PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2016-D4

PROVIDER –
St. Joseph Hospital of Eureka

Provider No.: 05-0006

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions

HEARING DATE –
August 06, 2015

Cost Reporting Period Ended –
June 30, 2007

CASE NO.: 09-0101

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ISSUE STATEMENT:

Does the Provider Reimbursement Review Board ("Board") have jurisdiction to review the Medicare Contractor's determination of the low-income patient ("LIP") adjustment pertaining to fiscal year ("FY") 2007 for St. Joseph Hospital of Eureka ("St. Joseph")?

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 St. Joseph's FY 2007 cost report, including the understatement of the LIP Social Security Income (SSI) ratio. The Board remands this matter to the Medicare Contractor to recalculate St. Joseph's LIP adjustment using St. Joseph's most recently updated SSI ratio published by CMS for FY 2007.

INTRODUCTION:

St. Joseph is a Medicare-certified acute care hospital that is located in Eureka, California and includes an inpatient rehabilitation unit. St. Joseph received a LIP adjustment payment for FY 2007 through Medicare's prospective payment system for inpatient rehabilitation facilities ("IRF-PPS"). The Medicare contractor[1] assigned to this appeal is Noridian Healthcare Solutions ("Medicare Contractor").

STATEMENT OF FACTS:

The Medicare Contractor reviewed St. Joseph's cost reports for FY 2007 and issued a Notice of Program Reimbursement ("NPR"). The Medicare Contractor reduced St. Joseph's payment using the latest available LIP SSI ratio published by CMS. St. Joseph timely appealed the Medicare Contractor's calculation of the LIP adjustment for FY 2007 on the basis that the Medicare Contractor used an understated LIP SSI ratio issued by CMS on the final settled cost report and, as such, improperly reduced payment to St. Joseph.

The Board requested jurisdictional briefs from the parties regarding the LIP adjustment issue. The Medicare Contractor and St. Joseph's representative, Thomas P. Knight of Toyon Associates Inc., responded to the Board's request. This LIP SSI issue for St Joseph is the only issue addressed in this decision.[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] IRF-PPS rates were established based on estimates of inpatient operating and capital costs of IRFs using

[1] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to as Medicare Contractors.
[2] *See*: *infra* at 7 for explanation of Board consolidation and redesignation of case.
[3] Pub. L. No. 105-33, § 4421, 111 Stat. 251, 410 (1997).

the most recent cost report data available.[4] The IRF-PPS rates are subject to certain adjustments.[5] 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."[6]

DISCUSSION, FINDINGS OF FACTS, AND CONCLUSIONS OF LAW:

JURISDICTION OVER THE LIP ADJUSTMENT

The Medicare Contractor contends that the language of 42 U.S.C. § 1395ww(j)(8)(B)[7] 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.[8] Accordingly, the Medicare Contractor argues that the Board is divested of jurisdiction to hear St. Joseph's appeal because the Board must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[9]

The Medicare Contractor further contends that the single common issue in this appeal is the SSI ratio used for calculating disproportionate share hospital ("DSH") payments. The Medicare Contractor maintains that the issue pertaining to the LIP SSI ratio is a separate legal issue from those issues appealed, was not raised in the appeal request, and therefore is invalid with respect to this appeal and should be dismissed as such.[10]

St. Joseph responds that the LIP adjustment is not a component of the IRF-PPS rate (*i.e.*, the unadjusted federal rates). St. Joseph argues that is not challenging the establishment of the underlying IRF LIP formula used to calculate LIP adjustments in general, rather the St. Joseph is disputing only the accuracy of the *provider-specific* SSI fraction supplied by CMS and used by the Medicare Contractor. [11] St. Joseph contends that § 1395ww(j)(8) does not prohibit its

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[4] 42 U,S.C. § 1395ww(j)(3)(A).
[5] *See* 42 U.S.C. §§ 1395ww(j)(3)(A)(i) – (v); 42 C.F.R. § 412.624(e).
[6] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[7] Formerly designated at paragraph (7). Section 3004(b) of the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, 124 Stat 119 (March 23, 2010) 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.
[8] Medicare Contractor's Jurisdictional Brief at 2.
[9] 42 C.F.R. § 405.1867;. Medicare Contractor's Jurisdictional Brief at 2.
[10] Medicare Contractor's Jurisdictional Brief at 3.
[11] Providers' Jurisdictional Brief at 3.

challenge as to whether CMS and its agents utilized the proper data elements in executing the underlying IRF LIP formula. St. Joseph 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.[12]

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).[13]

Consistent with its recent decision in *Mercy Hospital v. First Coast Service Options, Inc.* ("*Mercy*"),[14] 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 the Medicare Contractor in this appeal and the Administrator's decision to reverse the Board's decision in *Mercy*[15] 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 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).

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

The limitation on review is illustrated by the "area wage adjustment" enumerated in Paragraph (3). 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 wage index 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 specifically identified as an *adjustment* in Paragraph (3)(A)(iii) and Paragraph (3)(A)(iii) then cross references Paragraph (6) where the "wage index 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."[16] Similarly, 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).

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)" 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 selected* 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 more narrowly 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 § 1395ww(j).[17]

[16] (Emphasis added.)
[17] *Mercy* at 5-6.

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.[18] Similar to the provider in *Mercy*, St. Joseph 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, St. Joseph 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.[19]

   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.[20] 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* selected factors.[21] The statute is notably 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).[22] 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.

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[18] 42 U.S.C. § 1395ww(j)(8).
[19] Providers' Jurisdictional Brief at 2.
[20] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[21] 42 U.S.C. § 1395ww(j)(8).
[22] Reporting of quality data was required by § 3004 of the Patient Protection and 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).

> 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 took effect on October 1, 2013 which postdates the years at issue. Moreover, CMS did not specify any retroactive application of the changes to § 412.630.[23]

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 Medicare Contractor'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.

MEDICARE CONTRACTOR'S OTHER CONTENTIONS

The Medicare Contractor contends that the LIP SSI ratio issue should be dismissed from the appeal because the issue was not raised by the Providers in the group appeal request and is a separate legal issue. The Board notes that "St. Joseph Health System SSI Ratio CIRP Group," Case No. 09-0101GC, initially contained appeals of the SSI ratios used in both the DSH and LIP payment calculations. The *DSH* SSI ratio issue was remanded to the Medicare Contractor on June 16, 2015, pursuant to CMS Ruling 1498-R. However, because the initial remand of Case No. 09-0101GC did not specifically remand the LIP SSI issue, the Board reinstated Case No. 09-0101GC to address the LIP SSI issue for St. Joseph as well as Queen of the Valley Medical Center ("Queen").[24]

On October 19, 2015, the Board transferred Queen's FY 2007 LIP SSI ratio appeal from Case No. 09-0101GC into Case No. 13-0445GC as Case No. 13-0445GC already contained an appeal of Queen's FY 2007 LIP SSI calculation. This resulted in St Joseph being the only provider remaining in Case No. 09-0101GC. The Board converted Case No. 09-0101GC from a group appeal to an individual appeal, case number 09-0101. As such, the Board finds that St Joseph properly appealed the LIP SSI issue for FY 2007 and denies the Medicare Contractor's request to dismiss the LIP SSI ratio issue from case number 09-0101.

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

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[23] *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.
[24] Provider No. 05-0009, FY 2007.

issued revised SSI percentages for all hospitals for both DSH *and* LIP adjustment calculation purposes.[25] To this end, St. Joseph requested that the DSH SSI percentage issue be remanded to the Medicare Contractor.[26] Accordingly, as the Board has jurisdiction over LIP adjustments, the Board further remands this issue back to the Medicare Contractor for recalculation of St. Joseph's LIP adjustment for FY 2007 using St. Joseph's most recently updated SSI percentage published by CMS for FY 2007.

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 St. Joseph's FY 2007 cost report, including the understatement of the LIP SSI ratio. The Board remands this matter to the Medicare Contractor to recalculate St. Joseph's LIP adjustment using St. Joseph's most recently updated SSI ratio published by CMS for FY 2007.

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/s/
Michael W. Harty
Chairman

DATE: December 2, 2015

[25] *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)).

[26] The Board notes that the Provider specifically requested this remand consistent with CMS Ruling 1498-R. *See* Provider's March 11, 2013 Remand Request-Alternative Procedure; Provider's February 27, 2014 Remand Request-Standard Procedure.