PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2018-D8

PROVIDERS –
Toyon 2002-2006 LIP SSI Realignment Group

Provider Nos.: See APPENDIX A

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions

DATE OF HEARING –
April 25, 2017

Cost Reporting Periods Ended –
See APPENDIX A

CASE NO.: 09-0915G

INDEX

ISSUE STATEMENT

Whether the Supplemental Security Income ("SSI") ratio used to calculate the Medicare Low Income Patient ("LIP") adjustment for inpatient rehabilitation facilities ("IRFs") accurately reflects the number of patient days corresponding to the IRF cost reporting period?[1]

DECISION

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board concludes that the Medicare Contractor properly used LIP SSI ratios that were calculated based upon the federal fiscal year when settling the Medicare cost reports under appeal.

INTRODUCTION

The LIP SSI Realignment Group appeal consists of nine acute care hospitals ("Hospitals" or "Providers"), all with inpatient rehabilitation units located in the State of California ("Rehab Units"). The Rehab Units are reimbursed by Medicare under the Inpatient Rehabilitation Facilities Prospective Payment System ("IRF-PPS"). The cost reporting periods under appeal involve cost reports with year ends from 12/31/2002 to 12/31/2006.[2] The Medicare Contractor adjusted each of the Rehab Units' payment using an adjustment, known as a LIP adjustment, which is calculated based on the federal fiscal year. The Hospitals would like this adjustment calculated on the basis of each Providers' cost reporting year.

The Hospitals timely appealed this issue and met the jurisdictional requirements for a hearing before the Board.[3] The Board held a hearing on the record. The Medicare Contractor assigned to this appeal is Noridian Healthcare Solutions ("Medicare Contractor")[4] and was represented by Jerrod Olszewski, Esq., of Federal Specialized Services. The Hospitals were represented by Toyon Associates, Inc.

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[1] Provider's Final Position Paper at 1.

[2] Hospitals are listed on Appendix A.

[3] The Board issued an own motion expedited judicial review ("EJR") determination on February 29, 2016. The regulation at 42 C.F.R. § 405.1842(c) permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concluded that the Providers timely filed their Requests for Hearing, met the dissatisfaction requirement, and the amount in controversy exceeds the $50,000 threshold necessary for group appeals. As such, the Board determined that it has jurisdiction over the group appeal and the participants within the group. On the question of authority, the Board found that it has the authority to decide the legal question in this case (whether the SSI Ratio used to calculate the Medicare LIP for IRFs accurately reflects the number of patient days corresponding to the IRFs cost reporting period) as the legal question is neither a challenge to the constitutionality of a provision of statute, nor a challenge to the substantive or procedural validity of a regulation or Centers for Medicare and Medicaid Services ("CMS") Ruling. Consequently, the Board determined that EJR was not appropriate.

[4] Formerly known as Fiscal Intermediaries, CMS' payment and audit function under the Medicare program are now contracted to organizations known as Medicare Administrative Contractors. However, the term "intermediary" is still used in various statutes and regulations, and is interchangeable with the terms "Medicare Administrative Contractor" or "Medicare Contractor".

STATEMENT OF FACTS

As part of the Balanced Budget Act of 1997, Congress established the IRF-PPS for cost reporting periods beginning on or after October 1, 2002.[5] Pursuant to § 1395ww(j)(3)(A), IRF-PPS rates were established based on estimates of inpatient operating and capital costs of IRFs using the then most recent cost report data available. The IRF-PPS rates are subject to certain adjustments. One of them, the LIP adjustment, was intended to pay IRFs for the incremental increase in Medicare costs associated with a facility's percentage of low-income patients.[6] The LIP adjustment is calculated based on the addition of two ratios: the percentage of IRF Medicare patients who are receiving SSI compared to total IRF Medicare patients ("SSI ratio") and the percentage of IRF Medicaid patients who are not entitled to Medicare compared to total IRF patients ("Medicaid ratio"). These appeals involve only the calculation of the LIP SSI ratio.

Each fiscal year, CMS publishes a LIP SSI ratio for each IRF.[7] The Medicare Contractor uses these published ratios when settling the IRF's cost report. These LIP SSI ratios are calculated by CMS using patient data for the IRF for the federal fiscal year (i.e., the 12-month period from October 1 through September 30).

Originally, CMS developed the LIP payment using the same measure of low income utilization as used in the Disproportionate Share Hospital ("DSH") adjustment that Medicare pays to acute care hospitals. Each year CMS publishes a DSH SSI ratio for each acute care hospital based on the number of acute care Medicare patients who are receiving SSI to the total acute care Medicare patients ("DSH SSI ratio").[8] CMS calculates the DSH SSI ratio based on patient data for the acute care hospital for the federal fiscal year, however, the federal regulations allow acute care hospitals to request "realignment" of the calculation of their DSH SSI ratio to use its own cost reporting period rather than the federal fiscal year.[9] Unlike the calculation of the DSH adjustment for acute care hospitals, there is no federal regulation that explicitly allows IRFs to request "realignment" of their LIP SSI ratio to the IRF's own cost reporting period, in this case, July 1 to June 30.

DISCUSSION, FINDINGS OF FACTS, AND CONCLUSIONS OF LAW

The Rehab Units point out that CMS allows acute care hospitals to realign their DSH SSI ratios from a federal fiscal year basis to a cost reporting year basis in order to properly match or align all components of the DSH calculation to a cost reporting year. CMS does not allow IRFs the same process. The Rehab Units believe this prohibits IRF providers from being able to more accurately calculate the LIP adjustment by using actual cost reporting period data.

Further, the Rehab Units assert that CMS' refusal to establish a LIP SSI ratio realignment process is contrary to the intent set forth in the August 7, 2001 *Federal Register*. This *Federal*

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[5] Codified at 42 U.S.C. § 1395ww(j). *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997).
[6] *See* 42 U.S.C. §§ 1395ww(j)(3)(A)(i) – (v); 42 C.F.R. § 412.624(e)(2).
[7] The LIP SSI ratios can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html.
[8] 42 C.F.R. § 412.106(b)(2). The DSH SSI ratios can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInPatientPPS/dsh.html.
[9] 42 C.F.R. § 412.106(b)(3).

Register stated CMS' intent to "use the same measure of the percentage of low-income patients currently used for the acute care hospital inpatient prospective payment system, which is the DSH variable"[10] because it is "the best current predictor of costs associated with treating low-income patients in IRFs."[11] The Rehab Units contend CMS' application of the LIP adjustment is inconsistent with the DSH measure because IRFs are not allowed to adjust their SSI percentage from a federal fiscal year to a cost reporting year as is permitted to acute care hospitals.[12]

The Board reviewed the IRF-PPS statutory provisions and notes the LIP adjustment is not specifically mentioned in the statute. Rather, Congress gave discretionary authority to the Secretary 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."[13]

In creating the LIP adjustment, the Secretary promulgated regulations which state: "[w]e [CMS] adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services *as determined by us*."[14] Unlike the DSH regulations that allow an acute care hospital to request realignment,[15] the LIP regulations[16] do not address the realignment of the LIP SSI ratio to a cost reporting year.

The Board reviewed the preamble to the August 7, 2001 Final Rule and notes it also does not mention the realignment of the LIP SSI ratio from the federal fiscal year to the IRF's cost reporting period. Contrary to the position taken by the Hospitals, the Board believes that the preamble's intent does not require that the LIP SSI calculation for rehabilitation facilities and the DSH calculation be identical in all respects, but simply means that the LIP will be calculated using the same methodology that DSH uses. As stated in the Final Rule, the LIP measure is (1+DSH) raised to the power of .4838 where DSH equals Medicare SSI Days/Total Medicare Days + Medicaid Non-Medicare Days/Total Days.[17] Indeed, the LIP measure as established in 42 C.F.R. § 412.624(e)(2) is the same measure, i.e., the sum of the same two computations, as the acute care hospital DSH measure as provided in 42 C.F.R. § 412.106(b).

The Board also notes that in 1986, CMS, formerly the Health Care Financing Administration ("HCFA") stated that it believed that using a federal fiscal year instead of a hospital's own cost reporting period was the most feasible approach to implementing this provision in terms of accuracy, timeliness, and cost efficiency.[18] However, the federal statute required that the SSI/Medicare percentage be determined for each hospital "on a cost reporting basis."[19] In effect, CMS had no other choice but to provide some mechanism to allow hospitals to use their cost reporting period to compute their DSH SSI ratios. CMS allowed hospitals to send a written

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[10] 66 Fed. Reg. 41316, 41360 (Aug. 7, 2001).
[11] *Id.* at 41361.
[12] Providers' Supplemental Position Paper at 2-3.
[13] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[14] 42 C.F.R. § 412.624(e)(2) (emphasis added).
[15] 42 C.F.R. § 412.106(b)(3).
[16] 42 C.F.R. § 412.624(e)(2).
[17] 66 Fed. Reg. at 41360.
[18] 51 Fed. Reg. 31454, 31460 (Sept. 3, 1986).
[19] *Id.* at 31459.

request, including the hospital's name, provider number, and cost reporting period end date, to CMS through the fiscal intermediary to obtain realignment once per hospital cost reporting period.[20]

As stated above, Congress adopted no statutory provision requiring CMS to provide for realignment of SSI data for IRFs. Instead, in 2001, CMS pointly noted that "For the purposes of constructing the LIP adjustment for this final rule, we obtained *unit specific* measures of the ratio of the SSI days to the total number of Medicare days…. Therefore, to the extent possible, the LIP adjustment set forth in this final rule is based on data specific to the inpatient rehabilitation units, as well as freestanding inpatient rehabilitation hospitals."[21] This statement implies that by 2001 CMS had actual data "available on the cost reports"[22] and that it believed that this "data that are most reflective of the characteristics of the inpatient rehabilitation setting are most appropriate in determining payments under the IRF prospective payment system."[23]

While it is understandable that the Hospitals would like the same flexibility in the calculation of the SSI LIP as provided to acute care hospitals, the Board finds that there is no statutory provision that requires CMS to provide this flexibility and that it is within CMS' regulatory authority to design the calculation of the SSI LIP differently from the acute care DSH calculation. Therefore, the Board concludes that the Medicare Contractor was correct in using the LIP SSI ratios determined by CMS on a federal fiscal year basis in calculating the Rehab Units' LIP adjustment payments.

DECISION

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board concludes that the Medicare Contractor properly used LIP SSI ratios based upon the federal fiscal year when settling the Medicare cost reports under appeal.

BOARD MEMBERS PARTICIPATING

L. Sue Andersen, Esq.
Charlotte Benson, CPA
Gregory H. Ziegler CPA, CPC-A

FOR THE BOARD

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: December 5, 2017

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[20] 42 C.F.R § 412.106(b)(3).
[21] 66 Fed. Reg. at 41361.
[22] *Id.*
[23] *Id.*

APPENDIX A

	Provider No.	Provider Name	FYE
1	05-0305	Alta Bates Summit Medical Center	12/31/2002
2	05-0039	Enloe Medical Center	6/30/2006
3	05-0180	John Muir Medical Center	12/31/2006
4	05-0078	Little Company of Mary – San Pedro	12/31/2006
5	24-0019	Miller-Dwan Medical Center	6/30/2006
6	05-0278	Providence Holy Cross Medical Center	12/31/2006
7	05-0235	Providence St. Joseph Medical Center	12/31/2006
8	05-0006	St. Joseph Hospital of Eureka	6/30/2006
9	05-0599	UC Davis Medical Center	6/30/2003