PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2015-D7

PROVIDER -
Mercy Hospital
Miami, Florida

Provider No.: 10-0061

vs.

INTERMEDIARY –
First Coast Service Options, Inc./
Blue Cross and Blue Shield Association

DATE OF HEARING -
April 30, 2013

Cost Reporting Periods Ended -
December 31, 2002; December 31, 2003;
and December 31, 2004

CASE NOs.: 06-0686; 07-1177; 08-1362

INDEX

ISSUE STATEMENTS:

Issue 1: Whether the Provider Reimbursement Review Board ("Board") has jurisdiction to review the Medicare Contractor's determination that the days of patients who were both eligible for medical assistance under an approved Medicaid state plan and enrolled in a Medicare+Choice plan under Part C of the Medicare program should be excluded from the Medicaid fraction of the low-income payment adjustment for Mercy Hospital.[1]

Issue 2: Whether the Medicare Contractor properly determined Mercy Hospital's low-income percentage adjustment under the prospective payment system for rehabilitation facilities for fiscal years 2002, 2003, and 2004. In particular, the Medicare Contractor excluded from the Medicaid fraction of the low-income payment adjustment, the days of patients who were both eligible for medical assistance under an approved Medicaid state plan and enrolled in a Medicare+Choice plan under Part C of the Medicare program.[2]

DECISION:

JURISDICTION

The Board has jurisdiction to review the Medicare Contractor's determination that the days of patients who were both eligible for medical assistance under an approved Medicaid state plan and enrolled in a Medicare+Choice plan under Part C of the Medicare program should be excluded from the Medicaid fraction of Mercy Hospital's low-income payment adjustment.

LIP ADJUSTMENT ISSUE

It was improper for the Medicare Contractor to exclude from the Medicaid fraction of the low-income percentage adjustment for Mercy Hospital for FYs 2002, 2003, and 2004 the days of patients who were both eligible for medical assistance under an approved Medicaid state plan, enrolled in a Medicare+Choice plan under Part C of the Medicare program, and discharged prior to October 1, 2004. Accordingly, the Medicaid fraction of the low-income percentage adjustment calculation for FYs 2002, 2003, and 2004 should be modified by including these days which have been identified by the parties through the stipulation of facts.

INTRODUCTION:

Mercy Hospital ("Mercy") is a Medicare-certified acute care hospital that is located in Miami, Florida and includes an inpatient rehabilitation unit. The Medicare administrative contractor[3] assigned to Mercy is First Coast Service Options, Inc. ("Medicare Contractor"). This appeal involves the prospective payment system for inpatient rehabilitation facilities ("IRF-PPS").

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[1] Tr. at 7:4-17.
[2] Transcript ("Tr.") at 5-6.
[3] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") are referred to collectively as MACs.

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.[4] 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.[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. In this regard, § 1395ww(j)(3)(A)(v) empowers the Secretary to adjust the IFR-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]

The Medicare Contractor reviewed Mercy's cost reports for fiscal years ("FYs") 2002, 2003 and 2004 and issued Notices of Program Reimbursement for these FYs excluding from the Medicaid fraction of the LIP adjustment the days of patients who were both eligible for medical assistance under an approved Medicaid State plan and enrolled in a Medicare+Choice plan under Part C of the Medicare program. Mercy timely appealed the Medicare Contractor's calculation of the LIP adjustment under IRF-PPS for FYs 2002, 2003, and 2004. Specifically, Mercy challenges the Medicare Contractor's exclusion from the numerator of the "Medicaid fraction" of the LIP adjustment, the days of patients who were both eligible for medical assistance under an approved Medicaid State plan and enrolled in a Medicare+Choice plan under Part C of Medicare. The Medicare Contractor contests the Board's jurisdiction over the LIP issue because it maintains that 42 U.S.C. § 1395ww(j)(8) prohibits certain administrative review of the IRF-PPS and that these prohibitions encompass the LIP issue.

The parties submitted a joint stipulation of facts.[7] In particular, the parties stipulated that the Medicare Contractor reviewed the documentation submitted by Mercy to support the number of Medicare+Choice days it believes should be included in the numerator of Medicaid fraction of the LIP calculation. The parties further stipulated to the specific number of Medicare+Choice days contested for each year.[8]

The Board held a hearing on April 30, 2013 to consider the jurisdictional and substantive issues. Mercy was represented by Stephanie A. Webster, Esq., of Akin Gump Strauss Hauer & Feld LLP. The Medicare Contractor was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

[4] Pub. L. No. 105-33, 111 Stat. 251 (1997).
[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] *See* Stipulations dated Feb. 21, 2013.
[8] *See* Stipulations at ¶¶ 2-5.

DISCUSSION, FINDINGS OF FACTS, AND CONCLUSIONS OF LAW:

ARGUMENTS RELATED TO JURISDICTION

The Medicare Contractor contends the language of 42 U.S.C. § 1395ww(j)(8)(B) unambiguously precludes administrative and judicial review of the LIP adjustment because the IRF-PPS rate is comprised of both the general rate and adjustments to that rate — including the LIP adjustment.[9] The Medicare Contractor argues that review of the LIP adjustment would necessarily require review of the IRF-PPS rate, and such review is not permitted under § 1395ww(j)(8)(B).[10] As part of the final rule published on August 21, 2001 ("August 2001 Final Rule"), CMS promulgated 42 C.F.R. § 412.630 to implement § 1395ww(j)(8)(B).[11] The Medicare Contractor contends that this regulation must be read consistently with the statute and that, through such a reading, the Board will conclude that the list of matters over which review is not allowed is non-exclusive.[12]

The Provider maintains that the LIP adjustment is an adjustment to the "*unadjusted* Federal per discharge payment rate" and that this phrase as it is used in 42 C.F.R. § 412.630 merely prohibits administrative or judicial review of the "*unadjusted* Federal per discharge payment rates." Accordingly, the Provider concludes that § 412.630 prohibition does not encompass the LIP adjustment.[13]

The Medicare Contractor counters by saying that this jurisdictional position ignores the fact that the discussion in the preamble to August 2001 Final Rule specified that § 412.630 was "in accordance with" 42 U.S.C. § 1395ww (j)(8). The Medicare Contractor argues that, because § 1395ww (j)(8) precludes review of the IRF-PPS rate as a whole, including the adjustments, 42 C.F.R. § 412.630 cannot be "in accordance with" the statute if it allows administrative or judicial review of the adjustments to the IRF-PPS rate or the adjusted IRF-PPS rate.[14] Alternatively, to the extent that the regulation cannot be reconciled with the statute, the Medicare Contractor asserts that the Board must give effect to the statute, which constitutes the expressed intent of Congress, over the regulation.[15]

Finally, the Medicare Contractor argues that, to the extent that there was any ambiguity in the statutory or regulatory language regarding the scope of review of the LIP adjustment, CMS resolved this ambiguity in a clarification issued in a proposed rule published shortly after the hearing for this case in the Federal Register on May 8, 2013.[16] This clarification deleted the word "unadjusted" from 42 CFR § 412.630 "to honor the full breadth of the preclusion of administrative and judicial review provided by section 1886(j)(8) of the Act."[17] Since the

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[9] Medicare Contractor's Post-Hearing Brief at 6.
[10] *Id.*
[11] 66 Fed. Reg. 41316, 41393 (Aug. 7, 2001).
[12] *Id.* at 9.
[13] Provider's Response to Medicare Contractor's Jurisdictional Challenge at 6 (quoting 42 C.F.R. § 412.630 (emphasis added)).
[14] Medicare Contractor's Post-Hearing Brief at 9.
[15] *Id.*.
[16] *See* 78 Fed. Reg. 26880, 26908 (May 8, 2013); Medicare Contractor's Post-Hearing Brief at 13.
[17] *Id.*

agency made clear that the intent of this change was to clarify rather than change existing law, the Medicare Contractor asserts the Board should defer to this clarification.[18] The Board notes that the agency finalized this clarification in the final rule published on August 6, 2013 ("August 2013 Final Rule").[19]

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).

The Board finds that the statute prohibits administrative review of the establishment of both the IRF-PPS payment rates under 42 U.S.C. § 1395ww(j)(3) and certain enumerated adjustments to those rates specified in 42 U.S.C. §§ 1395ww(j)(2), (4), and (6). The Board finds that the Medicare Contractor reads the statutory language too broadly when it argues that the phrase "the prospective payment rates under paragraph (3)" as used in § 1395ww(j)(3)(B) encompasses both the general IRF-PPS rate and any and *all* adjustments to those rates including the LIP adjustment. The Board disagrees with the Medicare Contractor's conclusion for the following reasons:

1) A thoughtful examination of § 1395ww(j) confirms that the phrase "the prospective payment rates under paragraph (3)" in § 1395ww(j)(7) does not encompass all of paragraph (3). Rather, that reference is limited to the general "rates" prior to being "adjusted" by the items enumerated in Clauses (i) to (v) of Paragraph (3). The adjustments enumerated in these clauses include the LIP adjustment that the Secretary established pursuant to the discretionary authority granted under Clause (v). Significantly, the enumerated adjustments include in Clause (iii) an area wage adjustment which is defined in Paragraph (6). Significantly, § 1395ww(j)(8)(D) prohibits administrative review of the area wage adjustment by referring to Paragraph (6). Accordingly, if the phrase "the prospective payment rates under paragraph (3)" in § 1395ww(j)(8)(B) were interpreted to encompass both the general rate and any and all adjustments specified in Paragraph (3) as maintained by the Medicare Contractor, then it would render the prohibition on administrative review of the area wage adjustment in § 1395ww(j)(8)(D) meaningless and superfluous because such a prohibition would

[18] Medicare Contractor's Post-Hearing Brief at 14.
[19] 78 Fed. Reg. 47860, 47900 (Aug. 6, 2013)

already be encompassed by the reference to Paragraph (3) in § 1395ww(j)(8)(B). Similarly, this proposed interpretation would render other references in § 1395ww(j) to "the prospective payment rates" nonsensical. Specifically, this proposed interpretation would render the phrase "shall adjust . . . the prospective payment rates computed under paragraph (3) for area differences in wage levels" in Paragraph 6 nonsensical because, under this proposed interpretation "the prospective payment rates computed under paragraph (3)" already would include the area wage adjustment. Accordingly, the Board concludes that the Medicare Contractor's proposed interpretation of the phrase "the prospective payment rates under paragraph (3)" in § 1395ww(j)(8)(B) cannot be reconciled with § 1395(j).

2) The text of 1395ww(j)(8) prohibits administrative or judicial review of "*the establishment* of" the things listed in Subparagraphs (A) to (D). The Board finds that the use of the word "establishment" in the statute significant.[20] The Board finds that Mercy is not challenging "the *establishment* of" either the IRF-PPS rate or "the *establishment* of" the LIP adjustment, as the appeal challenges no part of the August 2001 Final Rule in which the LIP adjustment was established.

3) 42 U.S.C. § 1395ww(j)(3)(v) specifically gives discretion to the Secretary to adjust the IRF-PPS rate by "other factors" which she determines to be necessary to properly reflect variation in the costs of treatment among IRFs.[21] The LIP adjustment was one of the "other factors" created by the Secretary. When Congress limited providers' appeal rights, it specifically limited review over certain factors.[22] 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).[23] Clearly, Congress could have precluded review of all of the adjustments used in calculating payments rates to specific facilities, but it did not do so.

3) 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] 42U.S.C. § 1395ww(j)(8).
[21] 42U.S.C. § 1395ww(j)(3)(A)(v).
[22] 42U.S.C. § 1395ww(j)(8).
[23] Reporting of quality data was required by Section 3004 of the Affordable Care Act in 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 unadjusted Federal rate is defined in 42 C.F.R. § 412.624(c) and it does not include any of the adjustment 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 notes 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 had no specified retroactive application.[24]

Based on the above, the Board concludes it has jurisdiction to hear this appeal.

LIP ADJUSTMENT

Mercy contends that the IRF-PPS LIP adjustment incorporates without modification the DSH adjustment used in the inpatient prospective payment system ("the IPPS DSH adjustment"). Accordingly, to the extent the 2011 decision of U.S. Court of Appeals for the DC Circuit in *Northeast Hosp. Corp v. Sebelius* ("*Northeast*")[25] affected to the IPPS DSH adjustment calculation, it also affected the IRF-PPS LIP adjustment calculation. Mercy maintains that *Northeast* confirmed that Medicare+Choice days should be in the numerator of the Medicaid fraction.[26]

The Medicare Contractor counters that it properly determined Mercy's LIP adjustment by excluding the Medicare+Choice days from the numerator of the DSH variable in the LIP adjustment. The Medicare Contractor argues that the precise formula for the LIP adjustment stated in the August 2001 Final Rule is not identical to the formula used to calculate the DSH adjustment under the IPPS DSH adjustment.[27] Rather, the IPPS DSH adjustment is the sum of two fractions—the Medicare fraction and the Medicaid fraction as specified by 42 U.S.C. § 1395ww(d)(5)(F)(vi) while the LIP adjustment is "(1 + DSH [*i.e.*, the IPPS DSH adjustment]) raised to the power of 0.4838."[28] Further, the Medicare Contractor contends that Medicare+Choice days cannot be included in the Medicaid fraction of the IRF-PPS LIP adjustment calculation because "Medicare Part C is part of Medicare" and "must be included in either the numerator or the denominator of the Medicare fraction instead."[29] Finally, the Medicare Contractor maintains that Mercy has made no showing that the Medicare+Choice days had been routinely excluded from the Medicare fraction with respect to the LIP adjustment calculation.[30] Accordingly, the Medicare Contractor concludes that the D.C. Circuit's holding in *Northeast* does not apply to the IRF-PPS LIP adjustment.

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[24] *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").
[25] 657 F.3d 1 (D.C. Cir. 2011).
[26] *See* Provider's Post-Hearing Brief at 25.
[27] *See* Medicare Contractor's Post-Hearing Brief at 16.
[28] 66 Fed. Reg. at 41360.
[29] Medicare Contractor's Post-Hearing Brief at 17.
[30] *Id*. at 18.

The Board finds that the LIP adjustment was established pursuant to 42 U.S.C. § 1395ww(j)(3)(A)(v). This section empowers the Secretary to adjust the payment rate "by such other factors at the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." Pursuant to this authority, the Secretary promulgated the LIP adjustment regulations in the August 2001 Final Rule.[31] 42 C.F.R. § 412.624(e)(2) states: "*Adjustments for low-income patients.* We 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."[32]

The Board agrees with the Medicare Contractor that the IPPS DSH formula and the LIP formula differ. However, the Board finds that the "DSH" variable used in the LIP adjustment calculation is the IPPS DSH adjustment calculation. CMS make this clear in the preamble to the August 2001 Final Rule adopting the LIP adjustment. Specifically, CMS stated: ". . .we will refer to the adjustment for low-income patients as the LIP adjustment. However, we will use the term DSH when we refer to the measure used to compute IRF's percentage of low-income patients because *it is the **same measure** used to measure low-income patients in acute care hospitals*."[33]

In *Northeast*, the D.C. Circuit held that, while the statute does not foreclose the Secretary's interpretation that Medicare+Choice days should be included in the numerator of the Medicare fraction, the Secretary could not apply this interpretation to patient discharges prior to October 1, 2004. The effect of the D.C. Circuit's decision in *Northeast* was that Medicare+Choice days were included in the numerator of the Medicaid fraction of the Inpatient DSH percentage for inpatient discharges prior to October 1, 2004.[34] Because the LIP adjustment formula uses the IPPS DSH percentage calculation as a variable and the providers in *Northeast* demonstrated that the Secretary had routinely excluded Medicare+Choice days from the Medicare fraction for IPPS DSH adjustment calculation, the Board rejects the Medicare Contractor's assertion that Mercy must show that the Secretary had routinely exclude Medicare+Choice days from the Medicare fraction of the IRF LIP adjustment calculation. The Board finds that and concludes that, for the years in this appeal, the *Northeast* decision is applicable to the IRF-PPS LIP adjustment and, consistent with the IPPS DSH adjustment calculation for inpatient discharges prior to October 1, 2004, Medicare+Choice days also must be included in the IPPS DSH variable used for the LIP adjustment calculation for inpatient discharges prior to October 1, 2004.

DECISION AND ORDER:

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The Board has jurisdiction to review the Medicare Contractor's determination that the days of patients who were both eligible for medical assistance under an approved Medicaid state plan

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[31] 42 C.F.R. § 412.624(e)(2); 66 Fed. Reg. 41316, 41361 (Aug. 7, 2001).
[32] (Emphasis in original.)
[33] 66 Fed. Reg. at 41360 (emphasis added).
[34] *See Lifespan SWC 2003 DSH Medicare+Choice Days Group v. National Gov. Servs*, CMS Adm'r Dec. (Feb. 29, 2012) ("*Lifespan*"), *vacating*, PRRB Dec. No. 2012-D06 (Jan. 18, 2012); Tr. at 97 (BCBSA employee stating that "CMS issued instructions that said that for the period 1/1/1999 until 10/1/2004, the MAC was permitted to add M+C days to the Medicaid fraction for hospitals that had a valid appeal or were subject to reopening, or were reopenable.")

and enrolled in a Medicare+Choice plan under Part C of the Medicare program should be excluded from the Medicaid fraction of Mercy's LIP adjustment. .

LIP ADJUSTMENT ISSUE

It was improper for the Medicare Contractor to exclude from the Medicaid fraction of the LIP adjustment for Mercy for FYs 2002, 2003, and 2004 the days of patients who were both eligible for medical assistance under an approved Medicaid state plan, enrolled in a Medicare+Choice plan under Part C of the Medicare program, and discharged prior to October 1, 2004. Accordingly, the Medicaid fraction of the LIP adjustment calculation for FYs 2002, 2003, and 2004 should be modified by including these days which have been identified by the parties through the stipulation of facts.

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FOR THE BOARD:

/s/
Michael W. Harty
Chairman

APRIL 3, 2015