutorily mandated IME payment to subsection 1886(d) hospitals required of section 1886(d)(11) of the Act. The MAC's position, supported by CM, was that the CMS regulations and cost reporting instructions in effect during the cost reporting periods .under appeal did not allow for payment of Part C IME when the provider is paid based on the HSR.

Applying the foregoing provisions to the facts of this case, the Administrator finds that the MAC reimbursed the Provider utilizing the proper methodology for the cost reporting periods in dispute. As a SCH, the Provider was properly reimbursed, consistent with the controlling authority, on Worksheet E Part A at the higher of either the Federal rate or the HSR (without the IPPS add-on payments.) The Administrator disagrees with the Board determination that "the August 22, 2014 Final Rule simply established the methodology to calculate IME for Part C services for SCHs paid by the HSR, in order to correct the previous erroneous cost report instructions which did not comport with the statute." The Administrator finds that the FY 2015 IPPS proposed and final rule stated explicitly that the Secretary was implementing a prospective change in policy, effective for discharges occurring in cost reporting periods beginning on or after October 1, 2014, after further consideration, of the language at §1886(d)(11). There is no indication in the preamble, regulations, or cost reporting instructions that CMS was making a clarification in policy which would be applied retroactively.

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[8] *Id.*

Further, the prospective implementation is not inconsistent with the statute. The Provider states that the language of section 1886(d)(11) required the payment of IME related to MA/Part C managed care patients when a SCH is paid under the HSR methodology for the cost years at issue. The Provider argues that section 1886(d)(11) plainly indicates such payments for a section 1886(d) hospitals and the Provider is a section 1886(d) hospital, even though it was paid under the section 1886(b) HSR methodology, and cites to case law to support that the PRM cannot override the statutorily mandated payment.

However, while section 1886(d)(11) is instructive as to the payment under the section 1886(d) Federal rate payment determination, it is silent as to including a IME payment for a SCH HSR paid under the section 1886(b) methodology. The silence is relevant when viewed in the context of Congresses' specific statutory direction and instruction as to method of paying sole community hospitals under section 1886(d((5)(i), which incorporated the section 1886(b)(3)(C) non-IPPS HSR methodology and also the section 1886(b)(3)(I) non-IPPS HSR methodology.[9] In

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[9] For a review of the various changes to the HSR base year, s*ee* 74 Fed. Reg. 24080 (May 22, 2009)(Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates) ("Section 1886(b)(3)(I) of the Act (as added by section 405 of Pub. L. 106-113 (BBRA 1999) and further amended by section 213 of Public Law 106-554 (BIPA 2000)) contains a provision for SCHs to rebase their hospital-specific rate using the hospital's FY 1996 cost per discharge data. Specifically, beginning in FY 2001, SCHs can use their allowable FY 1996 operating costs for inpatient hospital services as the basis for their hospital-specific rate rather than only their FY 1982 or FY 1987 costs, if using FY 1996 costs would result in higher payments. Effective for cost reporting periods beginning on or after January 1, 2009, SCHs will be paid based on their hospital-specific rate using FY 2006 costs, if this rate yields higher payments (as provided for under section 122 of Pub. L. 110-275 (MIPPA 2008)). For the reasons explained above, the instructions for implementing both the FY 1996 and FY 2006 SCH rebasing provisions direct the fiscal intermediary or MAC to apply cumulative budget neutrality adjustment factors to account for DRG changes since FY 1993 in determining an SCH's hospital-specific rate based on either FY 1996 or FY 2006 cost data. (The FY 1996 SCH rebasing provision was implemented in Transmittal A-00-66 (Change Request 1331) dated September 18, 2000, and the FY 2006 SCH rebasing provision was implemented in a Joint Signature Memorandum (JSM/TDL-09052), dated November 17, 2008.)");

See also, 73 Fed. Reg. 48434, 48628 (August 19, 2008) (Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates)(For SCHs, effective with hospital cost reporting periods beginning on or after October 1, 2000, and before January 1, 2009, section 1886(d)(5)(D)(i) of the Act (as amended by section 6003(e) of Pub. L. 101-239) and section 1886(b)(3)(I) of the Act (as added by section 405 of Pub. L. 106-113 and further amended by section 213 of Pub. L. 106-554) provide that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period: • The Federal rate applicable to the hospital; • The updated hospital-specific rate based on FY 1982 costs per discharge; • The updated hospital-specific rate based on FY 1987 costs per discharge; or • The updated hospital-specific rate based on FY 1996 costs per

addition, CMS has repeatedly stated in notice and comment rulemaking that no IPPS add-ons were included in the HSR calculations throughout the time period prior to the 2015 effective change in methodology. It is reasonable to conclude that Congress was aware of CMS' pre-2015 stated policy when it repeatedly revisited the HSR methodology at section 1886(b) after the addition of section 1886(d)(11) and continued to remain silent as to the addition of the IME related managed care add-on under the HSR methodology. Thus, the Secretary reasonably concluded that the language at section 1886(d)(11) did not directly address the matter, but also did not prohibit going forward with the policy of allowing the inclusion of this payment in the HSRs for SCHs prospectively.

The MAC utilized the 1982 HSR that was based upon the Federal fiscal year 1982 and multiplied the updated 1982 rate by the DRG weight from the Provider's PS&R, which is consistent with 42 C.F.R. §412.92. As the Provider was reimbursed solely on the HSR consistent with the rules in

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discharge. For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 were based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate. For discharges during FY 2004 and subsequent fiscal years, payments based on the FY 1996 hospital-specific rate are based on 100 percent of the updated FY 1996 hospital-specific rate…. As discussed in detail in section IV.D.2. of this preamble, the recently enacted Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-275), contains a provision under section 122 that changes the provisions for rebasing the payments for SCHs, effective for cost reporting periods beginning on or after January 1, 2009.");

See also, 55 Fed Reg. 35990, 345855 (September 4, 1990)(Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1991 Rates)("Prior to enactment of Public Law 101-239, section 1886(d)(5)(C)(ii) of the Act provided that SCHs be paid a blended rate based on 75 percent of the hospital-specific rate and 25 percent of the Federal regional rate. ….Section 6003(e) (1) and (2) of Public Law 101-239, which amended section 1886(d)(5) of the Act, revised both the qualifying criteria and payment methodology for SCHs. … Section 6003(e) of Public Law 101-239 also revised the payment methodology for hospitals classified as SCHs effective with cost reporting periods beginning on or after April 1, 1990. As of that date, as provided in section 1886(d)(5)(D)(i) of the Act, SCHs will be paid based on whichever of the following rates yields the greatest aggregate payment for the cost reporting period: the Federal national rate applicable to the hospital, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge.")

See 52 Fed. Reg. 22080, 22091 (June 10, 1987) (Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1988 Rates)("Section 1886(d)(5)(C)(ii) of the Act requires that the special needs of sole community hospitals (SCHs) be taken into account under the prospective payment system. The statute specifies a special payment formula for hospitals so classified….")

effect for the cost year involved, any payments made during the year to the Provider for Part C IME cost were required to be recouped at final settlement.

In sum, when the record and law is reviewed, the Administrator finds that the MAC properly excluded Part C IME payments from the Provider's HSR for the cost years involved in this case.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 4/26/2018

/s/

Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services