CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Northeast Regional Medical Center	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: May 31, 2011**
Provider	
vs.	
WPS Government Health Administrators	**Review of: PRRB Dec. No. 2019-D38 Dated: August 30, 2019**
Medicare Administrative Contractor	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare (CM) and the Medicare Administrative Contractor (MAC) submitted comments, requesting reversal of the Board's decision. Comments were also received from the Provider requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Provider, as a Sole Community Hospital (SCH), was properly reimbursed for indirect medical education costs for services provided to Medicare Advantage (MA or Part C) patients for the cost reporting period in dispute. In particular, whether the Cost Report Worksheet E Part A properly calculates the indirect medical education (IME or indirect GME) settlement on Medicare Manage Care claims, for SCH whose hospital-specific rate (HSR) exceeds the hospital's inpatient prospective payment (IPPS) Federal rate.

The Board held that the MAC failed to properly pay the Provider a medical education payment for its discharges related to Medicare Part C managed care enrollees for its cost reporting period, ending May 31, 2011. The Board remanded the case to the MAC to pay the Provider a medical education payment for its discharges related to Medicare Part C manage care enrollees, in addition to payment determined by the HSR rate calculation.

In reaching this determination, the Board concluded that the language in § 1886(d)(11) and the regulations at 42 C.F.R. § 412.105(g) unambiguously mandated that "any" subsection (d) hospitals with approved medical residency training programs are entitled to an "additional payment" for medical education for their managed care enrollees. The Board found that Congress was clear – not silent – that "any" subsection (d) hospital is to be paid "additional payments" for managed care enrollees. In establishing "additional payments" for medical education for managed care enrollees, Congress did not modify the statutory provisions governing payment of IME for Medicare Part A patients or the IPPS payment rate for Part A inpatient discharges. Rather, Congress implemented a new §1886(d)(11) requiring an additional payment to "any" subsection (d) hospitals with an approved medical residency training program, for managed care discharges. Since Congress based this payment on the hospital's discharges of individuals who were enrolled under Part C, not discharges paid under Part A, the Board found there was no need for Congress to change either §§ 1886(d)(5)(D)(i) or 1886(b)(3) as argued by the Administrator in *Mary Imogene Bassett*,[1] since these statutory provisions pertain to Medicare Part A.

Finally, the Board stated that it was not bound by the Administrator's decision in *Mary Imogene Bassett*, because during the time period at issue, the Administrator's policy as stated therein had not been codified in regulation, statute, or ruling. Accordingly, the Board concluded that the "additional payment" for medical education for managed care enrollees was not an "IME" adjustment (as that term is used in § 1886ww(d)) to the IPPS rate and, therefore, an SCH that is also a teaching hospital must be paid a medical education payment for its managed care enrollees regardless of whether the SCHs payments are determined based on the IPPS Federal rate or the HSR rate.

SUMMARY OF COMMENTS

The MAC submitted comments, requesting that the Administrator reverse the Board's decision. The MAC's position is that the rational applied by the Administrator in *Mary Imogene Bassett*, reversing the Board's decision, should be applied in review of the Board's decision in this case.

The Provider submitted comments, requesting that the Administrator affirm the decision of the Board. The Provider contends that the explicit language of the statue entitles it to IME reimbursement for Medicare Part C patients.

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[1] *See*, PRRB Decision No. 2018-D25, rev'd Adm'r (Apr. 26, 2018).

The CM submitted comments, requesting that the Administrator reverse the Board's decision, and affirm that, for the cost reporting period under appeal, 2011, the MAC properly excluded Part C IME payments from the Provider's HSR-based IPPS payment.

The CM noted that Congress was silent to the question of whether a hospital reimbursed under the HSR rather than the IPPS Federal rate would be entitled to an additional IME payment for Part C enrollees. CM further noted that under *Chevron U.S.A., Inc. v Natural Resources Defense Council, Inc*., 476 U.S. 837 (1984), CMS has the authority to reasonable interpret the statutory provision, and did so. Specifically, in the FY 2015 IPPS final rule, CMS explained why it previously interpreted the statute to mean that a SCH paid based on its HSR was not entitled to receive payment for discharges of Medicare Part C patients under § 1886(d)(11): "[b]ecause a SCH that is paid based on its hospital-specific rate does not receive any IME add-on payment for Medicare Part A patients as provided under the section 1886(d)(5)(B) of the Act, CMS has interpreted section 1886(d)(11)(C) of the Act to mean that a SCH that is paid based on its HSR also is not entitled to receive payment for discharges of Medicare Part C patients under section 1886(d)(11) of the Act."

Finally, CM noted that the FFY 2015 IPPS proposed and final rule stated explicitly that the Secretary was implementing a prospective change in policy, effective for discharges occurring in cost reporting periods beginning on or after October 1, 2014, after further consideration, of the language at § 1886(d)(11) that neither addressed nor prohibited the payment. There is no indication in the preamble, regulations, or cost reporting instructions that CMS was making a clarification in policy which would be applied retroactively.

DISCUSSION

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

Pursuant to the Social Security Amendments of 1983,[2] congress established the inpatient prospective payment system (IPPS) for inpatient operating costs (PPS) as reflected in § 1886(d) of the Social Security Act (Act). Under IPPS, hospitals receive certain add-on payments such as disproportionate share adjustment and, relevant to this case, the indirect medical education (IME) adjustment under § 1886(d)(5)(B) of the Act.[3]

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[2] Social Security Amendments of 1983, §601, Pub. L. No. 98-21, 97 Stat. 65, 149-163 (1986).

[3] 48 *Fed. Reg.* 39752 (September 1, 1983 (("5. Indirect Medical Education – Section 1886(d)(5)(B) of the Act provides for additional payments to be made to hospitals under the prospective payment system for the indirect costs of medical education. This payment is computed in the same manner as the indirect teaching adjustment under the notice of

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

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

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

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

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hospital cost limits published September 30, 1982 (47 FR 43310), except that the educational adjustment factor is to equal twice the factor computed under that method…. The teaching adjustment *does not apply to any hospital not paid under the prospective payment system*, such as those hospitals or distinct part psychiatric and rehabilitation units that are paid on a reasonable cost basis, since the payments to those facilities already include the indirect costs of medical education.")

Regarding the HSR to be paid to a SCH, § 1886(b)(3)(C) explains:

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

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

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

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

In addition, under the IPPS payments, hospitals that incur the indirect costs of graduate medical education programs are paid pursuant to 42 C.F.R. § 412.105 *et.seq*. Specifically, 42 C.F.R. § 412.105, states:

> (1) The hospital's rate of full-time equivalent residents (except as limited under paragraph (f) of this section) to the number of beds (as determined under paragraph (b) of this section) …
> (2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made under the provisions of § 412.106.

Further, § 1886(d)(11) was implemented pursuant to final notice and comment rulemaking at 62 *Fed. Reg.* 45966 (August 29, 1997),[5] by adding a new paragraph (g) to § 412.105 to implement this provision, stating that:

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

The general rules for SCHs are set forth at 42 C.F.R. § 412.90 (2011) and state that:

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[5] 62 *Fed. Reg*. 45966 (august 29, 1997) (Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates) ("Section 4622 of Public Law 105-33 added a new section 1886(d)(11) to the Act to provider for IME payments to teaching hospitals for discharges associated with Medicare managed care beneficiaries for portions of cost reporting period occurring on or after January 1, 1998. The additional payment is equal to an "applicable percentage" of the estimated average per discharge amount that would have been made for that discharge if the beneficiary were not enrolled in managed care. The applicable percentage is set forth in section 1886(h)(3)(D)(ii) of the Act and is equal to 20 percent in 1998, 40 percent in 1999, and 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and subsequent years. We are adding a new paragraph (g) to § 412.105 to implement this provision.").

> (a) *Sole community hospital*. CMS may adjust the prospective payment rate for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under § 412.92(a), its prospective payment rates for inpatient operating costs are determined under § 412.92(d).

Regarding the payments for SCHs, 42 C.F.R. § 412.92(d) states that:

> (d) *Determining prospective payment rates for inpatient operating costs for sole community hospital-*
> (1) *General rule*. For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:
> (i) The Federal payment rate applicable to the hospitals as determined under subpart D of this part.
> (ii) The hospital-specific rate as determined under § 412.73.
> (iii) The hospital-specific rate as determined under § 412.75.
> (iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under § 412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section.).
> (v) For cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate as determined under § 412.78.[6]

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

For the cost year at issue (2011), § 3601.1 of the Provider Reimbursement Manual (PRM) 15-2 or PRM 15-2 § 4030 for worksheet E Part A applied. Historically, when payments to SCHs are based on the HSR[7] they do not include IME add-on payments.[8] The Secretary,

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[6] For a more detailed discussion of the original calculation of the FY 1982 hospital-specific rate and the FY 1987 hospital-specific rate, *see* the September 1, 1983 interim final rule (48 *Fed. Reg*. 39772); the April 20, 10990 final rule with comments (55 *Fed. Reg*. 15150); and the September 4, 1990 final rule (55 *Fed. Reg*. 35994).

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

[8] *See* 79 *Fed. Reg*. 27978, 28092-28093 (2014); *See also* 62 *Fed. Reg*. 45966, 46122 (Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and

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

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

Fiscal Year 1998 Rates) August 29, 1997) ("Because hospitals receiving their hospital-specific rate do not receive outliers, IME, or DSH, they are unaffected by the policy changes related to these additional payments.")

> As noted above, under section 1886(d)(5)(D) of the Act, SCHs are paid based on their hospital-specific rate or the IPPS Federal rate, whichever yields the higher payment for the hospital's cost reporting period. For each cost reporting period, the MAC determines which of the payment options will yield the higher aggregate payment. Interim payments are automatically made on a claim-by-claim basis at the higher rate using the best data available at the time the MAC makes the payment determination for each discharge. However, it may not be possible for the MAC to determine in advance precisely which of the rates will yield the higher aggregate payment by year's end. In many cases, it is not possible to forecast outlier payments or the final amount of the DSH payment adjustment or the IME adjustment until cost report settlement. As noted above, these adjustments amounts are applicable only to payments based on the Federal rate and not to payments based on the hospital-specific rate. The MAC makes a final adjustment at cost report settlement after it determines precisely which of the two payment rates would yield the higher aggregate payment to the hospital for its cost reporting period. This payment methodology makes SCHs unique because SCH payments can change on a yearly basis from payments based on the hospital-specific rate to payments based on the Federal rate, or vice versa.[9]

In this case, the Provider contends that it should have received IME payments for its Medicare Part C patients, because the statute "is clear, and requires that any subsection (d) hospital (which includes a SCH) be paid an 'additional payment' for medical education for manage care enrollees," and not doing so represents a failure on the part of CMS to comply with the statute and regulations. The MAC and CM contends that the statute was silent as to this payment being available to SCHs. In addition, the CMS regulations and cost reporting instructions in effect during the cost reporting period under review did not allow for payment of Part C IME when the provider is paid based on the HSR and that the change in the methodology in the regulation in the FFY 2015 final rule was only prospective.

Applying the foregoing provisions to the facts of this case, the Administrator finds that the MAC reimbursed the Provider utilizing the proper methodology for the cost reporting period, ending May 31, 2011. As a SCH, the Provider was properly reimbursed, consistent with Worksheet E Part A at the higher of either the Federal rate or the HSR (without the IPPS add-on payments) which is in accord with the controlling regulation and statute.. As the Administrator previously discussed in *Mary Imogene Bassett*, the FY 2015 IPPS proposed and final rule stated explicitly that the Secretary was implementing a prospective change in policy, effective for discharges occurring in cost reporting periods beginning on or after October 1, 2014, after further consideration, of the language at § 1886(d)(11). The Administrator finds that there is no indication in the preamble, regulations, or cost reporting

[9] *Id*.

instructions that the Secretary was making a clarification in policy which would be applied retroactively.

Further, the Secretary's prospective implementation is not inconsistent with the statute. The Provider states that the language of § 1886(d)(11) required the payment of IME related to Medicare Part C patients when a SCH is under the HSR methodology for the cost reporting period under review. The Provider argues that § 1886(d)(11) plainly indicates such payments for a § 1886(d) hospital and the Provider is a § 1886(d) hospital, even though it was paid under the § 1886(b) HSR methodology, and cites to case law to support that the PRM cannot override the statutorily mandated payment.

However, while § 1886(d)(11) is instructive as to the payment under § 1886(d) Federal rate payment determination, it is silent as to including an IME payment for a SCH HSR paid under the section 1886(b) methodology. The silence is relevant when viewed in the context of Congresses' specific statutory direction and instruction as to method of paying SCH under § 1886(d)(5)(i), which incorporated the §1886(b)(3)(C) SCHs under § 1886(b)(3)(I) non-IPPS HSR methodology.[10] In addition, CMS has repeatedly stated in notice and

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

See also, 73 *Fed. Reg*. 48434, 48628 (August 19, 2008) Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rate) (For SCHs, effective with hospital cost reporting periods beginning on or after October 1, 2000, and before January 1, 2009, section 1886(d)(5)(D)(i) of the Act (as amended by section 6003(e)

comment rulemaking that no IPPS add-ons were included in the HSR calculations throughout the time period prior to the 2015 effective change in methodology. It is reasonable to conclude that Congress was aware of CMS' pre-2015 stated policy when it

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of Pub. L. 101-239) and section 1886(b)(3)(1) of the Act (as added by section 405 of Pub. L. 106-554) provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period: • The Federal rate applicable to the hospital; • The updated hospital-specific rate based on FY 1982 costs per discharge; • The updated hospital-specific rate based on FY 1996 costs per discharge. For purposes of payment to SCHS for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 were updated FY 1982 or FY 1987 hospital-specific rate. For discharges during FY 2004 and subsequent fiscal years, payments based on the FY 1996 hospital-specific rate are based on 100 percent of the updated FY 1996 hospital-specific rate…. As discussed in detail in section IV.D.2. of this preamble, the recently enacted Medicare Improvements for Patients and Providers Act of 2008 (Pub. L 110-275), contains a provision under section 122 that changes the provisions for rebasing the payments for SCHs, effective for cost reporting periods beginning on or after January 1, 2009.");

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

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

repeatedly revisited the HSR methodology at section 1886(b) after the addition of section 1886(d)(l 1) and continued to remain silent as to the addition of the IME related managed care add-on under the HSR methodology. Thus, the Secretary reasonably concluded that the language at § l886 (d)(11) did not directly address the matter, but also did not prohibit going forward with the policy of allowing the inclusion of this payment in the HSRs for SCHs prospectively.

In sum, when the record and law is reviewed, the Administrator finds that the MAC properly excluded Part C IME payments from the Provider's HSR for the cost reporting period under review. The Secretary has not interpreted the statute to require a SCH, such as the Provider, to be paid IME for its Part C patients when the SCH is paid based on the HSR.

DECISION

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

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

Date: Oct. 29, 2019

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