PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D3

PROVIDER –
Crozer- Keystone Hospital Specific 2007 Wage Index Rural Floor Group

Provider Nos.: Various

Cost Reporting Period Ended – FFY 2007

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ Highmark Medicare Services

CASE NO.: 07-0793G

INDEX

ISSUE:

Did the Centers for Medicare & Medicaid Services (CMS) err in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effect of the rural floor on the wage index?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395-1395cc. CMS, formerly the Health Care Financing Administration, is the operating component of the Department of Health and Human Services charged with administering the Medicare Program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine the payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20 and 413.24.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. See, 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes to the PPS rates for hospital inpatient operating costs and the methodology for determining those rates.

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) of the Act requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment facts (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower

payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. Id. at 48147.

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since FFY 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. See e.g. , 71 Fed. Reg. 48145-48 (August 18, 2006).

Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. Id. at 48153. The wage index must be updated annually. Id. at 48005.

PROCEDURAL HISTORY:

This appeal was filed on February 12, 2007 from the notice of final inpatient PPS rates published in the Federal Register on August 18, 2006.[1] The Providers challenged CMS's calculation and application of the budget neutrality adjustment to the PPS standardized amount to account for annual adjustments to the PPS wage index. The Providers contend that CMS has erred in the computation of the annual budget neutrality adjustment factors, including the adjustment factor applied to the standardized amounts and hospital-specific rates for fiscal year (FY) 2007, to account for changes in the wage index and rural floor. The alleged error results in a systematic understatement of the PPS standardized amount and the hospital-specific rates because it overstates the budget neutrality factor for annual updates to the wage index. The Providers believe the error is annual and reoccurring and so the final rates established in the final PPS rule for FY 2007 are understated both as a result of the effect of the computational error for FY 2007 and as a result of the cumulative effect of the same error in prior years' calculations.

[1] In accordance with the Administrator's decision in District of Columbia Hospital Association Wage Index Group Appeal, (HCFA Adm. Dec. January 15, 1993) Medicare & Medicaid Guide ¶41,025, the wage index notice published in the Federal Register is a final determination.

On January 22, 2009, the Board advised the parties that it was considering determining on its own motion whether expedited judicial review[2] (EJR) was appropriate. The parties were also asked to comment on the basis for the Board's jurisdiction.

Basis for EJR

To establish the PPS rate for FFY 2007 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
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> *****
>
> These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. at 48147.

The Providers are challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFY 2007.[3] The Providers contend that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effect of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and reoccurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year. Consequently, the Providers allege, the final rates established in the final FFY 2007 PPS rule are understated, both as the result of erroneous methodology used to calculate the budget neutrality adjustment for the effect of the rural floor in FFY 2007 itself, and as a result of the cumulative effect of the same error in prior fiscal years.

As a result of the alleged recurring computation methodology error, the Providers contend that CMS has not applied the rural floor in a manner assuring that the aggregate payments are not greater or less than those which would have been made if the rural floor did not apply. The Providers assert that rather than achieving the budget neutrality required by law, CMS has computed and provided PPS payment reductions for FFY 2007 that exceeded CMS's statutory authority, are arbitrary and capricious, and otherwise contrary to law.

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[2] See, 42 C.F.R. §405.1842(c) (2008).

[3] The final PPS rates for this period were published in the Federal register on October 11, 2006. 71 Fed. Reg. 59886, 59889 (October 11, 2006). The August 18, 2006 federal Register cited above noted that the standardized amount was tentative because factors such as the outlier offset and budget neutrality adjustment for the wage index and reclassification that are applied to the standardized amount had not been determined pending the calculation of the occupational mix adjustment. 71 Fed. Reg. 47870, 48146.

Jurisdiction over the Issue

The Intermediary asserts that the Administrator's January 15, 2009 decision in Cape Cod HC 2007 Wage Index/Rural Floor Group, PRRB Case No. 07-0705G et al.[4] is the definitive decision over the question of the Board's jurisdiction. In that decision the CMS Deputy Administrator stated that the Board has jurisdiction over the appeal of the "rural budget neutrality issue" under 42 C.F.R. § 405.1801 and 42 U.S.C. § 1395oo. The Intermediary also pointed out that the Board had previously determined that if it had jurisdiction over the budget neutrality adjustment issue, EJR was appropriate and it agrees with the Board's position.

The Providers contend that the Board has jurisdiction over the appeal because the appeal was timely filed from the Federal Register notice setting forth the final PPS rates for FFY 2007[5] and the $50,000 amount in controversy has been met. The Providers point out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. §1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. §1395ww(d)(7) shall not be reviewed by the Board or any court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality factor. The Providers contend that this preclusion on review is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that total amounts paid under PPS, then a new system, were the same amounts that would have been spent under the Medicare law as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

Decision of the Board:

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. See, 42 U.S.C. §1395ww(d)(7); 42 U.S.C. §1395oo(g)(2); 42 C.F.R. §§405.1804 and 405.1840(b)(2). Because jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. §1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effective pursuant to subsection (e)(1) [budget neutrality] or

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[4] Intermediary's February 20, 2009 letter regarding EJR/jurisdiction, Ex. C.

[5] See, Washington Hospital Center v. Bowen, 795 F .2d 139, 146 (D.C. Cir. 1986) ("[A] year-end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal.") and District of Columbia Hospital Association Wage Index Group Appeal (HCFA Adm. Dec. January 15, 1993) Medicare & Medicaid Guide (CCH) ¶41,025 (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board.)

> the determination of the applicable percentage increase under paragraph (12)(A)(ii).

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

> The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determination and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> A determination of the requirement, or the proportional amount of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act.

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. See, 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In Amgen, Inc. v. Smith[6] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that appeal was precluded. The Court further noted that payments under PPS are made on a

[6] 357 F .3d 103 (D.C. Cir. 2004).

prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, Universal Health Services of McAllen, Inc. v. Sullivan,[7] (UHS) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In UHS, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

Allegation that Review of Budget Neutrality is Limited to FY 1984 and 1985

The Board is not persuaded by the Providers' argument that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. When Congress enacted the PPS payment rates for 1984 and 1985, it instructed the Secretary to determine the allowable operating cost from the most recently available cost reporting period for which data are available, updated to 1983 and further updated to 1984 by the market basket plus one percent. The resulting amounts were standardized by excluding specified costs and then an average standardized amount was computed for urban and rural hospitals under TEFRA. The average standardized amounts were reduced to be budget neutral. Congress noted that the method of calculating the PPS rates for 1986 and later were the same, but there was no step in the process for budget neutrality. Instead an independent panel would advise the Secretary regarding the updating factor to be used. The Secretary was required to publish the methodology and the data used to create the PPS rates, including any adjustment to produce budget neutrality, in the Federal Register on or before September 1 of each fiscal year. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 354-355 (1983).

In addressing the appeals process, Congress provided for the same administrative and judicial review of the reimbursement for payments made under PPS as was available for cost-based reimbursement. Review was permitted with the exception of determinations necessary to maintain budget neutrality and the establishment of diagnosis related groups (DRGs), the methods for classifying DRGs and the DRG weighting factors. Congress stated that such preclusion on judicial review was necessary to maintain a workable payment system. House Report No. 98-25(I) 1983 U.S.C.C.A.N. 219, 361-362 (1983) and Senate Report No. 98-23 1983 U.S.C.C.A.N. 143, 197-198 (1983). This preclusion on administrative and judicial review was codified in 42 U.S.C. §1395ww(d)(7).

Subsection (d)(7) states that there shall be no administrative or judicial review under 42 U.S.C. §1395oo of the determination of the requirement or the proportional amount of any adjustment effected pursuant to subsection (e)(1). 42 U.S.C. §1395ww(e)(1) provides that for cost reporting periods of hospitals beginning in FYE 1984 or 1985 the Secretary shall provide for a

[7] 770 F. Supp. 704 (D.C. Dist. 1991.)

proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure budget neutrality. Section 1395ww(b)(3)(B) references all cost reporting periods from 1986 through the present as being affected by the budget neutrality adjustment.

In response to the enactment of the above statutes, the Board's governing regulations were modified. In the September 1, 1983 preamble to new regulations, the Secretary explained that 42 U.S.C. § 1395oo(g)(2) was added by Pub. L. 98-21 to state that the determinations and decisions described in § 1395ww(d)(7) precludes administrative and judicial review of, among other things, a determination of the requirement, or proportional amount of any "budget neutrality" adjustment effected under §1395ww(e)(1). The Secretary stated that it was the clear intent of Congress that a hospital would not be permitted to argue that the level of payment that it receives under the prospective payment system is inadequate to cover its costs. The Secretary amended 42 C.F.R. Part 405, Subpart R to implement the changes to 42 U.S.C. § 1395(g)(2) contained in Pub. L. 98-21. The changes to the regulation included the addition of §405.1804 to describe matters not reviewable by the Board or the courts as provided in § 1395ww(d)(7).[8] Section 405.1804 states specifically that there is neither administrative nor judicial review of the determination of the requirement or the proportional amount of any budget neutrality adjustment in the prospective payment rate. Therefore, the Secretary clearly interpreted the statutory prohibition on review as not being confined to 1984 and 1985.

When the Secretary "updated, clarified and revised"[9] the Board's governing regulations in 2008, he separately and specifically addressed the limitations on the Board's jurisdiction. The original regulation at 42 C.F.R. §405.1804, stating that budget neutrality issues are not reviewable, was reissued without change or comment. In addition, the Secretary added 42 C.F.R. §405.1840 to the regulations specifically dealing with the Board's jurisdiction. Section 405.1840(b) states that certain matters at issue were removed from the jurisdiction of the Board and included "[c]ertain matters affecting payments to hospitals under the prospective payment system, as provided in [42 U.S.C. §1395ww(d)(7)] and §405.1804 of this subpart." If the budget neutrality provisions of §405.1804 were limited to appeals of FY 1984 and 1985, there would be no reason to leave the regulation unchanged during a comprehensive revision of the Board's regulations and certainly no need to add §405.1840(b)(2) reiterating and emphasizing the Board's lack of jurisdiction over the budget neutrality issue. The Secretary's action demonstrates a twenty five year consistent position that all budget neutrality determinations are off limits to the Board; not just those relating to fiscal years 1984 and 1985. Whether the Secretary's view is consistent with Congress' intent is not for the Board to decide for it is bound by the regulation.

EJR Determination

42 U.S.C. §1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal

[8] 48 Fed. Reg. 39740, 39785 (September 1, 1983).
[9] 73 Fed. Reg. 30190 (May 23, 2008).

under 42 U.S.C. §1395oo. 42 C.F.R. §405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the appeal.

Review of the Board's jurisdictional determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§405.1875 and 405.1877.

Cape Cod and the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in Cape Cod HC 2007 Wage Index/Rural Floor Group, PRRB case number 07-0705G et al, (Cape Cod), the Secretary has taken a contrary position. In Cape Cod, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[10] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.

The Providers in this appeal seek to have the final wage index rates published in the Federal Register modified by applying a different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. §412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[11] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to

[10] Cape Cod Hospital v. Leavitt, (D.D.C. July 21, 2008) (2008 WL 2791683).
[11] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

The Board finds that:

1) based upon the Providers' unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;
2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

Accordingly, the Board finds that the budget neutrality/rural floor issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and expedited judicial review is appropriate. Because this is the only issue under appeal in this case, the Board hereby closes the case.

Board Members Participating:

Suzanne Cochran, Esq.
Yvette C. Hayes
Michael D. Richards, CPA
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

DATE: OCT 20 2009

Schedule of Providers in Group (Schedule A)

Group Name: Crozer-Keystone Health System FFY 2007 Wage Index/Rural Floor Group

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Representative: King & Spalding, L.L.P.

Date Prepared: 2/19/2009

Group Case No.: 07-0793G

Issue: Whether CMS incorrectly computed and applied the budget neutrality adjustment to the standardized amount that is supposed to account for the effects of the rural floor on the PPS wage index.

	Provider Number	Provider Name (Location)	FFY	Intermediary	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No	G Date Add/ Transfer Filed
1	39-0081	Delaware County Memorial Hospital (Drexel Hill, Delaware, PA)	2007	Highmark Medicare Services	10/11/2006	2/12/2007	124	N/A	$115,000	Direct Add	(Ref: Tab 1-B)
2	39-0180	Crozer Chester Medical Center (Upland, Delaware, PA)	2007	Highmark Medicare Services	(Ref: Tab 1-A)	(Ref: Tab 1-B)	124	N/A	$350,000	Direct Add	(Ref: Tab 1-B)

Total Amount of Reimbursement: $465,000