PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2017-D26

PROVIDER –
Santa Rosa Memorial Hospital

Provider No.: 05-0174

vs.

MEDICARE CONTRACTOR –
Cahaba Safeguard Administrators, LLC

DATE OF HEARING –
February 8, 2017

Cost Reporting Period Ended –
June 30, 2008

CASE NO.: 13-3169

INDEX

ISSUE STATEMENT

Whether Santa Rosa Memorial Hospital's ("Santa Rosa" or Provider") Medicaid eligible days for the low-income patient ("LIP") adjustment for FY 2008 are correctly stated? [1]

DECISION

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Provider Reimbursement Review Board ("Board") finds that Santa Rosa properly protested and claimed those Medicaid eligible days which could not be identified and verified at the time of cost report filing. The Board reaffirms its jurisdiction over the Medicare Contractor's determination of the LIP adjustment for Santa Rosa's FY 2008 cost report, including the understatement of LIP Medicaid eligible days. Accordingly, the Board remands this matter to the Medicare Contractor to audit the LIP Medicaid eligible days and recalculate Santa Rosa's LIP adjustment for FY 2008.

INTRODUCTION

Santa Rosa is a Medicare-certified acute care hospital with an inpatient rehabilitation unit, located in Santa Rosa, California. Santa Rosa protested the number of Medicaid eligible days it reported on its FY 2008 cost report for the purposes of its LIP adjustment. The Medicare Contractor ("MAC"), Noridian Healthcare Solutions,[2] removed the protested amounts pertaining to the LIP adjustment and issued a Notice of Program Reimbursement ("NPR") on March 8, 2013. Santa Rosa filed a timely appeal on August 30, 2013.[3]

Santa Rosa met the jurisdictional requirements for a hearing before the Board. The Board granted the parties request for a hearing on the record. Toyon Associates, Inc. represented Santa Rosa. Edward Lau, Esq., of Federal Specialized Services represented the Medicare Contractor.

STATEMENT OF FACTS

As part of the Balanced Budget Act of 1997, Congress created the inpatient rehabilitation facility prospective payment system ("IRF-PPS") for cost reporting periods beginning on or after October 1, 2002.[4] IRF-PPS rates were established based on estimates of inpatient operating and capital costs of IRFs using the most recent cost report data available.[5] The IRF-PPS rates are subject to certain adjustments.[6] This case focuses on one of these adjustments, the LIP adjustment specified at 42 C.F.R. § 412.624(e)(2).

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[1] Provider's Final Position Paper at 5.
[2] Cahaba Safeguard Administrators, LLC is the Medicare Contractor assigned to this appeal. *See* Medicare Administrative Contractor's Supplemental Final Position Paper, Exhibit I-7.
[3] *See* Stipulation of Facts ("Stipulations") at ¶¶ 2-4.
[4] Pub. L. No. 105-33, § 4421, 111 Stat. 251, 410 (1997).
[5] 42 U.S.C §§ 1395ww(j)(3)(A).
[6] *See* 42 U.S.C. §§ 1395ww(j)(3)(A)(i) – (v); 42 C.F.R. § 412.624(e).

The LIP adjustment is not specifically mentioned in the IRF-PPS statutory provisions. Rather, the Secretary created and implemented the LIP adjustment based on discretionary authority established under § 1395ww(j)(3)(A)(v) to adjust IRF-PPS payment rates "by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities."[7] Similar to the disproportionate share hospital ("DSH") adjustment paid to an acute care hospital the LIP adjustment is intended to reimburse IRFs for the incremental increases in Medicare costs associated with the number of low-income patients the facility serves.

Medicare providers are required to submit cost reports within five months of the end of the provider's fiscal year end. When Santa Rosa filed its FY 2008 cost report it protested the number of Medicaid eligible days it used to calculate its LIP adjustment.[8] This protested amount was included because the California Medicaid program was unable to verify the accurate number of Medicaid eligible patient days served by a facility until at least 13 months after the facility's fiscal year end.[9] In calculating Santa Rosa's LIP adjustment the Medicare Contractor removed the protested amount from Santa Rosa's cost report. Santa Rosa appealed the Medicare Contractor's determination of its LIP adjustment to the Board.[10]

DISCUSSION, FINDINGS OF FACTS, AND CONCLUSIONS OF LAW

The Medicare Contractor challenges the Board's jurisdiction in this case contending that 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), including both the general IRF-PPS rate (*i.e.*, the unadjusted federal rate) and any and *all* adjustments to those rates, including the LIP adjustment.[11] The Medicare Contractor cites a recent decision of the U.S. District Court for the District of Columbia in *Mercy Hospital, Inc. v. Burwell ("Mercy")* which held that 42 U.S.C. § 1395ww(j)(8) "prohibits administrative or judicial review of the contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the Hospital's prospective payment rates."[12] The Medicare Contractor argues that the issue in *Mercy* is the same one presented in this appeal and accordingly the Board is divested of jurisdiction to decide this case.

The Board has consistently taken a different position, concluding that § 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 only *certain* enumerated adjustments to those rates as specified in 42 U.S.C. §§ 1395ww(j)(2), (4), and (6). The Board finds that the Secretary's use of the term

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[7] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[8] *See* Stipulations at ¶ 2, ¶ 3.
[9] *See* Stipulations at ¶ 5.
[10] Santa Rosa requested the Medicare Contractor to reopen its cost report, to allow an additional 115 days. The Medicare Contractor denied the reopening request because of Santa Rosa had a pending appeal on the issue. *See* Stipulations at ¶ 6.
[11] Medicare Contractor's Jurisdictional Brief (June 11, 2015) at 2.
[12] *See Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016). Decision can be found in the record at MAC's Supplemental Final Position Paper, Exhibit I-8.

"the unadjusted Federal rate"[13] as defined in 42 C.F.R. § 412.624(c) significantly limits what is precluded from review—and that the LIP adjustment discussed in § 412.624(e) is not precluded from review.[14]

In the August 6, 2013 Final Rule, the Secretary expanded the list of adjustments precluded from review by § 412.630 and included the LIP adjustment. However the Board has consistently taken the position that these regulatory changes were not effective until October 1, 2013 and the Secretary made no provision for the retroactive application of the changes to § 412.630.[15] Thus, the Board finds, consistent with its earlier decisions,[16] that neither the statute nor the regulation precluded the administrative or judicial review of the LIP adjustment during the period at issue in this appeal.

The Board believes its position related to jurisdiction over the number of Medicaid eligible days in this case is consistent with the Court's position in *Mercy*. In *Mercy*, the provider argued that if the limitation on review were as broad as the Secretary urges, then there would be nothing for inpatient rehabilitation providers to challenge.[17] The court responded, stating the following:

> But the Secretary's interpretation does not leave inpatient rehabilitation providers with *nothing* to appeal. Suppose that a contractor failed to account for a number of patients altogether, proposing reimbursement for 475 Medicare beneficiaries instead of the 600 Medicare beneficiaries that the provider believed it had treated. A challenge to the contractor's decision to exclude those 125 patients would ***not*** be a challenge to the prospective payment rates, and so would not be barred by paragraph (8)'s limitation on review.[18]

Santa Rosa is challenging exactly what the *Mercy* Court described as being allowable for purposes of an appeal. Santa Rosa is challenging the Medicare Contractor's failure to use an accurate count of Medicaid eligible patient days in the calculation of its LIP adjustment. Santa Rosa protested the number of Medicaid eligible days it included on its cost report because it was not able to get California Medicaid to accurately identify these days prior to the cost report filing deadline. The Medicare Contractor removed the protested days prior to issuing Santa Rosas's NPR. The Board concludes that Santa Rosa's appeal is not a challenge to the calculation of the prospective payment rate but rather an appeal of the accuracy of the Medicare Contractor's

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[13] 42 C.F.R. § 412.630.
[14] *See St. Joseph Hosp. of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D4 (Dec. 2, 2015) 2015 WL 10371515.
[15] *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*, 206 F. Supp. 3d at 102.
[16] *See St. Joseph Hosp. of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D04 (Dec. 2, 2015); *Sutter Auburn Faith Hosp. v. Cahaba Safeguard Adm'rs, LLC*, PRRB Dec. No. 2015-D27 (Sept. 24, 2015), 2015 WL 10381795.
[17] *Mercy*, 206 F. Supp. 3d at 102.
[18] *Id.* (emphasis added).

determination of the number of Medicaid eligible patient days. As such the Board concludes that Santa Rosa's appeal is not barred by paragraph (8)'s limitation on review.[19]

DECISION AND ORDER

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds that Santa Rosa properly protested and claimed those Medicaid eligible days which could not be identified and verified at the time of cost report filing. The Board reaffirms its jurisdiction over the Medicare Contractor's determination of the LIP adjustment for Santa Rosa's FY 2008 cost report, including the understatement of LIP Medicaid eligible days. Accordingly, the Board remands this matter to the Medicare Contractor to audit the LIP Medicaid eligible days documentation submitted and recalculate Santa Rosa's LIP adjustment for FY 2008.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte Benson, CPA
Jack Ahern, MBA, CHFP

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: September 8, 2017

[19]The Board notes, however, that even in the absence of this exception articulated by the court which is applicable in the instant case, it respectfully disagrees with the U.S. District Court for the District of Columbia's decision in *Mercy.* The Board has been clear on its decision in regards to this issue and continues to stand by its conclusion that prior to implementation of the August 6, 2013 Final Rule it has jurisdiction to review the Medicare Contractor's determination of the LIP calculation. *See St. Joseph Hosp. of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D04 (Dec. 2, 2015).