PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2015-D16

PROVIDER –
Sutter Auburn Faith Hospital
Auburn, California

Provider No.: 05-0498

vs.

MEDICARE CONTRACTOR–
Cahaba Safeguard Administrators, LLC

DATE OF HEARING -
July 15, 2015

Cost Reporting Period Ended -
December 31, 2006

CASE NO.: 08-2387

INDEX

ISSUE STATEMENT:

Does the Provider Reimbursement Review Board ("Board") have jurisdiction to review the Medicare Contractor's determination of low-income patient ("LIP") adjustment for Sutter Auburn Faith Hospital ("Auburn") for fiscal year ("FY") 2006? Specifically, Auburn filed an appeal with the Board claiming that:

1. the Medicare Contractor improperly excluded from the Medicaid fraction of Auburn's LIP adjustment calculation the days of Rehab patients who were eligible for medical assistance under an approved Medicaid state plan; and

2. the LIP Supplemental Security Income ("SSI") ratio published by Centers for Medicare and Medicaid Services ("CMS") and used by the Medicare contractor in the calculation of Auburn's LIP adjustment was understated.

DECISION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board concludes that it has jurisdiction to review the Medicare Contractor's determination of the LIP adjustment for Auburn's FY 2006, including the review of the number of inpatient days for individuals who were eligible for medical assistance under an approved Medicaid State Plan, and the understatement of the LIP SSI ratio. The Board remands this matter to the Medicare Contractor to: (1) review and audit the 13 Medicaid eligible Rehab days at issue for purposes of the Medicaid fraction of Auburn's LIP adjustment calculation for FY 2006; and (2) recalculate Auburn's LIP adjustment using Auburn's most recently updated SSI ratio published by CMS and the updated Medicaid fraction based on this audit.

INTRODUCTION:

Sutter Auburn Faith Hospital ("Auburn") is a Medicare-certified acute care hospital that is located in Auburn, California and includes an inpatient rehabilitation unit. This appeal involves LIP adjustment payments that Auburn received for FY 2006 from the Medicare program through the prospective payment system for inpatient rehabilitation facilities ("IRF-PPS"). The Medicare contractor[1] currently assigned to Auburn for FY 2006 is Cahaba Safeguard Administrators, LLC ("Medicare Contractor").

As part of the Balanced Budget Act of 1997, Congress promulgated 42 U.S.C. § 1395ww(j) to create the IRF-PPS for cost reporting periods beginning on or after October 1, 2002.[2] Pursuant to § 1395ww(j)(3)(A), IRF-PPS rates were established based on estimates of inpatient operating and capital costs of IRFs using the most recent cost report data available.

[1] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to as Medicare contractors.
[2] Pub. L. No. 105-33, § 4421, 111 Stat. 251, 410 (1997).

The IRF-PPS rates are subject to certain adjustments.[3] This case focuses on one of these adjustments, the low-income patient ("LIP") adjustment specified at 42 C.F.R. § 412.624(e)(2). The LIP adjustment is not specifically mentioned in the IRF-PPS statutory provisions. Rather, the Secretary created and implemented the LIP adjustment based on her discretionary authority established under § 1395ww(j)(3)(A)(v) to adjust the IRF-PPS payment rate "by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities."[4]

The Medicare Contractor reviewed Auburn's cost report for FY 2006 and issued a Notice of Program Reimbursement ("NPR"). As part of this NPR, the Medicare Contractor made adjustments to: (1) exclude from the Medicaid fraction of the LIP adjustment calculation certain inpatient Rehab days for individuals eligible for medical assistance under an approved Medicaid State Plan; and (2) use the latest LIP SSI ratio published by CMS prior to the issuance of the NPR. Auburn timely appealed the Medicare Contractor's calculation of the LIP adjustment for FY 2006. Through this appeal, Auburn challenges the Medicare Contractor's adjustment to exclude from the numerator of the "Medicaid fraction" of the LIP adjustment those inpatient days for individuals who were eligible for medical assistance under an approved Medicaid State plan and the understatement of the LIP SSI ratio issued by CMS and utilized by the Medicare Contractor on the final settled cost report.[5]

The Medicare Contractor filed a jurisdictional challenge regarding the LIP adjustment issue. Auburn's representative, Wade Jaeger of Sutter Health, responded to this jurisdictional challenge. This is the only issue remaining in this appeal as all other issues were either resolved or transferred to group appeals.

---

[3] *See* 42 U.S.C. §§ 1395ww(j)(3)(A)(i) – (v); 42 C.F.R. § 412.624(e).

[4] 42 U.S.C. § 1395ww(j)(3)(A)(v).

[5] The Board notes that, as part of its Supplemental Final Position Paper received by the Board on March 27, 2014, Auburn attempted to expand this LIP Medicaid eligible Rehab days issue to include dual eligible Rehab days. However, the time period for adding issues had tolled on October 20, 2008 and, accordingly, the Board will not consider LIP dual eligible Rehab days as part of this appeal. Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. Specifically, 42 C.F.R. §405.1835(c) (2011) provides in relevant part:

> (c) Adding issues to the hearing request.
> After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met: […]
> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180—day period prescribed in paragraph (a)(3) of this section.

For appeals already pending when this regulations was promulgated providers were given 60 days from the date the new regulation took effect, August 21, 2008, to add issues to their appeals. In practice this means that issues had to be added to pending appeals by October 20, 2008. *See* 73 Fed. Reg. 30190, 30236 (May 23, 2008).

DISCUSSION, FINDINGS OF FACTS, AND CONCLUSIONS OF LAW:

JURISDICTION OVER THE LIP ADJUSTMENT

The Medicare Contractor contends the language of 42 U.S.C. § 1395ww(j)(8)(B) unambiguously precludes administrative and judicial review of the IRF-PPS rates established under 42 U.S.C. § 1395ww(j)(3)(A). The Medicare Contractor maintains that, because the IRF-PPS rate is comprised of both the general federal rate based on historical costs and adjustments to that federal rate (including but not limited to the LIP adjustment at issue), the statute prohibits administrative and judicial review of the LIP adjustment.[6] Accordingly, the Medicare Contractor argues that the Board is divested of jurisdiction to hear Auburn's appeal because it must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[7]

Auburn responds that the LIP adjustment is not a component of the IRF-PPS rate (*i.e.*, the unadjusted federal rates) and that the Medicare Contractor has confused the IRF-PPS rate with the LIP adjustment. Auburn argues that it is disputing the accuracy of the provider-specific SSI fraction supplied by CMS and used by the Medicare Contractor, not the establishment of the underlying IRF LIP formula used to calculate LIP adjustments in general.[8] Auburn contends that § 1395ww(j)(8) does not prohibit its challenge as to whether CMS and its agents utilized the proper data elements in executing that formula.[9] Auburn maintains that, while § 1395ww(j)(8) prohibits administrative or judicial review for certain aspects of the establishment of the IRF payments, there is no specific language within § 1395ww(j)(8) prohibiting administrative or judicial review as it pertains to the establishment of LIP.[10]

In reviewing this matter, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

> There shall be no administrative or judicial review . . . of the establishment of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),
>
> (C) outlier and special payments under paragraph (4), and
>
> (D) area wage adjustments under paragraph (6).

[6] Medicare Contractor's Jurisdictional Challenge at 2.
[7] 42 C.F.R. § 405.1867.
[8] Provider's Opposition to Intermediary's Jurisdictional Challenge at 6.
[9] *Id.* at 7-8.
[10] *Id*. at 8.

Consistent with its recent decision in *Mercy Hospital v. First Coast Service Options, Inc.* ("*Mercy*"),[11] the Board concludes the statute prohibits administrative review of the establishment of both the IRF-PPS payment rates under 42 U.S.C. § 1395ww(j)(3) and certain enumerated adjustments to those rates as specified in 42 U.S.C. §§ 1395ww(j)(2), (4), and (6). In reaching this legal conclusion, the Board recognizes that the Medicare Contractor in this appeal and the Administrator's decision to reverse the Board's decision in *Mercy*[12]read the statutory language more broadly and maintain that the phrase "the prospective payment rates under paragraph (3)" as used in §1395ww(j)(3)(B) encompassed both the general IRF-PPS rate (*i.e.*, the undadjusted federal rate) and any and *all* adjustments to those rates including the LIP adjustment. However, the Board disagrees with the Medicare Contractor's and the Administrator's decision in *Mercy* for the following reasons:

1) A thoughtful examination of the *entirety* of § 1395ww(j) confirms that the phrase "the prospective payment rates under paragraph (3)" as used in § 1395ww(j)(8) does not encompass all of Paragraph (3). Rather, that reference is limited to the general federal "rates" before they are "adjusted" by the items enumerated in Clauses (i) to (v) of Paragraph (3)(A). The adjustments enumerated in these clauses include the LIP adjustment that the Secretary established pursuant to the discretionary authority granted under Clause (v). To illustrate, one of the enumerated adjustments includes an area wage adjustment defined in Paragraph (6). Significantly, § 1395ww(j)(8)(D) specifically prohibits administrative review of the area wage adjustment. Logically, if the phrase "the prospective payment rates under paragraph (3)" in § 1395ww(j)(8)(B) were interpreted to encompass both the general federal rate established in Paragraph (3) *and* any and all adjustments specified in Paragraph (3) as asserted by the Medicare Contractor and the Administrator, the specific prohibition on administrative review of the area wage adjustment in § 1395ww(j)(8)(D) would be redundant and superfluous because such a prohibition would already be encompassed by the reference to Paragraph (3) in § 1395ww(j)(8)(B). Similarly, this proposed interpretation would render other references in subsection (j), including outliers and special payments in paragraph (C) of (j)(8) redundant and equally nonsensical.

   Further, the Board notes that the phrase "the prospective payment rates under paragraph (3)" as used in § 1395ww(j)(8)(D) is used again almost verbatim in § 1395ww(j)(6) concerning the area wage adjustment. Specifically, Paragraph (6) states that the Secretary "shall adjust . . . *the prospective payment rates computed under paragraph (3)* for area differences in wage levels."[13] Again, under the Medicare Contractor's proposed interpretation, the term "the prospective rates under paragraph (3)" includes both the general federal rates and any and all adjustments named in Paragraph (3)(A), including but not limited to the area wage adjustment specified in Clause (iii) of Paragraph (3)(A). However, this proposed interpretation would render the directive in Paragraph 6 to "adjust . . . *the prospective payment rates computed under paragraph (3)* for area differences in wage levels" nonsensical because the proposed interpretation would necessarily mean that the Secretary was to adjust the "prospective payment rates under

[11]PRRB Dec. No. 2015-D7 (April 3, 2015)
[12]*Mercy*, Adm'r Dec. (June 1, 2015), *vacating and dismissing*, PRRB Dec. No. 2015-D7 (June 1, 2015).
[13] (Emphasis added.)

paragraph (3)" for the area wage adjustment notwithstanding that the term "prospective payment rates under paragraph (3)" already includes the area wage adjustment. The Board's reading avoids this nonsensical circular outcome.

Based on the above, the Board concludes that the statutory drafters clearly intended to limit review of only certain adjustments to the federal rate and, to this end, they specifically itemized those adjustments in (j)(8). Accordingly, the Board is convinced that the statute must be read in this manner based on its conclusion that the Medicare Contractor's proposed interpretation of the phrase "the prospective payment rates under paragraph (3)" in § 1395ww(j)(8)(B) cannot be reconciled with § 1395(j).[14]

2) The text of 1395ww(j)(8) prohibits administrative or judicial review of "*the establishment* of" the items listed in Subparagraphs (A) to (D). The Board finds that the use of the word "establishment" in the statute significant.[15] Similar to the provider in *Mercy*, Auburn is not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, as the appeal challenges no part of the August 2001 Final Rule in which the Secretary established the LIP adjustment itself (*i.e.*, the formula used to calculate the adjustment). Rather, Auburn is challenging whether the Medicare Contractor properly executed the LIP adjustment, specifically whether the Medicare Contractor's calculation of the LIP adjustment used the proper provider-specific data elements in that calculation.[16] The Board finds no prohibition in 1395ww(j)(8) to administrative or judicial review of *"the calculation of"* the LIP adjustment where the focus is on the accuracy of the provider-specific data elements being used in the LIP adjustment calculation. Significantly, the Administrator's decision in *Mercy* fails to address this distinction.

3) 42 U.S.C. § 1395ww(j)(3)(A)(v) specifically gives discretion to the Secretary to adjust the IRF-PPS rates by "other factors" which she determines to be necessary to properly reflect variation in the costs of treatment among IRFs.[17] The LIP adjustment is one of the "other factors" that the Secretary created. When Congress limited providers' appeal rights, it specifically limited review over certain factors.[18] The statute is silent on whether appeals are permitted for other adjustment factors, including transition period payments in Paragraph (1) or payment rate reductions for failure to report quality data in Paragraph (7).[19] Clearly, Congress could have precluded review of all of the adjustments to the IRF-PPS rates that are used to calculate the provider-specific payments rates for each IRF; however, it did not do so.

---

[14] *Mercy* at 5-6.
[15] 42 U.S.C. § 1395ww(j)(8).
[16] Provider's Opposition to Intermediary's Jurisdictional Challenge at 8.
[17] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[18] 42 U.S.C. § 1395ww(j)(8).
[19] Reporting of quality data was required by § 3004 of the Affordable Care Act of 2010. CMS has adopted final rules to allow reconsideration and Board appeals for failure to provide documentation for the IRF Quality Reporting Initiative. *See* 78 Fed. Reg. 47860, 47919 (Aug. 6, 2013).

4) The Secretary adopted a regulation limiting administrative and judicial review which mirrors the statutory limitations, specifically limiting review only to the "unadjusted" Federal payment rate. For the years in this appeal, 42 C.F.R. § 412.630 stated:

> Administrative or judicial review under 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factor, the *unadjusted* Federal per discharge payments rates, additional payments for outliers and special payments, and the area wage index.

Significantly, the term "the unadjusted Federal rate" is defined in 42 C.F.R. § 412.624(c) and it does not include any of the adjustments discussed in § 412.624(e), including the LIP adjustment. Further, the Secretary could have expanded the list of adjustments in § 412.630 to include the LIP adjustment but did not do so until the August 2013 Final Rule. During the period at issue, the Board finds that neither the statute nor the regulation precluded review of the LIP adjustment. In this regard, the Board concludes that the regulatory changes made in the August 2013 Final Rule are not applicable to this case because they were effective on October 1, 2013, and CMS did not specify any retroactive application of the changes to § 412.630.[20]

As noted above, the Administrator in *Mercy* reversed the Board's decision that it had jurisdiction over the LIP payment factors. The Administrator restated the MAC's assertion that administrative and judicial review of the LIP adjustment is precluded because § 1395ww(j)(8) precludes review of the prospective payment rate under paragraph (3) as well as all adjustments articulated in subsequent paragraphs. The Board, however, remains unconvinced, and continues to disagree with the Administrator's overly broad interpretation.

Based on the above, the Board concludes that it has jurisdiction to hear LIP adjustment issues.

JURISDICTION OVER THE LIP ADJUSTMENT ISSUE INVOLVING MEDICAID ELIGIBLE REHAB DAYS

On its own motion, the Board reviewed jurisdiction to hear more specifically the LIP adjustment issue as it pertains to Medicaid eligible Rehab days. At the outset, the Board notes that the jurisdiction issue for Medicaid eligible Rehab days used in calculating a LIP adjustment is the same for that used in calculating a disproportionate share hospital (DSH) adjustment because CMS adopted the DSH formula for purposes of the LIP calculation and Medicaid eligible days are used in the same manner for both calculations.[21] The jurisdictional issue surrounding

[20] *See* 78 Fed. Reg. at 47860, 47901 (stating at 47901 that "the statute . . . is applicable to all pending cases regardless of whether it is reflected in regulations or not"). *See also Mercy* at 6-7.

[21] *See* 66 Fed. Reg. 41316, 41360 (Aug. 7, 2001) (stating: "[W]e will refer to the adjustment for low-income patients as the LIP adjustment. However, we will use the term DSH when we refer to the measure used to compute IRF's percentage of low-income patients because it is the same measure used to measure low-income patients in acute care hospitals.").

Medicaid eligible days is thoroughly explained in the Board's decision in *Barberton Citizens Hosp. v. CGS Adm'rs*, PRRB Dec. No. 2015-D05 (Mar. 19, 2015) ("*Barberton*").[22]

The Board finds that, pursuant to the rationale in *Barberton*, Auburn was able to establish that there was a practical impediment to capturing every Medicaid eligible day by the deadline for filing its FY 2006 cost report. In *Barberton*, the Board states: "pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction of a hospital's appeal of additional Medicaid eligible days for the DSH adjustment calculation if that hospital can establish a 'practical impediment' as to why it could not claim these days at the time that it filed its cost report."[23] In response to the Board's Alert No. 10 requesting additional information on its jurisdiction over Medicaid eligible days, Auburn filed a brief explaining that the number of Medicaid eligible days reported on its FY 2006 as-filed cost report consists of State-verified paid days and an estimate of unpaid days and that "it is necessary for California providers to estimate [unpaid] eligible days because they are not allowed access to the State's eligibility/reverification system until well-after the cost reports have been submitted."[24] The Board notes that Auburn's experience with California is consistent with other California providers who have (or have had) a similar Medicaid eligible day issue before the Board. Accordingly, the Board finds that it has jurisdiction over Auburn's appeal of the Medicaid eligible days relating to the LIP adjustment calculation.

REMAND

With regard to the LIP adjustment issue involving Medicaid eligible Rehab days, Auburn had claimed 104 Medicaid eligible Rehab days on its FY 2006 cost report and, with this appeal, is requesting to have this increased by 13 days to 117 total Medicaid eligible Rehab days.[25] As the Board has jurisdiction over this issue, the Board remands this issue back to the Medicare Contractor to audit and review the 13 Medicaid eligible days at issue and update the Medicaid fraction used in calculating Auburn's LIP adjustment for FY 2006.

With regard to the LIP adjustment issue involving the SSI percentage, the Board notes that CMS Ruling 1498-R requires recalculation of the Medicare DSH SSI fraction component of the DSH payment percentage and, consistent with that Ruling, CMS has issued revised SSI percentages for all hospitals for both DSH *and* LIP adjustment calculation purposes.[26] To this end, Auburn requested that LIP SSI percentage issue be remanded to the Medicare Contractor.[27] Accordingly,

---

[22] *Declined review*, Adm'r Letter (Apr. 22, 2015).
[23] *Barberton* at 4.
[24] *See* Sutter Auburn Faith Hospital PRRB Alert No. 10 Supplemental request – Responsive Position Paper at 24.
[25] Detail on the 13 Medicaid eligible Rehab days at issue is contained in the appeal request and in Auburn's Supplemental to the Final Position Paper at Exhibit P-6, p. 178.
[26] *See* CMS MLN Matters No. SE122 entitled "The Supplemental Security Income (SSI) Rations for Fiscal Year (FY) 2006 through FY 2009 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)" (Released June 22, 2012) (stating that "[t]he SSI ratios are used for settlement purposes for IPPS and IRFs eligible for a Medicare DSH payment or *low income payment adjustment*, respectively" (emphasis added)).
[27] The Board notes that the Provider specifically requested this remand consistent with CMS Ruling 1498-R. *See* Provider's Rebuttal to Intermediary's Final Position Paper at 4, 12.

as the Board has jurisdiction over LIP adjustments, the Board further remands this issue back to the Medicare Contractor for recalculation of Auburn's LIP adjustment for FY 2006 using Auburn's most recently updated SSI percentage published by CMS.

DECISION AND ORDER:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board concludes that it has jurisdiction to review the Medicare Contractor's determination of the LIP adjustment for Auburn's FY 2006, including the review of the number of inpatient days for individuals who were eligible for medical assistance under an approved Medicaid State Plan, and the understatement of the LIP SSI ratio. The Board remands this matter to the Medicare Contractor to: (1) review and audit the 13 Medicaid eligible days at issue for purposes of the Medicaid fraction of Auburn's LIP adjustment calculation for FY 2006; and (2) recalculate Auburn's LIP adjustment using Auburn's most recently updated SSI ratio published by CMS and the updated Medicaid fraction based on this audit.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte Benson, C.P.A.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

August 19, 2015