CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Sutter Auburn Faith Hospital	**Provider Cost Reimbursement for Cost Reporting Period Ending: 12/31/2004**
Provider	
vs.	
Cahaba Safeguard Administrators, LLC	**Review of: PRRB Dec. No. 2015-D28**
Medicare Contractor	**Dated: September 28, 2015**

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 mandated in §1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. §1395oo(f)). The Center for Medicare submitted comments, requesting that the Board's decision be reversed regarding jurisdiction. Subsequently, the parties were notified of the Administrator's intention to review. The Provider submitted comments, requesting that the Board's decision be affirmed. The Medicare Contractor submitted comments, requesting that the Board's decision be reversed. Accordingly, this case is now before the Administrator for final agency review.

ISSUE

At issue was whether the Board had jurisdiction to review the Medicare Contractor's determination of the low-income patient (LIP) adjustment for the 2004 fiscal year (FY) for the inpatient rehabilitation facility (IRF).

BOARD DECISION

The Board concluded that it had jurisdiction to hear the LIP adjustment issues. The Board noted that CMS Ruling 1498-R requires recalculation of the Medicare disproportionate share hospital (DSH) Social Security Income (SSI) fraction component of the DSH payment percentage, and, consistent with that Ruling, CMS has issued revised SSI percentages for all hospitals for both DSH and LIP adjustment

calculation purposes. Thus, the Board remanded this issue back to the Medicare Contractor for recalculation of the Provider's LIP adjustment for FY 2005 using the Provider's most recently updated SSI percentage published by CMS.

The Board first looked at the statutory provision prohibiting certain judicial and administrative review, and noted that the statute only to the "establishment" of case mix groups, the prospective payment rates under paragraph (3), outlier and special payments under paragraph (4), and area wage adjustments under paragraph (6) Thus, the Board concluded that the statute only prohibits administrative review of the establishment of both the IRF-PPS payment rates and of certain enumerated adjustment to those rates. The Board recognized that the Administrator had reversed the Board's decision in a previous case, *Mercy Hospital v. First Coast Service Options, Inc.*[1], regarding this issue, but stated that it disagreed with the Administrator's decision.

The Board argued that the phrase "the prospective payment rates under paragraph (3)" as used in § 1886(j)(8) does not encompass all of paragraph (3), but instead is limited to the general Federal "rates" before they are "adjusted" by the items enumerated in clauses (i) to (v) of paragraph (3)(A). The Board noted that the adjustments enumerated in these clauses include the LIP adjustment that the Secretary established pursuant to the discretionary authority granted under clause (v). The Board found that § 1886(j)(8)(D) specifically prohibits administrative review of the area wage adjustment. If the phrase "the prospective payment rates under paragraph (3)" in § 1886(j)(8)(B) were interpreted to encompass both the general Federal rate established in Paragraph (3) and any and all adjustments specified in Paragraph (3), the specific prohibition on administrative review of the area wage adjustment in § 1886(j)(8)(D) would be redundant and superfluous. Such a prohibition would already be encompassed by the reference to Paragraph (3) in § 1886(j)(8)(B). The Board noted that the Administrator's interpretation articulated in the *Mercy* decision would also render other references in subsection (j), including outliers and special payments in paragraph (C) of (j)(8) "redundant and equally nonsensical".

The Board noted that the phrase "the prospective payment rates under paragraph (3)" as used in § 1886(j)(8)(D) is used again almost verbatim in § 1886(j)(6) concerning the area wage adjustment, and that paragraph (6) states that the Secretary "shall adjust . . . the prospective payment rates computed under paragraph (3) for area differences in wage levels." The Board argued that, by interpreting the term "the prospective rates under paragraph (3)" to include both the general Federal rates and

[1] PRRB Dec. No. 2015-D7 (April 3, 2015). The Administrator issued a decision on June 1, 2015, vacating and dismissing the Board's decision

any and all adjustments named in paragraph (3)(A), including but not limited to the area wage adjustment specified in clause (iii) of paragraph (3)(A), the directive in paragraph 6 to "adjust…the prospective payment rates computed under paragraph (3) for area differences in wage levels" would be "nonsensical". That interpretation would necessarily mean that the Secretary was to adjust the "prospective payment rates under paragraph (3)" for the area wage adjustment notwithstanding that the term "prospective payment rates under paragraph (3)" already includes the area wage adjustment. Thus, the Board concluded that the statutory drafters intended to limit review of only certain adjustments to the Federal rate and specifically itemized those adjustments in (j)(8).

The Board also found the use of the word "establishment" in § 1886(j)(8), which prohibits administrative or judicial review of the establishment of the items listed in Subparagraphs (A) to (D), to be significant. The Board noted that the Provider was not challenging "the establishment of" either the Federal rates or "the establishment of" the LIP adjustment to those rates, as the appeal challenged no part of the August 2001 Final Rule in which the Secretary established the LIP adjustment itself (*i.e.*, the formula used to calculate the adjustment). Rather, the challenge was to whether the Medicare Contractor properly executed the LIP adjustment, specifically, whether the Medicare Contractor's calculation of the LIP adjustment used the proper provider-specific data elements in that calculation. The Board stated that it could find no prohibition to administrative or judicial review of "the calculation of" the LIP adjustment where the focus is on the accuracy of the provider-specific data elements being used in the LIP adjustment calculation, and noted that the Administrator's decision in *Mercy* fails to address this distinction.

The Board stated that § 1886(j)(3)(A)(v) specifically gives discretion to the Secretary to adjust the IRF-PPS rates by "other factors" which she determines to be necessary to properly reflect variation in the costs of treatment among IRFs, and that the LIP adjustment is one of the "other factors" that the Secretary created. The Board noted that when Congress limited providers' appeal rights, it specifically limited review over certain factors, but that 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). The Board found that Congress could have precluded review of all of the adjustments to the IRF-PPS rates that are used to calculate the provider-specific payments rates for each IRF, but did not do so.

The Board stated that the regulation likewise limits review only to the "unadjusted" Federal payment rate. The Board noted that the term "unadjusted Federal rate" is defined in 42 C.F.R. § 412.624(c) and it does not include any of the adjustments discussed in § 412.624(e), including the LIP adjustment. The Board stated that 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. Thus, the Board found that during the period at issue, that neither the statute nor the regulation, precluded review of the LIP adjustment. The Board concluded 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 CMS did not specify any retroactive application of the changes to § 412.630. Thus, the Board concluded that it had jurisdiction to hear LIP adjustment issues.

The Board then noted that CMS Ruling 1498-R requires recalculation of the Medicare DSH SSI fraction component of the DSH payment percentage, and, consistent with that Ruling, CMS has issued revised SSI percentages for all hospitals for both DSH and LIP adjustment calculation purposes.[2] Thus, the Board remanded the issue to the Medicare Contractor to recalculate the Provider's LIP adjustment for FY 2004 using the Provider's most recently updated SSI percentage published by CMS.

SUMMARY OF COMMENTS

The Provider commented, requesting that the Board's decision be affirmed. The Provider stated that the matter in this case is not a component of the IRF-PPS Federal

[2] The Board cited to CMS MLN Matters No. SE1225 (which the Board incorrectly identified as SE122), entitled "The Supplemental Security Income (SSI) Ratios for Fiscal Year (FY) 2006 through FY 2009 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)", which was released June 22, 2012. This article gave notice that CMS had posted SSI Ratios for FYs 2006, 2007, 2008 and 2009 to the CMS website, and that these SSI ratios included Medicare Advantage (MA) patient days, and were calculated in the manner prescribed by CMS-1498-R. The article further noted that the SSI ratios were to be used for settlement purposes for IPPS and IRFs eligible for a Medicare DSH payment or low income payment adjustment. The FY 2006 SSI ratios were to be used to settle cost reports with cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006. The FY 2007 SSI ratios were to be used to settle cost reports with cost reporting periods beginning on or after October 1, 2006 and before October 1, 2007. The FY 2008 SSI ratios were to be used to settle cost reports with cost reporting periods beginning on or after October 1, 2007 and before October 1, 2008. The FY 2009 SSI ratios were to be used to settle cost reports with cost reporting periods beginning on or after October 1, 2008 and before October 1, 2009. However, the cost reporting period at issue in this case is for the period ending December 31, 2004. Thus, this article and the accompanying adjustments are not controlling.

specific rate, and that it is not disputing the unadjusted Federal rates. Instead, the Provider is maintaining that it be allowed to dispute and challenge the accuracy of the Provider specific SSI and Medicaid days components used in the IRF LIP adjustment to the federal rates.

The Provider argued that the statute covering IRF payments does preclude review of several aspects of the IRF payment system, but that not every component that comprises the IRF payment is exempt from review. The Provider argued that the hospital specific elements that determine the IRF (DSH) LIP payment amounts are subject to review, as the Board properly determined, and that the statute does not preclude review of the LIP. The Provider noted that the Secretary interpreted the preclusion in its rulemaking published August 7, 2001, clearly stating that the statutory preclusion from review applied only to "the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index."[3] The Provider pointed out that the LIP adjustment was not included as being exempt from review. The Provider challenged that, if the LIP adjustment was also exempt from review, then no part of the payment is subject to review. Congress and the Secretary could have simply stated that no part of the IRF rate was subject to review. Thus, the Provider argued, it is only those specifically identified unadjusted Federal rates that were precluded from review, however, other components of the IRF payment, including the IRF LIP payment, are subject to review.

The Provider noted that, while CMS in August 2013[4] removed "unadjusted" from the regulation in an attempt to clarify, it would not be relevant to this case because the CMS deletion of the word "unadjusted" became effective October 1, 2013, after the cost period at issue in this case. The Provider argued that CMS admitted in its own rulemaking that the original statute and regulation were ambiguous, and that for over 10 years, CMS allowed review of LIP adjustments. The Provider claimed that CMS could not retroactively apply this policy change. The Provider recognized that an agency is generally granted much deference to interpret its own statutes. However, retroactive application of CMS rulemaking is improper in this case, because the statutory language must be deemed to be ambiguous by CMS' own admission, rulemaking and actions of over 10 years. The Provider maintained that the SSI ratio and Medicaid days used in the IRF LIP adjustment must be based upon accurate and complete data. The Provider pointed to *Allina Health Svcs. v. Sebelius*, contending that the Secretary is precluded from "grossly twisting the plain and clear language of statute and intent of congress to suite some new preference".

---

[3] 66 Fed. Reg. 41,369.

[4] 78 Fed. Reg. 47,860, 47,900.

The Provider emphasized that the State of California does not allow DSH Medicaid eligibility verification testing until 13 months after the Provider's fiscal year end, which is eight months after the five month cost report submission due date. The Provider maintained that the Medicare Contractor is required to review and revise the Provider's IRF LIP Medicaid eligible days to reflect data that was not available from the State prior to the cost report filing deadline.

The Provider stated that the Secretary created the LIP adjustment as well as the teaching and rural adjustments based on the statute noting that the IRF PPS rates were to be adjusted "by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." The Provider noted that these adjustments include a prospectively determined factor but also include hospital-specific components, and that for interim payment purposes, the hospital specific components are often adjusted upon final settlement of the submitted cost report. The Provider argued that hospital specific factors come with well-established definitions and administrative and judicial review rights, and that preclusion of review would not apply to variable hospital-specific rates which are set on an interim basis and adjusted retrospectively upon audit and with the issuance of a final settlement. The Provider noted that the SSI factor and Medicaid eligible days have been subject to appeal and review for decades and the IRF LIP adjustment has been appealed and reviewed for over a decade. The Provider stated that the IRF LIP adjustment is not a prospectively set number or estimate determined by the Secretary, and that a provider can be dissatisfied with the SSI ratio and Medicaid eligible days used in the final settlement. The Provider pointed out that without the ability to be dissatisfied, a Medicare Contractor could potentially eliminate the SSI ratio and all Medicaid eligible days or understate the Medicaid eligible days, and a provider would have no recourse to correct the inaccurate data or known errors.

The Provider also contended that, pursuant to the *Mendenhall* doctrine, once a governmental agency is aware of the correct facts, it represent bad faith to refuse to respond appropriately to those facts.[5] The Provider argued that it was improper for the Medicare Contractor to take advantage of a known error once it was pointed out by the Provider, and that it was also improper for the Medicare Contractor to deny valid reimbursement once the error has been pointed out.

The Medicare Contractor commented, recommending that the Administrator reverse the Board's decision in this case for the same reasons *Mercy Hospital, supra,* was reversed.

---

[5] *Mendenhall v. Nat'l Transp. Safety Board*, 92 F.3d 871 (9th Cir. 1996).

The Center for Medicare (CM) commented, stating that it disagreed with the Board's decision that it had jurisdiction.[6] CM stated that the means of calculating an inpatient rehabilitation facility's LIP adjustment, including the formula required in order to calculate the adjustment, is an integral part of setting an inpatient rehabilitation facility's payment rate. Thus, CM noted, the calculated rate and the statutory and regulatory means of calculating that rate, including the LIP adjustment, are precluded from administrative and judicial review by the preclusion provision in § 1886(j)(8) of the Social Security Act.

CM stated that the Provider was challenging its FY 2004 rate, the formula used to calculate its FY 2004 rate (specifically, the use of an SSI ratio based on the provider's cost reporting period rather than the Federal fiscal year). CM pointed out that, as per the statute, the prospective payment rate for each year is calculated by adjusting cost data to properly reflect variations in the necessary costs of treatment, and that the LIP is one of those adjustments. CM stated that there is no reasonable way to read the preclusion in § 1886(j)(8)(B) of the Act as allowing for administrative review of the LIP adjustment, and that the reference in § 1886(j)(8)(B) to § 1886(j)(3), in the absence of any modifying language, necessarily includes all of § 1886(j)(3), including the underlying clauses and adjustments that go into the "payment rate".

CM noted, that while the Board suggested that the preclusion of review only applied to the unadjusted prospective payment rates", that is not the language of the statute. CM pointed out that, had Congress intended to limit the preclusion to the "unadjusted payment rate", it could have unambiguously done so by referring in § 1886(j)(8)(B) to the "unadjusted prospective payment rates under paragraph (3)". Congress used that construction in several places regarding standard Federal capital payment rates in § 1886(g)(l)(A). CM further noted that Congress used the term "per-payment-unit amount" to mean the unadjusted rate, distinguishable from "the prospective payment rate", which is adjusted in various ways.

CM stated that based on a plain reading of the statute, the statutory reference to "paragraph (3)," in the absence of any modifying language, should be construed to refer to paragraph (3) in its entirety, including the underlying clauses. CM pointed out that such a reading does not render the reference to the area wage adjustment in § 1886(j)(8)(D) meaningless. CM noted that § 1886(j)(6) sets the periodicity with which the wage index must be reset, and imposes a budget neutrality requirement on the wage adjustment factor. Had Congress not included § 1886(j)(6) within the preclusion in § 1886(j)(8), CM noted, providers might have argued that review of the

[6] CM also commented on the appropriate SSI ratio for calculating the LIP adjustment. CM noted that these comments were only to be construed "if the merits of the case were properly before the Board".

specific requirements in § 1886(j)(6) was allowed even though review of the payment rates were not. CM argued that the most precise interpretation of the statute is that Congress intended to entirely preclude review of the payment rates (which is the adjusted average cost) and the specific requirements in §§ 1886(j)(2), (4), and (6).

CM also disagreed with any implication that a poorly drafted 42 C.F.R. § 412.630 could have narrowed the breadth of preclusion established under § 1886(j)(8)(B). The Board noted the FY 2014 IRF PPS final rule clarification "to honor the full breadth of the preclusion of administrative and judicial review provided by section 1886(j)(8) of the Act"[7] as evidence that LIP adjustment calculations were not subject to preclusion prior to October 1, 2013. CM stated that CMS has never read 42 C.F.R. § 412.630 as anything less than what was available under the statute. The preamble to the FY 2014 IRF PPS final rule stated, "the LIP adjustment falls squarely within the statutory preclusion of review", and "[t]he preclusion of review has been effective since its enactment as part of the IRF prospective payment system in 2002"[8]. CM stated that, to the extent that the regulation could be construed to have permitted review where it would otherwise have been precluded by statute, the broader statutory preclusion must be given effect over the regulation.

Finally, CM stated, the preclusion applies to all aspects of the IRF PPS payment rates, not just the formulas, and courts[9] have applied nearly identical preclusion provisions in other parts of the Medicare statute to prevent review of all subsidiary aspects of the matter or determination protected from review. Consistent with this rationale, allowing review of a provider's challenge to the prospective payment rate established under § 1886(j)(3), regardless of the provider's characterization of its challenge, would not give adequate effect to the preclusion of review set forth in § 1886(j)(8)(B) of the Act.

DISCUSSION

Section 1886(d)(l)(B) of the Social Security Act (the Act) and Part 412 of the Medicare regulations define a Medicare certified hospital that is paid under the inpatient (acute care hospital) prospective payment system (IPPS). However, the statute and regulations also provide for the classification of special types of Medicare certified hospitals that are excluded from payment under the IPPS. These special types of hospitals must meet the criteria specified at subpart B of Part 412 of the Medicare regulations. Failure to meet any of these criteria results in the termination

---

[7] 78 Fed. Reg. 47,860, 47,900.

[8] *Id.* at 47,901.

[9] CM cited to *Am. Soc. Of Anesthesiologists v. Shalala*, 90 F. Supp. 2d 973, 975-76 (Mar. 31, 2000).

of the special classification, and the facility reverts to an acute care inpatient hospital or unit that is paid under the IPPS in accordance with all applicable Medicare certification and State licensing requirements.

One of the special types of hospitals excluded from the IPPS is an inpatient rehabilitation facility (IRF). The inpatient rehabilitation facility, or IRF, is an inpatient rehabilitation hospital or a unit, which provides an intensive rehabilitation program to inpatients. IRFs provide skilled nursing care to inpatients on a 24-hour basis, under the supervision of a doctor and a registered professional nurse. The IRF benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.[10]

Pursuant to § 4421 of the Balanced Budget Act of 1997[11], Congress established the IRF PPS for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act authorized the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals (or Critical Access Hospitals [CAHs]), collectively known as IRFs. As required by § 1886(j) of the Act, the Federal rates reflect all costs of furnishing IRF services (routine, ancillary, and capital related). With respect to the "prospective payment rates", § 1886(j)(3) of the Act states:

> (3) *Payment rate*.-
>
> (A) *In general*.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—
>
> (i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the

[10] *See* Medicare Benefits Manual section 110.
[11] Pub Law No. 105-33.

> midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;
>
> (ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);
>
> (iii) for variations among rehabilitation facilities by area under paragraph *(6)*;
>
> (iv) by the weighting factors established under paragraph (2)(B); and
>
> (v) *by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities*. (Emphasis added.)

Further § 1886(j)(6) sets forth the area wage adjustment:

> 6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

Thus, while the payment rate paragraph at § 1886(j)(3) cross references the wage area provision as an adjustment, § 1886(j)(6) in detail specifies the wage area

adjustment and the requirements of its productivity and budget neutrality components.

In implementing the Federal payment rates, the Secretary promulgated regulations at 42 C.F.R. § 412.624, which state that:

> (e) Calculation of the adjusted Federal prospective payment. For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate that is in effect for its cost reporting period that begins in a Federal fiscal year specified under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:
>
> (1) Adjustment for area wage levels. The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602. Adjustments or updates to the wage data used to adjust a facility's Federal prospective payment rate under paragraph (e)(l) of this section will be made in a budget neutral manner. CMS determines a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.
>
> (2) 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.

The regulation provision at 42 C.F.R. § 412.624(e)(2) providing for the LIP adjustment was authorized pursuant to § 1886(j)(3)(A)(v) of the Act. The Secretary, in explaining the methodology, stated that:

> We proposed 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. The low-income payment adjustment we chose improves the explanatory power of the IRF prospective payment system because as a facility's percentage of low-income patients increases, there is an incremental increase in a facility's costs. We proposed to adjust payments for each facility to

> reflect the facility's percentage of low-income patients using the DSH measure.[12]

In creating new paragraph (j), Congress also specified that there was a limitation on administrative and judicial review with respect to the IRF PPS payment rates. Specifically, § 1886(j)(8) of the Act[13] provides:

> (8) Limitation on review.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—
>
> > (A) case mix groups, of the methodology for the classification of patients within such groups, and of 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).

In originally promulgating the regulation at 42 C.F.R. § 412.630, the proposed § 412.630 specified that 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 factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index. The regulation at 42 C.F.R. § 412.630 stated regarding the "Limitation on Review" that:

> Administrative or judicial review under sections 1.869 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 factors, the unadjusted Federal per discharge

---

[12] 66 Fed. Reg. 41,316, 41,359 (August 7, 2001).

[13] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 1886(j)(7) of the Act to section 1886(j)(8) and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs.

> payment rates, additional payments for outliers and special payments, and the area wage index.

However, in the FFY 2014 Final IRF rule, consistent with the proposed rule pronouncement,[14] the Secretary clarified the language of 42 C.F.R. § 412.630 to be in full accord and accurately reflect the scope of § 1886(j)(8) of the Act. The Secretary explained that:

> XII. Clarification of the Regulations at § 412.630
>
> In the original rule establishing a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital, we stated that that there would be no administrative or judicial review, under sections 1869 and 1878 of the Act or otherwise, of the establishment of

[14] *See* IRF PPS FFY 2014 proposed rule at 78 Fed. Reg. 26,880, 26,908 (May 8, 2013) ("XI. Proposed Clarification of the Regulations at §412.630 In the original rule establishing a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital, we stated that that there would be no administrative or judicial review, under sections 1869 and 1878 of the Act or otherwise, of the establishment of case-mix groups, the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments. *See* 66 FR 41316, 41319 (August 7, 2001). Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. However, the regulatory text reflecting the preclusion of review has been at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act. Because we interpret the preclusion of review at section 1886(j)(8) of the Act to apply to all payments authorized under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are proposing to clarify our regulation at§ 412.630 by deleting the word "unadjusted" so that the regulation would clearly preclude review of "the Federal per discharge payment rates.' This clarification will better conform the regulation to the statutory language. As such, in accordance with sections 1886(j)(7)(A), (B), and (C) of the Act, we are proposing to revise the regulations at § 412.630 to clarify that administrative or judicial review under sections 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 factors, the federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.")

> case-mix groups, the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments. See FY 2002 IRF PPS final rule (66 FR 41316, 41319). Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. However, the regulatory text reflecting the preclusion of review has been at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act. Because we interpret the preclusion of review at § 1886(j)(8) of the Act to apply to all payments authorized under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are clarifying our regulation at §412.630 by deleting the word "unadjusted" so that the regulation will clearly preclude review of "the Federal per discharge payment rates." This clarification will provide for better conformity between the regulation and the statutory language.
>
> As such, in accordance with sections 1886(j)(7)(A), (B), and (C) of the Act, we are revising the regulations at § 412.630 to clarify that administrative or judicial review under sections 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 factors, the federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

The Secretary specifically addressed the characterization of the change as a clarification of the regulation at 42 C.F.R. § 412.630, stating that:

> We received two comments on the proposed clarification of the regulations at § 412.630, which are summarized below.
>
> Comment: The commenters expressed concerns with our proposal to revise the regulations at 42 C.F.R. 412.630 to clarify that the Medicare statute precludes administrative and judicial review of the Federal per discharge payment rates, including the LIP adjustment. One commenter stated that the proposal is not a "clarification" that can be applied to pending cases, is inconsistent with the statute, runs afoul of the presumption of judicial review, fails to give proper notice of the regulatory change, and is unconstitutional.

Response: We disagree with the commenter's statements. Our proposed change serves to clarify the regulation so that it clearly reflects the preclusion of review found in the statute. It also removes any doubt as to the conformity of the regulation to the preclusion of review found in the statute, which by its own terms is applicable to all pending cases regardless of whether it is reflected in regulations or not.

We also strongly disagree with the commenter's reading of the statute. Section 1886(j)(8) of the statute broadly precludes review of "the prospective payment rates under paragraph (3)," that is, section 1886(j)(3). Within this section, subsection 1886(j)(3)(A) authorizes certain adjustments to the IRF payment rates and, within that, subsection 1886(j)(3)(A)(v) authorizes adjustments to the rates by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." The LIP adjustment is made under authority of section 1886(j)(3)(A)(v). As that provision is contained within section 1886(j)(3), and the IRF payment rates under section 1886(j)(3) are precluded from review by section 1886(j)(8), the LIP adjustment falls squarely within the statutory preclusion of review. Such preclusion overcomes any presumption of reviewability that might generally apply, and it is not unconstitutional for Congress (which has the power to define the jurisdiction of the federal courts) to preclude review of certain issues as it has done here. Several virtually identical preclusions of review in other sections of the Medicare statute have been repeatedly upheld and applied by federal courts. Finally, as to notice, the proposed rule itself served as notice of our intention to revise the regulation. In addition, as discussed below, the longstanding language of the statute itself provides sufficient notice to apply the preclusion.

Comment: One commenter stated that our proposal cannot be a clarification because we have allowed review of matters concerning the LIP adjustment for many years. This commenter further stated that any preclusion of review should apply only to the "formulas" used in the IRF payment rates, and that to preclude review would prevent providers from correcting errors in their payments and would result in two separate methods being used to pay IRFs and hospitals paid under the inpatient prospective payment system (IPPS).

Response: We disagree with these comments. The preclusion of review has been effective since its enactment as part of the IRF

> prospective payment system in 2002. No regulation or revision of any regulation was necessary for the statutory preclusion to become effective, regardless of whether we or our contractors may have participated in review of IRF LIP matters in the past without making a jurisdictional objection. To the extent that such erroneous participation may have occurred, it does not override the mandate of the statute or prevent us from immediately applying the statutory preclusion of review.
>
> In addition, the preclusion applies to all aspects of the IRF PPS payment rates, not just the formulas. Courts have applied nearly identical preclusion provisions in other parts of the Medicare statute to prevent review of all subsidiary aspects of the matter or determination protected from review. Finally, while precluding review of the IRF LIP adjustment may prevent correction of certain errors, we can only conclude that Congress has made the judgment that such a result is an appropriate trade-off for the gains in efficiency and finality that are achieved by precluding review. Similarly, although applying the preclusion here may result in certain questions being reviewable for an IPPS hospital but not an IRF, this is a judgment that Congress has made. We note that there is a preclusion of review provision in the IPPS statute also, at section 1886(d)(7). The precise contours of these preclusive provisions were for Congress to draw.
>
> Final Decision: After careful review of the comments we received on the clarification of the regulations at §412.630, we are adopting our proposal to revise the regulations at 42 CFR 412.630 to clarify that the Medicare statute precludes administrative and judicial review of the Federal per discharge payment rates under section 1886(j)(3), including the LIP adjustment. This revision to the regulation is effective October 1, 2013.

Thus 42 C.F.R. § 412.630 was revised to read as follows:

> Limitation on review.
>
> Administrative or judicial review under sections 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 factors, the Federal per discharge payment rates,

> additional payments for outliers and special payments, and the area wage index.[15]

The Administrator finds that the determination at issue in this case is integral to the calculation of the Federal per discharge payment rate. The LIP is authorized under § 1886(j)(3)(A)(v) of the Act and is a component of the Federal per discharge payment rate as authorized under § 1886(j)(3) of the Act. Section 1886(j)(8)(B) of the Act specifically prohibits the administrative or judicial review under § 1878 of the Act of the "payment rate as provided for under paragraph (3) [section 1886(j)(3)]". As § 1886(j)(8) precludes review of matters under paragraph (3) and the LIP calculation is provided for under paragraph (3), administrative and judicial review is precluded of that matter.

Moreover, not only does the plain language of the statute support that Congress intended no review under the facts set forth in this case, but regardless of the Provider's characterization of its challenge, allowing review would render section 1886(j)(8)(B) of the Act void, as noted by several courts under similar situations. Courts have applied nearly similar preclusion provisions in other parts of the Medicare statute to prevent review of all subsidiary aspects of the matter or determination protected from review.[16] Thus, the Administrator finds that the appeal

---

[15] 78 Fed. Reg. 47933.

[16] *See, e.g., Am. Soc. of Anesthesiologists v. Shalala*, 90 F.Supp.2d 973, 975 (March 31, 2000) ("…[T]he 'strong presumption that Congress intends judicial review of administrative action'…comes into play only where there is a legitimate question as to congressional intent…there is no room for employing that presumption approach where…Congress has been so explicit in stating a prohibition against judicial review.") In *Am. Soc. Of Anesthesiologists*, the Associations were arguing that there was a dichotomy between nonreviewable matters and reviewable matters. As the Court noted, "…it simply will not do for Associations to say 'Oh, we're only challenging Secretary's decisions that must be made before the relative value and relative value unit determinations'… If Associations' position were accepted, the congressional mandate against court intervention would be totally frustrated, because the opportunity for parties such as Associations to launch in-court attacks on the individual strands—the specific items—that are both integral and essential components of the congressionally-protected determinations that Secretary must make would defeat her ability to make the determinations themselves." *See also Fischer v. Berwick*, Slip Copy, 2012 WL 1655320, D.Md.,2012 (May 09, 2012), *aff'd*, 2013 WL 59528, 4th Cir. (Md.) (Jan 07, 2013). *See also Am. Soc'y of Cataract & Refractive Surgery v. Thompson*, 279 F. 3d 447 , 452 (7th Cir. 2002); *Skagit Cnty. Pub. Hosp.. Dist. No. 2 v. Shalala*,. 80 F3d 379 (9th Cir 1996).

raised in this case falls under the statutory bar to limitations on review of section 1886(j)(8) of the Act.

The Administrator also finds that the regulatory change clarified the regulation when removing the inadvertently included term "unadjusted" and thoroughly discussed and explained that this was not a new policy. The preclusion of review is mandated by the statute, which by its own terms, is applicable to all pending cases. Just as the Secretary cannot limit Board jurisdiction prescribed by Congress, the Secretary cannot expand Board jurisdiction specifically precluded by Congress. A reading of the regulation to do so would be contrary to the clear mandated prohibition set forth at section 1886(j)(8) of the Act. While the Provider argued that it was past policy to allow for adjustments to the LIP, the Administrator points to the Federal Register discussion which clearly noted that "The preclusion of review has been effective since its enactment as part of the IRF prospective payment system in 2002." Additionally, as noted, "To the extent that such erroneous participation may have occurred, it does not override the mandate of the statute or prevent us from immediately applying the statutory preclusion of review."

Likewise, any administrative resolution in prior cases pursuant to the appeal mechanism of § 1878 of the Act by the MACs and/or CMS would not have been authorized by the statute and does not alter the plain reading of the statute prohibiting such review, nor authorize review in this case.[17] Such does not constitute a practice that can override the plain language of the statute and confer jurisdiction where the statute specifically prohibits jurisdiction for administrative and judicial review.

The interpretation of the statute adopted by the Board is contrary to the plain language of the statute. The Board asserts that only the specific adjustments listed in section 1886(j)(8)(A), (C) and (D) are precluded from review. The Board found that if Congress intended the adjustments cross-referenced under paragraph (3) to be shielded from review it would have been unnecessary to set forth the specific preclusion of certain adjustments at section 1886(j)(8)(A), (C) and (D) of the Act. But that presumes, among other things, these references are identical, perform the same purpose and function and, hence, are redundant. For example, while section

[17] Further, the inadvertent granting of jurisdiction in an administrative proceeding, on a matter where none exist, is not a bar to the correction of that error by the agency before the courts in that case. *See, e.g., Florida Health Science v. Secretary,* Civil Action No. 14-0791(ABJ) at n. 3 (March 31, 2015)(where the Board had granted jurisdiction). Similarly, the inadvertent granting of jurisdiction in an earlier administrative proceeding, where none exist, does not prohibit the assertion of a jurisdictional bar in a later case. This would be contrary to the general administrative law principle that an administrative agency cannot enlarge its own jurisdiction.

1886(j)(3)((A)(iv) refers to the adjustment for case mix and weighting factors under section 1886(j)(2)(B) being applied, the case mix provision at (2) includes paragraphs (A) and (C). In addition, as CM pointed out, if Congress had not included § 1886(j)(6) within the preclusion in 1886(j)(8), providers might have argued that review of the specific requirements in § 1886(j)(b) were allowed even though review of the payment rates were not.[18]

Regarding the Board's contention that the Provider in this case is not challenging the "establishment" of the LIP adjustment, but rather, whether the Medicare Contractor used the proper provider-specific data elements in the calculation of the LIP adjustment, the Administrator notes that even allowing review of the methodology used would render § 1886(j)(8)(B) virtually ineffectual.[19] Thus, the Administrator finds that the appeal falls under the statutory bar to limitations on review.[20]

[18] While the Board points to review allowed of quality reporting required at paragraph (7), that provision is not incorporated under paragraph (3) and stands alone as a requirement.

[19] *See supra* n. 16.

[20] As jurisdiction is not properly exercised in this case, the merits of the dispute are not properly before the Administrator.

DECISION

The Administrator vacates the Board's decision in accordance with the foregoing decision.

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

Date: 11/18/15

/s/

Patrick H. Conway, M.D., MSc
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services