PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2016-D2

PROVIDER –
Queen of the Valley Medical Center
Napa, California

Provider No.: 05-0009

vs.

INTERMEDIARY –
Noridian Healthcare Solutions, LLC

DATE OF HEARING -
August 31, 2015

Cost Reporting Period Ended -
June 30, 2006

CASE NO.: 15-2901

INDEX

ISSUE STATEMENT:

Does the Provider Reimbursement Review Board ("Board") have jurisdiction to review the Medicare Contractor's determination of the number of Medicaid eligible days included in the numerator of the low-income patient ("LIP") adjustment for Queen of the Valley Medical Center ("Queen") for fiscal year ("FY") 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 number of Medicaid eligible days used in Queen's FY 2006 LIP adjustment. The Board remands this matter to the Medicare Contractor to review and audit the Code 2 and 3 days under appeal based on an enhanced matching process to determine if the days should be included in the numerator of the Medicaid fraction of Queen's FY 2006 LIP adjustment.

INTRODUCTION:

Queen of the Valley Medical Center ("Queen") is a Medicare-certified acute care hospital that is located in Napa, California and includes an inpatient rehabilitation unit. This appeal involves LIP adjustment that Queen 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 Queen for FY 2006 is Noridian Healthcare Solutions, 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]

The Medicare Contractor reviewed Queen's cost report for FY 2006 and issued a Notice of Program Reimbursement ("NPR"). As part of this NPR, the Medicare Contractor adjusted

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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).

Queen's payment excluding from the numerator of Medicaid fraction of the LIP adjustment certain inpatient rehab days for individuals eligible for medical assistance under an approved Medicaid State Plan. Specifically, the Medicare Contractor excluded days where the State returned Code 2 or 3 without an aid code identified. Queen timely appealed the Medicare Contractor's determination to exclude from the numerator of the "Medicaid fraction" of the LIP adjustment, days for individuals eligible for medical assistance under an approved Medicaid State plan, where the State returned a Code 2 or 3 without an aid code identified. This is the only issue in this case.

The Medicare Contractor challenged the Board's jurisdiction regarding this LIP adjustment issue. Queen's representative, Glenn Bunting of Toyon Associates, responded to the jurisdictional challenge.

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)[5] 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 Queen's appeal because it must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[7]

Queen responds that the LIP adjustment is not a component of the IRF-PPS rate described in § 1395ww(j)(3)(A) (*i.e.*, the unadjusted federal rates) because LIP is calculated as a current cost reporting period add-on payment to the IRF-PPS federal payment and it is reported on a separate line within the Medicare cost report.[8] Queen argues that it is only disputing the accuracy of the provider-specific data elements used by the Medicare Contractor, not the establishment or methodology for development of the federal IRF prospective payments. Queen 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] Queen maintains that, while § 1395ww(j)(8) prohibits administrative or judicial review for certain aspects of the establishment of the IRF-PPS payments, there is no specific language within § 1395ww(j)(8) prohibiting administrative or judicial review as it pertains to the establishment of LIP.[10]

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[5] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 1886(j)(7) of the Act [42 U.S.C. § 1395ww(j)(7)] to section 1886(j)(8) [42 U.S.C. § 1395ww(j)(8)] and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs.
[6] Medicare Contractor's Jurisdictional Challenge at 2.
[7] 42 C.F.R. § 405.1867; Medicare Contractor's Jurisdictional Challenge at 3.
[8] Response to Medicare Contractor's Jurisdictional Challenge at 4.
[9] *Id.* at 5.
[10] *Id.*

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).

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 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 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)(8)(B) encompassed *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 position 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 § 1395(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 this 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*

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

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* 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."[13] And, again, under the Medicare Contractor's proposed interpretation, the term "the prospective rates under paragraph (3)" would include *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"[14] 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.

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 which are designated as non-reviewable in Paragraph (8). Accordingly, the Board is convinced that the phrase "the prospective payment rates under paragraph (3)" in Paragraph (8)(B) must be read more narrowly to logically reconcile with the entirety of § 1395ww(j).[15]

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. Similar to the provider in *Mercy*, Queen is not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, as 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, Queen 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-

[13] (Emphasis added.)
[14] (Emphasis added.)

[15] *Mercy* at 5-6.

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 specified 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.

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.[20]

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.[21]

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[16] Response to MAC's Jurisdictional Challenge at 5.
[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).
[20] (Emphasis added.)
[21] *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.

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.

REMAND

As the Board has jurisdiction over this issue, the Board remands this issue back to the Medicare Contractor to audit and review the Code 2 and 3 days under appeal based on an enhanced matching process to determine if the days should be included in the numerator of the Medicaid fraction of the FY 2006 LIP adjustment. Queen has agreed to this remand.[22]

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 number of Medicaid eligible days used in Queen's FY 2006LIP adjustment. The Board remands this matter to the Medicare Contractor to review and audit the Code 2 and 3 days under appeal based on an enhanced matching process to determine if the days should be included in the numerator of the Medicaid fraction of Queen's FY 2006 LIP adjustment.

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FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: October 15, 2015

[22] *See* email from the Provider to the Board dated Sept. 23, 2015.