CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Santa Rosa Memorial Hospital	**Provider Cost Reimbursement for Cost Reporting Period Ending: 06/30/2008**
Provider	
vs.	
Cahaba Safeguard Administrators, LLC	**Review of: PRRB Dec. No. 2017-D26**
Medicare Contractor	**Dated: September 8, 2017**

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 set forth in §1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. §1395oo(f)). The parties were notified of the Administrator's own motion review of the case. The Center for Medicare submitted comments, stating that it disagreed with the Board's decision, and that the case is precluded from review. The Medicare Contractor submitted comments, requesting that the Board's decision be reversed. The Provider submitted comments, requesting that the Administrator uphold the decision of the Board. Accordingly, this case is now before the Administrator for final agency review.

ISSUE

At issue is whether the Board has jurisdiction to review the Medicare Contractor's determination of the low-income patient (LIP) adjustment for the Provider for the 2008 fiscal years (FY).

BOARD DECISION

The Board concluded that it had jurisdiction to review the Medicare Contractor's determination of the LIP adjustment, including the understatement of the LIP Medical eligible days. Finding jurisdiction, the Board remanded the matter to the Medicare

Contractor to audit the Providers' LIP Medicaid eligible days using the documentation submitted and recalculate the Provider's LIP adjustment for FY 2008.

The Board concluded that the statute prohibiting administrative review applies only to the establishment of the inpatient rehabilitation facility (IRF) prospective payment system (PPS) payment rates under § 1886(j)(3) of the Act and certain enumerated adjustments to those rates as specified in §§ 1886(j)(2), (4), and (6). The Board found that the Secretary's use of the term "the unadjusted Federal rate" as defined in 42 C.F.R. § 412.624(c) significantly limits what is precluded from review, and that the LIP adjustment discussed in § 412.624(e) is not precluded from review.[1]

The Board noted that in the August 6, 2013 Final Rule, the Secretary expanded the list of adjustments precluded from review by § 412.630 and included the LIP adjustment. The Board stated that it has consistently taken the position that these regulatory changes were not effective until October 1, 2013 and that the Secretary made no provision for the retroactive application of the changes to § 412.630.[2] Thus, the Board noted that, consistent with its earlier decisions[3], it found that, neither the statute, nor the regulation precluded the administrative or judicial review of the LIP adjustment during the period at issue in this appeal.

The Board argued that its position related to jurisdiction over the number of Medicaid eligible days in this case was consistent with the Courts position in *Mercy Hosp., Inc. v. Burwell*, in which the provider argued that if the limitation on review were as broad as the Secretary urges, there would be nothing for inpatient rehabilitation providers to challenge. In response to this, the court in *Mercy* stated:

> But the Secretary's interpretation does not leave inpatient rehabilitation providers with *nothing* to appeal. Suppose that a contractor failed to account for a number of patients altogether, proposing reimbursement for 475 Medicare beneficiaries instead of the 600 Medicare beneficiaries that the provider believed it had treated. A challenge to the contractor's decision to exclude those 125 patients would ***not*** be a challenge to the prospective payment rates, and so would not be barred by paragraph (8)'s limitation on review.[4]

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[1] The Board cited to *St. Joseph Hosp. of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D04 (Dec. 2, 2015) (*Vacated* by the Administrator, Jan. 20, 2016).

[2] The Board cited to 78 Fed. Reg. at 47860, 47901 (stating at 47901 that "the statute . . . is applicable to all pending cases regardless of whether it is reflected in regulations or not"), and *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).

[3] The Board cited to *St. Joseph Hosp. of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D04 (Dec. 2, 2015) (*Vacated* by the Administrator, Jan. 20, 2016)., and *Sutter Auburn Faith Hosp. v. Cahaba Safeguard Adm'rs, LLC*, PRRB Dec. No. 2015-D27 (Sept. 24, 2015) (*Vacated* by the Administrator, Nov. 6, 2015).

[4] *Mercy*, 206 F. Supp. 3d at 102.

The Board stated that the Provider was challenging exactly what the *Mercy* Court described as being allowable for purposes of an appeal—i.e., the Medicare Contractor's failure to use an accurate count of Medicaid eligible patient days in the calculation of its LIP adjustment. The Provider protested the number of Medicaid eligible days included on its cost report because it was not able to procure accurate California Medicaid days prior to the cost report filing deadline, and these protested days were removed by the Medicare Contractor prior to issuing the Provider's Notice of Program Reimbursement. The Board concluded that the Provider's appeal was not a challenge to the calculation of the prospective payment rate, but rather, an appeal of the accuracy of the Medicare Contractor's determination of the number of Medicaid eligible patient days. As such, the Board concluded that the Provider's appeal was not barred by the limitation on review.[5]

SUMMARY OF COMMENTS

The Medicare Contractor submitted comments, recommending that the Administrator reverse the Board's decision in this case for the same reasons *Mercy* was reversed. The Medicare Contractor stated that, while the Board asserted that the Provider was challenging what the *Mercy* court described as being allowed for purposes of an appeal, the section of the holding quoted by the Board does not refer to days in the LIP adjustment calculation. Rather, the reasoning cited applies to appeals available to all providers, and clearly, the Medicare Contractor averred, not all providers are subject to the LIP adjustment. The Medicare Contractor noted that the Board omitted the clarifying conclusion of the Court's reasoning in *Mercy*, which continues:

> And even if the Secretary's interpretation of paragraph (8) leaves inpatient rehabilitation facilities with highly circumscribed appeal rights, that is not absurd or contradictory. The statutory provision that lets inpatient rehabilitation facilities seek judicial review, § 1395oo, is a general provision that applies to all types of Medicare providers, not just inpatient rehabilitation facilities. The Secretary's reading of paragraph (8), which is specifically addressed to inpatient rehabilitation facilities, therefore does not create a contradiction.[6]

The Medicare Contractor argued that the *Mercy* Court specifically stated that its example is of the sort that raise appeal rights for "all types of Medicare providers", whereas in this

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[5] The Board noted that, even in the absence of this exception articulated by the court which is applicable in the instant case, it respectfully disagreed with the U.S. District Court for the District of Columbia's decision in *Mercy.* The Board stated that it has been clear in its decisions in regard to this issue and continues to stand by its conclusion that prior to implementation of the August 6, 2013 Final Rule, it had jurisdiction to review the Medicare Contractor's determination of the LIP calculation. *See St. Joseph Hosp. of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D04 (Dec. 2, 2015).

[6] Mercy, 206 F. Supp. 3d at 102.

case the days at issue are only applicable to IRFs. Therefore, the Medicare Contractor pointed out, the Board's reliance on the *Mercy* Court's holding is not applicable in this appeal.

The Center for Medicare (CM) commented, noting that it disagreed with the Board's decision that it had jurisdiction.[7] CM stated that the plain language of the statute expressly precludes administrative or judicial review of the prospective payment rates for IRFs, providing that there shall be "no administrative or judicial review" of the prospective payment rates established under § 1886(j)(3). CM noted that as "prospective payment rates" is simply the value at which one arrives after having made the described calculations (including the aspects of those calculations called "adjustments" as defined in the statue and implementing regulations, the statutory preclusion language would have no effect if it were construed to mean anything other than the resulting value (i.e, the "rate") and the means by which the rate was calculated. CM stated that CMS has always interpreted § 1886(j)(8)(B) as protecting the calculated rate and the means by which the rate was calculated. The rate formula for IRF PPS includes certain statutorily defined adjustments, as well as any adjustments established through rulemaking to account for such "other factors" as may be required to adequately account for cost variation in accordance with § 1886(j)(3)(A)(v) of the Act.

CM stated that the Provider in this appeal is seeking administrative review of the prospective payment rate established under § 1886(j)(3) for FY 2008. Specifically, the Provider asks that the Medicare Contractor be required to recalculate the LIP adjustment for FY 2008 by using an updated Medicaid fraction based on a review and audit of the number of Medicaid eligible days. Thus, CM argued, the Provider is challenging its FY 2008 rate and the inputs to the formula used to calculate its FY 2008 rate. 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

[7] CM also commented that "if the merits of the case were properly before the Board", it would not dispute the Board's ruling regarding the review and audit of the number of Medicaid-eligible days used in the Medicaid fraction of the Provider's FY 2008 LIP adjustment and the recalculation of the Provider's LIP adjustment using the updated Medicaid fraction based on this audit.

construction in several places regarding standard Federal capital payment rates in § 1886(g)(l)(A). CM further noted that Congress has a term that it uses when it wishes to refer to the unadjusted rate, and it is not "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 specific requirements in § 1886(j)(6) was allowed even though review of the payment rates were not. CM argued that the best 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). While 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"[8] 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"[9]. 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[10] 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. CM argued that while precluding review of the IRF LIP adjustment may prevent correction of certain errors, it could only conclude that Congress made the judgment that such a result was an appropriate trade-off for the gains in efficiency and finality that are achieved by precluding review. Finally, CM disagreed with the Board's conclusion that its decision is consistent with the holding in *Mercy*.

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[8] 78 Fed. Reg. 47,860, 47,900.

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

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

With regard to the LIP adjustment there is no meaningful distinction between the appropriate calculation of the SSI fraction (found to be precluded from review in *Mercy*) and the calculation of the Medicaid fraction (found to be reviewable by the Board). 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.

The Provider submitted comments, arguing that the Board has jurisdiction over the appealed LIP adjustments. The Provider stated that the Medicare Contractor argues that LIP adjustments are precluded from administrative review because Paragraph (3) subsection (A)(v) mentions "other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities" and contends that those "factors" include LIP adjustments. The Provider noted that the Medicare Contractor then makes the tenuous inference that § 1886 (j)(8)(B) also precludes administrative review of those adjustments. The Provider argued that this position by the Medicare Contractor is groundless, as there is no specific language within § 1886(j)(8)(B) or Paragraph (3) expressly prohibiting administrative or judicial review as it pertains to LIP adjustments. While § 1886(j)(8) does expressly prohibit the administrative and judicial review of certain establishment aspects of IRF payments, such as case mix groups under Paragraph (2), outlier and special payments under Paragraph (4), area wage adjustments under Paragraph (6); and of course, prospective payment rates under Paragraph (3), the Provider stated, Congress specifically did not include LIP adjustments in that prohibition, though it could have, and thus, the Provider argued, it is improper for the Medicare Contractor to attempt to add meaning to the statute that Congress simply did not intend. The Provider pointed out that Congress chose to only prohibit the administrative or judicial review of the prospective payment rates under Paragraph (3) and stopped short of extending that prohibition to any adjustments applicable to that rate, and argued that had Congress intended to create a sweeping prohibition of PPS rates and applicable adjustments, it would have done so. The Provider argued that the Medicare Contractor failed to present any evidence showing that Congress intended for its prohibition to apply to anything other than what is established on the face of the Medicare Act.

Regarding the Medicare Contractor's position that § 1886(j)(3) serves as a blanket provision that protects unnamed "factors" and adjustments pertaining to PPS rates from administrative and judicial review, and that § 1886(j)(8)(B) should be interpreted to extend the prohibition of administrative and judicial review to both the general federal rate established in Paragraph (3) and any and all adjustments specified in Paragraph (3), the Provider noted that Paragraph (3)(A)(iii) specifically mentions area wage index adjustments under Paragraph (6), an adjustment that is also specifically referenced as being precluded from administrative and judicial review in Section G)(8)(D). Thus, the Provider argued, accepting the Medicare Contractor's position would mean that § 1886(j)(8)(D) was simply unnecessary and that Congress was redundant to include it in its legislation.

Next, the Provider argued that its appeal does not challenge the "establishment" of the prospective payment rate, but rather challenges the Medicare Contractor's execution of the LIP adjustment—specifically whether the Medicare Contractor's calculation of the LIP adjustment was proper in light of the fact that it removed the Provider's protested number of Medicaid eligible days before making its calculation. The Provider stated that the Board correctly noted that 42 C.F.R. § 412.624(c) discusses with great specificity what factors are involved in the "establishment" of the prospective payment rates, and not only defines how the Secretary is to calculate the federal rate but also effectively defines what is precluded from administrative and judicial review. The Provider stated that the LIP adjustment is not included in this limitation, but is instead discussed in 42 C.F.R. § 412.624(e), which includes adjustments the Secretary is to apply to the federal rate after it is established pursuant to subsection (c). Thus, the Provider noted, the Board appropriately found that the LIP adjustment is subject to administrative and judicial review because it is not used to establish the prospective payment rate. Further, the Provider argued that during the relevant year of the Provider's appeal, the regulation specifically established that administrative and judicial review was only limited "with regard to the establishment of the...unadjusted Federal per discharge payment rates…" The Provider noted that as the unadjusted Federal per discharge payment rates obviously do not include LIP adjustments, it is disingenuous for the Medicare Contractor to attempt to extend the limitation on review to an adjustment clearly not contemplated by the regulation. The Provider claimed that while the Medicare Contractor may argue § 1886(j)(8)(B) limits administrative and judicial review of the establishment of prospective payment rates, that argument is of little relevance to this action, as it is not not appealing the establishment of any rate.

Regarding *Mercy Hospital*, the Provider pointed out that while the *Mercy* court did rule narrowly that the Board could not review "the contractor's interpretation of the LIP adjustment" in that particular case, the court's holding does little to limit the Boards jurisdiction in this case, as it is not asking that the Board review the Medicare Contractor's "interpretation" of the LIP adjustment, but instead is seeking review of the Medicare Contractor's decision to simply not use an accurate count of Medicaid eligible patient days in the calculation of the LIP adjustment. The Provider noted that the court in *Mercy* expressly held that hospitals specifically had the right to seek review of such an action as happened in this case,[11] in which the Medicare Contractor removed the protested days prior to issuing the Provider's NPR, despite the fact that the Provider had protested the number of Medicaid eligible days it included on its cost report as California

[11] "Suppose that a contractor failed to account for a number of patients altogether, proposing reimbursement for 475 Medicare beneficiaries instead of the 600 Medicare beneficiaries that the provider believe it had treated. A challenge to the contractor's decision to exclude those 125 patients would not be a challenge to the prospective payment rates and so would not be barred by paragraph (8)'s limitation on review." *Mercy* at 102.

Medicaid could not accurately identify these days prior to the cost report filing deadline. The Provider stated that it is not challenging the calculation of its prospective payment rate, but instead challenging the Medicare Contractor's determination of the number of Medicaid eligible days, and that the *Mercy* court agrees such an appeal is not precluded by the law, and the Board has proper jurisdiction to review the Medicare Contractor's action.

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 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.[12]

Pursuant to § 4421 of the Balanced Budget Act of 1997[13], 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*.-
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> (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

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

> 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—
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> (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 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;
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> (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);
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> (iii) for variations among rehabilitation facilities by area under paragraph *(6)*;
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> (iv) by the weighting factors established under paragraph (2)(B); and
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> (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:
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> (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.
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> (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.[14]

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[15] provides:

> (8) Limitation on review.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—
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> > (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),
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> > (B) the prospective payment rates under paragraph (3),
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> > (C) outlier and special payments under paragraph (4), and
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> > (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 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.

However, in the FFY 2014 Final IRF rule, consistent with the proposed rule pronouncement,[16] the Secretary clarified the language of 42 C.F.R. § 412.630 to be in full

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[14] 66 Fed. Reg. 41,316, 41,359 (August 7, 2001).

[15] 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.

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
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> 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 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

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[16] *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.")

> 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.
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> 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.
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> 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.
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> 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.
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> 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.[17]

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.[18]

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[17] 78 Fed. Reg. 47933.

[18] *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

Thus, the Administrator finds that the appeal raised in this case falls under the statutory bar to limitations on review of section 1886(j)(8) of the Act.

The Administrator notes that in *Mercy Hospital, Inc. v. Burwell*[19], the United States District Court for the District of Columbia agreed with the Secretary that the statute prohibits administrative or judicial review of the contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the Hospital's prospective payment rates.

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.

Regarding the contention that the Provider in this case is not challenging the "establishment" of the LIP adjustment, but rather, whether the Medicare Contractor properly adjusted the number of Medicaid eligible days used to calculate the Provider's LIP adjustment, the Administrator notes that even allowing review of the methodology used would render § 1886(j)(8)(B) virtually ineffectual. Thus, the Administrator finds that the appeal falls under the statutory bar to limitations on review.[20]

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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).

[19] 206 F. Supp. 3d 93, 102 (D.D.C. 2016).

[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: 10/13/2017

/s/

Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services