CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Greenbrier Behavioral Health	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: December 31, 2008**
Provider	
vs.	
Wisconsin Physicians Services	**Review of: PRRB Dec. No. 2017-D8 Dated: February 24, 2017**
Medicare Administrative Contractor	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare (CM) and the Medicare Administrative Contractor (MAC) submitted comments, requesting reversal of the Board's decision. Comments were also received from the Provider requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Provider is eligible for the third year inpatient psychiatric facility prospective payment system (IPF-PPS) transition rate for the cost reporting period beginning on January 1, 2008 and ending on December 31, 2008.

The Board held that the MAC improperly paid the Provider 100 percent of the Federal *per diem* rate under IPF-PPS for the fiscal period in dispute and remanded the case to the MAC to reimburse the Provider at the rate for year-three of the transition to IPF-PPS, namely 25 percent of the facility-specific payment and 75 percent of the Federal *per diem* rate. In reaching this determination the Board concluded that, when there's a direct and un-resolved

conflict between dates stated in the regulation text and dates subsequently stated in the Preamble Tables, the regulation text is binding. To support this position the Board noted that when the Secretary issued the 2005 Correction to insert the dates at issue into 42 C.F.R. § 412.426(a) (3), the Secretary described the revision as a "correction [to] conform[] the regulation text to the actual policy." Therefore, the Board has no authority to override and substitute the dates stated in the regulation with the dates subsequently stated in the non-regulatory text (Preamble Table). Finally, with respect to the Secretary's revision in 2011 to 42 C.F.R. § 412.426(a) (3), the Board concluded that the revised regulation was not retroactive and not applicable to this appeal.

SUMMARY OF COMMENTS

The MAC submitted comments requesting that the Administrator reverse the Board's decision. The MAC stated that the Board incorrectly concluded that 42 C.F.R. § 412.426 was amended in 2011 without any retroactive application.

With respect to the 2011 revision to 42 C.F.R. § 412.426, the MAC stated that the regulation was amended in 2011 solely to correct typographical errors and conform the text of the regulation to the then existing policy and that there was no substantive change made or prohibited retroactive rulemaking. The policy existing applicable to the Provider's fiscal year January 1, 2008 through December 31, 2008 cost report specifically prohibited any blend to a cost reporting period beginning on or after January 1, 2008. Therefore, since the Provider's cost reporting period began on January 1, 2008, it fell squarely within the existing policy.

The MAC also argued that the Provider was on notice that the year three of the transition period only applied to cost reporting period beginning on or after January 1, 2007 but before January 1, 2008 and that IPF would be paid at 100 percent of the IPF-PPS for any cost reporting periods beginning on or after January 1, 2008. The MAC noted that the Provider was advised of the proper interpretation of 42 CFR 412.426 in Change Request 3541 which was issued December 1, 2004 and communicated by the MAC in the January 1, 2005 newsletter. The Provider was again advised on the proper interpretation in Change Request 5129 which was communicated by the MAC in the August 1, 2006 newsletter. The Provider was further advised on the proper interpretation in the Provider Reimbursement Manual 15-2 instructions. Notwithstanding ample advice regarding the proper interpretation of 42 CFR 412.426, the Provider chose to modify its fiscal year and chose to fall outside of the third transition year. The Provider cannot claim surprise against the backdrop of repeated interpretive advice.

The Provider submitted comments requesting that the Administrator affirm the Board's decision. The Provider argued that the 2011 Final Rule cannot be applied to this case as doing so would be an impermissible retroactive rulemaking under the Social Security Act

and the Administrative Procedure Act. Nothing can refute the fact that the plain language of the regulation at issue included in the third transition year cost reports beginning on January 1, 2008 and the regulatory text did not change until after the Provider filed its appeal in this case. Furthermore, it make no sense to refer to a table published twice in the Federal Register as evidence that the Provider was put on notice about the "actual policy" because interpretive rules or positions, even if published in bold font in the *Federal Register* cannot conflict with the express terms of the actual regulations they interpret.

The Center for Medicare (CM) commented requesting that the Administrator reverse the Board's decision and uphold the MAC's determination. The CM pointed out that as early as the April 1 2005 correction notice explained that the preamble of the November 2004 IPF PPS final rule clearly described the transition time frame as being based upon cost reporting periods and that the regulation text inadvertently used July 1 to June 30 IPF PPS update cycle for the transition timeframe (70 Fed Reg. 16726 to 16727) the Correction Notice amended 42 CFR 412.426 to correct the transition dates. The corrected regulation text stated that: "For cost reporting periods beginning on or after January 1, 2007 and on or before January 1, 2008, payment is based on 25 percent of the facility –specific payment and 75 percent is based on the Federal per diem payment amount." The correction notice stated that the change "does not reflect a change in policy, rather it conforms the regulation text to the actual policy." (70 Fed. Reg. 16726).The actual timeframes for the transition were clearly shown in the preambles of multiple subsequent IPF PPS rules and notices (71 Fed. Reg. 27042, 72 Fed. Reg. 25603 to 25604, 73 Fed. Reg. 25710 to 25711). The policy was further disseminated through Change Request 3541 and the accompanying MedLearn Matters article and in the Medicare Contractor newsletters issued to providers in January 2005 and August 2006 together, the preamble language in the rules, the notices and the CMS-issued guidance all included a table that showed the transition year and the applicable cost reporting periods as well as the Medicare payment percentages from each payments system (TEFRA and IPF PPS) that were applied, identifying year three as cost reporting periods beginning on or after January 1, 2007 and that cost reporting periods beginning on or after January 1, 2008 were paid 100 percent pursuant to the IPF PPS per diem rate.CM disagreed with the Board's conclusion and stated that there was persuasive court precedent for crediting a clear preamble over regulation text that inadvertently contains an error or omission. For example, in *Select Specialty Hospital-Akron LLC v. Sebelius*, 820 F. Supp. 2d 13 (D.D.C. 2011) the court relied that even though regulation text published in the Code of Federal Regulations did not correctly reflect the dates of a transition period affecting Long Term Care Hospitals, the preamble language published in the Federal regulation was an unequivocal expression of CMS' intended transition policy. In this instance, the actual IPF PPS transition policy was clearly stated in multiple rules and notices and four guidance documents. Therefore, CM stated that the MAC's application of the transition policy was appropriate.

In addition, the Provider voluntarily business decision to change its FYE from November 30, 2007 to December 31, 2007 created the situation that resulted in the Provider to no longer be eligible for the blended payment in year three of the transition period. Given the profusion of information about the transition policy it is reasonable to believe the Provider was aware of this policy when it made the change. Further evidence that it was aware of the policy was its action in trying to file a cost report with a December 31, 2007 start date.to correct its self - imposed exclusion from the three year transition payment. Based on the foregoing CM maintained that the Provider cannot reasonably argue it was unaware of the policy or that it was justified in relying on the erroneous regulation text.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Prior to 2005, Inpatient Psychiatric Facilities (IPFs) were paid on a reasonable cost basis, subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) methodology, and were exempt from the prospective payment methodologies.[1] However, § 124 (c) of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balance Budget Refinement Act of 1999 (BBRA)[2], mandated that the Secretary develop and implement a per diem prospective payment system (PPS) for IPFs. In November of 2004, the Secretary issued the IPF PPS final rule establishing the IPF PPS as required by § 124 of the BBRA.[3] This final rule included a policy to transition payments from the previous facility-based payment system under the TEFRA to the IPF PPS over a three-year period (that is, cost reporting periods beginning on, or after, January 1, 2005 and before January 1, 2008) to allow existing IPFs a period to adjust their cost structures and to integrate the effects of changing to the new IPF PPS payment methodology.[4]

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[1] *See* Pub. L. 98-21. Section 601 of the Social Security Amendments of 1984 added a new § 1886 (d) to the Act that replaced the reasonable cost-base payment system for most inpatient hospital services with a PPS.

[2] Pub. Law 106-113-Appendix F, § 124, 113 Stat. 1501A-332 (1999). In 2010, Congress incorporated the BBRA § 124 mandate into 42 U.S.C. § 1395ww(s) (1). See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3401(f), 124 Stat. 119, 483 (Mar. 23, 2010).

[3] *See* 69 Fed. Reg. 66922, 66977 (Nov. 15, 2004).

[4] *See* 69 Fed. Reg. 66922, 66980 (Nov. 15, 2004).

The transition period was codified at 42 C.R.F. § 412.426 (2005) and provided when first drafted that: "… for cost reporting periods beginning on or after January 1, 2005 through January 1, 2008, an inpatient psychiatric facility receives a payment comprised of a blend of the estimated Federal per diem payment amount, as specified in § 412.424(c) (and a facility-specific payment as specified under paragraph (b).

> (1) For cost reporting periods beginning on or after January 1, 2005 and on or before January 1, 2006, payment is based on 75 percent of the facility-specific payment and 25 percent is based on the Federal per diem payment amount.
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> (2) For cost reporting periods beginning on or after January 1, 2006 and on or before January 1, 2007, payment is based on 50 percent of the facility-specific payment and 50 percent is based on the Federal per diem payment amount.
>
> (3) For cost reporting periods beginning on or after January 1, 2007 and on or before January 1, 2008, payment is based on 25 percent of the facility-specific payment and 75 percent is based on the Federal per diem payment amount.
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> (4) For cost reporting periods beginning on or after July 1, 2008, payment is based entirely on the Federal per diem payment amount.

In April of 2005, the Secretary published a "correction of final rule" advising IPFs that incorrect dates were used for the three year transition cost reporting periods. CMS stated:

> In § 412.426 of the regulation text, we inadvertently used incorrect dates for the cost reporting periods for the transition period from a blended PPS payment to a full PPS payment. Our policy is clear from the discussion in the preamble on pages 66964 through 66966 that the transition period dates correlate to the cost reporting year. However, in § 412.426, we inadvertently inserted the dates that reflect the IPF PPS update cycle instead of cost reporting years. This correction does not reflect a change in policy, rather, it conforms the regulation text to the actual policy.[5]

On May 9, 2006, the Secretary published a table of "*IPF PPS Final Rule Transition Blend Factors*" in the *Federal Register*, for the three year transition period and stated that for "cost reporting periods beginning on or after January 1, 2008" the facility specific payment would

[5] *See*, 70 *Fed. Reg*. 16724, 16726-16727 (Apr. 1, 2005).

be zero percent and the federal per-diem payment amount would be 100 percent.[6] Again on May 4, 2007 and May 7, 2008, the Secretary published at the Table of "*IPF PPS Transition Blend Factors*" in the *Federal Register*, for the three year transition period and stated that for "cost reporting periods beginning on or after January 1, 2008" the facility specific payment would be zero percent and the federal per-diem payment amount would be 100 percent.[7]

In addition, during this period CMS issued various guidance on the IPF PPS transition period. The Change Request 3541 provided implementing instructions to the CMS Manual System, Pub 100-04 Medicare Claims Processing (Transmittal 384) dated December 1, 2004) as follows:

Transition (Phase-In Implementation):

- The IPF PPS will be phased-in over 3 years from the cost based reimbursement to the Federal prospective payment.
- All IPF providers must transition over the 3-year transition period. There is NO election of 100 percent PPS in the first year.
- During the transition period, payment is based on an increasing percentage of the IPF prospective payment and a decreasing percentage of each IPFs cost-based reimbursement rate for each case as follows:

Transition Year	Cost Reporting Periods Beginning on or After	TEFRA Rate Percentage	IPF PPS Federal Rate Percentage
1	January 1, 2005	75	25
2	January 1, 2006	50	50
3	January 1, 2007	25	75
	January 1, 2008	0	100

PLEASE NOTE: THE 3-YEAR TRANSITION PERIOD IS SEPARATE FROM THE ANNUAL UPDATE CYCLE. THE TRANSITION IS EFFECTIVE ACCORDING TO COST REPORTING PERIODS.

The MedLearn Matters (MLM) Number, MM 3541 for the related Change Request Number 3641 (effective date January 1, 2005 with an implementation date of April 4, 2005) the transition phase in implementation was discussed and stated:

> Transition (Phase-in Implementation)
> The IPF PPS will be phased in over 3 years from the current cost-based reimbursement and all IPFs must go through the transition, except for new IPF providers. (See CR 3541 for definitions of "new providers," who will be paid

[6] *See*, 71 *Fed. Reg*. 27042 (May 9, 2006).
[7] *See* 72 *Fed. Reg*. 25603 (May 4, 2007); *See also*, 73 *Fed. Reg*. 25710 (May 7, 2008).

> immediately at 100percent of the IPF PPS rate.) The transition period is as follows:
> • Year 1 (effective for cost reporting periods on or after January 1, 2005): 75 percent of payment will be at the current TEFRA rate and 25 percent at the IPF Federal rate.
> • Year 2 (effective for cost reporting periods on or after January 1, 2006): 50 percent of payment will be at the TEFRA rate and 50 percent at the IPF PPS Federal rate.
> • Year 3 (effective for cost reporting periods on or after January 1, 2007): 25 percent of payment will be at the TEFRA rate and 75 percent at the IPF PPS Federal rate.
> • Commencing with cost reporting periods on or after January 1, 2008: payments will be based 100 percent on the IPF PPS rate.

This timeline was repeated in Change Request 5287 (Transmittal 1101)(Dated November 3, 2006), which again showed the same chart that had been used in the prior guidance and preambles. MedLearn Matters MM 5619 (related Change Request No. 5619, effective date July 1, 2007 and later discharges) and also stated that: "the three year transition period is separate from the annual update cycle. The transition is effective according to cost reporting periods."

In 2011, CMS published in the *Federal Register* its intent to make several minor corrections to the regulatory text found at 42 C.F.R. § 412.426 to address typographical errors. CMS stated that:

> In each of paragraphs § 412.426(a) (1) through (a) (3), we are proposing to delete the words "on or" directly before the words "before January". For example, paragraph (a)(1) currently states, "For cost reporting periods beginning on or after January 1, 2005 and on or before January 1, 2006* * *" We are proposing that this statement read: "For cost reporting periods beginning on or after January 1, 2005 and before January 1, 2006 * * *" this correction does not represent a change in policy. Rather, it is a correction to conform the regulation text to our policy, which was established in our final rule that appeared in the Federal Register on November 15, 2004 (69FR 66980) (which was subsequently corrected on April 1, 2005 (70 FR 16729)). It is clear that the current regulation text is incorrect. The same January date (for example, January 1, 2007) cannot be both the date on which a new transition period begins and the date on which the previous transition period ends. Our policy, since we established the transition, has been to begin a transition period on or after a January 1 date and to end that transition period before the next transition period begins. Because our regulation text does not accurately reflect our actual policy, we are proposing this correction.

> At § 412.426(a)(4), we are proposing to replace the statement, "For cost reporting periods beginning on or after July 1, 2008, payment is based entirely on the Federal per diem payment amount" with the following statement: "For cost reporting periods beginning on or after January 1, 2008, payment is based entirely on the federal per diem payment amount." The transition period during which payment was based on a combination of the Federal per diem payment amount and TEFRA payments, ended on January 1, 2008, not July 1, 2008.[8]

The issue in this appeal is whether the Provider is eligible for the third year IPF PPS transition rate for the cost reporting period beginning on January 1, 2008 and ending on December 31, 2008. For cost reporting period beginning on December 1, 2005 and ending on November 30, 2006 the Provider received the appropriate blended facility-specific payment (75 percent TEFRA and 25 percent PPS). For cost reporting period beginning on December 1, 2006 and ending on December 31, 2007, the Provider received the appropriate blended facility-specific payment (50 percent TEFRA and 50 percent PPS). However, the Provider voluntarily changed its fiscal year from November 30, 2006 to December 31, 2007, resulting in a one-time 13-month cost reporting period of December 1, 2006 through December 31, 2007. For the Provider's cost reporting period beginning January 1, 2008 and ending on December 31, 2008, the Provider payment was based 100 percent on the Federal per diem amount.

The Provider contends that its entitled to the blended rate for year-three of the transition period for its January 1, 2008 to December 31, 2008 cost report based on the erroneous regulation language found in 42 C.F.R. §412.426 (a)(3), which provides for the year-three blended rate for cost reporting periods beginning on or before January 1, 2008. However, the Administrator finds that the Provider failed to meet the criteria for the third year transition based on the plain meaning of the regulation found at 42 C.F.R. § 412.426(a)(4). As stated above, "[t]he same January date (for example, January 1, 2007) cannot be both the date on which a new transition period begins and the date on which the previous transition period ends." The Administrator finds that CMS policy, since establishing the IPF PPS transition, has been to begin a transition period on or after a January 1 date and to end that transition period before the next transition period begins.

The Provider argues that the May 2011 amendment to 42 C.F.R. § 412.426, was impermissible retroactive rulemaking because it effected a substantive change. However, the Administrator finds that the notice of 42 C.F.R § 412.426 correction in the May 2011 amendment did not effect a substantive change and accordingly, is not retroactive

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[8] 76 Fed. Reg., 4998, 5022 (January 27, 2011). Finalized 76 Fed. Reg. 26432, 26459-26460 (May 6, 2011).

rulemaking. Taken as a whole, the language describing the IPF-PPS transition served as notice of CMS' policy established in the November 15, 2004 IPF PPS final rule, even if technical inconsistences existed between the regulation text and the preamble language before technical corrections were issued on May 6, 2011. Those technical errors were evident on the face of the text, *inter alia*, "[t]he same January date (for example, January 1, 2007) cannot be both the date on which a new transition period begins and the date on which the previous transition period ends."

Moreover, actual notice to the Provider was also provided through various CMS guidance. The Administrator finds that the Provider on notice of CMS' actual transition policy before the Provider decided to change its fiscal year. In addition to the transition policy and timelines set forth properly in the preamble of the proposed and final rule in 2004, (in contrast to the on its face conflicting and erroneous regulatory text), the record shows that the Provider and the IPF community was advised of 42 C.F.R. § 412.426's proper interpretation in Change Request 3541 which was issued December 1, 2004 and communicated by the Provider's MAC to the providers its served in the January 1, 2005 newsletter. The record further shows that the Provider and IPF community was advised of the proper interpretation in Change Request 5129 which was communicated by the MAC in the August 1, 2006 newsletter. The record also shows that the Provider was advised of the proper interpretation in the Provider Reimbursement Manual 15-2 §3633.1. The Administrator finds that the effect of the May 2011 correcting amendment was not to substantively change the final rule, but rather to correct the inadvertent error of the regulatory text so that it was consistent with CMS' intent as expressed in the preamble to the rule.[9]

Finally, there is evidence to suggest that the Provider knew that its cost reports beginning on or after January 1, 2008 would be ineligible for blended payment as part of the transition. In transitioning to its one-time 13 month cost report with a FYE of December 31, 2008, the Provider initially filed it cost report with a start date of December 31, 2007. However, because the same date cannot be allocated to two different cost-reporting years per 42 CFR § 413.24(f), the MAC rejected the cost report. The Provider subsequently refiled with a cost report start date of January 1, 2008. Thus, the Administrator concludes that the only reason the Provider attempted to file its cost report with an incorrect December 31, 2007 start date was to correct its self-imposed exclusion of the year-three blended payment.

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[9] *See*, e.g., *Select Specialty Hospital Akron, LLC v. Sebelius*, 820 F. Supp. 3d 13 (D.D.D. 2011). There the court ruled that even though regulations text published in the Code of Federal Regulations did not correctly reflect the dates of a transition period affecting Long Term Care Hospitals, the preamble language published in the Federal Register was an unequivocal expression of CMS' intended transition policy.

Accordingly, given the totality of the circumstances, and the clear articulation of the IPF PPS transition policy in multiple preambles of rules and notices and in guidance documents issued before the Provider's FYE December 31, 2008 cost reporting period, and prior to the Provider's voluntary change in its cost reporting period, the Administrator finds that the MAC properly assigned the Provider to 100 percent of the IPF PPS per diem payment rate instead of the blended payment of 25 percent TEFRA payment and 75 percent IPF PPS per diem payment provided under the year-three of the transition.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 4/25/17

/s/
Seema Verma
Administrator
Centers for Medicare & Medicaid Services