PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2026-D24

PROVIDER –
King & Spalding 2015 Tulsa Hospitals Wage Index Group

Saint Francis Health System 2016, 2017, and 2018 Wage Index CIRP Groups

PROVIDER NUMBERS - Various -See Appendix A

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
March 7, 2024

Cost Reporting Periods Ended –
September 30, 2015, September 30, 2016, September 30, 2017, September 30, 2018

CASE NUMBERS –
15-1299G, 16-0809GC, 17-0913GC, 18-0634GC

INDEX

ISSUE STATEMENT:

Whether CMS acted outside its authority, or otherwise arbitrarily and capriciously, when it excluded the average hourly wage of Southwestern Medical Center from the Tulsa CBSA in calculating the wage index for Federal Fiscal Years ("FFYs") 2015 through 2018.[1]

DECISION:

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

1. CMS acted within its authority when it excluded the average hourly wage of Southwestern Medical Center from the Tulsa CBSA in calculating the wage index for Federal Fiscal Years (FFYs) 2015 through 2018.

2. The Providers in the group Case No. 18-0634GC failed to include appropriate cost report claims on their cost reports for the wage index average hourly wage issue under appeal in this case, as required under 42 C.F.R. § 413.424(j)(1).

INTRODUCTION:

This is a consolidated case involving four group appeals. As shown in Appendix A, there are nine (9) hospitals in the 2015 King & Spalding ("K&S") Tulsa Hospitals Wage Index Group (Case No. 15-1299G) and two (2) Saint Francis Health System hospitals in each of the 2016, 2017 and 2018 Wage Index Groups (Case Nos. 16-0809GC, 17-0913GC, and 18-0634GC, respectively) (collectively, "Providers", and as specific to each group, "Group Providers").[2] The two Saint Francis Health System hospitals are also participants in the 2015 K&S Group. The Providers' assigned Medicare contractor[3] is Novitas Solutions, Inc. ("Medicare Contractor").[4] The Providers are acute care hospitals paid under the Inpatient Prospective Payment System ("IPPS").[5] These hospitals were located in the Tulsa, Oklahoma Core Based Statistical Area 46140 (the "Tulsa CBSA") during FFYs 2015 through 2018.[6] To calculate the wage index for the CBSA, CMS utilized wage index data submitted on the Medicare cost reports filed by all hospitals within the Tulsa CBSA, *except for* Southwestern Medical Center ("SMC"), aka Cancer

[1] Providers' Consolidated Final Position Paper ("Providers' Consolidated FPP") at 1 (Oct. 13, 2023).
[2] *See also* Parties' Joint Stipulations ("Stip.") at ¶ 1.1 and 1.2 (Mar. 1, 2024).
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations knows as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs as appropriate and relevant.
[4] Parties' Joint Stipulations at ¶ 1.3.
[5] *Id*. at ¶ 1.5.
[6] *Id*. at ¶ 1.4.

Treatment Center (Provider No. 37-0190).[7] SMC is not one of the Providers in these appeals.[8]

CMS determined the Tulsa CBSA's Wage Index for FFYs 2015 through 2018 using the data collected from the 2011 through 2014 cost reports.[9] CMS published the results in each respective Federal Register.[10] Hospitals located in the Tulsa CBSA participating in this appeal dispute the published wage indices, particularly CMS's exclusion of SMC's wage data from the calculation.[11]

STATEMENT OF LAW:

A. Relevant Law, Regulations, and Policy

1. Wage Index: 42 C.F.R. § 412.64(g), (h)

Medicare pays hospitals for inpatient services through the Inpatient Prospective Payment System ("IPPS").[12] Applicable to this discussion, 42 C.F.R. § 412.64(g) states:

> (g) *Computing Federal rates for inpatient operating costs for hospitals located in all areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a national prospective payment rate for inpatient operating costs based on the standardized amount for the fiscal year and the weighting factor determined under § 412.60(b) for that DRG.
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> (h) *Adjusting for different area wage levels.* CMS adjusts the proportion of the Federal rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The adjustment described in this paragraph (h) also takes into account the earnings and paid hours of employment by occupational category.
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> (1) The wage index is updated annually.

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[7] *Id.* at ¶ 2.5. *See* Medicare Contractor's Consolidated Final Position Paper ("Medicare Contractor's Consolidated FPP") at 4 (November 9, 2023), "In their appeal requests and preliminary papers for the consolidated cases, the Providers refer to 'Southwestern Regional Medical Center', DBA name as 'Cancer Treatment Center[']] (CTC) (Provider No. 37-0190) as the 'excluded' hospital."
[8] *Id*. at ¶ 1.6.
[9] *See* 79 Fed. Reg. 49854, 49964 (Aug. 22, 2014), 80 Fed. Reg. 49326, 49489 (Aug. 17, 2015), 81 Fed. Reg. 56762, 56914 (Aug. 22, 2016), and 82 Fed. Reg. 37990, 38131 (Aug. 14, 2017).
[10] *Id.*
[11] *See* Providers' Consolidated FPP at 13.
[12] *See* 42 U.S.C. § 1395ww(d).

> (2) CMS determines the proportion of the Federal rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual regulation updating the system of payment for inpatient hospital operating costs.
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> (3) For discharges occurring on or after October 1, 2004, CMS employs 62 percent as the proportion of the rate that is adjusted for the relative level of hospital wages and wage-related costs, unless employing that percentage would result in lower payments for the hospital than employing the proportion determined under the methodology described in paragraph (h)(2) of this section.[13]

Section 1886(d)(3)(E)(i) of the Social Security Act[14] requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts for different area wage levels:

> [T]he Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average wage level. Not later than October 1, 1990, and October 1, 1993 (and at least every 12 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. . .

Further, Section 1886(d)(3)(E)(i) requires the Secretary to update the wage index annually and to base the update on a survey of wages and wage-related costs of "subsection (d) hospitals," or *short-term, acute care hospitals*. This data is collected "on the Medicare cost report, CMS Form 2552-10, Worksheet S-3, Parts II, III, and IV."[15] The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Pursuant to Section 1886(d)(3)(E)(i), the Secretary delineated hospital labor markets based on their OMB-established CBSAs.[16]

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[13] 42 C.F.R. § 412.64(g), (h) (eff. Oct. 1, 2014). The quoted portions of Subsections (g) and (h) remained unchanged for each FFY at issue in this case (*i.e.*, FFY 2015 through 2018).
[14] 42 U.S.C. § 1395ww(d)(3)(E).
[15] 81 Fed. Reg. at 56912.
[16] *Id.* at 56913.

To that end, and using the FFY 2015 Hospital IPPS Final Rule as an example, CMS describes the annual wage index review process as follows:

> The wage data for the FY 2015 wage index were obtained from Worksheet S-3, Parts II and III of the Medicare cost report for cost reporting periods beginning on or after October 1, 2010, and before October 1, 2011. For wage index purposes, we refer to cost reports during this period as the "FY 2011 cost report," the "FY 2011 wage data," or the "FY 2011 data." Instructions for completing the wage index sections of Worksheet S-3 are included in the Provider Reimbursement Manual (PRM), Part 2 (Pub. No. 15-2), Chapter 40, Sections 4005.2 through 4005.4 for Form CMS-2552-10. The data file used to construct the FY 2015 wage index includes FY 2011 data submitted to us as of June 25, 2014. As in past years, we performed an extensive review of the wage data, mostly through the use of edits designed to identify aberrant data.
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> We asked our MACs to revise or verify data elements that result in specific edit failures. For the proposed FY 2015 wage index, we stated that we identified and excluded 50 providers with aberrant data that should not be included in the wage index, although we stated that if data elements are corrected, we intended to include data from those providers in the final FY 2015 wage index (79 FR 28064). We have since determined that we had only removed 49, not 50, providers with aberrant data from the proposed wage index. We have received corrected data from 19 providers and data from an additional provider, and therefore, we are including the data for these 20 providers in the final FY 2015 wage index. However, since issuance of the proposed rule, we have determined that the data from 4 other providers (not included in the original 49 providers) were aberrant and should not be included in the final FY 2015 wage index. Therefore, in total, we are excluding the data of 34 providers from the final FY 2015 wage index.[17]

Furthermore, CMS addresses its authority to exclude atypical but "properly documented" wage data as such:

> CMS has historically exercised its discretion in developing a wage index that reflects a relative measure of the value of the labor provided to a typical hospital in a particular labor market area.[18]

[17] 79 Fed. Reg. at 49964. FY 2016 Wage Data is addressed at 80 Fed. Reg. at 49489; FY 2017 Wage Data is addressed at 81 Fed. Reg. at 56914; and FY 2018 Wage Data is addressed at 82 Fed. Reg. at 38131.
[18] *Id*. at 49965.

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

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

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

> determined by reference to the cost report that the provider submits originally to, and was accepted by, the contractor for such period, provided that none of the following exceptions applies:
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> (i) If the provider submits an amended cost report for its cost reporting period and such amended cost report is accepted by the contractor, then whether there is an appropriate cost report claim for the specific item mut be determined by reference to such amended cost report, provided that neither of the exceptions set forth in paragraphs (j)(3)(ii) and (iii) of this section applies;
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> (ii) If the contractor adjusts the provider's cost report, as submitted originally by the provider and accepted by the contractor or as amended by the provider and accepted by the contractor, whichever is applicable, with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the final contractor determination (as defined in § 405.1801(a) of this chapter) for the provider's cost reporting period, provided that the exception set forth in paragraph (j)(3)(iii) of this section does not apply;
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> (iii) If the contractor reopens either the final contractor determination for the provider's cost reporting period (pursuant to § 405.1885 of this chapter) or a revised final contractor determination for such period (issued pursuant to § 405.1889 of this chapter) and the contractor adjusts the provider's cost report with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the most recent revised final contractor determination for such period.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) (2016) states:

> (a) General. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). ***If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item***, the Board must address such question in accordance with the procedures set forth in this section.[19]

[19] (Bold and italics emphasis added.)

The Board implemented 42 C.F.R. § 405.1873(a) in Board Rule 44.5 which states:

> Effective for cost reporting periods beginning on or after January 1, 2016, 42 C.F.R. § 413.24(j) (as restated at 42 C.F.R. § 405.1873(a)) includes a "[s]ubstantive reimbursement requirement of an appropriate cost report claim." Specifically, § 413.24(j)(1) states that, "[i]n order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, *the provider's cost report*, whether determined on an as-submitted, as-amended, or as-adjusted basis . . ., must include an appropriate claim for the specific item . . . ." (Emphasis added.) If any party to an appeal before the Board questions whether *the provider's cost report at issue in an appeal* complied with this regulatory requirement (*i.e*., questions whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed), then that party must follow the applicable process described below to file this "Substantive Claim Challenge" in order to initiate Board review of such question(s) under 42 C.F.R. § 405.1873(b).
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> NOTE: The Board adoption of the term "Substantive Claim Challenge" simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items.[20]

STATEMENT OF FACTS:

A. Wage Index Values

CMS based FFY 2015 through 2018 Tulsa CBSA wage index values on data collected from Medicare cost reports submitted by hospitals in the Tulsa CBSA during FFY 2011 through 2014, respectively.[21]

The IPPS Final Rules for FFY 2015 through 2018 excluded SMC's wage data from the Tulsa CBSA wage index.[22] CMS excluded SMC's wage data "because 'the hospital does not merely have the highest average hourly wage in the CBSA; its average hourly wage is extremely and unusually high, significantly higher than the next highest average hourly wage in that CBSA and in the surrounding areas.'"[23]

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[20] v. 3.1 (Nov. 1, 2021). (Italics emphasis in original.)
[21] *See* Stip. at ¶¶ 2.1 – 2.4.
[22] *See id.* at ¶ 2.5.
[23] *Id*. at ¶ 2.6, *citing* 80 Fed. Reg. 49491 and 79 Fed. Reg. at 49965.

The parties agree that no allegations were made that SMC's wage data was flawed; however they noted that:

> CMS stated in the IPPS Final Rules for FYs 2015 and 2016 that "while the hospital's wage data were properly documented, the hospital does not merely have the highest average hourly wage in the CBSA; its average hourly wage is extremely and unusually high, significantly higher than the next highest average hourly wage in that CBSA and in the surrounding areas."[24]

In FYE 2000, SMC attempted to be paid as a cancer hospital excluded from IPPS, by identifying itself as a "cancer" type of hospital (coded with a "3" on line 19 of Worksheet S-2).[25] At that time, SMC contended that it was a cancer specialty hospital and had filed cost reports as such since 1996.[26] In that case, the fiscal intermediary (Medicare contractor) stated that SMC "filed its cost reports for the 1993 through 1995 and 2003 fiscal year ends as an acute care hospital and for fiscal years 1996 through 2002 as a cancer hospital."[27] Under appeal, the Board concluded that SMC had not met all of the statutory requirements under 42 C.F.R. § 412.23(f) to qualify as a cancer hospital.[28]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

A. Providers' Position on the Substance of these Appeals

The Providers present three arguments challenging CMS' wage index policy on the grounds that it ignored valid wage data, was arbitrary and capricious, and was procedurally invalid.[29]

1. The Medicare Statute Forecloses Excluding "Properly Documented" Wage Data of Subsection (d) Hospitals from the Wage Index

First, the Providers argue that the law requires CMS to collect and use all verified hospital wage data to build a fair wage index for each region.[30] This index is supposed to reflect the most accurate picture of how wages in one area compare to the national average.[31] However, Providers contend that CMS refused to include SMC's wage data for fiscal years 2015–2018, even though the data had already been reviewed and approved.[32] While CMS claimed the data did not "accurately reflect [] the economic conditions in Tulsa,"[33] Providers argue the law does not give CMS the authority to discard verified data simply because the results seem unusual; CMS is only allowed to exclude data that is poorly documented or comes from hospitals that do

[24] *Id*. at ¶ 2.7, *citing* 80 Fed. Reg. 49491 and79 Fed. Reg. 49965.
[25] *See* Ex. C-5 at C-0022 (PRRB Dec. 2008-D44); *see also* Medicare Contractor's Consolidated FPP at 5.
[26] Ex. C-5 at C-0023.
[27] *Id*. at C-0025.
[28] *Id*. at C-0027.
[29] *See generally* Providers' Consolidated FPP.
[30] *See id*.at 4.
[31] *See id*. at 5.
[32] *See id*.
[33] *Id.*

not qualify, not data from an approved hospital just because its wages look different from others.[34]

Note, the parties have stipulated that "[t]here has been no allegation that SMC's wage data was erroneous or unreliable."[35] However, the parties also stipulate that CMS stated in the IPPS Final Rules for FYs 2015 and 2016 that "while the hospital's wage data were properly documented, the hospital does not merely have the highest average hourly wage in the CBSA; its average hourly wage is extremely and unusually high, significantly higher than the next highest average hourly wage in that CBSA and in the surrounding areas."[36]

The Providers also acknowledge that the statute does not require "CMS to include the wage data of *all* hospitals in the wage index."[37] For example, the Providers state that:

> [t]he statute supports excluding the wage data of a hospital that is not "properly documented," since its inclusion would produce a wage index that does not reflect the wage level of its area. And because the statute says that only subsection (d) hospitals are included in the survey, it supports excluding entire categories of hospitals (e.g., CAHs) that are no longer subsection (d) hospitals at the time their wage data is used to calculate the wage index, especially if those hospitals have 'significantly different labor costs from subsection (d) hospitals.'[38]

In summary, the Providers contend that the statute requires CMS to consistently apply and determine the wage index across all subsection (d) hospitals, citing to the statutory language's consistent use of the singular terms like 'the proportion" and "a factor", indicating that the wage index must be uniformly determined and applied.[39] The Providers assert that CMS has not adhered to this requirement "by excluding the "properly documented" wage data of SMC."[40] Further, they argue that "[a] policy that artificially adjusts the wage index of an area based on nothing more than CMS's conclusion that a hospital's wages are atypical is invariably not uniformly applied."[41] The Providers rely on *Bridgeport Hospital v. Becerra*[42] and *Kaweah Delta Health Care v. Becerra*[43] to support their claim that CMS did not apply consistent treatment to

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[34] *See id*. at 5-6.
[35] Stip. at ¶ 2.7.
[36] *Id*. at ¶¶ 2.6 and 2.7., *citing* 80 Fed. Reg. 49491 and 79 Fed. Reg. 49965.
[37] Providers' Consolidated FPP at 6.
[38] *Id.*, *citing Anna Jaques Hospital v. Sebelius,* 583, F.3d 1, 224 (D.C. Cir. 2009) (*citing* 68 Fed. Reg. 45346, 45397 (Aug. 11, 2004)).
[39] *See id*.at 7, citing *Atrium Medical Center v. U.S. Dept. of Health and Human Services*, 766 F.3d 560, 569 (6th Cir. 2014) and *Sarasota Memorial Hospital v. Shalala*, 60 F.3d 1507, 1513 (11th Cir. 1995).
[40] *Id*.
[41] *Id.*, *citing Bridgeport Hospital v. Becerra*, 589 F.Supp.3d 1, 11 (D.D.C. 2022).
[42] 589 F.Supp.3d at 11 (holding that low wage index policy violated Medicare statute's wage index provision and that the policy was not allowed under Medicare statute's exceptions and adjustments provision).
[43] 2022 WL 18278175 *5(holding the Low Wage Index policy exceeded the Secretary's authority under the Medicare Act in violation of the APA and remanding without vacatur), *affirmed in part, vacated in part, remanded by Kaweah Delta Health Care District v. Becerra*, 123 F.4th 939 (9th Cir. 2024)) (holding that the low-wage-index policy must be vacated).

all hospitals and did not calculate the final wage index based on values that reflect the relative hospital wage level in the geographic area of the hospital compared to the national average.[44]

2. Excluding SMC from the Wage Index in FYs 2015 Through 2018 Was Arbitrary and Capricious

Secondly, the Providers assert that excluding SMC from the wage index for FY 2015 through FY 2018 was "arbitrary and capricious."[45] The Providers claim that an analysis of wage data that CMS included in the wage index in FYs 2014 through 2024, shows CMS did not apply the same standard to other hospitals' wage data as it did to SMC's between FYs 2015 and 2018.[46] The Providers state that CMS considered the average hourly wage of SMC in FYs 2015 through 2018 – which "ranged from 1.36 to 1.63 times the average hourly wages of the other hospitals in the Tulsa MSA" – to be "so 'extremely and unusually high' that it had to be excluded from the wage index."[47] However, the Providers explain that "between 2014 and 2024, there were 55 instances in which CMS *included* in the wage index the wage data of hospitals with average hourly wages *greater than 1.36 or even 1.63 times* the average hourly wage of the other hospitals in their MSA."[48] Furthermore, the Providers note that other hospitals with higher average hourly wage than SMC's were not excluded from the wage index in their MSAs, highlighting the point that "CMS has not uniformly applied its policy of excluding wage data of hospitals with atypically higher average hourly wages."[49]

In response to the Medicare Contractor's counter-argument that comparing the 55 instances the Providers highlight to SMC is impractical due to varying geographic locations and labor markets (see below), Providers assert, "if the standard that CMS uses for identifying atypically high wages varies between MSAs, the [Medicare Contractor] should describe that standard so that the Board can evaluate it for reasonableness."[50]

The Providers contend CMS has acted arbitrarily and capriciously by failing to articulate a satisfactory explanation for excluding the SMC wage data.[51] The Providers contend that CMS's rationale that it "included [SMC's] wage data in previous years because the hospital's average hourly wage was lower and more reasonable relative to its labor market area in the prior years" "does not withstand scrutiny" because in FY 2014, SMC's average hourly wage was 1.5 times that of the other hospitals in Tulsa but was included in the wage index although the ratio by which it exceeded the CBSAs average hourly wage was higher than the ratio in future years when SMC's hourly wage was excluded.[52] The Providers conclude that "even if CMS indeed

[44] Providers' Consolidated FPP at 7.
[45] *Id.*
[46] *See id*.
[47] *Id*. at 7-8.
[48] *Id.* at 8 (emphasis added); *see also* Ex. P-3 (Table: SMC Compared to Providers Included in the Wage Index).
[49] *Id*.
[50] Providers' Consolidated Optional Response at 2 (Dec. 12, 2023).
[51] Providers' Consolidated FPP at 9, *relying on Athens Cmty. Hosp., Inc. v. Shalala*, 21 F.3d 1176, 1179 (D.C. Cir. 1994) (*quoting Motor Veh. Mfrs. Ass'n v. State Farm Ins.*, 463 U.S. 29, 43 (1983)).
[52] *Id*.

has some standard that provides the rhyme or reason to its seemingly arbitrary determinations, it is obligated to disclose that standard."[53]

3. CMS's Decision to Exclude SMC from the Wage Index Was Procedurally Invalid

Finally, the Providers argue that CMS's exclusion of SMC from the wage index is procedurally invalid because the agency did not engage in notice and comment rulemaking as required by *Allina* and the Medicare Statute for any "rule, requirement, or other statement of policy" that "establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under Medicare."[54] The Providers believe that the agency has removed wage data without formally promulgating any rules and argues "this policy is a 'substantive legal standard' that cannot take effect absent notice-and-comment rulemaking."[55] Therefore, the Providers maintain this failure violates the legal requirement that government agencies provide "fair notice" of any rules that affect the rights of those they regulate.[56]

In response to the Medicare Contractor's argument that established precedent, *i.e.*, *Anson General Hospital v. Azar*,[57] holds that a provider cannot challenge the accuracy of another provider's wage data, the Providers assert:

> In essence, *Anson* stands for the proposition that if a hospital fails to observe and comply with the deadlines in the wage data revisions process, neither that hospital nor any other in its MSA can challenge the accuracy of that data. But *Anson* is not instructive here because . . . the Providers are not challenging the accuracy of SMC's wage data, but rather CMS's decision to exclude that data from the wage index.[58]

In furtherance of the same rebuttal, Provider also calls out *Citrus HMA, LLC v. Becerra*,[59] where the Court found in favor of plaintiffs who were challenging CMS's decision to exclude the wage data of two urban hospitals that had reclassified as rural from the rural wage index. [60]

B. The Medicare Contractor's Position on the Substance of these Appeals

1. CMS properly disallowed SMC's Wage Data for the FYs 2015-2018 Wage Index

The Medicare Contractor maintains that CMS properly disallowed SMC's wage data for the FYs

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[53] *Id.* at 10.
[54] *Id*. at 11, *citing Azar v. Allina Health Services*, 139 S. Ct. 1804, 1809 (2019) (*quoting* 42 U.S.C. § 1395hh) (internal quotation omitted).
[55] *Id.* at 11-12.
[56] *Id.* at 13.
[57] 801 Fed. Appx. 273 (5th Cir. 2020).
[58] Provider's Consolidated Optional Response at 3.
[59] 597 F.Supp.3d 450 (D.D.C. 2022).
[60] *See* Provider's Consolidated Optional Response at 3.

2015-2018 wage index.[61] The Medicare Contractor disagrees with the Providers' first argument because it believes that CMS has "consistently constructed the wage index per Section 1886(d) of the Social Security Act."[62] Accordingly, the Medicare Contractor points to CMS' responses in the FFY 2016 Final Rule which state that the MACs and CMS "'evaluate the accuracy and reasonableness of hospitals' wage index data' each year and 'revise or verify data elements that result in specific edit failures.'"[63] The Medicare Contractor further states that "CMS has historically exercised its discretion in developing a wage index that reflects a relative measure of the value of the labor provided to a typical hospital in a particular labor market area."[64] Furthermore, the Medicare Contractor states that CMS agreed, in the 2016 final rule, that SMC's[65] "wage data was 'properly documented,' but noted that the hospital 'did not merely have the highest average hourly wage in the CBSA; its average hourly wage was extremely and unusually high, significantly higher than the next highest average hourly wage in that CBSA and in the surrounding areas."[66]

2. CMS acted consistently in the construction of the Wage Index determination

Next, the Medicare Contractor states that the Providers' second argument "is meritless since the method used to construct the FY [2015-2018] wage index has been consistently used in previous years as noted."[67] Further, the Medicare Contractor identifies that CMS stated "[w]e included the hospital's data in the wage index in previous years because the hospital's average hourly wage was lower and more reasonable relative to its labor market area in the prior years and, thus, we did not remove the hospital's wage data from the prior years' wage index."[68] The Medicare Contractor continues this argument by reiterating its first argument, that SMC's FFY 2014 average hourly wage was significantly higher than previous years.[69] The MAC then responds to the Provider's conclusion that CMS is obligated to disclose the standard it uses to make such determinations by asserting that "there were no substantial changes in the rule regarding this issue which would require a 'notice to hospitals.'"[70]

In addition, the Medicare Contractor rejects the Providers' claim that CMS has not held the wage data of other hospitals with "atypically high hourly wages" to the same standard as it held SMC's

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[61] Medicare Contractor's Consolidated FPP at 5.
[62] *Id.*
[63] *Id*. at 5-6, citing 80 Fed. Reg. at 49490.
[64] *Id*.
[65] Note: the Medicare Contractor calls Southwestern Medical Center (SMC) "Southwestern Regional Medical Center (SRMC")". To maintain consistency, SMC will be used throughout.
[66] Medicare Contractor's Consolidated FPP at 6.
[67] *Id.* The Board notes that as of Nov. 16, 2021, the date the Board's response to the Provider's Nov. 1, 2021 Request for Consolidated the Hearing, only Case No. 16-0809GC had been fully briefed. The Medicare Contractor's Final Position Paper for Case No. 16-0809GC contains virtually the same argument presented here as for FY 2018. It is unclear why in the Consolidated Final Position Paper the Medicare Contractor only calls out FY 2018. The Board, in the aforementioned response, indicated "the legal issue is the same in all of the appeals and there were no pertinent regulatory changes to the policy under appeal." Thus, despite the Medicare Contractor's use of the specific "FY 2018" in its Consolidated Final Position Paper, the Board will consider this argument relevant to all fiscal years under appeal and the Board's findings in this decision relate to all fiscal years under appeal.
[68] 79 Fed. Reg. at 49965.
[69] Medicare Contractor's Consolidated FPP at 6-7.
[70] *Id.*

data in FYs 2015 through 2018.[71] The Medicare Contractor argues that comparing the 55 instances the Providers highlight to SMC is impractical due to the fact that the providers in these 55 instances are in different CBSAs than SMC, "which have very different geographic locations and labor markets, . . . and does not support the Providers' argument for the issue in this case."[72]

3. Challenge of Another Provider's Wage Index Data

Finally, the Medicare Contractor argues that the Providers do not have grounds on which to challenge the wage index of another provider.[73] The Medicare Contractor notes that similar cases have appeared before the Board, District Courts, and Circuit Courts and concludes that "a provider challenging another provider's wage index data outside of the established wage data correction process, is unsupported by statute."[74] The Medicare Contractor also differentiates this case from the others and states that SMC has not appealed its own exclusion from the Tulsa CBSA "for any federal fiscal year end, including the ones at issue here."[75] The Medicare Contractor adds that neither the Providers nor SMC utilized the established process for the correction of wage data, a process the Medicare Contractor maintains "is the exclusive means to challenge another provider's wage index data" according to the Fifth Circuit.[76] To that end, the Medicare Contractor "encourages the Board to follow the precedent established in previous wage index cases of this nature and conduct an own motion review to consider expedited judicial review."[77]

C. Cost Report Claim

On **February 28, 2023**, the Medicare Contractor filed a Substantive Claim Challenge[78] in the Saint Francis FFY 2018 Wage Index CIRP Group (Case No. 18-0634GC), asserting that, based on the procedures at 42 C.F.R. § 413.24(j)(3):

> Group Providers have failed to include an appropriate cost report claim for the specific item in the Providers' cost reports. The Providers have not claimed reimbursement for the Wage Index issue in dispute in the Providers' accepted cost reports for the applicable cost reporting periods in accordance with Medicare

[71] *See* Medicare Contractor's Consolidated FPP at 7.
[72] *Id.*
[73] *Id.* at 7-10.
[74] *Id*. at 9. The Medicare Contractor refers to jurisdictional determinations by the Board in PRRB Case Nos. 15-1522, 15-1527, 15-1528 and 15-1564 (*see* Ex. C-6) and the judicial review that followed in *Anson Gen. Hosp. et al v. Azar*, 801 Fed.Appx. 273, 2020 WL 897104, Med & Med GD (CCH) P 306,725 (5th Cir. 2020) (*affirming* N. D. Texas, No. 1:18-CV-11, summary judgment upholding the Board Decision) (*see* Ex. C-7). *Id*. at 7-9. These cases involved the Abilene, TX CBSA and are referred to in the Medicare Contractor's Consolidated FPP as "the Abilene CBSA cases."
[75] *Id*. at 9.
[76] *Id*. at 9-10.
[77] *Id*. at 10.
[78] As noted above, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items." Board Rule 44.5 (Emphasis in original).

> policy, nor have the Providers self-disallowed the specific item in the Providers' cost reports. Furthermore, none of the exceptions at subsections (3)(i) through (3)(iii) apply.[79]

In its challenge, the Medicare Contractor takes notice of the following:

> The participating providers appeals from the [F[ederal [R]egister data 08/14/2017 (82 Fed Reg. at 38130), which applies to the 2018 Federal Fiscal Year (FFY). The FFY 2018 spans 10/01/2017 through 09/30/2018. The Group consists of two (2) providers, which take appeal from cost reporting periods ending on 06/30. Accordingly, for the 06/30 FYEs, FFY 2018 includes portions of two separate cost reporting periods (i.e., fiscal year ending (FYE) 06/30/2018 (with effective dates of 10/01/2017 through 06/30/2018) and FYE 06/30/2019 (with effective dates of 07/01/2018 through 09/30/2018) resulting in four cost-reporting periods under review.[80]

The Medicare Contractor reviewed the four applicable cost reports and determined the following:

1. Saint Francis Hospital, Inc., Provider No. 37-0091, FYE 6/30/2018 – The Provider filed its cost report identifying $1,587,117 in Part A Protested amounts.[81] Along with its cost report, the Provider submitted a list of Protested Items, also totaling $1,587,117.[82] The list did not contain any amount related to the Wage Index issue in dispute.[83]

2. Saint Francis Hospital, Inc., Provider No. 37-0091, FYE 6/30/2019 – The Provider filed its cost report identifying $563,668 in Part A Protested amounts.[84] Along with its cost report, the Provider submitted a list of Protested Items, also totaling $563,668.[85] The list did not contain any amount related to the Wage Index issue in dispute.[86]

3. Saint Francis Hospital, South LLC, Provider No. 37-0218, FYE 6/30/2018 - The Provider filed its cost report identifying $119,637 in Part A Protested amounts.[87] Along with its cost report, the Provider submitted a list of Protested Items, also totaling $119,637.[88] The list did not contain any amount related to the Wage Index issue in dispute.[89]

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[79] Case No. 18-0634GC, Medicare Contractor's Substantive Claim Letter ("Medicare Contractor's SCL") at 5 (Feb. 28, 2023).
[80] *Id.* at 1.
[81] *Id*. at 5. *See also* Case No. 18-0634GC, Medicare Contractor's SCL, Ex. C-3 at C-0009.
[82] Case No. 18-0634GC, Medicare Contractor's SCL, Ex. C-3 at C-0010.
[83] Case No. 18-0634GC, Medicare Contractor's SCL at 5.
[84] *Id*. at 6. *See also* Case No. 18-0634GC, Medicare Contractor's SCL, Ex. C-4 at C-0017.
[85] Case No. 18-0634GC, Medicare Contractor's SCL, Ex. C-4 at C-0018.
[86] Case No. 18-0634GC, Medicare Contractor's SCL at 6.
[87] *Id*.at 6. *See also* Case No. 18-0634GC, Medicare Contractor's SCL, Ex. C-5 at C-0025.
[88] Case No. 18-0634GC, Medicare Contractor's SCL, Ex. C-5 at C-0026.
[89] Case No. 18-0634GC, Medicare Contractor's SCL at 6.

4. Saint Francis Hospital, South LLC, Provider No. 37-0218, FYE 6/30/2019 - The Provider filed its cost report identifying $40,874 in Part A Protested amounts.[90] Along with its cost report, the Provider submitted a list of Protested Items, also totaling $40,874.[91] The list did not contain any amount related to the Wage Index issue in dispute.[92]

On **March 30, 2023**, the Group Providers filed a response to the Medicare Contractor's Substantive Claim Challenge. The Group Providers contend that the Board should dismiss the substantive claim challenge because the self-disallowance regulation on which the Medicare Contractor relies is "unlawful and unenforceable [and] Congress did not grant CMS authority to promulgate the rule in the first instance."[93]
Furthermore, the Group Providers assert that the self-disallowance policy unlawfully limits the Board's power to "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report."[94] The Group Providers rely on *Bethesda* and *Banner Health* which concluded that the presentment of futile claims is not a requirement for Board jurisdiction, to argue that self-disallowance cannot be a requirement for the Board to exercise its power.[95]

The Group Providers contend that "the current self-disallowance rule imposes conditions on the Board's administrative review authority that are not found in the text of the PRRB statute . . ."[96] The Group Providers argue that the self-disallowance regulation requires all claims to be presented to the Medicare Contractor, eliminating situations where the Board can use its statutory powers to revise cost report issues that were not considered by the Medicare Contractor.[97] The Group Providers believe the regulation makes the statute's provision for compelling payment on unreviewed issues redundant.[98]

Finally, the Group Providers assert that "[t]he self-disallowance regulation is arbitrary and capricious"[99] and is not supported by reasoned decision-making.[100]

D. Board Analysis

1. <u>CMS Properly Excluded SMC Wage Data</u>

In reviewing the record, the Board finds that CMS properly excluded the average hourly wage ("AHW") of SMC from the Tulsa CBSA in calculating the wage index for FFYs 2015 through 2018. Contrary to the Providers' position, the Board finds that CMS's decision was not based upon a certain undisclosed threshold by which SMC's AHW exceeded the AHW of the other

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[90] *Id*. at 7. *See also* Case No. 18-0634GC, Medicare Contractor's SCL, Ex, C-6 at C-0033.
[91] Case No. 18-0634GC, Medicare Contractor's SCL, Ex. C-6 at C-0034
[92] Case No. 18-0634GC, Medicare Contractor's SCL at 7.
[93] Case No. 18-0634GC, Provider's Response to Medicare Contractor's Substantive Claim Letter at 4 (Mar. 30, 2023)
[94] *Id*., *citing* 42 U.S.C. § 1395oo(d).
[95] *Id.* at 4-5, referring to *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016).
[96] *Id.* at 2.
[97] *Id.* at 5.
[98] *Id.*
[99] *Id.*
[100] *Id.*

hospitals in the same CBSA. As established above, "CMS evaluates the wage data for both accuracy and reasonableness to ensure that the wage index is a relative measure of the labor value provided to a *typical* hospital in a *particular* labor market area."[101] An in-depth review of the Tulsa CBSA wage data demonstrates that SMC was not "typical" of the Tulsa CBSA. [102]

The table below provides the AHW data for the hospitals' wage index in the Tulsa CBSA, as well as the national AHW that are reflected in the Final Rules for FFYs 2015 through 2018[103], and includes the Board's analysis:

**All Tulsa CBSA data excludes SMC, except estimated Tulsa CBSA with SMC.*	**FFY 2015**	**FFY 2016**	**FFY 2017**	**FFY 2018**
Tulsa CBSA AHW	$30.80	$31.05	$32.49	$34.53
Tulsa's Lowest single-hospital AHW	$22.42	$24.19	$26.26	$24.77
Tulsa's Highest single-hospital AHW	$33.66	$35.18	$36.29	$38.75
National AHW	$38.80	$39.81	$40.71	$41.58
SMC AHW (estimated per MAC exhibit)[104]	$50.07	$48.40	$47.58	$46.90
Tulsa Wage Index	.79	.78	.80	.83
Tulsa Wage Index with SMC (est. per MAC exhibit)	.82	.80	.82	.85
SMC AHW as a percent of National AHW	129%	122%	117%	113%
SMC AHW as a percent of Tulsa AHW	163%	156%	146%	136%
Amount SMC's AHW exceeds Tulsa AHW	$19.27	$17.35	$15.09	$12.37
Amount SMC's AHW exceeds the next highest Tulsa single-hospital AHW	$16.41	$13.22	$11.29	$8.15
Amount SMC's AHW exceeds the National AHW	$11.27	$8.59	$6.87	$5.32
Amount the lowest Tulsa single hospital AHW is below the Tulsa AHW	($8.38)	($6.86)	($6.23)	($9.76)
Percentage SMC's AHW exceeds Tulsa AHW	63%	56%	46%	36%
Percentage SMC's AHW exceeds Tulsa's next highest single hospital AHW	49%	38%	31%	21%

[101] 80 Fed. Reg. at 49490 (emphasis added).
[102] *See* Ex. C-4 (Tulsa CBSA (#46140) Wage data).
[103] *See id*.
[104] Per *id*., the Medicare contractor has obtained the data for SWC from the applicable year's preliminary Public Use File (PUF), released by CMS before the wage index is finalized.

Percentage SMC's AHW exceeds the National AHW	29%	22%	17%	13%
Percentage by which Tulsa's lowest single hospital AHW is below Tulsa AHW	(27%)	(22%)	(19%)	(28%)

From this analysis, the Board concludes the following:

1. For each year from 2015 to 2018, SMC's AHW surpassed that of the hospital with the next highest AHW in the Tulsa CBSA by 21% to 49%.
2. For each year from 2015 to 2018, SMC's AHW consistently exceeded the AHW for the Tulsa CBSA by 36% to 63%.
3. From 2015 to 2018, SMC's AHW was between 13% to 29% greater than the National AHW.

Additionally, the Board observed that none of the hospitals in the Tulsa CBSA have an AHW greater than the National AHW in any year.[105] In sum, the Board finds that the aforementioned data confirms that SMC's data was not "typical" of the Tulsa CBSA, thus providing ample justification for CMS to exclude SMC from the calculation of the Tulsa CBSA wage index for Federal Fiscal Years ("FFYs") 2015 through 2018.

Further, the Board examined the CMS Final Rule Table 2 (or 2-2 in 2015) – which includes Case Mix Index (CMI) and Wage Index data by CCN for FFY 2015 through 2018.[106] This table includes the CMI and AHW for SMC (CCN 37-0190) and all other IPPS hospitals. The Board observed that SMC has the second highest CMI in the Tulsa CBSA (2.29 in FFY 2015),[107] well above the calculated average of 1.49 (for all hospitals in the CBSA, including SMC). Tulsa Spine Hospital (CCN 37-0216) has the highest CMI (2.60 in FFY 2015)[108] but its AHWs are similar to other Tulsa hospitals, ranging from $28.26 to $31.49 between FFY 2015 and 2018.[109] In contrast, SMC's AHWs are substantially higher (ranging from $46.90 to $50.07 for FFY 2015 to 2018) than other hospitals in the CBSA.[110] SMC's AHWs are clearly unusual for the CBSA, even considering the higher acuity (CMI) of the patients that SMC treats and its skilled labor needs (SMC offers services for cancer patients). SMC's AHW consistently stands out as aberrant.

In sum, the Board finds that CMS acted within its authority when it excluded the average hourly wage of SMC from the Tulsa CBSA in calculating the wage index for FFYs 2015 through 2018. The Providers' argument that CMS "has decided as a matter of policy that the wage index would be distorted if it included hospitals with average hourly wages that are a certain "undisclosed

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[105] *See id*.
[106] Published at https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/wage-index-files. Final Rule Wage Index Tables (Final Rule and Correction Notice) for the applicable years 2015-2018. (*See* 2015 - WI_tables_FR_CN_FY_15_New_CBSA.xls (Sept. 30, 2014). 2016 - CMS-1632-F and CN Tables 2 and 3.xlsx (Sept. 27,2015), 2017 - CMS 1655-F and CN FY 2017 Tables 2 and 3.xlsx (Sept. 30, 2016), 2018 - CMS_1677_FR_CN_Tables_2_3.xlsx (Oct. 2, 2017).
[107] FFY 2015, Table 2-2.
[108] *Id.*
[109] FFY 2015, Table 2-2; FFY 2016 Table 2; FFY 2017 Table 2; and FFY 2018 Table 2.
[110] Ex. C-4.

threshold" above the wage levels of the other hospitals in the same area"[111] is misplaced. As evidenced in the Board's analysis (*see* Table *supra*) of the Medicare Contractor's Exhibit C-4, SMC's AHW is outside the "average" of the Tulsa CBSA in many different aspects. As such, the question to be answered is not simply whether SMC's data is "properly documented" but also whether SMC's data is "reasonable" or "typical" of the Tulsa CBSA. CMS reached a reasonable conclusion when it was determined that SMC's average hourly wage was extremely and unusually high, significantly higher than the next highest average hourly wage in the Tulsa CBSA. SMC's AHW did not accurately reflect the economic conditions in its labor market area, and, therefore, its inclusion in the Tulsa CBSA wage index would *not* ensure that the Tulsa CBSA wage index reflects "the relative hospital wage level in the geographic area of the hospital as compared to the national average hospital wage level"[112] as required by Section 1886(d)(3)(E) of the Social Security Act.

2. CMS Acted Consistently in Its Exclusion of SMC Wage Data

The Providers argue that CMS acted arbitrarily by not explaining its exclusion of SMC wage data, and if CMS has a standard for these decisions, it must disclose it.[113] The Medicare Contractor responded that the method used to construct the wage index was consistently used in previous years.[114] The Board agrees that there were no pertinent regulatory changes to the policy under appeal and that CMS acted consistently in its exclusion of SMC wage data.[115] Each fiscal year, CMS uses its discretion to remove the wage data of hospitals with unusually high and unusually low average hourly wages.[116] While the Providers call for disclosure of the standard for determining which hourly wages are unusually high and unusually low, "it has never been CMS' policy to disclose audit protocol; the protocol is for CMS and [Medicare Contractor] internal use only."[117] This is consistent with the Medicare contractors' handling of desk review thresholds that may require further review or even an audit in their annual cost report review.

3. CMS's Decision to Exclude SMC from the Wage Index Was Not Procedurally Invalid

The Board rejects the Providers' argument that CMS's decision to exclude SMC from the Tulsa CBSA wage index was procedurally invalid because the agency did not engage in notice and comment rulemaking.[118] The Board acknowledges that neither the statute nor the regulation explicitly addresses how a provider or a group of providers can request inclusion or exclusion of another facility's data from the wage index calculation.[119] CMS uses an informal method developed from commentary in the Federal Register.[120] The process set forth therein allows CMS

[111] Providers' Consolidated FPP at 5.
[112] 42 U.S.C. § 1395ww(d)(3)(E)(i).
[113] *See* Providers' Consolidated Optional Response at 2 and Providers' Consolidated FPP at 9-10.
[114] Medicare Contractor's Consolidated FPP at 5.
[115] *See supra* Statement of Law; Relevant Law, Regulations, and Policy; 1. Wage Index: 42 C.F.R. § 412.64(g), (h).
[116] *See e.g.,* 79 Fed. Reg. at 49965, 80 Fed. Reg. at 49491, 81 Fed. Reg. at 56914, 82 Fed. Reg. at 38131.
[117] 81 Fed. Reg. at 56915. *See also* 80 Fed. Reg. at 49491.
[118] *See* Providers' Consolidated FPP at 11-12.
[119] *See e.g.*, 42 U.S.C. § 1395ww(d)(3)(E) and 42 C.F.R. §412.64(h).
[120] 79 Fed. Reg. 27978, 28064 (May 15, 2014); 79 Fed. Reg. at 49964: Section D, Verification of Worksheet S-3 Wage Data.

to exclude unverifiable or aberrant data from the wage index calculation. Specifically, CMS stated in the FY 2015 IPPS Proposed Rule:

> In constructing the proposed FY 2015 wage index, we included the wage data for facilities that were IPPS hospitals in FY 2011, inclusive of those facilities that have since terminated their participation in the program as hospitals, as long as those data did not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period and to ensure that the current wage index represents the labor market area's current wages as compared to the national average of wages. However, we excluded the wage data for CAHs as discussed in the FY 2004 IPPS final rule (68 FR 45397 through 45398). For this proposed rule, we removed 6 hospitals that converted to CAH status on or after February 14, 2013, the cut-off date for CAH exclusion from the FY 2014 wage index, and through and including February 13, 2014, the cut-off date for CAH exclusion from the FY 2015 wage index. After removing hospitals with aberrant data and hospitals that converted to CAH status, the final FY 2015 wage index is calculated based on 3,400 hospitals.[121]

This process was restated in the FY 2015 IPPS Final Rule with the only substantive change being that "the final FY 2015 wage index is calculated based on 3,416 hospitals."[122] While the Providers argue "CMS has never put forward a rule through a formal notice-and-comment process to solicit comments on its policy of excluding the 'properly documented' wage data of hospitals,"[123] the Board notes that this process was stated in the Proposed Rule and comments were specifically submitted on behalf of some of the Providers in these appeals in response to the Proposed Rule.[124] In the 2015 Final Rule, CMS addressed those comments regarding the removal of SMC's data, as follows:

> *Comment*: Commenters representing hospitals located in [the Tulsa CBSA] disagreed with the removal of the wage data of one hospital in that CBSA from the FY 2015 wage index. They argued that CMS's removal of the hospital's data is arbitrary and capricious, based only on the fact that the hospital's average hourly wage is higher than those of the other hospitals in the CBSA. The commenters noted that the hospital's data were included in the wage index in previous years, and CMS has provided "no rational explanation for its inconsistent treatment now." The commenters further stated that "if CMS were to adopt a policy of excluding the

[121] 79 Fed. Reg. at 28064.
[122] 79 Fed. Reg. at 49964.
[123] Providers' Consolidated FPP at 11.
[124] *See* Ex. P-1 (Comment Letter FY 2015 Final Rule); Ex. P-2 (Comment Letter FY 2016 Final Rule).

hospital with the highest wage data from each CBSA, fairness would require that CMS also exclude the hospital with the lowest wage data from each CBSA." The commenters stated that if CMS is employing a "bright-line cut off," CMS must publish such "bright-line tests."

Response: Section 1886(d)(3)(E) of the Act requires the Secretary to adjust the proportion of hospitals' costs attributable to wages and wage-related costs for area differences reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. We also refer readers to section 1886(d)(9)(C)(iv)(I) of the Act. Since the origin of the IPPS, the wage index has been subject to its own annual review process, first by the MACs, and then by CMS. Hospitals are aware that both the MACs (via instructions issued by CMS) and CMS evaluate the accuracy and reasonableness of hospitals' wage index data. Each year, in every IPPS proposed rule, we discuss the process wherein CMS asks the MACs to "revise or verify data elements that result in specific edit failures" (most recently, in the FY 2015 IPPS/LTCH PPS proposed rule (79 FR 28064)). We state that, in constructing the wage index, we include the wage data for facilities that were IPPS hospitals in the relevant cost reporting year (that is, FY 2011 for the FY 2015 wage index), and that we include "those facilities that have since terminated their participation in the program as hospitals, *as long as those data did not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general appropriate to reflect the economic conditions in the various labor market areas during the relevant past period and to ensure that the current wage index represents the labor market area's current wages as compared to the national average of wages."* CMS has historically exercised its discretion in developing a wage index that reflects a relative measure of the value of the labor provided to a typical hospital in a particular labor market area. We applied these same procedures, as discussed below, to the hospital at issue, and we disagree with the commenters that we have arbitrarily and capriciously removed the wage data of the cited hospital from the FY 2015 wage index.

In the instance of the particular hospital to which the commenters refer, while the hospital's wage data was properly documented, it did not merely have the highest average hourly wage in the CBSA; its average hourly wage was extremely and unusually high, significantly higher than the next highest average hourly wage in that CBSA and in the surrounding areas. We do not believe that the average hourly wage of this particular hospital accurately

> reflects the economic conditions in its labor market area during the FY 2011 cost reporting period, and, therefore, its inclusion in the wage index would *not* ensure that the FY 2015 wage index represents the labor market area's current wages as compared to the national average of wages. Accordingly, we have exercised our discretion to remove this hospital's wage data from the February 20, 2014 PUF, and from the May 2, 2014 PUF as well. Similarly, we have exercised our discretion by removing from the wage index (in FY 2015 and in prior years) the data of hospitals with average hourly wages that are unusually and uncharacteristically low for their respective CBSAs because we believe that the wage data of those hospitals also do not accurately reflect the economic conditions in their labor market area. We included the hospital's wage data in the wage index in previous years because the hospital's average hourly wage was lower and more reasonable relative to its labor market area in the prior years and, thus we did not remove the hospital's wage data from the prior years' wage index.[125]

Therefore, the Providers' argument that the rule never went through a formal notice and comment process fails. Rather, the Secretary did not make the change requested by the Providers, and the Providers now challenge the Secretary's process.

The Board notes that the Medicare Contractor's request that the Board consider expedited judicial review, as presented in its Consolidated Final Position Paper,[126] is inappropriate and fatally flawed. Board Rule 42.2, Requests for EJR, states:

> Because an EJR request is time sensitive, the request for EJR is to be filed separately and clearly labeled. The request for EJR is not to be included in the text of another filing such as a jurisdictional brief or position paper and will not be considered filed if so included.

Thus, the Board does not consider this request properly filed and reminds the Medicare Contractor not only of Board Rule 42.2, but also of Rule 44, Motions, and the process to correctly make a motion to the Board.

E. The Providers in Case No. 18-0634GC failed to include an appropriate cost report claim for the AHW issue as required by 42 C.F.R. § 413.24(j)(1) [127]

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[125] 79 Fed. Reg. at 49964-65.

[126] *See* Medicare Contractor's Consolidated FPP at 10.

[127] In reviewing the other cases in this consolidated hearing, the Board notes that in Case Number 16-0809GC the Providers' FYE 6/30/2017 cost reporting period is implicated in FFY 2016 and for Case Number 17-0913GC the Providers' FYEs 6/30/2017 and 6/30/2018 cost reporting periods are implicated in FFY 2017. These cost reporting periods are subject to the substantive claim regulation, however, there is no evidence of any substantive claim challenges being filed in Case Numbers 16-0809GC or 17-0913GC. The Board interprets the regulation at 42

On February 28, 2023 the Medicare Contractor filed a Substantive Claim Challenge in Case No. 18-0634GC, questioning whether the Providers' cost reports included an appropriate claim for the Wage Index issue alleging that "[t]he Providers have not claimed reimbursement for the Wage Index issue in dispute in the Providers' accepted cost reports for the applicable cost reporting periods in accordance with Medicare policy, nor have the Providers self-disallowed the specific item in the Providers' cost reports."[128] As a result of this challenge, the Board must address this question in accordance with the procedures at 42 C.F.R. § 405.1873(b).

Based on its review of the record, the Board finds that the Providers did ***not*** include an appropriate cost report claim for the AHW issue as required by 42 C.F.R. § 413.24(j)(1). It is clear from the record that the Providers did not comply with their obligation under § 413.24(j)(1) to "include an appropriate claim for the ***specific*** item"[129] by either: (1) "[c]laiming full reimbursement" that it believes it is due under the Wage Index; or (2) protesting the Wage Index issue following the procedures set forth in § 413.424(j)(2) "for properly disallowing the specific item in the provider's cost report as a protested amount."[130] Here, the Providers failed to make a claim for the "specific item," namely the allegedly understated wage index due to the exclusion of data from Southwestern Medical Center in the Tulsa CBSA wage index calculation. In this regard, the Board notes that the Providers did not file any items under protest related to the issue. In fact, the Providers' only response to the Medicare Contractor's Substantive Claim Challenge is that the 2016 self-disallowance rule on which the Medicare Contractor relies is unlawful and unenforceable. Additionally, the Board finds that none of the three exceptions set forth at 42 C.F.R. § 413.24(j)(3)(i) through (3)(iii) apply to the Providers.

DECISION:

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

1. CMS acted within its authority when it excluded the average hourly wage of Southwestern Medical Center from the Tulsa CBSA in calculating the wage index for Federal Fiscal Years (FFYs) 2015 through 2018.

2. The Providers in the group Case No. 18-0634GC failed to include appropriate cost report claims on their cost reports for the wage index average hourly wage issue under appeal in this case, as required under 42 C.F.R. § 413.424(j)(1).

C.F.R. § 405.1873 to only require the Board to review a Provider's compliance with the reimbursement requirement of an appropriate cost report claim ***if*** a party to the appeal questions whether there was an appropriate claim made. Since no parties have questioned whether an appropriate cost report claim was made, the Board finds that there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered.

[128] Case. No. 18-0634GC, Medicare Contractor's SCL at 5.

[129] 42 C.F.R. § 413.24(j)(1) (bold and italics emphasis added).

[130] 42 C.F.R. § 413.24(j)(1)(ii).

BOARD MEMBERS:

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

FOR THE BOARD:

8/5/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

APPENDIX A

Provider Number	Provider Name
Case No. 15-1299G K&S 2015 Tulsa Hospitals Wage Index Group	
37-0018	Jane Phillips Memorial Medical Center (Bartlesville, Washington, OK)
37-0039	Hillcrest Hospital Claremore a/k/a Claremore Regional Hospital (Claremore, Rogers, OK)
37-0091	Saint Francis Hospital (Tulsa, Tulsa, OK)
37-0183	Hillcrest Hospital Henryetta (Henryetta, Okmulgee, OK)
37-0202	Hillcrest Hospital South (Tulsa, Tulsa, OK)
37-0218	Saint Francis Hospital South (Tulsa, Tulsa, OK)
37-0227	St. John Owasso (Owasso, Tulsa. OK)
37-0228	Bailey Medical Center (Owasso, Tulsa, OK)
37-0235	St. John Broken Arrow (Broken Arrow, Tulsa, OK)

Provider Number	Provider Name
Case No. 16-0809 2016 Saint Francis Wage Index Group Appeal	
37-0091	Saint Francis Hospital Tulsa, OK
37-0218	Saint Francis Hospital South Tulsa, OK
Case No. 17-0913GC Saint Francis Health System FFY 2017 Wage Index CIRP Group	
37-0091	Saint Francis Hospital (Tulsa, Tulsa, OK)
37-0218	Saint Francis Hospital South (Tulsa, Tulsa, OK)
Case No. 18-0634GC Saint Francis Health System FFY 2018 Wage Index CIRP Group	
37-0091	Saint Francis Hospital (Tulsa, Tulsa County, OK)
37-0218	Saint Francis Hospital South (Tulsa, Tulsa County, OK)

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