PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2015-D20

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, 2003

CASE NO.: 07-1509

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") 2003? Specifically, Auburn filed an appeal with the Board claiming, amongst other things, that the LIP Supplemental Security Income ("SSI") ratio published by the 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 2003, including the understatement of the LIP SSI ratio. The Board remands this matter to the Medicare Contractor to recalculate Auburn's LIP adjustment using Auburn's most recently updated SSI ratio published by CMS.

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 2003 from the Medicare program through the prospective payment system for inpatient rehabilitation facilities ("IRF-PPS"). The Medicare Contractor[1] assigned to Auburn for FY 2003 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.

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]

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[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).
[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).

The Medicare Contractor reviewed Auburn's cost report for FY 2003 and issued a Notice of Program Reimbursement ("NPRs"). As part of this NPR, the Medicare Contractor made adjustments to 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 2003. Through this appeal, Auburn challenges the understatement of the LIP SSI ratio issued by CMS and utilized by the Medicare Contractor on the final settled cost report.

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.

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.[5] 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.[6]

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.[7] 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.[8] 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.[9]

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—

[5] Medicare Contractor's Jurisdictional Challenge at 1-2.
[6] 42 C.F.R. § 405.1867; *Id.* at 2.
[7] Provider's Opposition to Intermediary's Jurisdictional Challenge at 5.
[8] *Id.* at 7.
[9] *Id.*

> (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).

Consistent with its recent decision in *Mercy Hospital v. First Coast Service Options, Inc.* ("*Mercy*"),[10] 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*[11]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)

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

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."[12] 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 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).[13]

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.[14] 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.[15] 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.[16] The LIP adjustment is one of the "other factors" that the Secretary created. When Congress limited providers' appeal

[12] (Emphasis added.)
[13] *Mercy* at 5-6.
[14] 42 U.S.C. § 1395ww(j)(8).
[15] Provider's Opposition to Intermediary's Jurisdictional Challenge at 7.
[16] 42 U.S.C. § 1395ww(j)(3)(A)(v).

rights, it specifically limited review over certain factors.[17] 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).[18] 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.

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.[19]

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.

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[17] 42 U.S.C. § 1395ww(j)(8).

[18] 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).

[19] *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.

JURISDICTION OVER THE LIP ADJUSTMENT ISSUE INVOLVING SSI PERCENTAGE

On its own motion, the Board reviewed jurisdiction to hear more specifically the LIP adjustment issue as it pertains to the SSI percentage. 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.[20] To this end, Auburn contends that the LIP SSI percentage issue should be read and handled in conjunction with CMS Ruling 1498-R.[21] Accordingly, 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 2003 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 2003, including the understatement of the LIP SSI ratio. The Board remands this matter to the Medicare Contractor to recalculate Auburn's LIP adjustment using Auburn's most recently updated SSI ratio published by CMS.

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

DATE: September 2, 2015

[20] *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)).
[21] *See* Provider's August 12, 2014 Opposition to Intermediary's Jurisdictional Challenge at 3.