CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Florida Section 1115 LIP Rehab DSH Waiver Days Groups	**Provider Cost Reimbursement for Cost Reporting Period Ending: Various**
Providers	
vs.	
First Coast Service Options	**Review of: PRRB Dec. No. 2018-D22**
Medicare Contractor	**Dated: February 8, 2018**

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 Providers submitted comments, requesting that the Administrator affirm the Board's Jurisdictional Decision, but set aside the Board's decision on the merits, and remand the case to the Medicare Contractor. The Medicare Contractor submitted comments, requesting that the Administrator vacate the decision of the Board, and dismiss the case for lack of subject matter jurisdiction. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue, as stated by the Board, was whether the Low-Income Pool Section 1115 waiver days should be included in the Medicaid fraction of the Low Income Patient (LIP) calculations for the inpatient rehabilitative facilities (IRFs).

The Board had previously held a consolidated hearing on the Florida Low-Income Pool issue that included group cases for acute care hospitals and group cases for inpatient rehabilitation facilities (IRF). The Board decided the IRF low income patient issue and the acute care hospital DSH issue were distinct as relates to jurisdiction, and thus, issued a separate decision for the acute care hospital group of cases and the IRF group of cases.

The cases under appeal in this decision involved multiple Florida IRS that provided inpatient services to individuals who were uninsured or underinsured, and received payment under a Medicaid § 1115 waiver program known as the Florida Low-Income Pool program. CMS approved the Florida waiver to allow federal Medicaid matching payments to cover some of the costs of services to these individuals. The Providers sought to include the Florida Low-Income Pool inpatient days when calculating the Medicare LIP payments on their cost reports. The Medicare Contractor excluded these days when finalzing the LIP payments for these IRFs for fiscal years 2007-2011 and 2013.

Regarding jurisdiction for the IRF groups in this case, the Board had previously granted jurisdiction for the Providers' LIP adjustments because the providers self-disallowed the § 1115 Low-Income Pool days at issue from their submitted cost reports. The Board found that for the years under appeal, neither§ 1886(j)(8) of the Social Security Act (Act) nor 42 C.F.R. § 412.630 precluded review of the LIP adjustment, as the Statute and regulations only preclude administrative or judicial review 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 payment for outliers and special payments; and the area wage index. The Board stated that, while the Administrator reversed the Board's decision in *Mercy Hosp., Inc. v. Burwell*[1], it remains unconvinced and continues to disagree with the Administrator's overly broad interpretation. The Board noted that as in *Mercy*, it found the LIP adjustment is an adjustment to the Federal rate not specifically enumerated in the adjustments precluded from review. The Board noted that the Providers in this case are not challenging "the establishment of" either the federal rates or "the establishment of" the LIP adjustment to those rates, as the Providers are not challenging any part of the August 2001 Final Rule in which the Secretary established the LIP adjustment.

On the merits, the Board found that the Medicare Contractor's exclusion of Florida Low-Income Pool days from the LIP calculation complied with the 2005 Federal statute and regulations. The Board noted that prior to January 2000, the federal DSH regulation at 42 C.F.R. § 412.106(b)(4) limited the inclusion of patient days for individuals who qualified under a § 1115 waiver who were or could have been made eligible under a State Medicaid plan. CMS expanded this definition in an interim final rule published January 20, 2000 to include "all days attributable to populations eligible for Title XIX matching payments" through a waiver approved under § 1115 of the Social Security Act. Thus, the Board stated, it was clear that under both versions of the regulations, the Secretary intended to limit the inclusion of patient days in the DSH calculation to individuals who became eligible under the terms of the waiver, or who received specific medical services provided under the waiver. The Board found that it was not intended to include payments made to a hospital to compensate it for services provided to an unspecified population whose patient days will be included in the Medicaid fraction.

[1] 206 F. Supp. 3d 93 (D.D.C. 2016)(D.C. Cir. argued Oct. 24, 2017).

SUMMARY OF COMMENTS

The Providers submitted comments, stating that they believed the Board's jurisdictional decision was correct, as the statutory preclusion of review applies only where providers are challenging the establishment of rates, not where providers are challenging the calculation of those rates. The Providers argued that § 1395ww(j)(8) of the Act only prohibits review 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),
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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).

However, the Providers stated, § 1395ww(j)(3)(A)(v) of the Act permits CMS to adjust the underlying IRF PPS payment rate to account for "other factors", including the IRF DSH payment set forth at 42 C.F.R. § 412.624(e)(2). The Providers commented that the Board's holding in this case was consistent with its holding in *Mercy*, in which it found that § 1395ww(j)(8) does not apply because the Providers were not challenging "establishment" of the federal rates or the "establishment" of the LIP adjustment to those rates, but rather, the "calculation" of the LIP adjustment, which is not precluded from review. The Providers noted that the Medicare Contractor, like the Court in *Mercy*, ignores the fact that the "prospective payment rates" established in paragraph (3) are the unadjusted IRF PPS rates, and do not include computation of the IRF DSH adjustment to those rates. The Providers pointed out that the statute does not preclude review of the "other factors", and argued that if Congress had intended to preclude review of the IRF DSH adjustment, it could have enumerated it among those adjustments that are beyond review. As Congress did not do so, the plain language of the Medicare statute requires Board jurisdiction, thus, the Providers requested that the Administrator reach the same conclusion.

Regarding the merits, the Providers argued that the Administrator should set aside the Board's decision, and remand the cases to the Medicare Contractor, with instructions to include the inpatient days associated with the LIP eligibility group in the numerator of the Providers' Medicaid fractions. The Providers stated that, after extensive negotiations with the State, CMS approved the § 1115 waiver in 2006, and reapproved the waiver in 2011. The Special Terms and Conditions of Florida's § 1115 waiver expressly state that LIP beneficiaries received "medical assistance" within the meaning of the Social Security Act, and that LIP expenditures are eligible for Title XIX matching payments. Consequently, the days should be included in the LIP calculation.

The Medicare Contractor submitted comments, requesting that the Administrator vacate the Board's Decision and dismiss the case for lack of subject matter jurisdiction pursuant

to 42 C.F.R. § 412.630. The Medicare Contractor stated that the applicable statutes, regulations, Administrator decisions, and the United States District Court for the District of Columbia decision in *Mercy* all support the contention that no part of the IRF LIP adjustment is subject to administrative or judicial review. The Medicare Contractor noted that in *Mercy*, the Court upheld the Administrator's decision, holding that § 1395ww(j)(8) prohibits judicial review of the contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the Hospital's prospective payment rates, and rejected the assertion that the statutory phrase "prospective payment rates" is limited only to the "unadjusted rate". The Medicare Contractor pointed out that ,while the Board has concluded in recent cases that it does not have jurisdiction over the LIP issues in which the Notice of Program Reimbursement (NPR) was issued after the October 1, 2013 (the effective date of the clarification of the regulation at 42 C.F.R. § 412.630), it seems that the Board considers the LIP adjustments occurring prior to this date to be within its purview of review.

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.[2]

Pursuant to § 4421 of the Balanced Budget Act of 1997[3], 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

[2] *See* Medicare Benefits Manual § 110.
[3] Pub Law No. 105-33.

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 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.[4]

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[5] 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),
> >
> > (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 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.

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[4] 66 Fed. Reg. 41,316, 41,359 (August 7, 2001).

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

However, in the FFY 2014 Final IRF rule, consistent with the proposed rule pronouncement,[6] 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
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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 apply to all payments authorized under

[6] *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 §§ 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 Fed. Reg. 41,316, 41,319 (Aug. 7, 2001). Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by § 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 § 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 § 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 §§ 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 §§ 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.")

> 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.
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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.
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> 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.
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> 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.[7]

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, allowing review would render § 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.[8] Thus, the Administrator finds that the appeal raised in this case falls under the statutory bar to limitations on review of § 1886(j)(8) of the Act.

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[7] 78 Fed. Reg. 47933.

[8] *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

The Administrator notes that in *Mercy*, 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 § 1886(j)(8) of the Act.

Regarding the contention that the Providers in this case are not challenging the "establishment" of the LIP adjustment, but rather, whether the Low-Income Pool § 1115 waiver days should be included in the Medicaid fraction of the LIP calculations, the matter is integral to the LIP adjustment and allowing review would render the prohibitions under § 1886(j)(8)(B) virtually ineffectual. Thus, the Administrator finds that the appeal falls under the statutory bar to limitations on review.[9]

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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).

[9] 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: 3/30/2018

/s/

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