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|  | Whether the federal standardized amount(s) (“Standardized Amount”) established under the Medicare Inpatient Prospective Payment System (IPPS) for federal fiscal year (“FFY”) 1983 is improper and whether the 1983 error reduces the FFY 2022 Standardized Amount. |

**A**. **Facts**

1. **Introduction**

The Providers included in this group appealed from the publication of the standardized rate for FFY 2022 on August 13, 2021. In this group case, the Providers contend that the standardized payment amounts were calculated improperly and set too low based on erroneous methodology. Specifically, the Providers contend that the base year 1981 data used to establish the Standardized Payment Rates for Hospitals’ PPS payments did not distinguish between patient discharges and patient transfers. According to the Group, on page 1 of its Preliminary Position Paper,

The error CMS made in 1983 described herein reduces the Standardized Amount used to settle the Providers’ cost reports for the fiscal years under appeal herein and will reduce the Standardized Amount used in all subsequent fiscal years until this challenge is resolved. The Standardized Amount CMS calculated for the fiscal years under appeal herein contain an approximately negative 0.9% due to CMS’ failure to remove transfer cases from its initial calculation of the Standardized Amount in 1983, an error that continues to this day.

The Decision of the D.C. Circuit Court in *St. Francis Medical Center et al. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) (*i.e.*, *St. Francis)* led to a flood of PRRB Appeals challenging the accuracy of the Inpatient Prospective Payment System (IPPS) Standardized Rate. In this case, the Providers argue that the IPPS rate was incorrectly understated when it was implemented in FFY 1984, and it can and should be corrected in the current FY. The *St. Francis* case dealt with a jurisdictional issue and did not reach the merits of the disputed issue, but it plays a key role in understanding the controversy.

The Group’s Preliminary Position Paper, page 9, states the issue as follows:

Whether, for the fiscal years under appeal, the Standardized Amount used to calculate Providers’ PPS Payments was understated, due to CMS’ failure to remove transfer cases from its discharge data, thereby decreasing the Standardized Amount in violation of the Medicare Act and the Administrative Procedure Act.

The issue statement is slanted in favor of the Group. It assumes a failure regarding transfer cases. Whether the actions involving the presence of transfer cases in the initial rate setting violated any law is the significant question raised in this dispute.

The standardized rates for FFY 2022 were published in the FFY 2022 IPPS Final Rules at 86 FR 45544 45570-45571 (August 13, 2021). Reference **Exhibits C-2.** The initial standardized rate was published at 48 FR 39763 (September 1, 1983). Reference **Exhibit C-3**. The complaint is that those rates should have been higher because of an error made some 35 years earlier, that resulted in the initial rate being understated by an alleged 0.9% (*i.e.*, one tenth of one percent) and that error persisted in the standardized rate through the FFY 2022. The purported back up falls far short of establishing the legitimacy of the argument.

As two preliminary notes, which need to be appropriately referenced in the following narrative, the agency responsible for implementing IPPS was the Health Care Financing Agency (HCFA) and the agency changed to the Centers for Medicare and Medicaid Services (CMS) in 2001. Next, the IPPS regulations were re-designated and modified to reflect the change.

1. **Medicare Administrative Contractor Overview Response**

The Group’s claim for additional reimbursement for FFY 2022 is built on a house of cards with a flawed foundation; the foundation being that the standardized amount was understated when it was first calculated based on 1981 data and used in part in the implementation of IPPS, starting in 1984. When the development of the standardized rate is evaluated in relation to law, regulation and rulemaking, it will be clear that the standardized amount was properly established *ab initio*. The methodology for calculating the Standardized Amount was publicly vetted. The burden would have been on aggrieved providers then to establish that in the face of all factors, the standardized amount was still wrong. The burden has not shifted to CMS because of the passage of 35 years**.**

In this appeal, the Group isolates one factor in the multiple new payment factors, which were introduced into IPPS and in the establishment of the standardized rate; that is the concept of transfer cases where a continuum of care takes place in two hospitals without a break for a single beneficiary’s course of treatment. The assertion is that the denominator in the calculation of the standardized rate was overstated by the presence of transfer cases. The argument ignores a variety of balancing factors that need to be considered.

1. ***St. Francis* and Its Role in the Appeal**

While the *St. Francis* D.C. Circuit Decision did not address the reimbursement question presented on its merits, its role as a catalyst for this appeal deserves some background discussion. However, in order to understand *St. Francis*, it is necessary to go back and consider the PRRB’s Decision in *Kaiser Foundation Hospitals v. Palmetto GBA/First Coast Service Options*, PRRB Decision 2011-D1 (October 1, 2010), and its eventual outcome, unfavorable to CMS, in *Kaiser Foundation Hospitals v. Sebelius*, 708 F.3d 226 (D.C. Cir. 2013) (*i.e.*, *Kaiser*).

The *Kaiser* reimbursement dispute was over the accuracy of the full-time equivalent (FTE) cap imposed by law (and regulation) for Direct Graduate Medical Education (DGME) for cost reporting periods beginning on or after October 1, 1997.[[1]](#footnote-1) The cost-reporting period for establishing the cap was a “base” period and did not affect Medicare payments in the base period.

When the cap was established for many of the *Kaiser* owned hospitals, a significant number of countable residents were omitted, which understated the cap. This shortfall was not realized by the *Kaiser* hospitals until several years into the cap application, making the cap a “predicate fact”. In the ensuing appeal, the *Kaiser* hospitals and the MAC stipulated to the accuracy of the FTE counts. The appeal proceeded solely on the “predicate fact” legal issue, *i.e.* whether the understated cap count could be corrected in the later years when the cap imposed a payment limit, through a PRRB appeal. The D.C. Circuit rejected the Secretary’s position that the only way a predicate fact could be altered was through a successful appeal or a voluntary reopening within the three-year time frame.

In December 2013, after the *Kaiser* proceedings, the Secretary revised 42 C.F.R. § 405.1885, with the objective to bar predicate fact appeals. When the regulation was changed, a number of appeals raising the current challenge to the standardized rate were filed. The Board summarily dismissed the appeals for lack of jurisdiction based on the revised regulation. Judicial review of the dismissals followed. The *St. Francis* Court overruled the jurisdictional dismissal holding that appeal challenges to predicate facts are not barred. The appeals consolidated into *St. Francis* have been remanded to the PRRB for further proceedings.

Here, the Group still bears the burden of establishing that the standardized rate was understated. A bare recitation of a 35-year-old perceived problem with weak quantification offers no basis for any relief. The *Kaiser* hospitals met their burden of proof through stipulation. The Group here is nowhere close.

1. **Arguments**
2. **Statutory Directive for the Standardized Amount**

The Standardized Amount was and still is the foundation for payments under IPPS. Congress’s directive to the Secretary to develop the amount was stated in very broad terms at § 1886(d)(2) of the Social Security Act:

The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title.

This Congressional directive could not have been broader. The word “average” which underlies the Group’s argument is not used in the law.

The Group ostensibly wants § 1886(d)(2) to be read the same as § 1886(d)(2)(A). However, that subsection refers to the calculation of an individual hospital’s own specific rate (HSR). A hospital’s own rate would be influenced by admissions where the patient had to be transferred to another hospital to complete care or received a transfer to receive care.

The HSR was a temporary component of IPPS. Payments for IPPS discharges were initially based on a blending of its HSR, a regional rate and the national standardized amount at issue. The difference in the law and math covering the development of the standardized amount and the HSR are further covered below.

An intrinsic component of the implementation of IPPS and the establishment of the challenged standardized amount was the “budget neutrality” adjustment. Review of the budget neutrality adjustment is barred by law and regulation. Had hospitals questioned the methodology used to establish the Standardized Amount and had convinced HCFA to adjust the denominator downwards in the calculation and produce a different (higher) standardized amount, the budget neutrality adjustment would have reduced the rate to achieve the budget neutrality goal. See below for further discussion of budget neutrality.

1. **Establishment of the Standardized Amount with the Transfer Policy**

The Interim Final Rule at 48 FR 39763-39764 (**Exhibit C-3**) is the source for the arithmetic argument that the denominator in the determination of the standardized amount included two discharges if a patient was transferred from Hospital A to Hospital B to complete a course of treatment. It followed that both discharges would be in the denominator while the combined costs were included in the numerator without distinction. Therefore, the Group argues there was a fatal flaw made in 1983.

Payments when patients were transferred between what would become IPPS hospitals were described in the interim final rule at 48 FR 39759:

Since the final discharging hospital will generally provide the greatest portion of the patient’s treatment, payment to this hospital will be made at the full prospective payment rate. The transferring hospital, generally providing a limited amount of treatment to the transferred patient, is not entitled to payment at the full prospective payment rate. Therefore, payment to the transferring hospital will be made based on a per diem rate (*i.e.* the prospective payment rate divided by the average length of stay for the specific DRG into which the case falls) and the patient’s length of stay at the transferring hospital. Payment to the transferring hospital may not exceed the full prospective payment rate.

48 FR 39759 (September 1, 1983) at **Exhibit C-3.**

The preamble discusses four examples. The first two will be presented here. In Example 1, a total of $12,000 will be paid to the two hospitals for a DRG valued at $10,000. In Example 2, a total of $22,000 will be paid to the two hospitals for a DRG valued at $12,000.

The simple examples highlight a reality, that the Providers ignore, which is that in using the 1981 data base to calculate the standardized rate, the presence of “transfer” cases (which the Providers complain overstated the denominator) would also have increased costs in the numerator of the calculation. Once IPPS was implemented, a transfer case could even be paid the full DRG if the length of stay equaled the mean length of stay for that DRG. Therefore, the numerator in the calculation of the standardized amount would reflect additional costs resulting from the same patient being treated at two hospitals for the same diagnosis in the pre-IPPS implementation when both admissions would have met the “then” definition of discharges when hospital care at both hospitals ended. This represents the other side of the complaint, *i.e.* that the denominator in the standardized rate determination was overstated. HCFA’s statement, in the interim final rule discussion, would have applied with equal force to the base period used to calculate the standardized amount.

At **Exhibit P-3**, the Providers present a 1993 report by a HCFA researcher, William Buczko, Ph.D., studying transfer cases in 1987. Remember, the Providers assert that the standardized rate is understated by 0.9% and that the Buczko report cites (page two) a 9% incidence of transfers in 1987. If a reader is expected to correlate the 0.9% alleged understatement to the standardized rate to the 9% incidence of transfers three years later, the correlation misses badly. The report at Page 2 also cites to a 25% increase in transfers between 1984 and 1988. If anything, the report supports the lack of error in the development of the standardized rate.

What the report helps establish is the legitimacy of HCFA’s basic considerations in establishing the transfer policy as it relates to the original determination of the standardized rate. First, when a transfer is involved, the duration of care (and cost) will be greater than if care is completed in a single stay. As a rule, the admission to be paid on a per diem basis under the transfer policy will be more for stabilization and the more intense/complex care will be at the receiving hospital. The receiving hospital is typically a teaching hospital, which has a higher cost structure.

When the standardized rate was developed, the objective was to start IPPS with a rate that factored out differences in acuity of care due to the reason for admission, capital costs, difference in compensation structures across hospitals nationwide, and the direct cost of medical education. Ideally, it would be a single rate applicable to all hospitals as a starting point. However, the cost increasing factors associated with the indirect cost of medical education (IME) and the impact of a significant share of low-income patients could not be factored out. Therefore, a reasonable argument could be made that the standardized rate given its objective was overstated in favor of all hospitals. The standardized rate would have a factor associated with DSH. Hospitals which would did not treat a “disproportionate share” of low-income patients would have a piece of the cost in the standardized rate. Hospitals that later experienced DSH both would have a payment added on to the standardized rate.

These points and others will be revisited later in this position paper. The arguments below consider the Group’s allegation that it has reliable evidence of the incidence of transfers in the 1981 data.

1. **Further Discussion of the Transfer Policy**

Under the prospective payment methodology that replaced the reasonable cost reimbursement methodology, there was an obvious need to recognize the fact that there would be circumstances where there would be a medical need to transfer a patient to another hospital without a break in the delivery of inpatient care. A payment method to recognize this new reality had to be developed. Therefore, the transfer policy was created to compensate both hospitals.

The Final Rule was published at 49 FR 243-244 in early January 1984. Reference **Exhibit C-4.**  It read as follows:

A) Discharges and Transfers (§ 405.470(c))[[2]](#footnote-2)

The terms “discharge” and “transfer” are defined, for purposes of the prospective payment system, in § 405.470(c) of the regulations. It was necessary to distinguish between discharges where patients have received complete treatment and discharges where patients are transferred to other institutions for related care. Generally, a patient is considered discharged when the patient:

* Is formally released from the hospital (Release of the patient to another hospital as described in § 405.470(c)(2) of these regulations will not be recognized as a discharge for the purpose of determining payment under the prospective payment system.);
* Dies in the hospital; or
* Is transferred to another hospital or unit that is excluded from the prospective payment system.

Hospitals releasing a patient under circumstances constituting a transfer as defined in § 405.470(c) are paid a per diem amount. The per diem amount is determined by dividing the appropriate prospective payment rate by the geometric mean length-of-stay for the specific DRG into which the case falls.

We received numerous comments involving various aspects of our discharge/transfer policy as presented below.

Two and a half pages of comments followed. On Page 245, one commenter,

…called into question the basis for the transfer policy by stating that the DRG prices themselves already take transfers into consideration. This is because, in the data base, transfers are considered as discharges. (Top of middle column.)

In its response, HCFA addressed the calculation of the standardized amount with the transfer policy.

With respect to the data used in computing prospective payment rates, we recognize that transfers were previously considered as discharges. Under the interim final rule, the transfer of a patient between two hospitals, each of which is subject to the prospective payment system, will not be considered a discharge for the transferring hospital. This type of transfer would have been a discharge under the reasonable cost reimbursement system. However, no data were presented to indicate the actual effect, if any, that this difference between the definitions of discharge under the old and new payment system might have on the DRG rates.

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. This is because patients transferred to another hospital constitute only a small fraction of the total number of discharges. It should also be noted that certain transfers under the prospective payment system will still be considered discharges, namely, transfers between a hospital subject to prospective payment and an excluded hospital. This would reduce even further the already small discrepancy between the definition of discharges under the old system and the definition under the new system.

HCFA’s position that the transfer policy was sound and based on reasonable considerations was clearly set forth in the Final Rule. At page 251 of the Final Rule, the methodology for calculating the standardized amount, that the Group bases its complaint upon, was repeated. Some commenters were concerned about obtaining access to the data and methodologies used in calculating the prospective payment rates. HCFA responded:

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.

The above-cited dialogue at the onset of IPPS can be interpreted as a challenge to the Hospital Industry. That challenge can be stated as follows: “If you see something wrong with our processes including the establishment of the standardized rate, take some initiative and go after the data you think you need and show us why we are wrong and by how much!” There would have been legal obstacles to raising the challenge back in the IPPS implementation, but at least, the alleged problem would have been exposed for a more contemporary analysis.

It is fair to presume that both of the Providers in the Group were in operation when the transition from cost reimbursement to IPPS took place. No evidence has been presented that any of them tried to attack the alleged problem when it first surfaced. Beyond repetition of the basic arithmetic behind calculating the standardized amount, followed by a throwback to CMS to go back 35 years and come up with a better starting standardized amount, nothing has been presented to warrant relief.

This argument had been presented in earlier cases with the same representative in MAC filed preliminary position papers. In the present case, the point was misread as a suggestion that a more contemporary effort should have been made to find worthwhile documentation concerning the alleged 35 years past mishandling of transfer cases.

Specifically, at **Exhibit P-11**, the Group’s counsel requested the “Medicare National Claims History for FFY 1981”. On May 5, 2020, the Freedom of Information Act (FOIA) group responded to the Representative’s request, stating:

After a careful search of the Centers for Medicare & Medicaid Services (CMS) files, *i.e.*, a search reasonably calculated to locate records responsive to your request and employing reasonable standards, we were unable to locate any records responsive to your request.

No one should be surprised that the effort was unsuccessful. The Group has not advanced any argument that CMS and its predecessor HCFA was obligated to retain the “Medicare National Claims History for FFY 1981” forever. This “too little-too late” unsuccessful effort does not support the Group’s basic argument that the standardized rate was understated when first calculated. Lack of diligence in pursuing facts in an appeal based on a complaint about a predicate fact being wrong is simply not an effective argument.

To be clear, the MAC is not attempting to raise the predicate fact argument in disguise. The Providers are free to pursue a decision on the merits or seek expedited judicial review (EJR) under 42 C.F.R. § 405.1842, if the requirements are met. This assumes Board subject matter jurisdiction is present. The MAC’s position is that no basis for relief exists. The inherent difficulties in establishing a mathematical error 35 years past falls on the proponents of the alleged error and not the accused.

In later years, as IPPS evolved, the method of paying the transferring hospital became more complicated. However, a payment based on a per diem concept remained for the transferring hospital and a full DRG payment for the receiving IPPS hospital that discharges that patient is still in effect. (Reference Page 314 of the 1984 Final Rule at **Exhibit C-4** and the transfer payment regulation, 42 C.F.R. § 412.4, as it reads currently, at **Exhibit C-5**.

1. **Capital PPS Implementation**

Effective for FFY 1992, Medicare reimbursement for capital related costs transitioned from an individual hospital’s reasonable cost to a new prospective payment system. At **Exhibit P-10**, the Group references a response to a comment at 56 FR 43386 (August 30, 1991) to support the basic argument that the standardized amount was fatally understated from the first day IPPS was implemented. The entire comment should be considered with the response. See also **Exhibit C-6**.

Comment: Several commenters questioned the treatment of transfers in determining the hospital-specific rate. Some commenters suggested that transfers 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 the full DRG rate. Since some transfers are paid on a per diem basis and other transfers are paid at the full DRG rate amount, either the total inclusion or exclusion of transfers will distort the hospital specific rate unless the costs of all transfer cases are removed from 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 an adjustment to the discharge count used to calculate the hospital specific rate. We constructed from MEDPAR a beneficiary file for each hospital’s base year cost reporting period, and then counted each case as the lower of 1.0 or the result obtained by dividing the length of stay (LOS) for the case by the geometric mean LOS for the DRG. Thus, a full discharge, or transfer case that received the full discharge payment would be counted as a 1.0, while a transfer case that stayed for 2 days in a DRG with a geometric mean length of 5 days would count as 0.4 of a discharge.

Contrary to the Group’s implication**,** “problematic” is not synonymous with “erroneous”.Capital PPS was implemented on a roughly similar basis as IPPS. There was a component that was hospital specific based on a provider’s costs and cases in a base year well after IPPS was implemented in FFY 1990. Then there was a standard rate using national data applicable to all hospitals subject to certain adjustments. The new capital cost payment system would start with a blend of hospital specific and national adjusted rates transitioning over time to a fully prospective period.

The complaint in this appeal is over the standardized rate. The analogy drawn from Capital PPS is to the hospital specific rate. The capital payment HSR, like the IPPS HSR, should be based on the specific hospital’s base period experience and whether a discharge was the end of covered hospital care or an initial transfer to another hospital. The nature of the discharge in the context of quantifying a specific hospital’s average cost would not affect the integrity of its own average. Consider a further discussion using the example at the end of the Capital PPS citation. Instead of the standardized rate being the payment for the beneficiary’s care, 1.4 times the standardized rate was paid with the potential to pay twice the standardized rate.

As noted at 56 FR 43386 (August 30, 1991), the base period for calculating a hospital’s capital HSR was FFY 1990. This was nine years after the data base to calculate the standardized rate and six years into the implementation of IPPS. Again, the Group has offered only a vague token quantification to back up its complaint that the standardized rate was ever wrong. However, it is reasonable to believe that the new system with its transfer policy would have materially influenced admission and discharge practices. The Buczko Report highlighted the 25% increase in transfers between 1984 and 1988. This would neutralize any suggestion that the methodology for implementing capital PPS was a confession by HCFA of a flaw in implementing IPPS. There is nothing in the reference to the calculation of the hospital specific capital cost rate that supports the allegation that the IPPS Standardized Amount was developed contrary to law. The Group confuses issues with setting a go-forward rate applicable at the start to all affected hospitals with the issues involved in setting a rate based on a hospital’s unique experience in a period.

1. **Budget Neutrality**

A critical factor in establishing the standardized amount for use at the start of IPPS in FFY 1984 was the “budget neutrality adjustment.” Consideration of budget neutrality when the standardized amount was finalized for use at the start of IPPS would have defeated any effort to change the rate. The passage of 35 years has not eliminated budget neutrality as the Group’s obstacle.

Budget neutrality is discussed in the interim final rule at 48 FR 39774 (September 1, 1983). For a more detailed discussion of the principal of budget neutrality, refer to Section VIII of the Rule’s addendum at 48 FR 39887. Reference **Exhibit C-3**. The **Overview** describes the budget neutrality adjustment as follows:

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.

The budget neutrality adjustment is a major procedural issue/obstacle for providers to overcome to establish that the asserted “predicate fact” was wrong and to perfect the argument that the FFY 2022 standardized rates are consequently wrong. The Interim Rule Budget Neutrality Adjustment Addendum describes the following additional elements:

B) Assumptions and Data

C) Estimated Payments Per Discharge Under Prior Law (TEFRA Limits)

D) Estimated Payment on a Federal Rate (DRG) Basis

E) Estimated Hospital Specific (HSP) Payment Per discharge

F) Adjustments for Outlier payments

G) Calculation of Budget Neutrality Adjustment Factors

H) Summary—TABLE OF OUTLIER AND BUDGET NEUTRALITY ADJUSTMENT FACTORS-FEDERAL FISCAL YEAR 1984

The budget neutrality adjustment is obviously extremely complex. In accordance with the SSA, complaints about the budget neutrality factor and other elements of IPPS are precluded from judicial and administrative review. Specifically, per Section 1886(d)(7):

There shall be no administrative or judicial review under section 1878 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),

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4), including the selection and revision of codes under paragraph (4)(D);

Subsection (e)(1) is the law regarding budget neutrality. Section 1878, specifically 1878(g)(2), is the PRRB’s enabling legislation. The prohibition on administrative review is incorporated into 42 C.F.R. § 405.1804:

Neither administrative nor judicial review is available for controversies about the following matters:

(a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective payment rates required under section 1886(e)(1) of the Social Security Act.

(b) The establishment of –

(1) Diagnosis related groups (DRGs);

(2) The methodology for the classification of inpatient discharges within the DRGs; or

(3) Appropriate weighting factors that reflect the relative hospital resources used with respect to discharge within each DRG.

Had any provider raised the argument made in this appeal when the standardized amount was first established, it would have had to overcome the bar on challenging the budget neutrality adjustment. The passage of 35 years has not improved the chances of doing so.

Availability of information regarding the budget neutrality adjustment was again addressed in the preamble to the Final Rule at 49 FR 251 (January 3, 1984) (**Exhibit C-4**):

Similarly, we do not agree that it is necessary to afford further opportunity for comment on the adjustment methodologies, such as for the budget neutrality factor. Section VIII of the Addendum to the interim final rule included an explanation of the budget neutrality determination, including descriptions and interpretations of special studies, sufficient to permit replication of the determinations, as noted above. We believe this explanation meets the requirements of section 1886(d)(6) of the Act, which requires that the published notice of methodology, data, and rates include an explanation of any adjustments. We fully expect to be actively involved in dialogue with hospitals and other parties during the implementation of the prospective payment system. Further, we will publish future notices of methodology, data, and rates for public review and comment on an annual basis. Accordingly, we have not offered further opportunity for comment on this rulemaking, as commenters suggested.

To reiterate the Providers’ claim, the standardized amount for IPPS payments in FFY 2022 must be increased because the standardized amount to be used in part in FFY 1984 was wrong. Even before considering budget neutrality, the Providers do not put together arguments to support that basic assertion or starting point.

As the budget neutrality adjustment would have been different, had the standardized amount been set higher, two additional points emerge. The budget neutrality adjustment would have served to downward adjust the perceived higher standardized amount and effectively preserved the rate as first established. As the budget neutrality adjustment was barred from appeal by law and regulation when the standardized amount was first established, a challenge to the rate would have been dismissed from any judicial or administrative proceeding for lack of subject matter jurisdiction.[[3]](#footnote-3)

Whether the budget neutrality adjustment in the initial rate setting forms the basis for an independent motion for jurisdictional subject matter dismissal is under evaluation. While the argument is identified, the primary objective of this position paper is to focus on the forensic arguments.

1. **“*Chevron*”**

The Group refers to *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837 (1984) to support a perceived notion that the calculation of the standardized rate was flawed from the beginning because the rate was established when the difference between a true discharge and a transfer from Hospital A to Hospital B for a continuation of care was not determinable in 1981. It raises *Chevron* as a challenge to the Board to think like a court and ask the question as, “Whether Congress has directly spoken to the question at issue.” The *Chevron* case factually involved a very complicated environmental air pollution control dispute. The matter was decided against *Chevron* when the Court found that the Clean Air Act did not in its precise language support *Chevron’s* argument.

Applying the Providers’ *Chevron* argument to the present problem, the question is to see what Congress said. At SSA Section 1886(d)(2), Congress tasked the Secretary to implement a new Medicare Inpatient Hospital payment system with the following directive:

The Secretary shall determine a national adjusted DRG prospective payment rate, for each hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title.

There was no specific congressional direction as to how the national adjusted rate (*i.e.*, the standardized amount) was to be developed. The law did not contain a directive to determine “a nationally adjusted DRG prospective payment rate for each hospital discharge in fiscal year 1984”based on somepreconceived idea of a discharge**.** The Group’s *Chevron* argument mixes the calculation of the hospital specific rate (HSR) with the Standardized Amount. As discussed earlier, the HSR was part of an IPPS payment in its early years before transition to payments based on the national standardized amount. Per Section 1886(d)(2)(A):

(A) 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.

That is exactly how the HSR was calculated. Allowable (*i.e.*, reasonable costs) from the base period were divided by discharges, as the term was defined for the base period. The Group is trying to apply the method for calculating a hospital’s HSR to be used in the transition with the determination of the standardized rate and is somehow construing § 1886(d)(2) to mandate a recognition that “discharge” will have a different meaning once IPPS is implemented. Congress did not direct the Secretary to consider the need for a transfer policy in IPPS and to use the concept in developing the standardized amount. No such requirement can possibly be divined from the law. Congress did not, in any way, direct the Secretary, with any degree of specificity, on how to develop the standardized amount. In the rulemaking process, both Interim and Final, discussed previously, HCFA was quite clear over the role of the need to separate transfers from final discharges and the factors considered. The Providers gain nothing from the citation to “*Chevron*.” The Group is confusing the difference between a prospective rate and a rate based on a hospital’s own experiences.

1. **Quantification**

The MAC’s counter can be further developed quantitatively. Referring to **Exhibit C-2,** 86 FR 45544 45570-45571 (August 13, 2021), **Exhibit C-3**, 48 FR 39763, (September 1, 1983), and using a simple example, an urban hospital with a wage index greater than 1 and fully compliant with all reporting requirements had a published standardized amount of $6,121.71[[4]](#footnote-4) for FFY 2022. The Group’s case is based on an assertion that the FFY 2022 standardized should have been 0.9% higher or $6,176.81. That follows an implicit argument that the comparable standardized rate at the implementation of IPPS should have been proportionately higher. That rate, following the Providers’ math should have been set at $2,863.45 (1.009 x $2,837.91[[5]](#footnote-5)). Therefore, the Group suggests that an initial $25.54[[6]](#footnote-6) shortfall has grown to $55.10[[7]](#footnote-7) over time. Each group member should have its payment increased per FFY 2022 discharge based on exactly how that differential applies to it.

The theory of the appeal is flawed on both a theoretical and quantified level. The Group seems to believe that the standardized rate set at the outset perfectly reflected a neutral, one-size-fits-all starting point (*i.e.* neutral of wage differences, diagnosis severity, capital costs and direct GME costs), except for the glitch resulting from not accurately reflecting the impact of transfer cases in the rate setting denominator.

That shortsighted argument fails to recognize the complexity and differences between traditional reasonable cost reimbursement and the new prospective payment system. The numerator in the calculation did not factor out the indirect cost of medical education and the presence of a disproportionate share of low-income patients resulting in costs in the numerator that would be supplemented over the standardized rate under IPPS. Following, the Group’s ideal of a perfect average starting standardized rate, it was overstated from the start to its advantage.

Other pre-IPPS claim situations would have also served to inflate the cost in the numerator of the overall data used to set the standardized rate. Consider a Medicare beneficiary who suffered a severe stroke and was admitted for five days to a community hospital for stabilization and then transferred to a larger hospital that had the capability of acute specialized rehab for another 15 days. An element of IPPS was the recognition of a separate cost-based payment for specialized rehab. In that example, for base year data, there would be 20 days of costs in the numerator and two discharges. However, only five days would be IPPS days. Consider the same example, except the entire stay was in the hospital that could provide both the stabilization and rehab care. There would still be 20 days of care in the numerator, but only one discharge with only five days being IPPS days. In summary, the Group complains about a detriment in the rate-setting denominator and ignores material benefits in the numerator.

The implementation of the transfer payment policy serves to neutralize the Group’s complaint. The revisionist history highway travels in two directions. Had the rate been set at the Group’s absolute vision of perfection, it would have been unlikely that the transfer payment methodology would have been needed. The “perfect” rate could have been apportioned based on the relative use of days compared to the ALOS. The transfer policy in place will always pay more than the standardized rate and can be up to double the standardized rate.

In its position paper, the Group continues its pursuit of a more favorable denominator with an assertion that the incidence of short-term hospital to short-term hospital transfers was 2.5%. This assertion was extracted from **Exhibits P-12** and **P-13**, a May 2002 DHHS Survey of hospital discharges from 1979-2000. The Group wants a reader to consider the 2.5% figure to be specifically applicable to 1981. A review of both **Exhibits P-12** and **P-13** will show that the 2.5% transfer rate is the average over the entire 22-year period. However, statements in the *Buczko* report at **Exhibit P-3, page 2,** belie the Group’s effort.

Discharge-level research by the staff of the Prospective Payment Assessment Commission (ProPAC) found that the rate of transfers (transfers per 10,000 live discharges) had increased by about 25 percent from 1984 to 1988 and that the annual rate of increase in transfers was about 9 percent (Prospective Payment Assessment Commission. 1990a). Transfer rates declined with age and were substantially lower for beneficiaries 80 years of age or over than for beneficiaries under 80 years of age.

The next paragraph added information on the incidence of transfers in the critical 1981 year.

Sloan, Morris and Valvona (1988), using Commission on Professional and Hospital Activities (CPHA) data containing discharges from a sample of 467 hospitals for 4 years (1980, 1983, 1984, and 1985), found an increase in transfer rates from 1983 to 1985, but found far less evidence of a trend toward increased transfer rates when data for 1980 were also considered, suggesting that an increase in transfers following PPS may be caused by other factors in addition to the beginning of PPS. Among Medicare patients, transferred cases were in no instance more than 3 percent of total Medicare discharges. Sloan et al. (1988) also found that most of the conditions representing a high volume of transfers involved some type of cardiovascular condition.

If anything, the *Buczko* report comes far closer to supporting HCFA’s position that the incidence of transfers between short-term acute care hospitals was minimal in 1981 and grew exponentially once IPPS was implemented, then rebutting it. Even if a reader were to assign contemporary relevance to a 2.5% incidence of transfers in 1981, other previously cited factors would balance out complaints about transfers and validate the integrity of the standardized rate when set and increased after IPPS was implemented.

The MAC also disagrees with the Group’s application of the “Two midnight” dispute in *Shands Jacksonville Medical Center v. Burwell*, 139 F.Supp.3d 240 (D.D.C. 2015) to the standardized rate controversy. In *Shands,* a very specific measurable deflation of the year’s standardized rate (.02% not 2% as advanced by the Group) was applied because of concern over very short admissions having a distortion of total IPPS payments. (A simple description of a complex problem not developed by the Group). In the disputed standardized rate issue here, there was a broad grant to the Secretary to develop a value where none previously existed.

The *St. Francis* Decision may have opened the door for the Group to launch a contemporary complaint that the standardized rate was set wrong. However, as the merits were not touched on in the Court’s analysis, the Group is not relieved of the impact of actions after the point where a complaint could have been made. Had the complaint here been successfully made when the alleged problem first could have been identified, the transfer policy could have been different. Instead, if the Group is correct, a point not agreed to, significant overpayments were made in each IPPS year. Similar to its *Chevron* argument, the Group throws out accusations that the standardized rate setting process violated the intent of Congress and was otherwise *ultra vires.*The arguments follow the erroneous position that the Group has legitimately established a flaw in the initial rate setting process. Reasonable notice was given, and no remotely contemporaneous complaints were raised. Therefore, no flaw exists.

In its preliminary position paper, the Group mentions standard of review and identified *Pomona Valley Hospital Medical Center v. Azar*, 1:18-cv-02763-ABJ, 2020 WL 5816486 (September 30, 2020), in which the MAC noted that the Court did not afford deference to the PRRB’s interpretation of 42 C.F.R. §§ 413.20(a) and 413.24(c) regarding adequate documentation and adequate proof of the specific patient’s eligibility for Medicare Part A and Social Security Benefits associated with days in the disproportionate share hospital (DSH) calculation. In that case, the Courts remanded to the Department of Health and Human Services for proper adjudication in conformity with the Court’s opinion. The central issue in the instant case is whether DRG rates should have been higher because of an alleged error made 35 years earlier, which could have resulted in the initial rate being understated by an alleged 0.9% that could have persisted in the standardized rate through the Providers’ FYs at issue in this case. The MAC contends the Providers in this case have not established an auditable, documentable quantification of the alleged error or that an error has occurred.

**8.** **Notice and Comment**

The Group states that the inclusion of the transfers in the Standardized Amount were not subjected to Notice and Comment Rulemaking under the Medicare Act, and therefore, *Azar v. Allina Health Services,* 139 S.Ct. 1804 (2019) applies and requires reversal of the adverse adjustments. That argument, while scholarly in its presentation lacks a meaningful foundation.

By ignoring 48 FR 39759-39887 (September 1, 1983) and 49 FR 243-251, 314 (January 3, 1984), as noted in our discussion in Arguments 2 and 3 above, the Provider wants to take advantage of the Supreme Court’s *Allina* Decision. The MAC would question whether *Allina* has any relevance at the Board level as it is bound by regulation, and the MAC’s adjustments are based on its application of facts to regulation. However, a brief discussion of *Allina* will be presented.

The Board and the Provider clearly have familiarity with how the Part C controversy arose in the *Allina* proceedings. Consider the Supreme Court’s summary of the key *Allina* facts:

The case before us arose in 2014. That is when the agency got around to calculating hospital’s Medicare Fractions for fiscal year 2012. When it did so, the agency still wanted to count Part C patients. But it couldn’t rely on the 2004 rule that had been vacated. And it couldn’t rely on the 2013 rule, which bore only prospective effect. The Agency’s solution? It posted on a website a spreadsheet announcing the 2012 Medicare fractions nationwide and noting that the fractions included Part C patients.

Publication of the annual SSI fractions on the website is CMS’s longstanding communication to MACs and hospitals of the fraction to use in the DSH calculation. For 2012, CMS simply included the Part C days in the Fraction it thought correct and advised readers almost in passing. The Court found that approach to be violative of law.

The Part C DSH proxy issue in *Allina* is basically a “yes or no” binary question. The providers in *Allina* wanted “A”. CMS thought “B” was correct. The Court concluded:

We need not, however, go so far as to say that the hospitals interpretation adopted by the court of appeals, is correct in every particular. To affirm the judgment before us, it is enough to say the government’s arguments for reversal fail to withstand scrutiny. Other questions about the statute’s meaning can await other cases.

The pending controversy is at best an “other case”. The set-up of the pending controversy bears no resemblance to *Allina*.

1. **PRRB Decisions 2000-D74 (*Columbia /HCA 1984-1986 Federal Rate/Malpractice Group v. BCBSA/Blue Cross of Florida*) and 2000-D75 (*Tenet 1985-1991 Retroactive Adjustment of DRG Base Rate National Portion Group Appeal v. Mutual of Omaha*).**

These were two substantially identical appeals brought by two large proprietary hospital systems. Although the captions differ slightly, the appeals were argued on the same day (June 4, 1998) with the same counsel on both sides. The issue was identical. See **Exhibits C-7 and C-8**.

Should the federal portion of the prospective payment system (“PPS”) rate be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid method of reimbursing malpractice costs, that is, the 1979 malpractice rule?

In these Decisions, the challenge was brought to the Board through Appeals of the Notices of Program Reimbursement (NPRs), which based payment on the alleged understated federal prospective payment rate. There can be no dispute that “standardized rate” in the pending appeal here and “federal potion of the prospective payment system (PPS)” refers to the same subject. The argument in the appeal here is based on characterizing the challenge as a “predicate fact” raised long after the rate was established. In any legal or factual analysis, the advocate’s position cannot improve through a long period of silence.

The two decisions present a very complex analysis of how the standardized rate was set. It concluded that there was no legal basis for changing the rate. Both decisions give credibility to the Intermediaries’ argument that the required need for maintaining budget neutrality would be violated. The Decisions also reflect the Intermediaries point that Expedited Judicial Review can be considered. However, the Board’s outcome can be considered as “merit” based decisions.

**10. Response to Argument VI(I) on Page 23 of the Provider Preliminary Position Paper**

Section VI(I) of the Providers Preliminary Position paper is captioned “**CMS Should Be Required to Produce Data through Discovery, as the prohibiting regulation was unlawfully implemented”.** The argument is flawed in multiple respects.

First, there is no evidence of an attempt to seek discovery against CMS or HHS on which the arguments presented in the sections are premised. Even if there was some authority for discovery, the Providers have failed to avail themselves of the opportunity. Furthermore, the arguments presented make clear that there are no such regulations that allow discovery. While several regulations were considered, as the Providers own arguments highlights, 42 C.F.R. § 405.1852(e) and 42 C.F.R. § 405.1857 bar either discovery or subpoena. As the Board is bound by the Medicare regulations (42 C.F.R. § 405.1867), it lacks any authority to issue a discovery order or subpoena against CMS or HHS.

The Group appears to argue that if it had “notice” before May 23, 2008, that discovery/subpoena against CMS/HHS would be barred, it would have taken more aggressive action 15 years ago to seek the data complained of as being wrongly withheld. This argument just rings hollow and deserves no consideration.

The section concludes: “**The only entity in possession of the data to quantify the issue is CMS. CMS should not be permitted to hide behind improperly promulgated regulations to avoid producing data.”** There is nothing to support the accusation that any data has been hidden.

In addition, that accusation invites a pragmatic response. At page 20 of its Preliminary Position Paper, Providers state that the MAC argues that they “might easily obtain the required data to prove the understatement”. The verbiage reads as a present or future statement that the data is available if sought.

That is a mischaracterization, as the MAC’s source is a January 3, 1984, response to a comment in the first IPPS Final Rule (49 FR 251). What follows in the Providers’ narrative is a reference to P-11, a May 5, 2020, FOIA response to a January 24, 2020, request stating that no data was found in response to a request for the “**Medicare National Claims History for FFY 1981”.**

The Providers do not demonstrate the math which identifies a 35-year gap between the Federal Register cited and the effort. The Providers offer no support for the argument that a far more timely FOIA request (i.e. closer to January 3rd, 1984) would not have produced a more favorable response. In lieu of any support, the Providers merely assert that a discovery request or subpoena request authorized by some Regulation applicable to the Board, if it been made closer to January of 1984, would have been productive.

While a judicial precedent exists for fixing an “erroneous predicate” fact, the burden is still on the proponent to establish the inaccuracy of the specific predicate fact. The principle does not offer sympathy for failure to challenge the predicate fact with timely action. A 36-year wait to pursue data, counts heavily against the proponent. There is no evidence to support the accusation that CMS is hiding anything.

**C. Conclusion**

The Providers have failed to establish that the standardized amount was understated when first implemented in FFY 1984. It follows that there is no basis to increase the standardized amounts in FFY 2022.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

Laws:

**Law – Title XVIII of the Social Security Act:**

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| Social Security Act 1886(d)(2) |  |
| Social Security Act 1886(d)(7) |  |
| Social Security Act 1878(g)(2) |  |

**Regulations – 42 C.F.R. §:**

|  |  |
| --- | --- |
| 42 C.F.R. § 405.1804 |  |
| 42 C.F.R. § 405.1842 |  |
| 42 C.F.R. § 405.1885 |  |
| 42 C.F.R. § 405.470(c) |  |
| 42 C.F.R. § 412.4 |  |

**Federal Register Notices:**

|  |  |
| --- | --- |
| 48 FR 39759-39887 (September 1, 1983) |  |
| 49 FR 243-251, 314 (January 3, 1984) |  |
| 56 FR 43386-43387 (August 30, 1991) |  |

**Case Law:**

|  |
| --- |
| *St. Francis Medical Center et al. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) |
| *Kaiser Foundations Hospitals v. Palmetto GBA/First Coast Service Options*, PRRB Decision 2011-D1 |
| *Kaiser Foundation Hospitals v. Sebelius*, 708 F.3d 226 (D.C. Cir. 2013) |
| *Shands Jacksonville Medical Center v. Burwell*, 139 F.Supp.3d 240 (D.D.C. 2015) |
| *Columbia/HCA 1984-1986 Federal Rate/Malpractice Group v. BCBSA/Blue Cross of Florida* (PRRB Decision 2000-D74), August 18, 2000 |
| *Tenet 1985-1991 Retroactive Adjustment of DRG Base Rate National Portion Group Appeal v. Mutual of Omaha*  (PRRB Decision 2000-D75), August 18, 2000 |
| *Chevron U.S.A. Inc., v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) |

V. EXHIBITS

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| C-1. | Schedule of Providers |
| C-2. | 86 FR 45544 45570-45571 (August 13, 2021) |
| C-3. | 48 FR 39752-39764, 39774, 39887-39890 (September 1, 1983) |
| C-4. | 49 FR 234-235, 243-251, 314 (January 3, 1984) |
| C-5. | 42 C.F.R. § 412.4 |
| C-6. | 56 FR 43386-43387 (August 30, 1991) |
| C-7. | *Columbia/HCA 1984-1986 Federal Rate/Malpractice Group v. BCBSA/Blue Cross of Florida* (PRRB Decision 2000-D74) |
| C-8. | *Tenet 1985-1991 Retroactive Adjustment of DRG Base Rate National Portion Group Appeal v. Mutual of Omaha*  (PRRB Decision 2000-D75) |

1. This discussion assumes familiarity with the FTE Cap, and if not, the neutral explanation in the Board’s Decision is a good source. [↑](#footnote-ref-1)
2. Now 42 C.F.R. § 412.4. [↑](#footnote-ref-2)
3. Based on our review, we believe there is a jurisdictional impediment related to the providers included on the Schedule of Providers. The appealed issue is intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts and 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations) prohibit administrative and judicial review of those budget neutrality adjustments. The MAC intends to file a jurisdictional challenge to the Board. [↑](#footnote-ref-3)
4. Labor ($4,138.28) + Non-labor ($1,983.43) = $6,121.71. [↑](#footnote-ref-4)
5. Per 48 FR 39763, the national standardized amount for FY 84 has been calculated to be $2,837.91 ($2,206.22 for the labor share and $631.69 for the non-labor share) (**Exhibit C-3, pg. 13**). [↑](#footnote-ref-5)
6. $2,863.45-$2,837.91= $25.54. [↑](#footnote-ref-6)
7. $6,176.81-$6,121.71 = $55.10. [↑](#footnote-ref-7)