PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2015-D30

PROVIDERS –
BMHCC 2004-2006 LIP SSI% CIRP Group

Provider Nos.: Various

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

HEARING DATE –
September 1, 2015

Cost Reporting Periods Ended –
September 30, 2004
September 30, 2005
September 30, 2006

CASE NO.: 11-0121GC

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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 Baptist Memorial Hospital-Germantown and Baptist Memorial Hospital North Mississippi ("Baptist") for fiscal years ("FYs") 2004, 2005, and 2006?

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 Baptist's FYs 2004, 2005, and 2006 cost reports, including the understatement of the LIP SSI ratio. The Board remands this matter to the Medicare Contractor to recalculate Baptist's LIP adjustment using Baptist's most recently updated SSI ratio published by the Centers for Medicare & Medicaid Services ("CMS") for FYs 2004, 2005, and 2006.

INTRODUCTION:

Baptist Memorial Hospital-Germantown and Baptist Memorial Hospital North Mississippi ("Baptist") are Medicare-certified acute care hospitals located in Germantown, Tennessee and Oxford, Mississippi which have inpatient rehabilitation units. The Medicare contractor[1] issued Notices of Program Reimbursement ("NPRs") for FYs 2004, 2005, and 2006. Baptist appealed whether the LIP SSI ratios were properly calculated by CMS for FYs 2004, 2005, and 2006.

STATEMENT OF FACTS

Baptist timely appealed the Medicare Contractor's calculation of the LIP adjustment payments for FYs 2004, 2005, and 2006 cost reports, on the basis that the SSI ratios issued by CMS and utilized by the Medicare Contractor on the final settled cost reports were understated, and as such, improperly reduced the LIP adjustment payments to Baptist. The Medicare Contractor challenged the Board jurisdiction on the basis that the federal statute precludes administrative review of the LIP adjustment.[2]

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.[3] 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.

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[1] Fiscal intermediaries ("FIs") and Medicare Administrative Contractors ("MACs") will be referred to as "Medicare Contractors".
[2] *See* Medicare Contractor's Jurisdictional Challenge at 3, ¶10.
[3] Pub. L. No. 105-33, § 4421, 111 Stat. 251, 410 (1997).

The IRF-PPS rates are subject to certain adjustments.[4] 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."[5]

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)[6] 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.[7] Accordingly, the Medicare Contractor argues that the Board is divested of jurisdiction to hear Baptist's appeal because it must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[8]

Baptist maintains that, for the same reasons on which the Board based its decision in *Mercy Hosp. v. First Coast Serv. Options, Inc.*, ("*Mercy*"),[9] the Board should reject the Medicare Contractor's jurisdictional challenge regarding the LIP issue and find that the Board possesses jurisdiction over the LIP issue. Alternatively, Baptist points out that, while the CMS Administrator reversed the Board's decision in *Mercy*,[10] Mercy Hospital has filed an appeal in the U.S. District Court for the District of Columbia and, accordingly, requests that the Board defer issuing its jurisdictional decision until a final decision in *Mercy* is issued.[11]

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—

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[4] *See* 42 U.S.C. §§ 1395ww(j)(3)(A)(i) – (v); 42 C.F.R. § 412.624(e).
[5] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[6] Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and redesignated 42 U.S.C. § 1395ww(j)(7) to 42 U.S.C. § 1395ww(j)(8) and inserted a new section 1886(j)(7) which contains requirements for the Secretary to establish a quality reporting program for IRFs.
[7] Medicare Contractor's Jurisdictional Challenge at 1-2.
[8] 42 C.F.R. § 405.1867; Medicare Contractor's Jurisdictional Challenge at 2.
[9] PRRB Dec. No. 2015-D7 (April 3, 2015).
[10] *Mercy*, Adm'r Dec. (June 1, 2015), *vacating and dismissing*, PRRB Dec. No. 2015-D7 (Apr. 3, 2015).
[11] Provider's Response to Medicare Contractor's Jurisdictional Challenge, July 31, 2015 at 2.

(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*, the Board concludes § 1395ww(j)(8) prohibits the administrative review of the *establishment* of both the IRF-PPS payment rates under 42 U.S.C. § 1395ww(j)(3) and of *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 both the Medicare Contractor in this appeal and the Administrator's decision to reverse the Board's decision in *Mercy* read the statutory language much more broadly by maintaining that the phrase "the prospective payment rates under paragraph (3)" as used in §1395ww(j)(8)(B) encompasses both the general IRF-PPS rate (*i.e.*, the unadjusted 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) As explained below, 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) ("Paragraph 8") does *not* encompass *all* of § 1395ww(j)(3) ("Paragraph (3)"). Rather, the Paragraph 8 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 adjustments enumerated in Paragraph (3) is the area wage adjustment. Specifically, the area wage index is named as an adjustment in Paragraph (3)(A)(iii) and Paragraph (3)(A)(iii) then cross references Paragraph (6) where the area wage adjustment is defined. Significantly, Paragraph (8) specifically prohibits administrative review of the area wage adjustment under Paragraph (6). Logically, if the phrase "the prospective payment rates under paragraph (3)" in Paragraph (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, then the specific prohibition on administrative review of the area wage adjustment in Paragraph (8)(D) would be redundant and superfluous because such a prohibition would *already* be encompassed by the reference to Paragraph (3) in Paragraph (8)(B). Similarly, this proposed interpretation would render other references in subsection (j), including outliers and special payments in Paragraph (8)(C) redundant and equally nonsensical.

   Further, the Board notes that the phrase "the prospective payment rates under paragraph (3)" as used in Paragraph (8)(B) is used again almost verbatim in Paragraph (6)

concerning the area wage adjustment. Again, the area wage index is named as an adjustment *to* the prospective payment rates in Paragraph (3)(A)(iii) and Paragraph (3)(A)(iii) then cross references Paragraph (6) where this adjustment is defined. Paragraph (6) states that the Secretary "shall adjust . . . *the prospective payment rates computed under paragraph (3)* for area differences in wage levels."[12] And, 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 (*i.e.*, "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)" would, per the Medicare Contractor's interpretation, already *include* the area wage adjustment. The Board's reading avoids this nonsensical circular outcome by finding that the adjustments *to* the "prospective payment rates computed under paragraph 3" are completely separate and external to the federal prospective payment rates which they modify.

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 in Paragraph (8) those adjustments which are designated as non-reviewable. Accordingly, the Board is convinced that the statute must be read and interpreted in this more narrow manner based on the Board's conclusion that the Medicare Contractor's proposed broader interpretation of the phrase "the prospective payment rates under paragraph (3)" in Paragraph (8)(B) cannot logically be reconciled with the entirety of § 1395ww(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*, Baptist is not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, since this 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, Baptist 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 foundational distinction.

[12] (Emphasis added.)
[13] *Mercy* at 5-6.
[14] 42 U.S.C. § 1395ww(j)(8).
[15] Providers' Response to Medicare Contractor's Jurisdictional Challenge at 2.

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 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 chose not to 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.

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[16] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[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.

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

REMAND

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] Accordingly, as the Board has jurisdiction over LIP adjustments, the Board further remands this issue back to the Medicare Contractor for recalculation of Baptist's LIP adjustment for FYs 2004, 2005, and 2006 using Baptist'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 Baptist's FY 2004, 2005, and 2006 including the understatement of the LIP SSI ratio. The Board remands this matter to the Medicare Contractor to recalculate Baptist's LIP adjustment using Baptist's most recently updated SSI ratio published by CMS for FYs 2004, 2005, and 2006.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 29, 2015

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[20] *See* CMS MLN Matters No. SE1225 entitled "The Supplemental Security Income (SSI) Ratios 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)).

APPENDIX I

	Provider No.	Provider Name	FYE
1	44-0147	Baptist Memorial Hospital Germantown	9/30/2004
2	44-0147	Baptist Memorial Hospital Germantown	9/30/2005
3	25-0034	Baptist Memorial Hospital North Mississippi	9/30/2006