PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2016-D7

PROVIDER –
Provena Health 2006 LIP SSI Percentage Calc. Group

Provider Nos.: 14-T007, 14-T217

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

DATE OF HEARING -
November 6, 2015

Cost Reporting Period Ended -
December 31, 2006

CASE NO.: 09-0939GC

INDEX

	Page No.
Issue Statement	**2**
Decision	**2**
Introduction	**2**
Statement of Facts	**2**
Discussion, Findings of Facts, and Conclusions of Law	**3**
Decision and Order	**7**

ISSUE STATEMENT:

Does the Provider Reimbursement Review Board ("Board") have jurisdiction to review the Medicare Contractor's[1] determination of the low-income patient ("LIP") adjustment for Provena St. Joseph Medical Center and Provena St. Joseph Hospital (collectively "Provena Health" or "Providers") for the fiscal years ("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 LIP adjustment for Provena Health's FY 2006 cost reports, including the understatement of the LIP SSI ratios. Accordingly, the Board remands this matter to the Medicare Contractor to recalculate Provena Health's LIP adjustments using Provena Health's most recently updated SSI ratios published by the Centers for Medicare & Medicaid Services ("CMS") for FY 2006.

INTRODUCTION:

Provena St. Joseph Medical Center and Provena St. Joseph Hospital are Medicare-certified acute care hospitals, located in Joliet and Elgin, Illinois respectively, and both have inpatient rehabilitation units. Provena Health received a LIP adjustment payment for FY 2006 through Medicare's prospective payment system for inpatient rehabilitation facilities ("IRF-PPS"). The Medicare contractor assigned to this appeal is National Government Services, Inc. ("Medicare Contractor").

STATEMENT OF FACTS:

The Medicare Contractor reviewed Provena Health's cost reports for FY 2006 and issued Notices of Program Reimbursements ("NPRs"). As part of the NPRs, the Medicare Contractor adjusted Provena Health's payments using the latest available LIP SSI ratios published by CMS. Provena Health timely appealed the Medicare Contractor's calculation of the LIP adjustments for FY 2006 on the basis that the LIP SSI ratios issued by CMS and utilized by the Medicare Contractor on the final settled cost reports were understated, and as such, improperly reduced payments to Provena Health. The Medicare Contractor challenged the Board's jurisdiction by asserting 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] 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.[4]

---

[1] Fiscal Intermediaries ('FIs") and Medicare Administrative Contractors (MACs") will be referred to as "Medicare contractors".
[2] *See* Medicare Contractor's Jurisdictional Challenge at 1¶ 3.
[3] Pub. L. No. 105-33, § 4421, 111 Stat. 251, 410 (1997).
[4] *See* 42 U.S.C. §§ 1395ww(j)(3)(A)(i) – (v); 42 C.F.R. § 412.624(e).

This case focuses on one of these adjustments, the 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 that 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 does not have jurisdiction to hear Provena Health's appeal because it must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[8]

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).[9]

---

[5] 42 U.S.C. § 1395ww(j)(3)(A)(v).

[6] Formerly designated at paragraph (7). Section 3004(b) of the Patient Protection and Affordable Care Act, 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.

[7] Medicare Administrative Contractor's Motion to Dismiss Issue for Lack of Subject Matter Jurisdiction at 2.

[8] 42 C.F.R. § 405.1867; Medicare Administrative Contractor's Motion to Dismiss at 2.

[9] (Emphasis added.)

Consistent with its recent decision in *Mercy Hospital v. First Coast Service Options, Inc.* ("*Mercy*"),[10] 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*[11] 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 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 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."[12] Similarly, under the Medicare Contractor's proposed interpretation, the term "the prospective rates under paragraph (3)"

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

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).[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*, Provena Health does not appear to be 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.*, Provena Health is not challenging the formula used to calculate the adjustment). 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 (*i.e.*, the accuracy of the provider-specific values being plugged into the formula to calculate the provider-specific LIP adjustment). 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.[15] 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.[16] 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

[13] *Mercy* at 5-6.
[14] 42 U.S.C. § 1395ww(j)(8).
[15] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[16] 42 U.S.C. § 1395ww(j)(8).

Paragraph (7).[17] 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 which postdates the time period at issue in this case, and CMS did not specify any retroactive application of the changes to § 412.630.[18]

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.

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

[17] 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).

[18] *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.

purposes.[19] Accordingly, as the Board has jurisdiction over LIP adjustments, the Board further remands this issue back to the Medicare Contractor for recalculation of Provena Health's LIP adjustments for FY 2006 using Provena Health's most recently updated SSI percentages published by CMS.[20]

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 adjustments for Provena Health's FY 2006 cost reports including the understatement of the LIP SSI ratios. The Board remands this matter to the Medicare Contractor to recalculate Provena Health's LIP adjustments using Provena Health's most recently updated SSI ratios published by CMS for FY 2006.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: December 30, 2015

[19] *See* CMS MLN Matters No. SE122 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)).

[20] See Board email to the Provider dated Dec. 15, 2015 to which the Provider did not timely respond.