IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

NEW LIFECARE HOSPITALS OF CHESTER COUNTY LLC, *et al.*, Plaintiffs, v. ALEX M. AZAR II, Secretary U.S. Department of Health and Human Services Defendant.	Civil Action No. 19-cv-705 (EGS)

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Plaintiffs New LifeCare Hospitals of Chester County LLC, *et al.*, pursuant to Federal Rule of Civil Procedure 56, respectfully move for summary judgment in their favor on the grounds that there are no material facts in dispute and that Plaintiffs are entitled to judgment as a matter of law.

The Centers for Medicare and Medicaid Services ("CMS," represented here by the Secretary of the Department of Health and Human Services ("HHS")) applies a duplicative budget neutrality adjustment ("BNA") under 42 C.F.R. § 412.522(c)(2)(i) to the site neutral payment rate under the Long Term Care Hospital Prospective Payment System ("LTCH PPS"). CMS calculated this BNA as negative 5.1 percent in the fiscal year ("FY") 2019 IPPS/LTCH PPS Final Rule (83 Fed. Reg. at 41737-38), which is the same percentage that CMS calculated and applied in FYs 2016 through 2018, and that CMS has proposed for FY 2020. CMS applies this duplicative BNA even though the Plaintiffs, hospital trade associations, the Medicare Payment Advisory Commission ("MedPAC"), and others explained the Defendant's error in comments submitted to CMS during the notice-and-comment rulemaking process. CMS'

decision to apply the duplicative BNA adversely impacts Plaintiffs by reducing Plaintiffs' aggregate Medicare payments by millions of dollars each year. The Plaintiffs challenged this duplicative BNA by filing an appeal with the HHS Provider Reimbursement Review Board ("PRRB") and requested expedited judicial review. The PRRB granted Plaintiffs' request.

CMS' duplicative BNA is legally invalid because it is arbitrary and capricious, an abuse of discretion, or otherwise not in accordance with law, it is unsupported by substantial evidence, and it violates the APA's notice and comment rulemaking requirements, for the following reasons. *First*, the BNA is arbitrary and capricious because CMS did not account for the budget neutrality adjustments already included in the IPPS comparable per diem amount. *Second*, CMS' decision to apply a second outlier BNA to the LTCH site neutral payment rate is not supported by substantial evidence. *Third*, CMS' duplicative BNA violates the Social Security Act and other federal laws. *Finally*, CMS violated the APA's notice and comment rulemaking requirements when CMS did not provide a sufficient response to comments raising major issues regarding the duplicative BNA.

For these reasons, and the reasons set forth in the accompanying Memorandum of Points and Authorities, which is hereby incorporated by reference, CMS' duplicative BNA should be set aside and the Court should order the Secretary to reimburse Plaintiffs for the Medicare payments that CMS withheld from Plaintiffs in the amount of the duplicative 5.1 percent outlier BNA in federal fiscal years 2016 through 2019, with interest, costs and fees, and order the Secretary to not apply the duplicative BNA to LTCH PPS site neutral payments in federal fiscal year 2020 and later years.

Dated: June 19, 2019

Respectfully Submitted,

/s/ *Jason M. Healy*

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ALEX M. AZAR II, Secretary
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PLAINTIFFS' MEMORANDUM OF POINTS AND AUTHORITIES
IN SUPPORT OF THE MOTION FOR SUMMARY JUDGMENT

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GLOSSARY

AHA	American Hospital Association
BBRA	Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, 113 Stat. 1501 (1999)
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, 114 Stat. 2763 (2000)
BNA	Budget Neutrality Adjustment
CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
FAH	Federation of American Hospitals
HCO	High-Cost Outlier
ICU	Intensive Care Unit
IME	Indirect Medical Education
IPPS	Inpatient Prospective Payment System
LTCH	Long-Term Care Hospital
MedPAC	Medicare Payment Advisory Commission
MS-DRG	Medicare Severity Diagnosis Related Group
MS-LTC-DRG	Medicare Severity Long-Term Care Diagnosis Related Group
PPS	Prospective Payment System
PRRB	Provider Reimbursement Review Board
PSRA	Pathway for SGR Reform Act of 2013, Pub. L. No. 113-67, Div. B, 127 Stat. 1165 (2013)
SSA	Social Security Act
SSO	Short-Stay Outlier

I. INTRODUCTION

This case is about a duplicative budget neutrality adjustment ("BNA") that the Defendant's Centers for Medicare & Medicaid Services ("CMS") calculates in the annual payment update and applies to the site neutral payment rate under the Long-Term Care Hospital Prospective Payment System ("LTCH PPS") pursuant to the regulation at 42 C.F.R. § 412.522(c)(2)(i). Plaintiffs' Medicare certified long-term care hospitals ("LTCHs") operated by LifeCare Health Partners ("LifeCare Hospitals"), Post Acute Medical, LLC ("Post Acute Medical"), Vibra Healthcare, LLC ("Vibra Healthcare"), and Kindred Healthcare, Inc. ("Kindred Healthcare"), located throughout the United States, challenge the Defendant's unlawful adoption and implementation of a negative 5.1 percent outlier BNA that Defendant is applying *twice* to LTCH PPS site neutral case payments. The 101 Plaintiffs represent more than one-quarter of the total number of LTCHs nationwide. Plaintiffs' LTCHs provide care for medically complex patients who require acute care hospital services for an extended period of time. Defendant's duplicative BNA is based on a flawed methodology that improperly reduces Medicare payments to the Plaintiffs and results in a windfall for the Medicare program. Plaintiffs explained the Defendant's error in comments submitted to CMS during the notice-and-comment rulemaking process. The Defendant has dismissed these comments and has refused to take a "hard look" at this issue. Moreover, the duplicative BNA is not the product of reasoned decisionmaking and reflects a clear error in judgment by Defendant's CMS. This erroneous BNA is therefore a textbook violation of the arbitrary and capricious standard under the Administrative Procedure Act ("APA"). 5 U.S.C. § 705(2)(A). In addition, this duplicative BNA violates the Social Security Act ("SSA") and other federal laws.

II. STATUTORY AND REGULATORY BACKGROUND

A. LTCH PPS

The Medicare reimbursement system for LTCHs, the LTCH PPS, is based on different levels of cost than the system applicable to general acute care hospitals, the inpatient hospital prospective payment system ("IPPS"). For a hospital to be reimbursed under the LTCH PPS, by contrast, it must have an average Medicare inpatient length of stay that is greater than twenty-five days, which reflects the medically complex cases treated in LTCHs. Each patient discharged from a LTCH is assigned to a distinct Medicare severity long-term care diagnosis related group ("MS-LTC-DRG"),[1] and the LTCH is generally paid a predetermined fixed amount applicable to the assigned MS-LTC-DRG (adjusted for area wage differences). The payment amount for each MS-LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to that MS-LTC-DRG in a LTCH.

Weights are assigned to MS-DRGs and MS-LTC-DRGs on an annual basis that are multiplied against a Federal standard rate to arrive at the payment for the discharged patient, after taking other adjustments into consideration. *See* 42 C.F.R. §§ 412.515, 412.521. Most of the MS-LTC-DRGs for LTCHs are the same as the MS-DRGs for general acute care hospitals, but the weights are generally higher. In addition, the Federal standard rate has been much higher for LTCHs than for general acute care hospitals because of the longer average length of stay and medical complexity of LTCH patients: $41,558.68 under the LTCH PPS for FY 2019, *see* 83 Fed. Reg. 49836, 49847 (Oct. 3, 2018) (correction notice), compared to approximately $6,000 under the IPPS for FY 2019, *see id.* at 49844-45 (operating and capital rates combined).

[1] The IPPS final rule for FY 2008 also created Medicare-severity DRGs for LTCH PPS, referred to as "MS-LTC-DRGs". *See* 72 Fed. Reg. 47130 (Aug. 22, 2007).

B. LTCH Site Neutral Payment

For LTCH discharges in cost reporting periods beginning on or after October 1, 2015, Congress established a new dual-rate payment structure under the LTCH PPS, with two distinct payment rates. 42 U.S.C. § 1395ww(m)(6) (SSA § 1886(m)(6)). The first payment rate is the LTCH PPS standard Federal payment rate, discussed above. *Id.* at § 1395ww(m)(6)(A)(ii) (SSA § 1886(m)(6)(A)(ii)). This first payment rate only applies to discharges that meet one of the two patient criteria established by section 1206 of the Pathway for SGR Reform Act of 2013 ("PSRA"), Pub. L. No. 113-67, Div. B, 127 Stat. 1165 (2013)[2]—3 or more days in a "subsection (d) hospital"[3] intensive care unit ("ICU") or LTCH ventilator services of at least 96 hours—and a principal diagnosis that is not psychiatric or rehabilitation. *Id.* at §§ 1395ww(m)(6)(A)(ii),(iii),(iv) (SSA §§ 1886(m)(6)(A)(ii),(iii),(iv)). All other LTCH Part A discharges are reimbursed at the site neutral payment rate, which is the lesser of the IPPS comparable per diem amount (including any applicable outlier payments) or 100 percent of the estimated cost of the services involved. *Id.* at § 1395ww(m)(6)(B)(ii) (SSA § 1886(m)(6)(B)(ii)).

CMS implemented the site neutral payment rate through the regulation at 42 C.F.R. § 412.522. The IPPS comparable per diem amount used for determining LTCH site neutral payments is calculated by adding the adjusted standardized IPPS operating amount to the adjusted capital IPPS Federal rate, divided by the geometric average length of stay of the specific

[2] Congress has amended Section 1206 of the Pathway for SGR Reform Act of 2013 on several occasions. However, none of the amendments are at issue in this case. *See* Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 51005, 132 Stat. 64 (2018); 21st Century Cures Act, Pub. L. No. 114-255, §§ 15009(a), 15010(a), 130 Stat. 1033 (2016); Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 231, 129 Stat. 2242 (2015); Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 112(a), 128 Stat. 1040 (2014).

[3] A reference to section 1861(d)(1)(B) of the SSA (42 U.S.C. § 1395x(d)(1)(B)). These are primarily general short-term acute care hospitals paid by Medicare under the IPPS.

MS-DRG under the IPPS, and multiplying that amount by the covered days of the LTCH stay, but no higher than the full IPPS payment amount. FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49608-09 (Aug. 17, 2015) (Rulemaking Record ("R.R.) at 1250-51).

CMS bases the IPPS comparable per diem amount for LTCH site neutral cases on the IPPS rate as instructed by Congress in section 1206(a)(1) of the PSRA. The definition of the LTCH PPS site neutral payment rate in the statute directs CMS to use the "IPPS comparable per diem amount" as determined under 42 C.F.R. § 412.529(d)(4). 42 U.S.C. § 1395ww(m)(6)(B)(ii); *see also* 42 C.F.R. § 412.522(c)(1)(i). The regulation at 42 C.F.R. § 412.529 contains CMS' payment policy for LTCH short-stay outliers.[4] Subparagraph (d)(4)(i)(A) of this regulation generally describes how CMS calculates the IPPS comparable per diem amount as: "An amount comparable to what would otherwise be paid under the hospital inpatient prospective payment system based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge." 42 C.F.R. § 412.529(d)(4)(i)(A). Clauses (ii) and (iii) list numerous adjustments that CMS applies to the IPPS operating standardized amount and IPPS capital Federal rate, including adjustments for: IPPS DRG weighting factors, different area wage levels, indirect medical education ("IME") costs, and costs of serving a disproportionate share of low-income patients ("DSH"). *Id.* at §§ 412.529(d)(4)(ii),(iii).

[4] Short-stay outliers are cases where the beneficiary's length of stay at the LTCH is significantly less than the average. FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144, 41520 (Aug. 17, 2018) (R.R. at 5787). Short-stay outliers are not specifically at issue in this case, except that the definition of the LTCH site neutral payment rate borrows the concept of the IPPS comparable per diem amount from the short-stay outlier regulation (42 C.F.R. § 412.529). *See* 42 U.S.C. § 1395ww(m)(6)(B)(ii).

The IPPS operating standardized amount and IPPS capital Federal rate are calculated each year in the payment update rulemaking. Both include a 5.1 percent BNA for outlier payments, although the BNA to capital payments can vary slightly. These BNAs are clearly specified by the agency in the IPPS rate tables to each rule. *See, e.g.*, **Exhibit A,** 83 Fed. Reg. at 41724-25, 41729. CMS states that the previous year outlier BNAs are removed before the current year outlier BNAs are applied.[5] This avoids duplication for IPPS payments.

The flow chart at **Exhibit B** illustrates how the LTCH site neutral payment is calculated based on the IPPS comparable per diem amount using, as an example, a stroke patient who does not meet the criteria for Medicare payment at the standard Federal payment rate under the LTCH PPS. *See* Exhibit B (Calculation of LTCH Site Neutral Payment Based on IPPS Comparable Per Diem Amount).

LTCHs are transitioning to the new LTCH PPS dual-rate structure with a blended payment rate that applies to site neutral discharges in cost reporting periods beginning on or after October 1, 2015 and on or before September 30, 2019. 42 U.S.C. § 1395ww(m)(6)(B)(i)(I) (SSA § 1886(m)(6)(B)(i)(I)). During this transition period, the blended payment rate for site neutral cases is equal to one-half the site neutral payment rate and one-half the LTCH PPS standard Federal payment rate. *Id.* at § 1395ww(m)(6)(B)(ii) (SSA § 1886(m)(6)(B)(ii)). FY 2019 is the last year of the transition period. LTCH site neutral discharges in cost reporting periods beginning on or after October 1, 2019 will be paid at 100% of the site neutral payment rate.

C. High-Cost Outlier Payments for LTCH Site Neutral Cases

[5] *See id*. at 21724, Table (the left column states "FY 2018 Base Rate after removing: . . . "2. FY 2018 Operating Outlier Offset (0.948998)"); *id*. at 41729, First Table, n.2 ("The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate.").

In addition to the standard Federal payment rate for a Medicare discharge, Medicare makes additional payments for high cost outlier ("HCO") cases that have extraordinarily high costs relative to the costs of most discharges. These high cost outlier payments are a feature of both the IPPS and the LTCH PPS. 42 U.S.C. § 1395ww(d)(5)(A)(ii) (SSA § 1886(d)(5)(A)(ii)); 42 C.F.R. § 412.525(a)(1).

Like LTCH cases that are paid the standard Federal payment rate, site neutral cases paid at the IPPS comparable per diem amount may include a LTCH outlier payment. 42 U.S.C. § 1395ww(m)(6)(B)(ii)(I) (SSA § 1886(m)(6)(B)(ii)(I)). For LTCH site neutral cases, CMS sets the same target amount of total HCO payments and fixed-loss amount as they do for IPPS hospitals. 83 Fed. Reg. at 41734 ("For site neutral payment rate cases, we adopted the operating IPPS HCO target (currently 5.1 percent) and set the fixed-loss amount for site neutral payment rate cases at the value of the IPPS fixed-loss amount.") (R.R. at 6001). CMS uses the same HCO target amount and fixed-loss amounts each year because CMS actuaries project that the costs and resource use for LTCH site neutral patients "will likely mirror the costs and resource use for IPPS cases assigned to the same MS-DRG." *Id*. at 41737 (R.R. at 6004); FY 2020 IPPS/LTCH PPS Proposed Rule, 84 Fed. Reg. 19158, 19616 (May 3, 2019).

D. Outlier Budget Neutrality Adjustment to LTCH Site Neutral Payments

Pursuant to the LTCH site neutral payment rate regulation, CMS applies a budget neutrality adjustment for HCO payments to the site neutral payment rate equal to the target amount. 42 C.F.R. § 412.522(c)(2)(i) ("(2) *Adjustments.* CMS adjusts the payment rate determined under paragraph (c)(1) of this section to account for− . . . (i) Outlier payments, by applying a reduction factor equal to the estimated proportion of outlier payments under § 412.525(a) payable for discharges from a long-term care hospital described in paragraph (a)(1)

of this section to total estimated payments under the long-term care hospital prospective payment system to discharges from a long-term care hospital described in paragraph (a)(1) of this section."). This BNA does not apply to the portion of the blended payment during the transition period for the standard LTCH PPS payment rate. *Id*. ("The adjustment under this paragraph (c)(2)(i) does not include the portion of the blended payment rate described in paragraph (c)(3)(ii) of this section."). The target amount is 5.1 percent—the same as the IPPS HCO target amount, as discussed above. The target amount and BNA methodology are stated in the proposed and final payment update rules each year, as discussed below. The application of this BNA is illustrated at page 2 of Exhibit B.

III. STATEMENT OF MATERIAL FACTS ON THE ADMINISTRATIVE RECORD

A. FY 2016 Rulemaking

CMS first implemented the site neutral payment rate for LTCHs during the FY 2016 IPPS/LTCH PPS rulemaking. In the FY 2016 IPPS/LTCH PPS Final Rule, CMS adopted a budget neutrality factor (adjustment) for the site neutral portion of the LTCH site neutral blended payment rate. FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49805 (Aug. 17, 2015) (R.R. at 1447). CMS claimed that this BNA was necessary "to ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2016 do not result [in] any increase in estimated aggregate FY 2016 LTCH PPS payments . . . ." *Id.* CMS finalized this BNA to reduce the LTCH site neutral payment rate amount by 5.1%. *Id.* In the same FY 2016 Final Rule, CMS finalized high cost outlier BNAs of negative 5.1% to the IPPS operating standardized amount and approximately the same amount to the IPPS capital Federal rate.[6] *Id.* at 49785, 49794-95

[6] Payment rates for operating and capital costs are handled separately under the IPPS, but combined under the LTCH PPS. Each year, the IPPS operating standardized amount budget

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(R.R. at 1427, 1436-37). The IPPS payment rate, as reduced by these IPPS outlier BNAs, is used to determine the IPPS comparable per diem amount under the LTCH PPS site neutral payment rate discussed above.

During the comment period for the FY 2016 LTCH PPS rulemaking, the Plaintiffs and other stakeholders submitted comments to CMS objecting to the BNA. The Plaintiffs explained to CMS that the proposed BNA was duplicative of the outlier BNAs already applied to the IPPS payment rate. For example, Kindred Healthcare, the parent company of many of the Plaintiffs, and another LTCH company submitted a comment letter to CMS that stated:

> Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers. In determining these payment rates for FY 2016, CMS reduced the IPPS payment rate by a factor of 0.948999 and CMS reduced the capital PPS payment rate by a factor of 0.935731. **It would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed site neutral HCO BNA. This would be the case because the IPPS comparable per diem amount will be based on the FY 2016 IPPS payment rate, which has already been adjusted by the 5.1 percent outlier target. Since CMS has already reduced the FY 2016 IPPS payment rate by the 5.1 percent of estimated outlier payments in FY 2016, it would be inappropriate for CMS to reduce LTCH payments that are based on the IPPS rate again for site neutral cases that qualify as HCOs. Therefore, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments.**[7]

The above section from Kindred Healthcare's FY 2016 comment letter was also included in Plaintiffs' Complaint. Complaint ¶23. The Defendant admits that this information from the comment letter is accurate. Answer ¶23. Post Acute Medical and Vibra Healthcare, the parent

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neutrality adjustment is 5.1% and the IPPS capital outlier budget neutrality adjustment is approximately 5.1%. Accordingly, for the sake of clarity, this Memorandum of Points and Authorities In Support Of Plaintiffs' Motion for Summary Judgment will generally refer to both IPPS adjustments as a budget neutrality adjustment of 5.1%.

[7] Kindred Healthcare, Inc. & Select Medical Holdings Corp., Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 39 (June 16, 2015) (footnote omitted) (R.R. at 689).

companies of other Plaintiffs, also submitted comments to CMS objecting to the duplicative BNA.[8] Vibra Healthcare's FY 2016 comment letter explained that Vibra Healthcare objected to the BNA because the IPPS comparable per diem amount was already reduced by the same 5.1%. *See* Vibra Healthcare, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 21.

Leading hospital trade associations also submitted comments to CMS during the FY 2016 rulemaking opposing the erroneous BNA. The American Hospital Association ("AHA") submitted a comment letter to CMS objecting to the "two outlier-related BNAs for site-neutral rates." American Hospital Association, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 7 (June 15, 2015) (R.R. at 426). The AHA explained:

> Specifically, the inpatient PPS rates used as the basis for site-neutral payment rates are already subject to a BNA for the inpatient PPS's 5.1 percent outlier pool. However, within the LTCH payment framework, CMS proposes a second BNA of 2.3 percent for the site-neutral outlier pool. CMS's rationale for this second BNA is to ensure that site-neutral HCO payments do not increase aggregate LTCH PPS payments. **However, we strongly disagree that the additional 2.3 percent BNA is necessary to achieve this goal; rather, it was already achieved when the 5.1 percent BNA was applied to the inpatient PPS rates used as the basis for the site-neutral rates. We recommend that CMS calculate standard LTCH PPS and site-neutral rates separately, without any co-mingling of these payments, as mentioned previously.** Furthermore, the second BNA prevents LTCH site-neutral payments from aligning with inpatient PPS payments for associated MS-DRG and MS-LTC-DRGs, which would counter the goals of BiBA.[9]

[8] Post Acute Medical, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 23-25 (June 16, 2015) (R.R. at 632); Vibra Healthcare, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 19-21 (June 15, 2015).

[9] American Hospital Association, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 7 (emphasis in original) (R.R. at 426). The AHA's FY 2016 comment letter references a 2.3% budget neutrality adjustment. CMS initially proposed a 2.3% adjustment in the FY 2016 Proposed Rule because CMS planned to apply a budget neutrality adjustment to all LTCH PPS payments. FY 2016 IPPS/LTCH PPS Proposed Rule, 80 Fed. Reg. 24324, 24649 (Apr. 30, 2015) (R.R. at 326). However, in the FY 2016 Final Rule, CMS decided that it would instead apply a 5.1% adjustment only to site neutral case payments. *See* FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. at 49805 (R.R. at 1447).

The Federation of American Hospitals ("FAH") submitted similar comments in response to the FY 2016 Proposed Rule. The FAH opposed the outlier BNA for LTCH site neutral cases because "CMS has already accounted for estimated outlier payments for site neutral cases when it adjusted the IPPS payment rate for FY 2016."[10] The FAH explained that because LTCH site neutral cases are already paid at the IPPS comparable rate, the additional BNA is "an additional unwarranted reduction in payment." Federation of American Hospitals, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 67 (R.R. at 587).

In the FY 2016 Final Rule, CMS acknowledged that it received comments objecting to the site neutral outlier BNA. 80 Fed. Reg. at 49622 (R.R. at 1264). In response to these objections, CMS stated:

> We disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is unnecessary or duplicative. While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments, that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate. The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS. Without a budget neutrality adjustment when determining payment for a case under the LTCH PPS, any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases. Therefore, our proposed approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases. For these reasons, we are not adopting the commenters' recommendation to change the calculation of the IPPS comparable per diem amount to adjust the IPPS operating standardized amount used in that

[10] Federation of American Hospitals, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 67 (June 16, 2015) (R.R. at 587).

> calculation to account for the application of the IPPS HCO budget neutrality adjustment.

Id. Despite admitting that the "HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS," CMS kept this HCO BNA and the separate LTCH site neutral outlier BNA of negative 5.1 percent in the calculation of the LTCH site neutral payment rate. *Id.*

B. FY 2017 Rulemaking

A similar process played out during the FY 2017 LTCH PPS rulemaking. However, this time the Medicare Payment Advisory Commission ("MedPAC") also strongly opposed the duplicative BNA. MedPAC is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program.[11] CMS proposed a 5.1% BNA to the LTCH site neutral payment rate portion of the blended payment rate. FY 2017 IPPS/LTCH PPS Proposed Rule, 81 Fed. Reg. 24946, 25288-89 (Apr. 27, 2016) (R.R. at 1826-27). MedPAC's FY 2017 comment letter objected to this separate BNA for LTCH site neutral high-cost outliers because, as the Plaintiffs and hospital trade associations were telling CMS, "the IPPS standard payment amount is already adjusted to account for HCO payments."[12] MedPAC explained why it was incorrect for CMS to apply another BNA to the LTCH site neutral payment rate:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates

[11] *See* MedPAC, *March 2019 Report to the Congress: Medicare Payment Policy*, Prologue (2019), http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0.

[12] MedPAC, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 16 (May 31, 2016) (R.R. at 1879).

> will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.**
>
> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**

MedPAC, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 16-17 (emphasis added) (R.R. at 1879-80).

Kindred Healthcare,[13] LifeCare Hospitals,[14] Post Acute Medical,[15] and Vibra HealthCare[16] each submitted comments objecting to the proposed BNA in the FY 2017 Proposed Rule. Kindred Healthcare included a table that clearly shows the duplication using the components of the site neutral payment rate. *See* Exhibit D (Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule, Table 1). Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

[13] Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 18-25 (June 17, 2016) (R.R. at 2109-16).

[14] LifeCare Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 7-11 (June 15, 2016) (R.R. at 1900-04).

[15] Post Acute Medical, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 14-21 (June 17, 2016) (R.R. at 2328-35).

[16] Vibra Healthcare, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 14-21 (June 17, 2016) (R.R. at 2019-26).

Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 18-25 at 22 (R.R. at 2113). The AHA[17] and FAH[18] also opposed the proposed site neutral BNA in the FY 2017 Proposed Rule. Many of these comments requested that CMS not only fix the erroneous calculation of the BNA for FY 2017, but also correct the adjustment CMS applied in FY 2016 because the hospitals were systematically underpaid. *See e.g.*, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 23 ("CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.") (R.R. at 2114).

Despite these strong objections from MedPAC, the Plaintiffs, other hospitals and hospital trade associations in written comments to the agency, CMS again dismissed these concerns and finalized the BNA for FY 2017. *See* FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56762, 57308-09 (Aug. 22, 2016) (R.R. at 2908-09).[19]

C. FY 2018 Rulemaking

In FY 2018, CMS continued applying the BNA over the objections of the Plaintiffs and others. The FY 2018 IPPS/LTCH PPS Final Rule contained an identical BNA. FY 2018 IPPS/LTCH PPS Final Rule, 82 Fed. Reg. 37990, 38544-46 (Aug. 14, 2017) (R.R. at 4611-13).

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[17] American Hospital Association, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 5-8 (June 17, 2016), https://www.aha.org/system/files/advocacy-issues/letter/2016/160617-let-nickels-slavitt-ltch.pdf.

[18] Federation of American Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 48-49 (June 17, 2016) (R.R. at 2230-31).

[19] In the FY 2017 IPPS/LTCH PPS Final Rule, CMS did make one change to the BNA. CMS decided that the budget neutrality adjustment would not be applied to the HCO payment itself for site neutral payment rate cases. 81 Fed. Reg. at 57309 (R.R. at 2909).

During the FY 2018 comment period, Kindred Healthcare,[20] LifeCare Hospitals,[21] Post Acute Medical,[22] and Vibra HealthCare[23] each submitted comments opposing the proposed adjustment for FY 2018. The Plaintiffs also continued to request that CMS correct the duplicative adjustment that CMS already applied to FY 2016 and FY 2017 LTCH site neutral payments.[24] In addition to the Plaintiffs, the AHA and FAH again objected to the FY 2018 BNA.[25] Despite these objections for a third year, CMS again finalized the BNA without any change. *See* FY 2018 IPPS/LTCH PPS Final Rule, 82 Fed. Reg. 37990, 38544-46 (Aug. 14, 2017) (R.R. at 4611-13). CMS reiterated its belief that it has "the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner" and referred readers to its responses to comments in the two previous years. *Id.* at 38546 (R.R. at 4613).

D. FY 2019 Rulemaking

In the FY 2019 IPPS/LTCH PPS Proposed Rule, CMS again proposed an outlier BNA for all LTCH site neutral cases. CMS claimed this adjustment is necessary so that HCO

[20] Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 5-12 (June 13, 2017) (R.R. at 3589-96).

[21] LifeCare Hospitals, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 14-18 (June 13, 2017) (R.R. at 3491-95).

[22] Post Acute Medical, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 4 (June 12, 2017) (R.R. at 3427).

[23] Vibra Healthcare, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 20-23 (June 13, 2017) (R.R. at 3457-60).

[24] *See e.g.*, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 12 ("CMS should reverse this adjustment to all FY 2016 and FY 2017 payments, or make an equivalent prospective increase in payments to FY 2018 site neutral rate cases to account for this underpayment.") (R.R. at 3596).

[25] American Hospital Association, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 4-7 (June 13, 2017) (R.R. at 3569-72); Federation of American Hospitals, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 62-63 (June 13, 2017) (R.R. at 3773-74).

payments for such cases do not result in any change to estimated aggregate LTCH payments. FY 2019 IPPS/LTCH PPS Proposed Rule, 83 Fed. Reg. 20164, 20596 (May 7, 2018) (R.R. at 5089). The proposed BNA would reduce the LTCH site neutral payment rate amount by 5.1% to offset the cost of LTCH site neutral HCO payments in FY 2019. *Id.* In addition to this BNA for LTCH site neutral HCO cases, CMS again proposed adjusting the IPPS payment rate to account for projected IPPS outlier payments. 83 Fed. Reg. at 20583 (R.R. at 5076). CMS proposed a BNA to reduce the IPPS payment rate by 5.1%. *Id.* As in prior years, the IPPS rate is used to determine the IPPS comparable per diem amount for LTCH site neutral payment rate cases. The IPPS rate tables show that a 5.1% outlier BNA has already been applied to both the operating and capital components of the IPPS rate. *See* Exhibit A, 83 Fed. Reg. at 41724-25, 41729.

In response to the FY 2019 IPPS/LTCH PPS Proposed Rule, the Plaintiffs and other commenters again objected to the BNA on the grounds that the adjustment is duplicative of the BNA CMS proposed to apply to the IPPS payment rate. Kindred Healthcare stated that CMS' calculation of the 5.1 percent LTCH PPS site neutral BNA did not account for the BNA CMS already proposed for the IPPS payment rate:

> Consistent with MedPAC's and the AHA's comments, we strongly disagree with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS already reduced the FY 2019 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.[26]

Similar to prior years, Kindred Healthcare's comment letter included a table showing the duplication and its effect on the LTCH PPS site neutral payment rate. *See* Exhibit E (Kindred

[26] Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42 (June 25, 2018) (R.R. at 5428).

Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule, Table 1). LifeCare Hospitals also explained to CMS that the proposed LTCH site neutral adjustment was duplicative of the adjustments already included in the LTCH site neutral payment rate:

> This BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases.[27]

Similarly, Vibra Healthcare submitted comments to CMS explaining CMS' error in calculating the BNA.[28] As in prior years, the AHA and FAH also objected to the BNA.[29] The comment letters to the proposed rule specifically asked CMS to take a fresh look at this issue and consider the detrimental effect the duplicative adjustment would have on LTCHs in FY 2019, as well as the harm that already occurred by applying the BNA in FYs 2016 through 2018.[30]

In spite of these comments, CMS finalized the duplicative BNA for all LTCH site neutral payment rate cases in the FY 2019 IPPS/LTCH PPS Final Rule. 83 Fed. Reg. 41144, 41737-38 (Aug. 17, 2018) (R.R. at 6004-05). At the same time, CMS finalized the 5.1% BNA to the IPPS payment rate. *Id.* at 41723, 41728 (R.R. at 5990, 5995). CMS offered only a brief response to the

[27] LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 14 (June 21, 2018) (R.R. at 5165).

[28] Vibra Healthcare, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 21-25 (June 25, 2018) (R.R. at 5285-89).

[29] American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 6-8 (June 25, 2018) (R.R. at 5401-03); Federation of American Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42-43 (June 25, 2018) (R.R. at 5352).

[30] LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 15 (R.R. at 5166); Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 36, 42 (R.R. at 5242, 5248).

Plaintiffs' comments objecting to the duplicative BNA, essentially repeating what it had said in the FY 2018 Final Rule:

> We continue to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative. As we discussed in response to similar comments (82 FR 38545 through 38546, 81 FR 57308 through 57309, and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner. More importantly, we continue to believe this budget neutrality adjustment is appropriate for reasons outlined in our response to the nearly identical comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57308 through 57309) and our response to similar comments in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49621 through 49622).

Id. at 41738 (R.R. at 6005).

Accordingly, CMS is applying a BNA factor of 0.949 (5.1%) pursuant to 42 C.F.R. § 412.522(c)(2)(i) to reduce the site neutral payment rate portion of the LTCH PPS blended payment rate for all site neutral cases, despite the fact that the IPPS comparable per diem amount has already been reduced by the same percentage by the IPPS outlier BNA. This BNA reduces site neutral case payments by an *additional* 5.1% for all LTCHs, including the Plaintiffs' LTCHs. The Plaintiffs gave CMS ample opportunity to correct the flawed methodology for determining the BNA. The Plaintiffs clearly spelled out the duplication in their comments, and MedPAC agreed that a separate BNA should not be applied for this reason. However, CMS has been dismissive of the Plaintiffs' concerns.

The Plaintiffs had hoped that CMS would correct the error before the end of the LTCH site neutral transition period because when the transition period ends on September 30, 2019, the financial impact of CMS' error will double. *See* 42 U.S.C. § 1395ww(m)(6)(B)(i)(I) (SSA § 1886(m)(6)(B)(i)(I)). Starting in FY 2020, the entire payment for site neutral cases will be the lesser of the IPPS comparable per diem amount or 100% of the estimated costs of the case. *Id.* at §§ 1395ww(m)(6)(B)(i)-(ii). If CMS continues to insist on applying the duplicative outlier BNA

in FY 2020, the adjustment will apply to the entire payment for site neutral cases. The Plaintiffs' LTCHs are already experiencing significantly reduced Medicare payments under the site neutral payment policy for many of their patients. Applying a BNA twice to site neutral payments only increases the financial pressure on these hospitals and unnecessarily deters care for Medicare patients in LTCHs. The millions of dollars in lost Medicare reimbursement significantly threatens the Plaintiffs' ability to continue their business operations. In fact, since the Plaintiffs filed the Complaint, 12 of the hospital Plaintiffs filed for bankruptcy. *See* Voluntary Pet. for Non-Individuals Filing for Bankruptcy, *In re Hospital Acquisition LLC*, No. 19-10998 (Bankr. D.Del. May 6, 2019), Dkt. 1. The harm caused by the duplicative BNA has left the Plaintiffs with no choice but to seek relief from the courts.

E. Amount in Controversy

The Plaintiffs estimate that the duplicative BNA reduces their aggregate Medicare payments in FY 2019 by approximately $9,388,544 based on CMS data, but no less than $3,358,322. Administrative Record ("A.R.") at 58; Dkt. 8-1 ¶7; Dkt. 8-2 ¶7; Dkt. 8-3 ¶7; Dkt. 8-4 ¶7. During their FY 2016 through FY 2018 cost reporting periods, Plaintiffs estimate that they have lost at least $12,502,353 in Medicare reimbursement as a result of the duplicative BNA. Dkt. 8-1 ¶6; Dkt. 8-2 ¶6; Dkt. 8-3 ¶6; Dkt. 8-4 ¶6.

IV. PROCEDURAL HISTORY

The Plaintiffs submitted an Initial Group Appeal Request and a Request for Expedited Judicial Review to the Provider Reimbursement Review Board ("PRRB") on November 20, 2018. A.R. at 1078-1153; Dkt. 1-1 at 2.[31] The PRRB granted Plaintiffs' request for Expedited

[31] The PRRB is a five member administrative tribunal that sits in Baltimore, Maryland and decides disputes between Medicare providers and CMS over the amount of reimbursement owed

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Judicial Review on January 28, 2019. A.R. at 2-16; Dkt. 1-1. The Plaintiffs filed the Complaint challenging the duplicative BNA on March 13, 2019. Dkt. 1. On April 5, 2019, Plaintiffs filed an application for a preliminary injunction with this Court to prevent CMS from applying the duplicative BNA during this litigation. Dkt. 8. The Court has not yet ruled on Plaintiffs' application for a preliminary injunction. On May 22, 2019, the Court issued a schedule for summary judgment briefing. *See* Minute Order, May 22, 2019.

V. JURISDICTION AND VENUE

Plaintiffs' claims arise under the Medicare Act. Jurisdiction is therefore proper under 42 U.S.C. § 1395oo(f) and this is the proper venue under 42 U.S.C. § 1395oo(f)(1). Plaintiffs' Complaint for Review of Agency Action, Dkt. 1, requested relief that included: (1) an order setting aside the duplicative BNA in the FY 2019 IPPS/LTCH PPS Final Rule (Dkt. 1 ¶49), (2) an order directing the Secretary to remove the duplicative BNA from all LTCH PPS site neutral payments made by CMS in federal FYs 2016 through 2018 (Dkt. 1 ¶51), and (3) an order directing the Secretary not to apply the duplicative BNA to LTCH site neutral payments in federal FY 2020 and later years (Dkt. 1 ¶52).

Defendant's Answer argues that the Court lacks jurisdiction over Plaintiffs' claims regarding years other than FY 2019. Answer (Dkt. 20) at 9. Subject matter jurisdiction under the Medicare Act requires a plaintiff to both present the claim to the agency and exhaust the agency's administrative remedies. *See Mathews v. Eldridge*, 424 U.S. 319, 328 (1976); *see also Heckler v. Ringer*, 466 U.S. 602, 617 (1984). Here, the Plaintiffs satisfied both requirements for

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by the Medicare program for services rendered to Medicare patients. *See generally* 42 U.S.C. § 1395oo.

subject matter jurisdiction when they filed an appeal with the PRRB and requested Expedited Judicial Review. A.R. at 1078-1153. Plaintiffs' exhausted their administrative remedies when the PRRB granted the request for EJR. *See Tucson Med. Ctr. v. Sullivan*, 947 F.2d 971, 978 (D.C. Cir. 1991) ("The PRRB had granted appellants' petition for expedited judicial review on December 15, 1988, thereby exhausting appellants' administrative remedies."). The PRRB's decision notes that the Plaintiffs objected to the duplicative BNA that CMS applied in FY 2016 and subsequent years. Dkt. 1-1 at 5-6 (A.R. at 5-6). Plaintiffs' request for Expedited Judicial Review clearly shows that the Plaintiffs objected to the BNA since it was first adopted by CMS in the FY 2016 IPPS/LTCH PPS Final Rule. *See* A.R. at 37-49. Plaintiffs' request for Expedited Judicial Review also argued that "CMS has committed a 'clear error of judgment' by refusing to correct this error in the FY 2016, FY 2017, FY 2018 and FY 2019 IPPS/LTCH PPS Final Rules." A.R. at 74. Accordingly, the Court has jurisdiction over Plaintiffs' claims challenging the duplicative BNA in FY 2019 and prior years based on the same flawed methodology, because Plaintiffs filed an appeal with the PRRB and the PRRB granted the Plaintiffs' request for Expedited Judicial Review.

The Court should also find that it has jurisdiction over Plaintiffs' claims regarding the duplicative BNA CMS will apply in FY 2020. CMS has already issued the FY 2020 proposed rule containing identical BNAs. *See* FY 2020 IPPS/LTCH PPS Proposed Rule, 84 Fed. Reg. 19158, 19593-94, 19598, 19606, 19617 (May 3, 2019). Plaintiffs are working on comment letters objecting again to the duplicative BNA, especially because it will apply to the entire site neutral payment for cost reporting periods beginning on or after October 1, 2019. However, based on CMS' dismissive responses in prior years, we expect that CMS will finalize the duplicative BNA

for FY 2020 based on the same flawed methodology. In fact, the Defendant admits in his answer that the BNA at issue "will apply to the site-neutral payment rate in 2020 . . . ." Answer ¶39.

If the Court does not find that it has jurisdiction over Plaintiffs' claim challenging the duplicative BNA in FY 2020, Plaintiffs will be forced to file another civil action in this Court to review the same BNA after CMS issues the final rule for FY 2020 and Plaintiffs again obtain expedited judicial review from the PRRB. This will unnecessarily waste valuable time and resources of Plaintiffs and the Court. A federal court has "broad power to restrain acts which are of the same type or class as unlawful acts which the court has found to have been committed or whose commission in the future unless enjoined, may fairly be anticipated from the defendant's conduct in the past." *NLRB v. Express Publishing Co.*, 312 U.S. 426, 435 (1941); *also United States Dep't of Justice v. Daniel Chapter One*, 89 F. Supp. 3d 132, 143 (D.D.C. 2015) (Sullivan, J.), *aff'd*, 650 F. App'x 20 (D.C. Cir. 2016). The Court can fairly anticipate from CMS' past conduct and its admission in the Answer that it will finalize its proposed BNA for the upcoming fiscal year based on the same flawed methodology. Pursuant to this "broad power," the Court should find that it has the jurisdiction to order CMS not to apply the duplicative BNA in FY 2019 and in future years, including federal FY 2020.

VI. STANDARD OF REVIEW

A. Summary Judgment Standard

Summary judgment is warranted where the moving party establishes that no genuine issue of material fact is in dispute and that it is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a); *accord Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247 (1986). "In a case involving review of a final agency action under the [APA], 5 U.S.C. § 706, however, the standard set forth in Rule 56[ ] does not apply because of the limited role of a court in reviewing the administrative record." *Sierra Club v. Mainella*, 459 F. Supp. 2d 76, 89 (D.D.C. 2006); *see*

also Charter Operators of Alaska v. Blank, 844 F. Supp. 2d 122, 126-27 (D.D.C. 2012). Under the APA, the agency's role is to resolve factual issues to reach a decision supported by the administrative record, while "'the function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did.'" *Sierra Club*, 459 F. Supp. 2d at 90 (quoting *Occidental Eng'g Co. v. INS*, 753 F.2d 766, 769 (9th Cir. 1985)). "Summary judgment thus serves as the mechanism for deciding, as a matter of law, whether the agency action is supported by the administrative record and otherwise consistent with the APA standard of review." *Id.* (citing *Richards v. INS*, 554 F.2d 1173, 1177 & n.28 (D.C. Cir. 1977)).

B. Administrative Procedure Act Standard

The APA requires an agency action to be set aside if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law;" "contrary to constitutional right, power, privilege, or immunity;" or "in excess of statutory jurisdiction authority or limitations, or short of statutory right." 5 U.S.C. §§ 706(2)(A)-(C). The APA directs reviewing courts to engage in "a thorough, probing, in-depth review." *James Madison Ltd. by Hecht v. Ludwig*, 82 F.3d 1085, 1099 (D.C. Cir. 1996) (quoting *Citizens to Preserve Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415 (1971)). The scope of review under an arbitrary and capricious standard entails a careful, sharp inquiry as to:

> [whether] the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins., 463 U.S. 29, 43 (1983). "'Where the agency has failed to provide a reasoned explanation, or where the record belies the agency's conclusion, [the court] must undo its action.'" *Cty. of L.A. v. Shalala*, 192 F.3d 1005,

1021 (D.C. Cir. 1999) (quoting *BellSouth Corp. v. FCC*, 162 F.3d 1215, 1222 (D.C. Cir. 1999)). The Court may only consider the reasons relied upon by the agency in reaching its conclusion and may not consider *post hoc* rationalizations by government counsel. *E.g.*, *Chamber of Commerce of the U.S. v. SEC*, 412 F.3d 133, 143-44 (D.C. Cir. 2005).

The APA also directs courts to hold unlawful agency actions which are "unsupported by substantial evidence in a case." 5 U.S.C. § 706(2)(E). Substantial evidence "means 'such relevant evidence as a reasonable mind might accept as adequate to support a conclusion' taking into account 'whatever in the record detracts from its weight.'" *Banner Health v. Sebelius*, 715 F. Supp. 2d 142, 153 (D.D.C. 2010) (quoting *AT&T Corp. v. FCC*, 86 F.3d 242, 247 (D.C. Cir. 1996)) (internal citations omitted).

VII. ARGUMENT

The Plaintiffs do not dispute that CMS can apply a BNA to LTCH site neutral case payments so that overall LTCH payments do not increase due to high cost outlier payments for qualifying site neutral cases. What the Plaintiffs dispute is a BNA pursuant to 42 C.F.R. § 412.522(c)(2)(i) that *reduces* overall LTCH payments *below* what they would otherwise be in the absence of high cost outlier payments for qualifying site neutral cases. This is not budget neutrality. It is a payment cut that is completely arbitrary and unsupported, and results in a windfall to the Medicare program.

CMS set the target amount of LTCH HCO payments at 5.1% of total LTCH site neutral payments. The simple math is clear that CMS can only reduce total LTCH site neutral payments by 5.1% to maintain budget neutrality. Yet, the extra BNA at issue here reduces total LTCH site neutral payments by *another* 5.1% in the name of budget neutrality, based on the methodology in the annual payment update rulemakings.

The Plaintiffs, hospital trade associations and MedPAC repeatedly told CMS not to apply the extra BNA. CMS has stubbornly refused, with unconvincing attempts to recast the IPPS outlier BNA as "inputs" that only relate to the IPPS. But this form over function argument does not change the math. CMS has continued to set the LTCH site neutral payment rate based on an erroneous calculation that includes *double* the budget neutrality adjustment for HCO payments.

Congress has not "directly spoken to the precise question at issue" in this case: whether CMS may apply two identical outlier BNAs to the LTCH PPS site neutral payment rate. *See Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 842 (1984). The statutory section at issue, 42 U.S.C. § 1395ww(m)(6)(B)(ii), defines the "site neutral payment rate," but is silent as to the issue of outlier budget neutrality adjustments. Accordingly, this is a *Chevron* step two case because "the statute is silent or ambiguous with respect to the specific issue." *Chevron*, 467 U.S. at 843. "[T]he question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* Analysis under *Chevron* step two requires the Court to determine "whether an agency interpretation is arbitrary or capricious in substance." *Judulang v. Holder*, 565 U.S. 42, 52 n.7 (2011) (internal quotations omitted). The Court must set-aside the duplicative BNA because it is a textbook violation of the arbitrary and capricious standard.

A. The BNA Is Arbitrary and Capricious Because CMS Did Not Account For the Budget Neutrality Adjustments Already Included in the IPPS Comparable Amount

CMS' promulgation of the duplicative BNA is very clearly "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law" for several reasons. 5 U.S.C. § 706(2)(A). First, the duplicative BNA is arbitrary and capricious because it is unreasonable. *See U.S. Postal Serv. v. Postal Regulatory Comm'n*, 785 F.3d 740, 750 (D.C. Cir. 2015) (recognizing that agency action must be reasonable to survive arbitrary and capricious review under the APA). Second, the duplicative BNA is arbitrary and capricious because "the agency . .

. entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 43 (1983). Third, the duplicative BNA is arbitrary and capricious because CMS' reasoning is "internally inconsistent." *See District Hosp. Partners v. Burwell*, 786 F.3d 46, 59 (D.C. Cir. 2015) (finding agency action arbitrary and capricious when it is "internally inconsistent and inadequately explained"). Finally, the duplicative BNA is arbitrary and capricious because it reflects a clear error of judgment. *See Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971) (noting that agency action is arbitrary and capricious when "there has been a clear error of judgment" by the agency). Each of these reasons is discussed more fully below.

1. The BNA is Duplicative

CMS applies duplicative outlier BNAs to the LTCH PPS site neutral payment rate. Plaintiffs do *not* argue that the IPPS outlier BNAs and LTCH PPS site neutral outlier BNA are duplicative *when applied to their own respective payment systems*, the IPPS and the LTCH PPS. However, duplication occurs when the agency applies *both* BNAs to site neutral payments under the LTCH payment system. The outlier BNA from the IPPS reduces site neutral payments under the LTCH PPS by 5.1%, and the additional outlier BNA created for the LTCH PPS site neutral payment rate reduces the same site neutral payments by another 5.1%. The result is that LTCHs receive site neutral payments (or portion of the blended payment during the transition period) that have been reduced by 10.2% for outlier payment budget neutrality. CMS' decision to include both BNAs in the LTCH PPS site neutral payment rate is a textbook violation of the APA arbitrary and capricious standard. *See U.S. Postal Serv.*, 785 F.3d at 750; *Cty. of L.A. v. Shalala*, 192 F.3d 1005, 1021 (D.C. Cir. 1999).

The Defendant's Answer says that the "IPPS payment rates are used as *inputs* to determine the IPPS comparable per diem amount under the LTCH PPS site neutral payment rate . . . ." Answer ¶22 (emphasis added). The Secretary therefore admits that CMS uses the IPPS outlier BNA in the calculation of LTCH site neutral payments, but calls it an "input" to avoid the appearance of duplication. This form over function argument fails because the *only* outlier payments the IPPS outlier BNA could be offsetting in the LTCH site neutral payment rate are LTCH outlier payments.[32]

As discussed in Section II.B above, CMS bases the IPPS comparable per diem amount for LTCH site neutral cases on the IPPS rate as instructed by Congress in section 1206(a)(1) of the PSRA. The definition of the LTCH PPS site neutral payment rate in the statute directs CMS to use the "IPPS comparable per diem amount" as determined under 42 C.F.R. § 412.529(d)(4). 42 U.S.C. § 1395ww(m)(6)(B)(ii). The regulation at 42 C.F.R. § 412.529 contains CMS' payment policy for LTCH short-stay outliers. It describes how CMS calculates the IPPS comparable per diem amount and the adjustments that CMS applies to the IPPS operating standardized amount and IPPS capital amount. *Id.* at §§ 412.529(d)(4)(i),(ii),(iii). Importantly, this regulation does *not* say to use the outlier BNAs from the IPPS operating and capital amounts in this calculation of the IPPS comparable per diem amount, nor does it say to apply a separate BNA for outlier payments. Likewise, CMS' subregulatory guidance implementing the LTCH

[32] Similarly, the Defendant's Opposition to Plaintiffs' Application for a Preliminary Injunction (Dkt. 10) argued that to "maintain budget neutrality within LTCH PPS, the Secretary reasonably determined that it is not sufficient to merely rely on adjustments incorporated into certain of the inputs for the calculation of the site-neutral payment rate because those adjustments account only for outliers in IPPS hospitals." Dkt. 10 at 29. This is not an accurate statement because the IPPS outlier BNA only adjusts payments *to IPPS hospitals* for outlier payments made *to IPPS hospitals*. When CMS uses the IPPS outlier BNA to adjust site neutral payments to LTCH hospitals it cannot possibly be for outlier payments made to IPPS hospitals—it must either be for outlier payments made to LTCH hospitals or it is a purely arbitrary payment reduction.

short-stay outlier policy also does not reference any budget neutrality adjustment. *See* Exhibit C (CMS, *Medicare Claims Processing Manual* (CMS Pub. 100-04), Ch. 3 § 150.9.1.1) (providing a more detailed explanation of the same adjustments listed in the regulation)).

When CMS implemented the LTCH site neutral payment rate, CMS again explained that based on 42 C.F.R. § 412.529(d)(4)(i)(A) the IPPS comparable per diem amount includes adjustments for applicable DRG weighting factors, differences in area wage levels, the DSH payment adjustment, and an IME payment adjustment. FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49608 (Aug. 17, 2015) (R.R. at 1250). But the agency also is applying the IPPS outlier BNA, in addition to the separate "budget neutrality factor to the LTCH PPS payments for [high-cost outlier] cases to maintain budget neutrality." *Id.* at 49609 (R.R. at 1251). The first BNA applies because "the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments." *Id.* at 49622 (R.R. at 1264). The second BNA is a separate "budget neutrality factor to the payment for all site neutral payment rate cases" under 42 C.F.R. § 412.522(c)(2)(i). *Id.* at 49621 (R.R. at 1263). CMS is reducing LTCH site neutral payments twice for budget neutrality related to LTCH high-cost outliers. The same two BNAs have been used to reduce LTCH site neutral payments in each subsequent year, including FY 2019, 83 Fed. Reg. at 41723, 41728, 41737-38, and FY 2020 (proposed), FY 2020 IPPS/LTCH PPS Proposed Rule, 84 Fed. Reg. 19158, 19593-94, 19598, 19606, 19617 (May 3, 2019).

Accordingly, based on the plain reading of CMS' regulations and subregulatory guidance, it is impossible to see how Congress was aware that the LTCH site neutral payment rate would include multiple BNAs. None of these authorities addressing the IPPS payment rate used for the IPPS comparable per diem amount reference a budget neutrality adjustment.

Moreover, Congress never specifically authorized CMS to apply two BNAs to the LTCH site neutral payment rate. Therefore, it is incorrect for CMS to imply that Congress approved the use of a duplicative BNA because "Congress was well aware of how we had implemented our HCO policy under the LTCH PPS under § 412.525 at the time of the enactment of section 1206 of Public Law 113–67." 81 Fed. Reg. at 57308 (R.R. at 2908). The regulations and guidance show in detail that each part of the IPPS rate CMS uses for the IPPS comparable per diem amount has a specific function or purpose that applies to each LTCH site neutral case. The characteristics of each site neutral patient and LTCH where services are provided determine the appropriate DRG weighting factor, area wage level, and applicable DSH and IME payment adjustments. These are not meaningless "inputs," so the IPPS outlier BNA cannot be a meaningless input either.

In his Answer to Plaintiffs' Complaint, the Secretary continues to argue that "the IPPS payment rates are used as *inputs* to determine the IPPS comparable per diem amount under the LTCH PPS site neutral payment rate . . . ." Answer ¶33. If the Court accepts this sleight of hand at face value, it would have to conclude that the Secretary violated the APA and the Medicare statute because it is necessarily a meaningless number and therefore arbitrary and capricious. *See Select Specialty Hosp.-Bloomington, Inc. v. Burwell*, 757 F.3d 308, 314 (D.C. Cir. 2014) ("[W]hen ambiguity begets ambiguity, making it such that we cannot discern the decisional standard, much less the correctness of its application, we have little choice but to declare the decision arbitrary and capricious . . . ."); *see also Amerijet Int'l, Inc. v. Pistole*, 753 F.3d 1343, 1350 (D.C. Cir. 2014) ("[C]onclusory statements will not do; 'an agency's statement must be one of *reasoning*.'"). The Secretary also argued that Congress understood the LTCH site neutral payment rate would include the IPPS outlier BNA because Congress instructed CMS to calculate the "IPPS comparable per diem amount" in accordance with 42 C.F.R. § 412.529(d)(4). Dkt. 10

at 28. However, Congress never instructed CMS to apply two BNAs for outlier payments to the LTCH site neutral payment rate, and his argument is not supported by the agency's own regulation and instructions on how the IPPS comparable per diem amount is calculated.

2. CMS' Unwarranted BNA is Arbitrary and Capricious Because it is Unreasonable

To survive arbitrary and capricious review under the APA, an agency's "exercise of its authority must be 'reasonable and reasonably explained.'" *U.S. Postal Serv. v. Postal Regulatory Comm'n*, 785 F.3d 740, 750 (D.C. Cir. 2015) (quoting *Mfrs. Ry. Co. v. Surface Transp. Bd.*, 676 F.3d 1094, 1096 (D.C. Cir. 2012)). Agency action must be set aside if "the agency has failed to provide a reasoned explanation, or where the record belies the agency's conclusion . . . ." *Cty. of L.A. v. Shalala*, 192 F.3d 1005, 1021 (D.C. Cir. 1999); *see also FiberTower Spectrum Holdings, LLC v. F.C.C.*, 782 F.3d 692, 699 (D.C. Cir. 2015) (stating that if an agency's "interpretation is 'plainly erroneous or inconsistent with the regulation[s]' or there is any other 'reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question,'" courts will not "defer to an agency's interpretation of its regulations").

CMS' unreasonable decision to apply a second outlier BNA to the LTCH site neutral payment rate is a clear violation of the APA's arbitrary and capricious standard. It is not reasonable for CMS to apply a 5.1% BNA to the LTCH site neutral payment rate to offset the cost of high cost outlier payments *after* CMS already applied the same 5.1% BNA to the IPPS payment rate. CMS uses the IPPS payment rate, as reduced by the BNAs of 5.1%, to determine the LTCH site neutral payment rate. It was not reasonable for CMS to ignore the BNA already included in the IPPS comparable per diem amount (which is the basis for the LTCH site neutral payment rate in most cases) when adopting the additional BNA. Under a reasonable approach, CMS would have *either* applied the negative 5.1% BNAs to the IPPS rate when calculating the

LTCH site neutral payment rate, *or* applied the separate negative 5.1% BNA to that calculation, *but not both*. Instead of adopting either of these approaches, CMS used both, resulting in a negative 10.2% adjustment to the LTCH site neutral payment rate—*double* the amount needed to maintain budget neutrality.

As noted above, the IPPS outlier BNA used in the IPPS comparable per diem amount must be accounting for outlier payments to LTCHs or it is meaningless. CMS only applies one outlier BNA to the regular LTCH PPS payment rate. Likewise, CMS only applies one outlier BNA to the IPPS operating and capital payment rates. In fact, when CMS calculates these IPPS payment rates each year, the agency is careful to remove the outlier BNA from the previous year to avoid duplication. *See* 83 Fed. Reg. at 41724-25 (IPPS operating standardized amount is calculated by first removing the previous year "Operating Outlier Offset" of 0.949 (5.1%) before adding the current year "Operating Outlier Factor" of 0.949 (5.1%)) (R.R. at 5991-92); *id*. at 41729 ("The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate.") (R.R. at 5996). CMS should have been at least as cautious in developing the outlier BNA policy for LTCH site neutral payments. Instead, the agency offered "'insufficient reasons for treating similar situations differently,'" *Cty. of L.A.*, 192 F.3d at 1022 (quoting *Transactive Corp. v. U.S.*, 91 F.3d 232, 237 (D.C. Cir. 1996)), with no legitimate purpose for the extra BNA at 42 C.F.R. § 412.522(c)(2)(i). *See supra* Part VII.A.1.

CMS has trivialized the comments and evidence submitted during the comment period about this duplication, and insisted on a second adjustment to the LTCH site neutral payment rate. As a result, Medicare has arbitrarily cut aggregate payment to all LTCHs by tens of millions

of dollars each year.[33] This is clearly unreasonable. Accordingly, the duplicative BNA is arbitrary and capricious under the APA.

3. CMS Did Not Engage in a Reasoned Analysis When It Implemented the Duplicative BNA without Accounting for the Adjustments Already Applied to the IPPS Comparable Per Diem Amount

An agency violates the APA's reasoned analysis requirement if it fails to consider an important aspect of the problem. *See St. James Hosp. v. Heckler*, 760 F.2d 1460 (7th Cir. 1985), *accord*, *Walter O. Boswell Mem'l Hosp. v Heckler*, 628 F. Supp. 1121 (D.D.C. 1985) (holding that malpractice rule was arbitrary and capricious because HHS entirely failed to consider an important aspect of the problem by not examining the relationship between actual malpractice loss experience and premium costs, and its rule was not adequately supported by the study it relied on); *Wood v. Betlach*, 922 F. Supp. 2d 836 (D. Ariz. 2013) (finding that HHS failed to address an important aspect of the problem because the record contains no evidence that HHS considered or responded to plaintiffs' expert opinion that none of the demonstration project's hypotheses test anything new); *Shays v. Fed. Election Comm'n*, 337 F. Supp. 2d 28, 72 (D.D.C. 2004). Although courts typically exercise restraint in reviewing agency action, the courts will intervene if "the agency has not really taken a 'hard look' at the salient problems, and has not genuinely engaged in reasoned decision-making." *Greater Boston Television Corp. v. F.C.C.*, 444 F.2d 841, 851 (D.C. Cir. 1970).

The Plaintiffs do not dispute that CMS has the authority to apply a BNA to reduce LTCH site neutral payments to account for HCO payments for LTCH site neutral payment rate cases.

[33] The AHA's analysis of FY 2016 MedPAR data found that the duplicative budget neutrality adjustment reduces aggregate payments by approximately $28 million per year. American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 6 (R.R. at 5401).

However, the Plaintiffs do object to a BNA on top of BNAs of the same size.[34] The BNA is duplicative of the adjustments CMS borrows from the IPPS payment rates. CMS' refusal to seriously consider whether the adjustment is duplicative shows that the agency has not taken a "hard look" to ensure that the math behind the calculation of the BNA is valid. *See Greater Boston Television Crop.*, 444 F.2d at 851. A serious examination of the way the IPPS comparable per diem amount is calculated for LTCH site neutral payments would reveal the fact that this extra LTCH BNA results in underpayments to LTCHs and a savings for the Medicare program. Accordingly, CMS has "entirely failed to consider an important aspect of the problem" because the agency refuses to recognize that it is applying a duplicative BNA. *See State Farm Mut. Auto. Ins.*¸ 463 U.S. at 43.

CMS believes that a separate BNA for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems." 83 Fed. Reg. at 41737 (R.R. at 6004). However, by aligning this policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS did not adequately consider the adjustment that it *already* made to the IPPS payment rate to account for outlier payments. Specifically, CMS already reduced the IPPS payment rate for outlier budget neutrality. For FY 2019, CMS reduced the operating portion of the IPPS payment rate by a factor of 0.948999 and the capital portion of the IPPS payment rate by a factor of 0.949431. *Id.* at 41723 (R.R. at 5990). As CMS explains, these budget neutrality

[34] *See* Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 37 (R.R. at 5243); LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 16 (R.R. at 5167).

factors result in a 5.1% outlier adjustment that already reduces the IPPS payment rate. *Id.* at 41723-24 (R.R. at 5990-91). CMS has therefore not taken a "hard look" at the salient problem and is not engaging in reasoned decisionmaking because CMS is unwilling to consider the duplicative effect of the extra BNA. *See Greater Boston Television Corp.*, 444 F.2d at 851. Moreover, this extra 5.1% adjustment to LTCH site neutral payments in the name of budget neutrality does not "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS"—it exacerbates differences—and it does not "promote fairness between the two systems"—it is patently unfair to LTCHs.

Accordingly, CMS' decision to adopt the BNA for FY 2019 is arbitrary and capricious because CMS did not engage in reasoned decisionmaking when the agency's adoption of the BNA failed to account for the budget neutrality adjustment to the IPPS standard Federal payment rate that is used in the calculation of the LTCH site neutral payment rate.

4. CMS' Decision to Apply a Duplicative Budget Neutrality Adjustment is Arbitrary and Capricious Because CMS' Reasoning is Internally Inconsistent

An agency's decision is also arbitrary and capricious if it is "internally inconsistent and inadequately explained." *District Hosp. Partners v. Burwell*, 786 F.3d 46, 59 (D.C. Cir. 2015) (citing *General Chem. Corp. v. United States*, 817 F.2d 844, 846 (D.C. Cir. 1987). CMS' rationale for the duplicative BNA suffers from "internal inconsistency" for several reasons. First, the BNA is "internally inconsistent" because CMS chose to make the LTCH site neutral outlier policy identical to the IPPS outlier policy, but adds an extra BNA to LTCH site neutral payments. CMS uses the same outlier policy as the IPPS for LTCH site neutral cases because CMS actuaries "projected that the costs and resource use for cases paid at the site neutral payment rate . . . would likely mirror the costs and resource use for IPPS cases assigned to the same MS-DRG" and "site neutral payment rate cases would generally be paid based on an IPPS

comparable per diem amount," rather than 100% of the estimated costs of the case. FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737 (R.R. at 6004). CMS therefore uses the same IPPS fixed-loss amount for LTCH site neutral outlier cases. *Id.* ("[W]e continue to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2019 is the IPPS fixed-loss amount for FY 2019."). CMS also uses the same target amount of 5.1% of total payments for outlier cases. *Id.* To be internally consistent, the LTCH site neutral payment rate would be considered budget neutral after applying the negative 5.1% IPPS outlier BNA. *See id.* at 41723, 41728 (establishing a 0.948999 outlier adjustment factor to the IPPS operating standardized amount and a 0.949431 outlier adjustment factor to the IPPS capital federal rate) (R.R. at 5990, 5995). But CMS did not stop there. The agency applied an additional BNA of 5.1%, thereby doubling the reduction to LTCH site neutral payments. *Id.* at 41737 (R.R. at 6004). This approach is very clearly "internally inconsistent."

Second, CMS' LTCH PPS outlier policies are "internally inconsistent" because LTCH PPS standard rate payments are subject to a single outlier BNA, yet CMS applies two BNAs to the site neutral payment rate. The AHA explained this issue in their comments to CMS on the FY 2017 and FY 2018 LTCH PPS rulemakings. The AHA's FY 2017 comment letter states:

> When calculating any of the LTCH PPS standard rate payments[], only one BNA applies. Similarly, when pricing out the LTCH PPS short-stay outliers . . . that are paid either an IPPS comparable amount or cost (similar to what site-neutral cases are being paid), only one BNA applies. However, by contrast, when calculating rates for site-neutral cases paid the IPPS comparable amount, two BNAs apply.

American Hospital Association, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 6 (footnote omitted). The AHA's FY 2018 comment letter included a chart that diagrams the BNA CMS applies to other LTCH PPS payment rates and the two BNAs CMS applies to the LTCH site neutral payment rate. Exhibit F (American Hospital Association, Comment Letter on

FY 2018 IPPS/LTCH PPS Proposed Rule at 6, Chart). CMS' deviation from its standard practice of applying only one outlier BNA indicates that CMS' outlier policies are "internally inconsistent."

Finally, the BNA is "internally inconsistent" because it is contrary to the intent of budget neutrality. The intent of budget neutrality is to ensure that a particular payment policy does not raise *or lower* the aggregate payments to providers. In fact, CMS states in the FY 2019 Final Rule that the LTCH site neutral HCO policy should be budget neutral, "meaning that estimated site neutral payment rate HCO payments should not result in *any change* in estimated aggregate LTCH PPS payments." FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737 (emphasis added) (R.R. at 6004). However, CMS' implementation of the BNA reduces aggregate site neutral payments to LTCHs to a level that is *below* the budget neutral baseline. In other words, the BNA the Plaintiffs are challenging in these appeals is not an adjustment that achieves budget neutrality at all—it is purely a payment cut. This unwarranted reduction is therefore "internally inconsistent" with the goals of budget neutrality.

Each of these examples of "internal inconsistency" on their own renders CMS' duplicative BNA arbitrary and capricious. *Banner Health v. Price*, 867 F.3d 1323 (D.C. Cir. 2017); *District Hosp. Partners v. Burwell*, 786 F.3d 46, 59 (D.C. Cir. 2015). CMS' rationale for the duplicative budget neutrality adjustment is fatally defective and must be reversed.

5. CMS' Decision to Apply a Duplicative Budget Neutrality Adjustment is Arbitrary and Capricious Because it Reflects a Clear Error of Judgment

Review of agency action under the APA's arbitrary and capricious standard requires consideration of "whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971). A "clear error of judgment" is evaluated by looking at the

substance of the agency's decision, not just the agency's procedures for promulgating the rule. *James Madison Ltd. by Hecht v. Ludwig*, 82 F.3d 1085, 1098 (D.C. Cir. 1996).

In *James Madison Ltd.*, the D.C. Circuit stated that "judicial review of agency action under the APA must go beyond the agency's procedures to include the substantive reasonableness of its decision." *Id.* Relying on the Supreme Court's decision in *Overton Park*, the D.C. Circuit stated: "Although the reasonableness of the agency's procedures is relevant to the court's inquiry, reasonable procedures alone cannot absolve a court from making a 'thorough, probing, in-depth review' to determine if the agency has considered the relevant factors or committed a clear error of judgment." *Id.* (citing *Overton Park*, 401 U.S. at 415-16). According to the D.C. Circuit, the agency's action would amount to a substantive violation of the APA if the agency ignored salient facts or offered "patently implausible justifications." *Id.* In other circuits, there is a "clear error of judgment" that is "sufficient to constitute arbitrary and capricious agency action . . . when 'the agency offer[s] an explanation that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Sierra Club v. E.P.A.*, 346 F.3d 955, 961 (9th Cir. 2003) (alteration in original) (quoting *Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 43 (1983)).

The "clear error of judgment" standard requires reversing the agency action "if the error is so clear as to deprive the agency's decision of a rational basis." *Ethyl Corp. v. Envtl. Prot. Agency*, 541 F.2d 1, 34-35 n. 74 (D.C. Cir. 1976), *cert. denied*, 426 U.S. 941, (1976). In the context of an agency's informal rulemaking, as opposed to agency decisions made after an evidentiary hearing, it is even more important that the record contain a rational basis for the

agency's decision because it is easier for the agency to abuse informal rulemaking proceedings. *Almay, Inc. v. Califano*, 569 F.2d 674, 681 (D.C. Cir. 1977).

Here, CMS' duplicative BNA is arbitrary and capricious because the agency committed a "clear error of judgment" when it ignored evidence that the IPPS comparable per diem amount for LTCH site neutral payment cases already includes a 5.1% BNA from the IPPS rates to offset the cost of LTCH outlier cases. The Plaintiffs submitted comments to CMS explaining why the proposed BNA was unnecessary and duplicative because the IPPS comparable per diem amount already includes a BNA. *See e.g.*, Post Acute Medical, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 25 ("It would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed site neutral HCO BNA. This would be the case because the IPPS comparable per diem amount will be based on the FY 2016 IPPS payment rate, which has already been adjusted by the 5.1 percent outlier target.") (R.R. at 634). The Plaintiffs, and other stakeholders, submitted additional comments to CMS during the FY 2017, FY 2018, and FY 2019 LTCH PPS rulemakings making the same point. *See supra* Parts III.B.-D. Even MedPAC submitted a comment letter objecting to the BNA because it is "duplicative and exaggerates the disparity in payment rates across provider settings." MedPAC, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 16-17 (R.R. at 1879-80).

Based on these comments, CMS had more than enough information to know that the BNA was erroneous and unnecessary as early as FY 2016. In every rulemaking since FY 2016, commenters including the Plaintiffs explained to CMS that it erred when it failed to account for the IPPS outlier BNA already applied to the IPPS comparable per diem amount when calculating the LTCH PPS site neutral outlier BNA. *See e.g.*, LifeCare Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 10 ("CMS already reduced the FY 2017 site neutral

payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.") (R.R. at 1903); Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42 ("CMS already reduced the FY 2019 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor.") (R.R. at 5248).

The D.C. Circuit has stated that CMS cannot continue using payment rates based on computational errors. *See Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 214-15 (D.C. Cir. 2011) ("[W]e never suggested that even after the error in the data on which the Secretary had relied was brought to her attention, she could have chosen to continue using the inaccurate wage index in calculating future payments."). Here, CMS is setting the LTCH site neutral payment rate based upon an erroneous calculation that includes double the BNA for HCO payments, even after MedPAC, the Plaintiffs, and others repeatedly brought the error to CMS' attention. Accordingly, CMS has committed a "clear error of judgment" by refusing to correct this error in the FY 2016, FY 2017, FY 2018 and FY 2019 IPPS/LTCH PPS Final Rules.

B. CMS' Decision to Apply a Second Outlier Budget Neutrality Adjustment to the LTCH Site Neutral Payment Rate is Not Supported by Substantial Evidence

CMS' duplicative BNA should also be set aside because CMS' determination that a second adjustment is necessary to offset the cost of site neutral high cost outlier payments is not supported by substantial evidence. Pursuant to 5 U.S.C. § 706(2)(E) of the APA, a reviewing court is required to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of any agency hearing provided by statute." 5 U.S.C. § 706(2)(E). According to the Supreme Court, this substantial evidence test applies "when the

agency action is taken pursuant to a rulemaking provision of the Administrative Procedure Act itself, 5 U.S.C. § 553 . . . ." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 414 (1971), *abrogated on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977). CMS' duplicative BNA at issue here was adopted through the APA's notice and comment rulemaking procedures. *See* 5 U.S.C. § 553.

Substantial evidence supports the agency's action when there is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Banner Health v. Sebelius*, 715 F. Supp. 2d 142, 153 (D.D.C. 2010). No such evidence exists here to support CMS' decision to apply a second outlier BNA to the LTCH site neutral payment rate. CMS claims that this second BNA is necessary "to ensure estimated HCO payments payable for site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments . . . ." 83 Fed. Reg. at 41737 (R.R. at 6004) . However, CMS offers no evidence in support of its claim that this second BNA is *not* duplicative of the adjustment already applied to the IPPS payment rate used to determine the IPPS comparable per diem amount for LTCH site neutral cases. Instead, the rulemaking record confirms that CMS is applying multiple outlier BNAs to the LTCH site neutral payment rate.

Specifically, the rulemaking record shows that CMS included the 5.1% BNA to reduce the IPPS payment rate amount used for the IPPS comparable per diem amount before applying the separate negative 5.1% BNA. *Id.* at 41723, 41728 (R.R. at 5990, 5995). The site neutral payment rate for most LTCH site neutral cases is based on the IPPS comparable per diem amount. 42 U.S.C. § 1395ww(m)(6)(B)(ii)(I); 83 Fed. Reg. at 41737 ("[S]ite neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount . . . .") (R.R.

at 6004). Because there is no evidence to contradict that this second budget neutrality adjustment is duplicative, it must be set aside.

C. CMS Did Not Provide a Sufficient Response to Comments Raising Major Issues Regarding the Duplicative BNA in the FY 2019 IPPS/LTCH PPS Final Rule

In addition to the substantive deficiencies with CMS' site neutral BNA, CMS' nominal response to comments in the FY 2019 IPPS/LTCH PPS Final Rule also violates the procedural requirements for notice and comment rulemaking at section 553(c) of the APA. The APA requires the agency's response to comments, the basis and purpose statement, "must identify 'what major issues of policy were ventilated by the informal proceedings and why the agency reacted to them as it did.'" *St. James Hosp. v. Heckler*, 760 F.2d 1460, 1469 (7th Cir. 1985) (citing *Automotive Parts & Accessories Ass'n v. Boyd*, 407 F.2d 330, 338 (D.C. Cir. 1968)).

Here, CMS' three sentence response to commenters, including the Plaintiffs, in the FY 2019 IPPS/LTCH PPS Final Rule shows that the agency is disregarding major issues with the BNA raised by commenters. Just as the Secretary's response to comments in *St. James Hospital* made no effort to respond to comments regarding a statistically unreliable study, CMS' response here did not attempt to explain why the BNA is not duplicative. CMS only responded that it "continue[s] to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative" and referred readers to CMS' responses in prior years. 83 Fed. Reg. at 41738 (R.R. at 6005). There was no effort by CMS to develop a substantive response to the commenters, who provided additional information for CMS to consider and responded to CMS' previous statements, and explain why the BNA is *not* duplicative of the adjustment already applied to the IPPS payment rate used to determine the IPPS comparable per diem amount for LTCH site neutral cases. In sum, CMS did not even attempt to explain why commenters' criticisms of the BNA were invalid. *See St. James Hosp.*,

760 F.2d at 1470. CMS' lack of a reasoned response to comments regarding the duplicative nature of the BNA violates the procedural requirements for notice and comment rulemaking at section 553(c) of the APA.

The agency does not need to respond to every individual issue raised by commenters. *See Auto. Parts & Accessories Ass'n v. Boyd*, 407 F.2d 330, 338 (D.C. Cir. 1968) ("We do not expect the agency to discuss every item of fact or opinion included in the submissions . . . ."). However, the agency "must respond in a reasoned manner to those [comments] that raise significant problems." *Reytblatt v. U.S. Nuclear Regulatory Comm'n*, 105 F.3d 715, 722 (D.C. Cir. 1997). Here, the Plaintiffs submitted comment letters to CMS identifying a "significant problem." That is, CMS is underpaying LTCH site neutral cases due to a duplicative outlier BNA. The significance of this problem is only confirmed by the fact that many LTCH organizations, MedPAC, the AHA, and the FAH submitted comment letters to CMS objecting to the duplicative BNA. Although CMS may disagree with comments, it cannot simply dismiss comments from MedPAC and others as insignificant. Accordingly, the unwarranted reduction to the LTCH site neutral payment rate that resulted from the duplicative BNA was a "significant problem" that required a substantive response from CMS. Unfortunately, CMS' response in the FY 2019 Final Rule and the referenced prior rules cannot be considered a substantive response. CMS has not shown that the challenged budget neutrality adjustment is the only 5.1% outlier budget neutrality adjustment to the LTCH site neutral payment rate.

D. CMS' Duplicative BNA Violates the Social Security Act and Other Federal Laws

CMS' decision to apply a second outlier BNA to the LTCH site neutral payment rate violates several provisions of the SSA and other pieces of legislation. First, the duplicative BNA violates the Federal statutes authorizing the LTCH PPS because it is not an "appropriate

adjustment." Second, the adjustment is contrary to the SSA's authorization of only two payment rates for LTCH cases, the standard federal payment rate and the site neutral payment rate. Finally, the unwarranted BNA violates the SSA's prohibition on cost-shifting.

1. The Extra BNA is Not an "Appropriate Adjustment"

In prior rulemakings, CMS asserted that it has "ongoing authority to make annual HCO budget neutrality adjustments for payments under the LTCH PPS . . . using the broad authority provided by section 123 of Public Law 106-113 and section 307 of Public Law 106-554." FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. at 57308 (R.R. at 2908). However, CMS' exercise of this authority in applying the duplicative BNA is contrary to the statutory text. Section 123 of the Balanced Budget Refinement Act of 1999 ("BBRA"), Pub. L. No. 106-113, 113 Stat. 1501 (1999), required CMS to develop and implement a LTCH PPS that "shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality."[35] BBRA § 123(a)(1). Section 307 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), Pub. L. No. 106-554, 114 Stat. 2763 (2000), states that the Secretary "may provide for appropriate adjustment to the long-term hospital payment system." BIPA § 307(b)(1). The duplicative BNA is not an "appropriate adjustment."

CMS claims that it has the authority to implement the additional BNA and that the BNA is necessary because "estimated site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments." 83 Fed. Reg. at 41737 (R.R. at 6004).

[35] CMS interprets BBRA's "budget neutrality" requirement as applying only to the first year of the LTCH PPS. *See* FY 2013 IPPS/LTCH PPS Final Rule, 77 Fed. Reg. 53258, 53494 (Aug. 31, 2012) ("[I]t has been our consistent interpretation that the statutory requirement for budget neutrality applies exclusively to FY 2003 when the LTCH PPS was implemented.").

Plaintiffs do not dispute that CMS generally possesses the authority under BBRA section 123 and BIPA section 307 to apply a BNA to prevent LTCH high cost outlier payments from increasing aggregate LTCH payments. CMS applies such a BNA to account for outlier payments for LTCH standard rate cases. Similarly, CMS applies a BNA to the IPPS payment rate to account for IPPS outlier payments. However, CMS exceeded its statutory authority, in violation of BIPA section 307(b)(1), when it applied a duplicative BNA to the LTCH site neutral payment rate because this extra adjustment is not an "appropriate adjustment."

An "appropriate adjustment" to maintain budget neutrality for site neutral outlier payments would have achieved actual budget neutrality and ensured that LTCH site neutral outlier payments did not increase *or decrease* aggregate LTCH payments. This was already accomplished by the 5.1% outlier BNA from IPPS rate setting that CMS uses to calculate the IPPS comparable per diem amount for LTCH site neutral payments. This adjustment achieved the 5.1% offset (reduction) to LTCH site neutral payments equal to the target amount of LTCH site neutral outlier payments. The BNA from the IPPS is arguably an "appropriate adjustment" to the LTCH site neutral payment rate. Any additional adjustment to LTCH site neutral payments to maintain budget neutrality due to LTCH site neutral outlier payments cannot be considered an "appropriate adjustment" under BIPA section 307(b)(1). Therefore, the extra 5.1% BNA at issue here violates BIPA section 307(b)(1). It is budget neutral in name only.

2. CMS' Duplicative BNA Violates the Social Security Act's Dual-Rate Structure for the LTCH PPS

CMS' duplicative BNA also violates the Social Security Act's dual-rate structure for the LTCH PPS. As discussed above, Congress established a new dual-rate payment structure under the LTCH PPS in section 1206 of the Pathway for SGR Reform Act of 2013. CMS has stated with regard to the dual rate LTCH PPS that it does "not have the authority to pay LTCH

discharges that fail to meet the patient-level criteria for payment at the LTCH PPS standard Federal payment rate at a rate other than the site neutral payment rate . . . ." FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. at 57070 (R.R. at 2670). However, CMS is doing just that by applying the duplicative BNA. CMS is acting in direct contradiction of its own position on the dual rate LTCH PPS by paying LTCH site neutral cases a rate other than the site neutral payment rate contemplated by the statute. Furthermore, because CMS applies multiple BNAs to the site neutral payment rate, LTCHs may receive a *lower* Medicare payment for these cases than a short term acute care hospital would receive for the case under the IPPS. This violates the clear language of the SSA that the site neutral payment be "comparable" to the IPPS payment, when compared on a *per diem* (i.e., per day) basis. Therefore, the duplicative budget neutrality adjustment must be set aside because it is contrary to the SSA.

3. The Extra BNA Violates the Medicare Prohibition on Cost-Shifting

The Social Security Act prohibits CMS from shifting Medicare costs to non-beneficiaries (*i.e.*, "cost-shifting"). 42 U.S.C. § 1395x(v)(1)(A) (SSA § 1861(v)(1)(A)) ("[T]he necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered . . . ."). Courts have regularly recognized Medicare's cost-shifting prohibition (sometimes referred to as "anti-cross-subsidization provisions"). *E.g.*, *Abington Crest Nursing and Rehab. Ctr. v. Leavitt*, 541 F. Supp. 2d 99, 106 (D.D.C. 2008); *Foothill Hosp.-Morris L. Johnston Mem'l v. Leavitt*, 558 F. Supp. 2d 1, 3 (D.D.C. 2008). In *Howard Univ. v. Bowen*, No. 85-3342, 1988 WL 33508 (D.D.C. Mar. 29, 1988), the D.C. District Court found that the cost-shifting prohibition superseded a contrary Medicare regulation, stating ". . . the Secretary failed to note that the prohibition against cost-shifting is not merely a general regulation, but, as noted above, is an integral part of the Medicare statute itself and has been so found by numerous courts." *Id.* at *2. Here, CMS' decision to apply

a second outlier BNA to the LTCH site neutral payment rate violates the prohibition on cost-shifting at 42 U.S.C. § 1395x(v)(1)(A)(i) because it results in Medicare costs being shifted to non-Medicare beneficiaries. This duplicative BNA reduces aggregate LTCH payments by approximately $28 million per year. *See* American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 6 (R.R. at 5401). This is a windfall for the Medicare program that violates the SSA's cost-shifting prohibition.

The duplicative outlier budget neutrality adjustment should be set aside because it violates the Social Security Act and other federal laws (*i.e.*, BIPA § 307(b)(1)). As a result of these statutory violations, the budget neutrality adjustment also must be set aside under the APA because the adjustment is "not in accordance with the law." 5 U.S.C. § 706(2)(A).

VIII. CONCLUSION

For the reasons discussed herein, Plaintiffs respectfully request that the Court grant Plaintiffs' Motion for Summary Judgment, set-aside the duplicative negative 5.1 percent outlier budget neutrality adjustment that CMS applies to LTCH PPS site neutral case payments, order that the Secretary reimburse Plaintiffs for the payments that CMS withheld from Plaintiffs during FY 2019 and prior years as a result of the duplicative 5.1 percent outlier budget neutrality adjustment (plus statutory interest and fees), and order the Secretary not to apply the duplicative BNA to LTCH PPS site neutral payments in FY 2020 and later years.

Dated: June 19, 2019

Respectfully Submitted,

/s/ *Jason M. Healy*

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EXHIBIT A

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 424, and 495

[CMS–1694–F]

RIN 0938–AT27

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2019. Some of these changes implement certain statutory provisions contained in the 21st Century Cures Act and the Bipartisan Budget Act of 2018, and other legislation. We also are making changes relating to Medicare graduate medical education (GME) affiliation agreements for new urban teaching hospitals. In addition, we are providing the market basket update that will apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis, subject to these limits for FY 2019. We are updating the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2019.

In addition, we are establishing new requirements or revising existing requirements for quality reporting by specific Medicare providers (acute care hospitals, PPS-exempt cancer hospitals, and LTCHs). We also are establishing new requirements or revising existing requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (now referred to as the Promoting Interoperability Programs). In addition, we are finalizing modifications to the requirements that apply to States operating Medicaid Promoting Interoperability Programs. We are updating policies for the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program.

We also are making changes relating to the required supporting documentation for an acceptable Medicare cost report submission and the supporting information for physician certification and recertification of claims.

DATES: This final rule is effective on October 1, 2018.

FOR FURTHER INFORMATION CONTACT:

Donald Thompson, (410) 786–4487, and Michele Hudson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Sole Community Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Medicare-Dependent Small Rural Hospital (MDH) Program, and Low-Volume Hospital Payment Adjustment Issues.

Michele Hudson, (410) 786–4487, Mark Luxton, (410) 786–4530, and Emily Lipkin, (410) 786–3633, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

Jeris Smith, (410) 786–0110, Frontier Community Health Integration Project Demonstration Issues.

Cindy Tourison, (410) 786–1093, Hospital Readmissions Reduction Program—Readmission Measures for Hospitals Issues.

James Poyer, (410) 786–2261, Hospital Readmissions Reduction Program—Administration Issues.

Elizabeth Bainger, (410) 786–0529, Hospital-Acquired Condition Reduction Program Issues.

Joseph Clift, (410) 786–4165, Hospital-Acquired Condition Reduction Program—Measures Issues.

Grace Snyder, (410) 786–0700 and James Poyer, (410) 786–2261, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Program Administration, Validation, and Reconsideration Issues.

Reena Duseja, (410) 786–1999 and Cindy Tourison, (410) 786–1093, Hospital Inpatient Quality Reporting—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues; and Readmission Measures for Hospitals Issues.

Kim Spalding Bush, (410) 786–3232, Hospital Value-Based Purchasing Efficiency Measures Issues.

Elizabeth Goldstein, (410) 786–6665, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Joel Andress, (410) 786–5237 and Caitlin Cromer, (410) 786–3106, PPS-Exempt Cancer Hospital Quality Reporting Issues.

Mary Pratt, (410) 786–6867, Long-Term Care Hospital Quality Data Reporting Issues.

Elizabeth Holland, (410) 786–1309, Promoting Interoperability Programs Clinical Quality Measure Related Issues.

Kathleen Johnson, (410) 786–3295 and Steven Johnson (410) 786–3332, Promoting Interoperability Programs Nonclinical Quality Measure Related Issues.

Kellie Shannon, (410) 786–0416, Acceptable Medicare Cost Report Submissions Issues.

Thomas Kessler, (410) 786–1991, Physician Certification and Recertification of Claims.

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is available from the **Federal Register** online database through Federal Digital System (FDsys), a service of the U.S. Government Printing Office. This database can be accessed via the internet at: *http://www.gpo.gov/fdsys.*

Tables Available Through the Internet on the CMS Website

In the past, a majority of the tables referred to throughout this preamble and in the Addendum to the proposed rule and the final rule were published in the **Federal Register** as part of the annual proposed and final rules. However, beginning in FY 2012, the majority of the IPPS tables and LTCH PPS tables are no longer published in the **Federal Register**. Instead, these tables, generally, will be available only through the internet. The IPPS tables for this final rule are available through the internet on the CMS website at: *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/*

for FY 2017, the percentage of actual outlier payments relative to actual total payments is higher than we projected for FY 2017. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2017 are equal to 5.1 percent of total MS–DRG payments. As explained in the FY 2003 Outlier Final Rule (68 FR 34502), if we were to make retroactive adjustments to all outlier payments to ensure total payments are 5.1 percent of MS–DRG payments (by retroactively adjusting outlier payments), we would be removing the important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized. We believe it would be neither necessary nor appropriate to make such an aggregate retroactive adjustment. Furthermore, we believe it is consistent with the statutory language at section 1886(d)(5)(A)(iv) of the Act not to make retroactive adjustments to outlier payments. This section states that outlier payments be equal to or greater than 5 percent and less than or equal to 6 percent of projected or estimated (not actual) MS–DRG payments. We believe that an important goal of a PPS is predictability. Therefore, we believe that the fixed-loss outlier threshold should be projected based on the best available historical data and should not be adjusted retroactively. A retroactive change to the fixed-loss outlier threshold would affect all hospitals subject to the IPPS, thereby undercutting the predictability of the system as a whole.

We note that, because the MedPAR claims data for the entire FY 2018 will not be available until after September 30, 2018, we are unable to provide an estimate of actual outlier payments for FY 2018 based on FY 2018 claims data in this final rule. We will provide an estimate of actual FY 2018 outlier payments in the FY 2020 IPPS/LTCH PPS proposed rule.

Comment: One commenter noted that, in the proposed rule, CMS stated that actual outlier payments for FY 2017 were approximately 5.53 percent of total MS–DRG payments. The commenter performed its own analysis and concluded that outlier payments for FY 2017 are approximately 5.30 percent of total MS–DRG payments. The commenter was concerned that CMS' estimate was overstated.

Response: We thank the commenter for the comments. We reviewed our data to ensure the estimate provided is accurate. Therefore, we believe we have provided a reliable estimate of the outlier percentage for FY 2017. The commenter did not provide details regarding the discrepancy. We welcome additional suggestions from the public, including the commenter, to improve the accuracy of our estimate of actual outlier payments.

5. FY 2019 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B listed and published in section VI. of this Addendum (and available via the internet on the CMS website) contain the national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2019. The standardized amount for hospitals in Puerto Rico is shown in Table 1C listed and published in section VI. of this Addendum (and available via the internet on the CMS website). The amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is 68.3 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless application of that percentage would result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include the standardized amounts reflecting the applicable percentage increases for FY 2019.

The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2019 are set forth in Table 1C listed and published in section VI. of this Addendum (and available via the internet on the CMS website). Similar to above, section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.

The following table illustrates the changes from the FY 2018 national standardized amount to the FY 2019 national standardized amount. The second through fifth columns display the changes from the FY 2018 standardized amounts for each applicable FY 2019 standardized amount. The first row of the table shows the updated (through FY 2018) average standardized amount after restoring the FY 2018 offsets for outlier payments and the geographic reclassification budget neutrality. The MS–DRG reclassification and recalibration and wage index budget neutrality adjustment factors are cumulative. Therefore, those FY 2018 adjustment factors are not removed from this table.

CHANGES FROM FY 2018 STANDARDIZED AMOUNTS TO THE FY 2019 STANDARDIZED AMOUNTS

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
FY 2018 Base Rate after removing: 1. FY 2018 Geographic Reclassification Budget Neutrality (0.987985) 2. FY 2018 Operating Outlier Offset (0.948998)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36. Nonlabor (30.4%): $1,884.07. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92. Nonlabor (38%): $2,258.50.	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36. Nonlabor (30.4%): $1,884.07. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92. Nonlabor (38%): $2,258.50.	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36. Nonlabor (30.4%): $1,884.07. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92. Nonlabor (38%): $2,258.50.	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36. Nonlabor (30.4%): $1,884.07. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92. Nonlabor (38%): $2,258.50.
FY 2019 Update Factor	1.0135	0.99175	1.00625	0.9845.
FY 2019 MS-DRG Recalibration Budget Neutrality Factor.	0.997192	0.997192	0.997192	0.997192.
FY 2019 Wage Index Budget Neutrality Factor.	1.000748	1.000748	1.000748	1.000748.
FY 2019 Reclassification Budget Neutrality Factor.	0.985932	0.985932	0.985932	0.985932.
FY 2019 Operating Outlier Factor	0.948999	0.948999	0.948999	0.948999.
FY 2019 Rural Demonstration Budget Neutrality Factor.	0.999467	0.999467	0.999467	0.999467.
Adjustment for FY 2019 Required under Section 414 of Public Law 114–10 (MACRA).	1.005	1.005	1.005	1.005.
National Standardized Amount for FY 2019 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (68.3/31.7).	Labor: $3,858.62 Nonlabor: $1,790.90	Labor: $3,775.81 Nonlabor: $1,752.47	Labor: $3,831.02 Nonlabor: $1,778.09	Labor: $3,748.21. Nonlabor: $1,739.66.

CHANGES FROM FY 2018 STANDARDIZED AMOUNTS TO THE FY 2019 STANDARDIZED AMOUNTS—Continued

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
National Standardized Amount for FY 2019 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38).	Labor: $3,502.70 ..... Nonlabor: $2,146.82	Labor: $3,427.53 ..... Nonlabor: $2,100.75	Labor: $3,477.65 ..... Nonlabor: $2,131.46	Labor: $3,402.48. Nonlabor: $2,085.39.

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as published in section VI. of this Addendum (and available via the internet on the CMS website), contain the labor-related and nonlabor-related shares that we used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2019. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national prospective payment rate to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. For FY 2019, as discussed in section IV.B.3. of the preamble of this final rule, we are applying a labor-related share of 68.3 percent for the national standardized amounts for all IPPS hospitals (including hospitals in Puerto Rico) that have a wage index value that is greater than 1.0000. Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a labor-related share of 62 percent of the national standardized amount for all IPPS hospitals (including hospitals in Puerto Rico) whose wage index values are less than or equal to 1.0000. In section III. of the preamble of this final rule, we discuss the data and methodology for the FY 2019 wage index.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act provides discretionary authority to the Secretary to make adjustments as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. To account for higher nonlabor-related costs for these two States, we multiply the nonlabor-related portion of the standardized amount for hospitals in Alaska and Hawaii by an adjustment factor.

In the FY 2013 IPPS/LTCH PPS final rule, we established a methodology to update the COLA factors for Alaska and Hawaii that were published by the U.S. Office of Personnel Management (OPM) every 4 years (at the same time as the update to the labor-related share of the IPPS market basket), beginning in FY 2014. We refer readers to the FY 2013 IPPS/LTCH PPS proposed and final rules for additional background and a detailed description of this methodology (77 FR 28145 through 28146 and 77 FR 53700 through 53701, respectively).

For FY 2018, in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38530 through 38531), we updated the COLA factors published by OPM for 2009 (as these are the last COLA factors OPM published prior to transitioning from COLAs to locality pay) using the methodology that we finalized in the FY 2013 IPPS/LTCH PPS final rule.

Based on the policy finalized in the FY 2013 IPPS/LTCH PPS final rule, for FY 2019, as we proposed, we are continuing to use the same COLA factors in FY 2019 that were used in FY 2018 to adjust the nonlabor-related portion of the standardized amount for hospitals located in Alaska and Hawaii. Below is a table listing the COLA factors for FY 2019.

FY 2019 COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.25
Rest of Alaska	1.25
City and County of Honolulu	1.25
County of Hawaii	1.21
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Based on the policy finalized in the FY 2013 IPPS/LTCH PPS final rule, the next update to the COLA factors for Alaska and Hawaii would occur at the same time as the update to the labor-related share of the IPPS market basket (no later than FY 2022).

C. Calculation of the Prospective Payment Rates

General Formula for Calculation of the Prospective Payment Rates for FY 2019

In general, the operating prospective payment rate for all hospitals (including hospitals in Puerto Rico) paid under the IPPS, except SCHs and MDHs, for FY 2019 equals the Federal rate (which includes uncompensated care payments).

Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10, enacted on April 16, 2015) extended the MDH program (which, under previous law, was to be in effect for discharges on or before March 31, 2015 only) for discharges occurring on or after April 1, 2015, through FY 2017 (that is, for discharges occurring on or before September 30, 2017). Section 50205 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123), enacted February 9, 2018, extended the MDH program for discharges on or after October 1, 2017 through September 30, 2022.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate (which, as discussed in section V.G. of the preamble of this final rule, includes uncompensated care payments); the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

The prospective payment rate for SCHs for FY 2019 equals the higher of the applicable

relative weights. Under the capital IPPS, there is a single GAF/DRG budget neutrality adjustment factor for changes in the GAF (including geographic reclassification) and the MS–DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

The incremental adjustment factor of 0.9975 (the product of the incremental national GAF budget neutrality adjustment factor of 0.9986 and the incremental DRG budget neutrality adjustment factor of 0.9989) accounts for the MS–DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the GAFs of FY 2019 geographic reclassification decisions made by the MGCRB compared to FY 2018 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

4. Capital Federal Rate for FY 2019

For FY 2018, we established a capital Federal rate of $453.95 (82 FR 46144 through 46145). We are establishing an update of 1.4 percent in determining the FY 2019 capital Federal rate for all hospitals. As a result of this update and the budget neutrality factors discussed earlier, we are establishing a national capital Federal rate of $459.72 for FY 2019. The national capital Federal rate for FY 2019 was calculated as follows:

- The FY 2019 update factor is 1.014; that is, the update is 1.4 percent.
- The FY 2019 budget neutrality adjustment factor that is applied to the capital Federal rate for changes in the MS–DRG classifications and relative weights and changes in the GAFs is 0.9975.
- The FY 2019 outlier adjustment factor is 0.9494.

We are providing the following chart that shows how each of the factors and adjustments for FY 2019 affects the computation of the FY 2019 national capital Federal rate in comparison to the FY 2018 national capital Federal rate as presented in the FY 2018 IPPS/LTCH PPS Correction Notice (82 FR 46144 through 46145). The FY 2019 update factor has the effect of increasing the capital Federal rate by 1.4 percent compared to the FY 2018 capital Federal rate. The GAF/DRG budget neutrality adjustment factor has the effect of decreasing the capital Federal rate by 0.25 percent. The FY 2019 outlier adjustment factor has the effect of increasing the capital Federal rate by 0.12 percent compared to the FY 2018 capital Federal rate. The combined effect of all the changes will increase the national capital Federal rate by approximately 1.27 percent, compared to the FY 2018 national capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2018 CAPITAL FEDERAL RATE AND FY 2019 CAPITAL FEDERAL RATE

	FY 2018	FY 2019	Change	Percent change
Update Factor [1]	1.0130	1.0140	1.014	1.40
GAF/DRG Adjustment Factor [1]	0.9987	0.9975	0.9975	−0.25
Outlier Adjustment Factor [2]	0.9483	0.9494	1.0012	0.12
Capital Federal Rate	$453.95	$459.72	1.0127	1.27 [3]

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2018 to FY 2019 resulting from the application of the 0.9975 GAF/DRG budget neutrality adjustment factor for FY 2019 is a net change of 0.9975 (or –0.25 percent).

[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2019 outlier adjustment factor is 0.9494/0.9483 or 1.0012 (or 0.12 percent).

[3] Percent change may not sum due to rounding.

In this final rule, we also are providing the following chart that shows how the final FY 2019 capital Federal rate differs from the proposed FY 2019 capital Federal rate as presented in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20587 through 20589).

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2019 CAPITAL FEDERAL RATE AND FINAL FY 2019 CAPITAL FEDERAL RATE

	Proposed FY 2019	Final FY 2019	Change	Percent change *
Update Factor	1.0120	1.0140	1.0020	0.20
GAF/DRG Adjustment Factor	0.9997	0.9975	−0.0022	−0.22
Outlier Adjustment Factor	0.9494	0.9494	0.0000	0.00
Capital Federal Rate	$459.78	$459.72	0.9999	−0.01

* Percent change may not sum due to rounding.

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2019

For purposes of calculating payments for each discharge during FY 2019, the capital Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2019 are in section II.A. of this Addendum. For FY 2019, a case will qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments (including both the empirically justified Medicare DSH payment and the estimated uncompensated care payment, as discussed in section II.A.4.g.(1) of this Addendum) is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $25,769.

Currently, as provided under § 412.304(c)(2), we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation, unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior

cases that would qualify as LTCH PPS standard Federal payment rate cases versus site neutral payment rate cases under the statutory provisions would remain consistent with what is reflected in the historical LTCH PPS claims data. Although our actuaries did not project an immediate change in the proportions found in the historical data, they did project cost and resource changes to account for the lower payment rates. Our actuaries also projected that the costs and resource use for cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and would likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. As discussed in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49619), this actuarial assumption is based on our expectation that site neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount under the statutory LTCH PPS payment changes that began in FY 2016, which, in the majority of cases, is much lower than the payment that would have been paid if these statutory changes were not enacted. In light of these projections and expectations, we discussed that we believed that the use of a single fixed-loss amount and HCO target for all LTCH PPS cases would be problematic. In addition, we discussed that we did not believe that it would be appropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS (80 FR 49617 through 49619 and 81 FR 57305 through 57307). For those reasons, we stated that we believed that the most appropriate fixed-loss amount for site neutral payment rate cases for FYs 2016 through 2018 would be equal to the IPPS fixed-loss amount for that particular fiscal year. Therefore, we established the fixed-loss amount for site neutral payment rate cases as the corresponding IPPS fixed-loss amounts for FYs 2016 through 2018. In particular, in FY 2018, we established the fixed-loss amount for site neutral payment rate cases as the FY 2018 IPPS fixed-loss amount of $26,537 (82 FR 46145).

As noted earlier, because not all claims in the data used for this final rule were subject to the site neutral payment rate, we continue to rely on the same considerations and actuarial projections used in FYs 2016 through 2018 when developing a fixed-loss amount for site neutral payment rate cases for FY 2019. Because our actuaries continue to project that site neutral payment rate cases in FY 2019 will continue to mirror an IPPS case paid under the same MS–DRG, we continue to believe that it would be inappropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS. More specifically, as with FYs 2016 through 2018, our actuaries project that the costs and resource use for FY 2019 cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and will likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. (Based on the most recent FY 2017 LTCH claims data, approximately 64 percent of LTCH cases would have been paid the LTCH PPS standard Federal payment rate and approximately 36 percent of LTCH cases would have been paid the site neutral payment rate for discharges occurring in FY 2017.)

For these reasons, we continue to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2019 is the IPPS fixed-loss amount for FY 2019. Therefore, consistent with past practice, in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20595 and 20596), for FY 2019, we proposed that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. That is, we proposed a fixed-loss amount for site neutral payment rate cases of $27,545, which is the same proposed FY 2019 IPPS fixed-loss amount discussed in section II.A.4.g.(1) of the Addendum to the proposed rule. We continue to believe that this policy would reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, for FY 2019, we proposed to calculate a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed site neutral payment rate payment and the proposed fixed-loss amount for site neutral payment rate cases of $27,545).

We did not receive any public comments on our proposals to use the FY 2019 IPPS fixed-loss amount and 5.1 percent HCO target for LTCH discharges paid at the site neutral payment rate in FY 2019. In this final rule, we are finalizing these proposals without modification.

Therefore, for FY 2019, as we proposed, we are establishing that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed loss amount. That is, we are establishing a fixed-loss amount for site neutral payment rate cases of $25,769, which is the same FY 2019 IPPS fixed-loss amount discussed in section II.A.4.g.(1). of the Addendum to this final rule. We continue to believe that this policy will reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, under this policy, for FY 2019, we will calculate a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount, which is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of site neutral payment rate payment and the fixed loss amount for site neutral payment rate cases of $25,769).

In establishing a HCO policy for site neutral payment rate cases, we established a budget neutrality adjustment under § 412.522(c)(2)(i). We established this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases is budget neutral, meaning that estimated site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments.

To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2019. In order to achieve this, for FY 2019, in general, as we proposed, we are continuing to use the policy adopted for FY 2018.

As discussed earlier, consistent with the IPPS HCO payment threshold, we estimate our fixed-loss threshold of $25,769 results in HCO payments for site neutral payment rate cases to equal 5.1 percent of the site neutral payment rate payments that are based on the IPPS comparable per diem amount. As such, to ensure estimated HCO payments payable for site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce the site neutral payment rate amount paid under § 412.522(c)(1)(i) by 5.1 percent to account for the estimated additional HCO payments payable for site neutral payment rate cases in FY 2019. In order to achieve this, for FY 2019, we proposed to apply a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as $1.0 - 5.1/100 = 0.949$) to the site neutral payment rate for those site neutral payment rate cases paid under § 412.522(c)(1)(i). We noted that, consistent with the policy adopted for FY 2018, this proposed HCO budget neutrality adjustment would not be applied to the HCO portion of the site neutral payment rate amount (81 FR 57309).

Comment: As was the case in the FY 2016 through FY 2018 rulemaking cycles, commenters again objected to the proposed site neutral payment rate HCO budget neutrality adjustment, claiming that it results in savings to the Medicare program instead of being budget neutral. The commenters' primary objection was again based on their belief that, because the IPPS base rates used in the IPPS comparable per diem amount calculation of the site neutral payment rate include a budget neutrality adjustment for IPPS HCO payments (that is, a 5.1 percent adjustment on the operating IPPS

standardized amount), an ''additional'' budget neutrality factor is not necessary and is, in fact, duplicative.

Response: We continue to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative. As we discussed in response to similar comments (82 FR 38545 through 38546, 81 FR 57308 through 57309, and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner. More importantly, we continue to believe this budget neutrality adjustment is appropriate for reasons outlined in our response to the nearly identical comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57308 through 57309) and our response to similar comments in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49621 through 49622).

After consideration of the public comments we received, we are finalizing our proposal to apply a budget neutrality adjustment for HCO payments made to site neutral payment rate cases. Therefore, to ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2019 will not result any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2019. In order to achieve this, for FY 2019, in this final rule, as proposed, we are applying a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as 1.0 − 5.1/100 = 0.949) to the site neutral payment rate (without any applicable HCO payment).

E. Update to the IPPS Comparable Amount To Reflect the Statutory Changes to the IPPS DSH Payment Adjustment Methodology

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50766), we established a policy to reflect the changes to the Medicare IPPS DSH payment adjustment methodology made by section 3133 of the Affordable Care Act in the calculation of the ''IPPS comparable amount'' under the SSO policy at § 412.529 and the ''IPPS equivalent amount'' under the 25-percent threshold payment adjustment policy at § 412.534 and § 412.536. Historically, the determination of both the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' includes an amount for inpatient operating costs ''for the costs of serving a disproportionate share of low-income patients.'' Under the statutory changes to the Medicare DSH payment adjustment methodology that began in FY 2014, in general, eligible IPPS hospitals receive an empirically justified Medicare DSH payment equal to 25 percent of the amount they otherwise would have received under the statutory formula for Medicare DSH payments prior to the amendments made by the Affordable Care Act. The remaining amount, equal to an estimate of 75 percent of the amount that otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals who are uninsured, is made available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The additional uncompensated care payments are based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all IPPS hospitals that receive Medicare DSH payments.

To reflect the statutory changes to the Medicare DSH payment adjustment methodology in the calculation of the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS, we stated that we will include a reduced Medicare DSH payment amount that reflects the projected percentage of the payment amount calculated based on the statutory Medicare DSH payment formula prior to the amendments made by the Affordable Care Act that will be paid to eligible IPPS hospitals as empirically justified Medicare DSH payments and uncompensated care payments in that year (that is, a percentage of the operating Medicare DSH payment amount that has historically been reflected in the LTCH PPS payments that is based on IPPS rates). We also stated that the projected percentage will be updated annually, consistent with the annual determination of the amount of uncompensated care payments that will be made to eligible IPPS hospitals. We believe that this approach results in appropriate payments under the LTCH PPS and is consistent with our intention that the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS closely resemble what an IPPS payment would have been for the same episode of care, while recognizing that some features of the IPPS cannot be translated directly into the LTCH PPS (79 FR 50766 through 50767).

For FY 2019, as discussed in greater detail in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20596) as well as in section IV.F.3. of the preamble of this final rule, based on the most recent data available, our estimate of 75 percent of the amount that would otherwise have been paid as Medicare DSH payments (under the methodology outlined in section 1886(r)(2) of the Act) is adjusted to 67.51 percent of that amount to reflect the change in the percentage of individuals who are uninsured. The resulting amount is then used to determine the amount available to make uncompensated care payments to eligible IPPS hospitals in FY 2018. In other words, the amount of the Medicare DSH payments that would have been made prior to the amendments made by the Affordable Care Act will be adjusted to 50.63 percent (the product of 75 percent and 67.51 percent) and the resulting amount will be used to calculate the uncompensated care payments to eligible hospitals. As a result, for FY 2019, we projected that the reduction in the amount of Medicare DSH payments pursuant to section 1886(r)(1) of the Act, along with the payments for uncompensated care under section 1886(r)(2) of the Act, will result in overall Medicare DSH payments of 75.63 percent of the amount of Medicare DSH payments that would otherwise have been made in the absence of the amendments made by the Affordable Care Act (that is, 25 percent + 50.63 percent = 75.63 percent).

In the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20596), for FY 2019, we proposed to establish that the calculation of the ''IPPS comparable amount'' under § 412.529 would include an applicable operating Medicare DSH payment amount that is equal to 75.63 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula absent the amendments made by the Affordable Care Act. Furthermore, consistent with our historical practice, we proposed that if more recent data became available, if appropriate, we would use that data to determine this factor in this final rule.

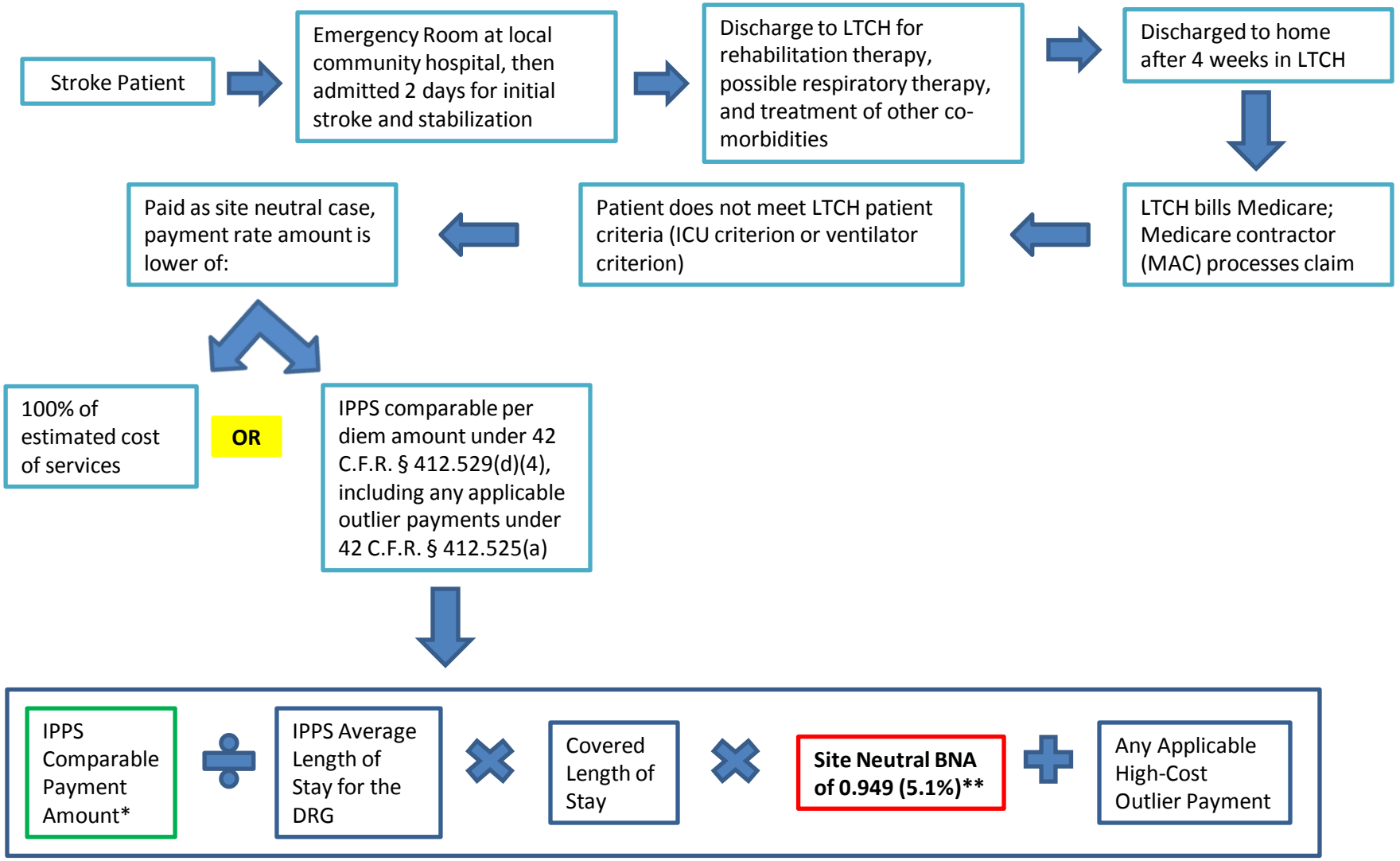
We did not receive any public comments in response to our proposal. In addition, there are no more recent data available to use that would affect the calculations determined in the proposed rule. Therefore, we are finalizing our proposal that, for FY 2019, the calculation of the ''IPPS comparable amount'' under § 412.529 includes an applicable operating Medicare DSH payment amount that is equal to 75.63 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula absent the amendments made by the Affordable Care Act. (We note that we also proposed that the ''IPPS equivalent amount'' under § 412.538 would include an applicable operating Medicare DSH payment amount that is equal to 75.63 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula absent the amendments made by the Affordable Care Act. However, as discussed in section VII.E. of the preamble of this final rule, we are finalizing our proposal to remove the provisions of § 412.538, and reserving this section.)

F. Computing the Adjusted LTCH PPS Federal Prospective Payments for FY 2019

Section 412.525 sets forth the adjustments to the LTCH PPS standard Federal payment rate. Under the dual rate LTCH PPS payment structure, only LTCH PPS cases that meet the statutory criteria to be excluded from the site neutral payment rate are paid based on the LTCH PPS standard Federal payment rate. Under § 412.525(c), the LTCH PPS standard Federal payment rate is adjusted to account for differences in area wages by multiplying the labor-related share of the LTCH PPS standard Federal payment rate for a case by the applicable LTCH PPS wage index (the FY 2019 values are shown in Tables 12A through 12B listed in section VI. of the Addendum to this final rule and are available via the internet on the CMS website). The LTCH PPS standard Federal payment rate is also adjusted to account for the higher costs of LTCHs located in Alaska and Hawaii by the applicable COLA factors (the FY 2019 factors are shown in the chart in section V.C. of this Addendum) in accordance with § 412.525(b). In this final rule, as we proposed, we are establishing an LTCH PPS standard Federal payment rate for FY 2019 of $41,579.65, as discussed in section V.A. of the Addendum to this final rule. We illustrate the

EXHIBIT B

Calculation of LTCH Site Neutral Payment Based on IPPS Comparable Per Diem Amount



* See next page for calculation

** Per 42 C.F.R. § 412.522(c)(2)(i) with factor specified in rulemaking. *See*, *e.g.*, 83 Fed. Reg. 41144, 41737-38 (Aug. 17, 2018).

IPPS comparable payment amount under 42 C.F.R. § 412.529(d)(4)(i)(A)

=

Adjusted Operating IPPS Standardized Amount

((**Labor-Share Standardized Amount*** x IPPS Wage Index) + **(Non Labor-Share Standardized Amount*** x COLA)) x (IPPS DRG Relative Weight) x (1 + Indirect Medical Education Adjustment for Operating Costs + Disproportionate Share Hospital Adjustment for Operating Costs)

***Labor-Share and Non Labor-Share Standardized Amounts include:**

- Update Factor
- MS-DRG Recalibration Budget Neutrality Factor
- Wage Index Budget Neutrality Factor
- **Operating Outlier Factor (0.948999) (5.1%)**
- Rural Demonstration Budget Neutrality Factor
- Adjustment Required under Section 414 of Public Law 114-10 (MACRA)
- National Standardized Amount if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (68.3/31.7)
- National Standardized Amount if Wage Index is Less Than or Equal to 1.0000; Non-Labor Share Percentage (62/38)

+

Adjusted Capital IPPS Federal Rate

(IPPS Capital Federal Rate)** x (IPPS DRG Relative Weight) x (Geographic Adjustment Factor) x (COLA for Capital Costs) x (1 + Indirect Medical Education Adjustment for Capital Costs + Disproportionate Share Hospital Adjustment for Capital Costs)

****IPPS Capital Federal Rate includes:**

- Update Factor
- GAF/DRG Adjustment Factor
- **Outlier Adjustment Factor (0.9494) (5.1%)**
- Capital Federal Rate

* *See, e.g.*, 83 Fed. Reg. at 41724-25.
** *See, e.g.*, 83 Fed. Reg. at 41729.

EXHIBIT C

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

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(Rev. 4271, 03-29-19)

Payments to LTCHs under the LTCH PPS are based on a single standard Federal rate for both the inpatient operating and capital-related costs (including routine and ancillary services), but not certain pass through costs (i.e., bad debts, direct medical education, new technologies, and blood clotting factors). This single standard Federal rate is updated annually by the excluded hospital with capital market basket index. The formula for an unadjusted LTCH PPS prospective payment is as follows:

- Federal Prospective Payment = LTC-DRG Relative Weight * Standard Federal Rate Case-Level Adjustments

Effective July 1, 2003, the annual update to the standard Federal rate is based on the "LTCH PPS rate year" of July 1 through June 30, rather than the Federal fiscal year (October 1 through September 30). July 1, 2008, is the final rate year; LTCH PPS is moving back to a Federal Fiscal Year effective October 1, 2009.

150.9.1 - Case-Level Adjustments
(Rev. 1, 10-01-03)

Payments are based on the LTC-DRG described as well as possible adjustments specific to the case. Because LTCHs are distinguished from other inpatient hospital settings by an average length of stay of greater than 25 days, it was necessary to establish payment categories for certain cases that have stays of considerably less than the average length of stay. The following case-level adjustments are applied to cases that, based on length of stay at the LTCH, receive significantly less than the full course of treatment for a specific LTC-DRG.

150.9.1.1 - Short-Stay Outliers
(Rev. 2060, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10)

- Generally, a short-stay outlier (SSO) is a case that has a covered length of stay between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG to which the case is grouped. Effective for LTCH PPS discharges occurring on or before June 30, 2006, the adjusted payment for an SSO case is the least of:

  - 120 percent of the cost of the case (determined using the facility-specific cost to charge ratio (CCR) and covered charges from the bill);

  - 120 percent of the LTC-DRG specific per diem payment (determined using the LTC-DRG relative weight, the average length of stay of the LTC-DRG, and the length of stay of the case); or

  - The full LTC-DRG payment.

To compute 120% of cost:

- Charges x CCR = Cost ($13,870.33) x (0.8114) = $11,254.39

- 120% of cost = $11,254.39 x 1.2 = $13,505.27

To compute 120% of the specific LTC-DRG per diem:

- Full LTC-DRG payment / ALOS LTC-DRG x LOS of the case x 1.2

  Full LTC-DRG payment:

  $34,956.15 (FY 2003 standard Federal rate)

  x 0.72885 (labor %)

  $25,477.79 (labor share)

  x 1.0301 (1/5th wage index value for FY 2003)

  $26,244.67 (wage adjusted labor share)

  + 9,478.36 (non-labor share=$34,956 x 0.27115)

  $35,723.03 (adjusted standard Federal rate)

  x 1.4103 (LTC-DRG 113 relative weight)

  $50,380.19 (full LTC-DRG payment

  Per Diem = $50,380.19 / 36.9 (ALOS LTC-DRG 113) = $1365.32 per day

  If LOS of case is 10 days, then 120% of per diem = $1365.32 per day x 10 days x 1.2 = $16,383.80.

In this example, the case is paid 120% of cost ($13,505.27) since it is less than $120% of the specific LTC-DRG per diem ($16,383.80) and the full LTC-DRG payment ($50,380.19).

For discharges occurring on or after August 8, 2003, short-stay outlier payments are to be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 - 34513).

For RY 2007, the SSO policy was revised as follows:

- Effective for LTCH PPS discharges occurring on or after July 1, 2006, the adjusted payment for a SSO case is equal the least of:

- 100 percent of estimated cost of the case,
- 120 percent of the LTC-DRG per diem amount,
- the full LTC-DRG payment, or
- a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

Under the blend alternative, the percentage of the 120 percent LTC-DRG per diem amount is based on the ratio of the (covered) length of stay of the case to the lesser of the SSO threshold for the LTC-DRG (i.e., 5/6ths of the geometric ALOS of the LTC-DRG) or 25 days. As the length of stay reaches the lower of the five-sixths SSO threshold or 25 days, the adjusted SSO payment is no longer be limited by this fourth option. This is because for SSO cases with a LOS of 25 days or more, the amount determined under the blend alternative is equal to 100 percent of the 120 percent of the LTC- DRG specific per diem amount and 0 percent of the IPPS comparable per diem amount. In addition, the LOS in the numerator cannot exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent). The remaining percent of the blend alternative (that is, 100 percent minus the percentage applied to the 120 percent of the LTC-DRG per diem amount) is applied to the IPPS comparable per diem amount (capped at the full IPPS comparable amount).

The following examples illustrate how the blend alternative is calculated when the LTCH patient is grouped to hypothetical DRG XYZ. For purposes of this example, for DRG XYZ, the full LTC DRG payment is $38,597.41, the LTCH PPS geometric ALOS is 33.6 days, the LTCH PPS SSO threshold (i.e., 5/6ths of the geometric ALOS) is 28.0 days, the full IPPS comparable amount is $8,019.82, and the IPPS geometric ALOS is 4.5 days.

SSO Example #1 - LOS equals 11 Days:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$38,597.41 x11 days x 1.2 33.6 days	$15,163.27

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days	11 days ÷ 25 days	0.44
1c	Determine the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the LTC-DRG per diem amount in step (1-a)	0.44 x $15,163.28	$6,671.84
2a	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$\frac{\$8,019.82}{4.5 \text{ days}} \times 11 \text{ days}$	$19,604.00
2b	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount ($8,019.82) is lower than the IPPS comparable per diem amount ($19,604.00)	$8,019.82
2c	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 - 0.44	0.56
2d	Determine the IPPS comparable per diem portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable amount determined in step (2-b)	0.56 x $8,019.82	$4,491.10

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
3	Compute the blend alternative	Add the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	$6,671.84 + $4,491.10	$11,162.94

* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

SSO Example #2 - LOS equals 27 Days:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$38,597.41 x 27 days 33.6 days x 1.2	$37,218.93
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days; however, since the LOS in the numerator exceeds the number of days in the denominator, the percentage equals 100 percent	27 days ÷ 25 days is > 1; therefore percent is 1.00	1.00
1c	Determine the 120 percent of the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the 120 percent of the LTC-DRG per diem amount in step (1-a)	1.0 x $37,218.93	$37,218.93

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
2a	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$\frac{\$8,019.82}{4.5 \text{ days}} \times 11 \text{ days}$	$48,118.92
2b	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount ($8,019.82) is lower than the IPPS comparable per diem amount ($48,118.92)	$8,019.82
2c	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 - 1.00	0.00
2d	Determine the IPPS comparable per diem amount portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable per diem amount determined in step (2-b)	0.00 x $8,019.82	$0.00
3	Compute the blend alternative	Add the 120 percent of the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	$37,218.93 + $0.00	$37,218.93**

* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

** Note that, since in this example the LOS of the SSO case exceeds 25 days, the blend percentage applicable to the 120 percent of the LTC-DRG specific per diem amount is 100 percent and the percentage applicable to the IPPS comparable per diem amount is 0 percent, therefore the amount computed under the blend option is equal to 120 percent of the LTC-DRG specific per diem amount.

Under the blend alternative of the SSO payment formula, an amount comparable to what would otherwise be paid under the IPPS (i.e., full IPPS comparable amount) includes payment for the costs of inpatient operating services based on the standardized amount determined under §412.64(c), adjusted by the applicable DRG weighting factors determined under §412.60 as specified at §412.64(g). This amount is further adjusted to account for different area wage levels by geographic area using the applicable IPPS labor-related share, based on the CBSA where the LTCH is physically located as set forth at §412.525(c) and using the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. (In the RY 2006 LTCH PPS final rule (70 FR 24200), we discuss the inapplicability of geographic reclassification procedures for LTCHs.) For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable proposed COLA factor used under the IPPS published annually in the IPPS final rule. (Currently, the same COLA factors are used under both the IPPS and the LTCH PPS.)

Additionally, an amount comparable to what would be paid under the IPPS for the case includes a disproportionate share (DSH) adjustment (see §412.106), if applicable, and includes an indirect medical education (IME) adjustment (see §412.105), if applicable. For the comparable IPPS DSH adjustment, provider specific file elements 24 (Bed Size), 27 (Supplemental Security Income Ratio (SSI)), and 28 (Medicaid Ratio) are required, as discussed below. In determining a LTCH's SSI ratio and Medicaid ratio used in the calculation of the comparable IPPS DSH adjustment, refer to sections 20.3.1.1 and 20.3.1.2 of this manual.

For the comparable IPPS IME adjustment, provider specific file elements 23 (Intern/Beds Ratio) and 49 (Capital Indirect Medical Education Ratio) are required, as discussed below. Furthermore, the IPPS comparable IME adjustment for a LTCH is determined by imputing a limit on the number of full-time equivalent (FTE) residents that may be counted for IME (IME cap) based on the LTCH's direct GME cap as set forth at §413.79(c)(2) (which will already be established for a LTCH which had residency programs). In determining the IPPS comparable IME adjustment for a LTCH, if applicable, the use of a proxy for the IME cap is necessary because it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment. The full IPPS comparable amount used under the blend alternative in the SSO payment adjustment, also includes payment for inpatient capital-related costs, based on the capital Federal rate at §412.308(c), which is adjusted by the applicable IPPS DRG weighting factors. This amount is further adjusted by the applicable geographic adjustment factors set forth at §412.316, including wage index (based on the CBSA where a LTCH is physically located and derived from the IPPS wage index for non-reclassified hospitals as published in the annual IPPS final rule), and large urban location, if applicable. A LTCH PPS payment amount comparable to what would be paid under the IPPS does not include additional

payments for extraordinarily high cost cases under the IPPS outlier policy (§412.80(a)). Under existing LTCH PPS policy, a SSO case that meets the criteria for a LTCH PPS high cost outlier payment at §412.525(a)(1) (i.e., if the estimated costs of the case exceeds the adjusted LTCH PPS SSO payment plus the fixed-loss amount) will receive an additional payment under the LTCH PPS HCO high cost outlier at §412.525(a) (67 FR 56026; August 30, 2002). Under the revised SSO payment formula, we will continue to use the fixed-loss amount calculated under §412.525(a), and not a fixed-loss amount based on §412.80(a), to determine whether a SSO case receives an additional payment as a high cost outlier case.

For RY 2008, the SSO policy was revised as follows:

Effective for LTCH PPS discharges occurring on or after July 1, 2007, and on or before December 28, 2007*, the payment adjustment formula for SSO cases was revised for those cases where the patient's LTCH covered LOS is less than, or equal to an "IPPS-comparable" threshold. For cases falling within this "IPPS-comparable" threshold, Medicare payment under the SSO policy is subject to an additional adjustment.

The IPPS-comparable threshold is defined as the geometric average length of stay for the same DRG under the IPPS plus one standard deviation (refer to Table 3 in the LTCH PPS RY 2008 final rule (72 FR 26870 at 27019- 27029)).

If the covered LOS at the LTCH is less than or equal to the IPPS-comparable threshold for the LTC-DRG, Medicare payment is based on the IPPS comparable per diem amount, capped at the full IPPS comparable amount. This option replaces the "blend" amount in the adjusted LTCH PPS SSO payment formula.

Effective for discharges occurring on or after July 1, 2007 and on or before December 28, 2007*, therefore, the adjusted Medicare payment for an SSO case where the covered LOS at the LTCH is within the IPPS-comparable threshold, is equal the least of:

- 100 percent of estimated cost of the case,
- 120 percent of the LTC-DRG per diem amount,
- the full LTC-DRG payment, or
- the "IPPS comparable" per diem amount , capped at the full IPPS comparable amount

The IPPS comparable amount is determined by the same methodology as the IPPS comparable portion of the blend alternative, specified above in the above examples at 2a.

For SSO cases where the covered length of stay exceeds the "IPPS threshold," payment is made under the SSO payment formula that became effective beginning in RY 2007, as specified above.

***NOTE:** On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted that mandated a modification to the SSO payment adjustment formula for a 3-year period beginning on the date of enactment of the Act. Specifically, section 114(c)(3) of the MMSEA specifies that the revision to the SSO policy implemented in RY 2008 shall not apply for a 3-year period beginning with discharges occurring on or after December 29, 2007. Consequently, the fourth option in the SSO payment adjustment formula at §412.529(c)(3)(i) will not apply during this 3-year period, and therefore, there will be no comparison of the covered LOS of the SSO case to the "IPPS threshold" in determining the payment adjustment for SSO cases. Therefore, for SSO discharges occurring on or after December 29, 2007, and before December 29, 2012, the adjusted payment for a SSO case is equal to the least of:

- 100 percent of estimated cost of the case,
- 120 percent of the LTC-DRG per diem amount,
- the full LTC-DRG payment, or
- a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

As noted above, during this 3-year period specified by the MMSEA, all SSO cases (including those where the covered LOS exceeds the "IPPS threshold") are paid under the SSO payment formula that became effective beginning in RY 2007, as described above.

Short Stay Outlier Policy for LTCHs qualifying under §1886(d)(1)(B)(II)

A "subsection (II)" hospital:

- Was excluded as a LTCH in 1986
- Has an average inpatient LOS of greater than 20 days, and
- Demonstrates that 80 percent of its annual Medicare inpatient discharges in the 12-month reporting period ending FFY 1997 have a principal finding of neoplastic disease.

For a "subsection (II)" hospital there is a special short-stay outlier policy effective for the remainder of the transition period (i.e., **discharges** occurring on or after July 1, 2003 through December 31, 2006), where the lesser of 120 percent of cost or120 percent of the per diem LTC-DRG in the existing short-stay outlier policy is replaced with the follow percentages:

- Effective for **discharges** occurring on or after **July 1, 2003 through the first year of transition 195%**;

- Effective for **discharges** during the second year of the transition, **193%**;

- Effective for **discharges** during the third year of the transition, **165%**;

- Effective for **discharges** during the fourth year of the transition, **136%**; and

- Effective for **discharges** for the last year and thereafter, the percentage returns to **120%**.

150.9.1.2 - Interrupted Stays

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Beginning on July 1, 2004, there are two interruption of stay policies in effect under the LTCH PPS.

A 3-day or less interruption of stay is a stay at an LTCH during which the beneficiary is discharged from the LTCH to an acute care hospital, IRF, SNF, or home and readmitted to the same LTCH within 3-days of the discharge. The 3-day or less period begins with the date of discharge from the LTCH and ends not later than midnight of the third day.

Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the “interruption" would be the responsibility of the LTCH “under arrangements” with one limited exception: for RY 2005 and RY 2006, if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the IPPS for that care. Effective for dates of service on or after July 1, 2006 (RY 2007**)**, this limited exception for surgical DRGs is no longer applicable. No further separate payment to an acute care hospital will be made. Any tests or procedures, that were administered to the patient during that period of time of interruption will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability.

If no additional Medicare services are delivered during the3-day or less interruption (e.g., the patient is home and doesn’t receive any outpatient or inpatient services at an acute care hospital or IRF or care at a SNF) prior to readmission to the LTCH, the number of days away from the LTCH will not be included in the total length of stay for that beneficiary stay. If care is delivered on any day during the interruption, however, that the LTCH pays for “under arrangements,” all the days of the interruption are included in the total length of stay for that beneficiary stay. Therefore, if a patient receives services on only one of the days of the interruption but is away from the LTCH for 3 days, all 3 days will be deemed a part of the total episode of care and counted towards the length of stay for that patient stay. If an interruption of stay exceeds 3-days, the original interrupted stay policy, below, governs payment.

EXHIBIT D

TABLE 1

FY 2017 LTCH Site Neutral Payment Amount Comparison – With and Without Proposed Budget Neutrality Adjustment to Site Neutral Payments

Duplicate BNAs in Proposed Rule		**Apply BNA Once by Not Applying LTCH Site Neutral HCO BNA**
IPPS Standardized Amount (before adjustments)[1]		
Labor	$4,394.09	$4,394.09
Non-Labor	$1,919.26	$1,919.26
Subtotal	$6,313.35	$6,313.35
IPPS HCO Outlier Factor (0.94899)[2]	**$(281.10)**	**$(281.10)**
Other Adjustments[3]	$(520.46)	$(520.46)
IPPS Standardized Amount (after adjustments)[4]		
Labor	$3,836.20	$3,836.20
Non-Labor	$1,675.59	$1,675.59
Subtotal	$5,511.79	$5,511.79
Capital PPS Rate (before adjustments)[5]	$438.75	$438.75
Capital PPS Outlier Factor (0.937400)[6]	**$(43.87)**	**$(43.87)**
Other Adjustments[7]	$51.47	$51.47
Capital PPS Rate (after adjustments)[8]	$446.35	$446.35
Subtotal	$5,958.14	$5,958.14
LTCH Site Neutral Outlier Factor (0.949)[9]	**$(303.87)**	**N/A**
Total	$5,654.27	$5,958.14

[1] 81 Fed. Reg. at 25,274-75 (assuming full update and wage index greater than 1.0).
[2] Id. at 25,274.
[3] Id. at 25,274-75.
[4] Id. at 25,275.
[5] Id. at 25,280.
[6] Id. (net change of this factor is 1.0010 or 0.10%).
[7] Id.
[8] Id.

[9] Id. at 25,289.

As **Table 1** shows, CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. This can be achieved under what we have labelled "Apply BNA Once" in the third column of the table. MedPAC's comments align with this approach. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[32] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[33] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced by 5.1% for IPPS outlier payments and 6.26% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not make a second BNA to LTCH site neutral payments.

d. Based Upon MedPAC's Comments, CMS Also Should Not Have Finalized This BNA In FY 2016

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency failed to see the duplication that we identified and that MedPAC now agrees is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[34] CMS referred to this BNA as "one of the inputs" used to calculate

[32] 80 Fed. Reg. at 49,622.
[33] Id.
[34] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments . . .").

EXHIBIT E

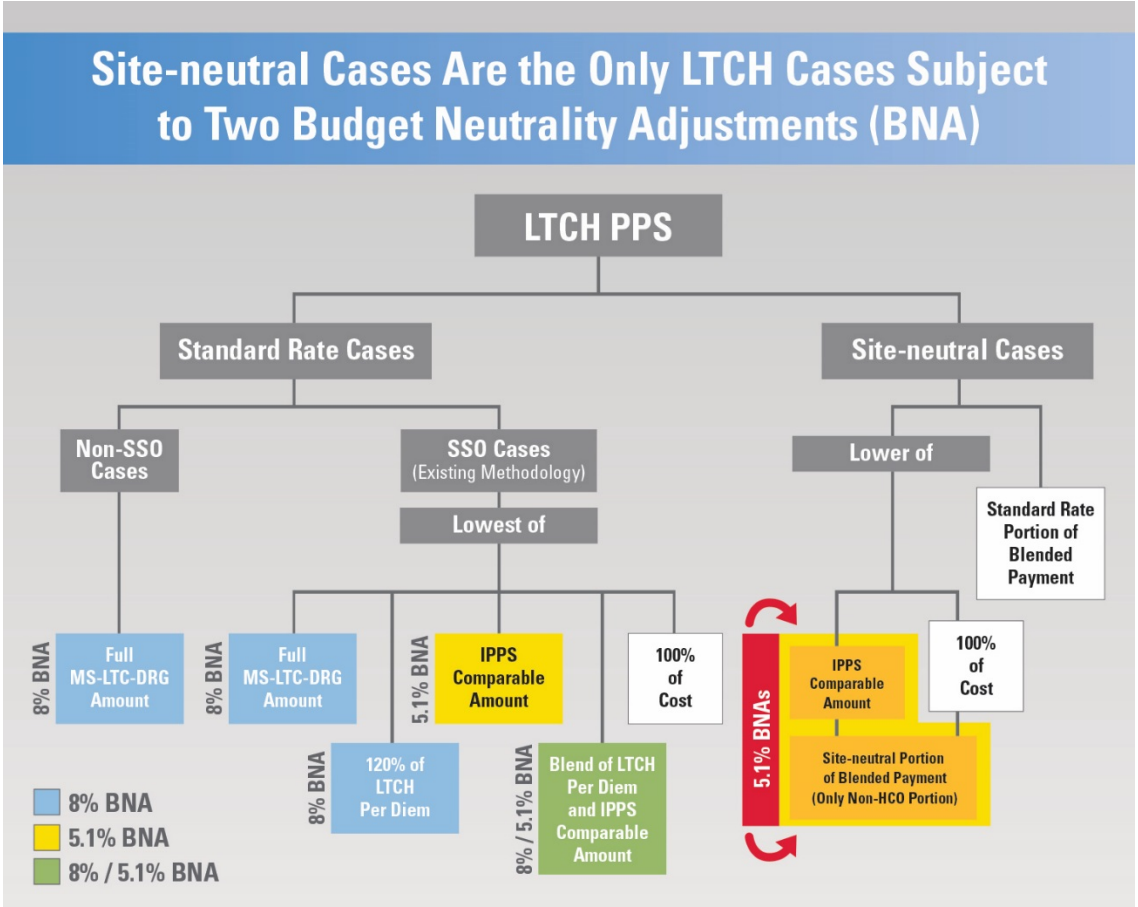
TABLE 1

FY 2019 LTCH Site Neutral Payment Amount Comparison – With and Without Proposed Budget Neutrality Adjustment to Site Neutral Payments

Duplicate BNAs in Proposed Rule		**Apply BNA Once by Not Applying LTCH Site Neutral HCO BNA**
IPPS Standardized Amount (before adjustments)[1]		
Labor	$4,059.36	$4,059.36
Non-Labor	$1,884.07	$1,884.07
Subtotal A	$5,943.43	$5,943.43
IPPS HCO Outlier Factor (0.948999)[2]	**$(303.12)**	**$(303.12)**
Other Adjustments[3]	$15.87	$15.87
IPPS Standardized Amount (after adjustments)[4]		
Labor	$3,863.17	$3,863.17
Non-Labor	$1,793.01	$1,793.01
Subtotal B	$5,656.18	$5,656.18
Capital PPS Rate (before adjustments)[5]	$453.95	$453.95
Capital PPS Outlier Factor (0.9494)[6]	**$(22.97)**	**$(22.97)**
Other Adjustments[7]	$28.80	$28.80
Capital PPS Rate (after adjustments)[8]	$459.78	$459.78
Subtotal B + Capital PPS Rate (after adjustments)	$6,115.96	$6,115.96
LTCH Site Neutral Outlier Factor (0.949)[9]	**$(311.91)**	**N/A**
Total	$5,804.05	$6,115.96

[1] 83 Fed. Reg. at 20,584 (assuming full update and wage index greater than 1.0).
[2] Id.
[3] Id.
[4] Id.
[5] Id. at 20,589.
[6] Id. (net change of this factor is 1.0012 or 0.12%).
[7] Id.
[8] Id.
[9] Id. at 20,596.

EXHIBIT F



- Duplicative BNA does not promote fairness between IPPS and the LTCH PPS. In the FY 2018 IPPS/LTCH proposed rule and other prior rules, CMS states that it believes that using the same fixed-loss amount for site-neutral cases as it does for IPPS cases "will reduce differences between HCO payments for similar cases under the IPPS and site-neutral payment rate cases under the LTCH PPS and promote fairness between the two systems." Yet CMS continues to apply the second, duplicative BNA to the non-HCO portion of the site-neutral payment – this not only causes disparities in the HCO and non-HCO portions of payments between IPPS and the LTCH PPS, but reduces fairness between the two systems. This disparity was also expressed by MedPAC, as noted below.

- MedPAC also views the second BNA as duplicative. In its May 31, 2016 comment letter on the FY 2017 IPPS/LTCH PPS proposed rule, the commission states that "[g]iven that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further."

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

NEW LIFECARE HOSPITALS OF CHESTER COUNTY LLC, *et al.*,

Plaintiffs,

v.

ALEX M. AZAR II, Secretary
U.S. Department of Health and Human Services

Defendant.

Civil Action No. 19-cv-705 (EGS)

ORDER

Upon consideration of Plaintiffs' Motion for Summary Judgment, Defendant's Opposition and Cross-Motion for Summary Judgment, and the entire record herein, it is hereby

ORDERED that Plaintiffs' Motion for Summary Judgment is GRANTED; and it is further

ORDERED that Defendant's Cross-Motion for Summary Judgment is DENIED; and it is further

ORDERED that the duplicative outlier budget neutrality adjustment ("BNA") that CMS calculated as negative 5.1 percent in the FY 2019 IPPS/LTCH PPS Final Rule (83 Fed. Reg. at 41737-38), which is the same percentage in the final rules for FYs 2016 through 2018, and the proposed rule for FY 2020, and applies to site neutral payments under the Long Term Care Hospital Prospective Payment System ("LTCH PPS") regulation at 42 C.F.R. § 412.522(c)(2)(i) is set aside as: arbitrary and capricious, an abuse of discretion, unsupported by substantial evidence, and otherwise not in accordance with the law, under the Administrative Procedure Act, 5 U.S.C. §§ 551 *et seq.*; an inappropriate adjustment under section 307 of the Medicare, Medicaid,

and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, 114 Stat. 2763 (2000); a violation of section 1886(m)(6) of the Social Security Act by paying LTCH PPS site neutral cases a rate that is contrary to the statute when CMS adopted this extra BNA; and a violation of the Medicare prohibition on cost-shifting under 42 U.S.C. § 1395x(v)(1)(A); and it is further

ORDERED that Defendant, through the Plaintiffs' current Medicare payment contractors, shall pay Plaintiffs the amounts CMS withheld during fiscal years 2016 through 2019 as a result of the duplicative BNA; and it is further

ORDERED that Defendant shall not apply the duplicative BNA to LTCH PPS site neutral payments in fiscal year 2020 and later years; and it is further

ORDERED that Plaintiffs shall be awarded prejudgment interest to which they are entitled to as a matter of right under 42 U.S.C. § 1395oo(f)(2); and it is further

ORDERED that Plaintiffs shall be awarded Plaintiffs' costs and legal fees pursuant to 28 U.S.C. § 2412; and it is further

ORDERED that the Court shall retain jurisdiction of this matter until such time as the Defendant or his agent have made the payments set forth above, and the Clerk shall not close the docket for this matter until further order from the Court.

On this _____ day of _____, 2019, IT IS SO ORDERED.

_____

Hon. Emmet G. Sullivan, United States District Judge