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A SLIP on the LIP Adjustment: No Judicial Review Available for Hospitals' LIP Challenges

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In *Northeast Hosp. Corp. v Sebelius*, 657 F.3d 1 (D.C. Cir. 2011), the United States Court of Appeals for the District of Columbia Circuit upheld hospitals' challenge to CMS's disproportionate share hospital (DSH) calculation for years prior to Fiscal Year (FY) 2005. The court concluded that, prior to 2005, the CMS's regulations placed Medicare managed care days in the Medicaid, rather than the Medicare, fraction of that calculation. The D.C. Circuit has now ruled, however, that a similar challenge by hospitals to the low-income percentage (LIP) adjustment for payments to inpatient rehabilitation hospitals is beyond review. *Mercy Hospital, Inc. v. Azar*, Case No. 16-5267 (June 8, 2018)

The Medicare statute at 42 U.S.C. § 1395ww(j) directs CMS to set Medicare rates for inpatient rehabilitation services through a two-step process. The first step involves establishing a standardized reimbursement rate for each discharged patient based on the average estimated cost of inpatient operating facilities and treating patients for the upcoming year. The second step takes place after the fiscal year has ended, when CMS adjusts the standardized rates to reflect the particular circumstances of each hospital for that year. These adjustments authorized in the statute include four specific adjustments for price increases in the relevant market, outlier adjustments, wage index adjustments, and case mix adjustments. In addition, the statute authorizes CMS to create such additional adjustments as the Secretary determines are "necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." 42 U.S.C. § 1395ww(j)(3)(A)(5). The meaning of this last provision – termed the residual clause by the court – is not described in the statute, but instead, is described only in CMS rulemaking.

Relying on the residual clause, CMS created the LIP adjustment in 2001. In its FY 2005 regulation, however, CMS changed its position on which patients were to be included in that adjustment. Mercy Hospital then challenged the application of this revised adjustment as applied to its Fiscal Years 2002 – 2004. The hospital argued that the D.C. Circuit's earlier decision in *Northeast Hospital* precluded use of the FY 2005 formula for years before 2005. The PRRB, however, rejected the hospital's appeal, ruling that it had no jurisdiction to consider the hospital's challenge because the language in 42 U.S.C. § 1395ww(j)(8)(B) bars administrative and judicial review of the "prospective payment rates" established under the inpatient rehabilitation payment statute. The federal district court agreed with this position, and now the D.C. Circuit has concurred.

The D.C. Circuit ruled that subsection (8) expressly shields from administrative and judicial review "prospective payment rates" and most statutory adjustments used to calculate them under the inpatient rehabilitation payment formula. The court rejected the hospital's limited reading of the language "prospective payment rates" as including only the unadjusted rates at step one of the formula, that is, the standardized payment rates. The court concluded that the statute defines "prospective payment rate" as the amount that is determined after the fiscal year ends, when CMS, as the second step of the payment process, adjusts the standardized rates to reflect the particular circumstances of each hospital for that year. The court ruled that both as a textual and practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and thus that the preclusion provision applies to the LIP adjustment just as it applies to the other adjustments described in paragraph (8).

The court rejected arguments made by Mercy that, as a matter of statutory construction, the preclusion language should not apply to the LIP adjustment. The court concluded that the statute's meaning is otherwise plain and that the multiple arguments advanced by Mercy could not stand in the face of that plain language. Mercy also argued that preventing hospitals from seeking recourse from arbitrary and capricious adjustments was fundamentally unfair. The court, however, was not persuaded. The court said that it could not overlook a statutory provision's plain meaning simply because it might disagree with the policy. The court said that it can only interpret statutes and not rewrite them.

Implications for Providers

Without question, the position taken by the government here is unfair. The *Northeast Hospital* decision rejected the application of CMS's 2004 regulation to IPPS hospitals prior to 2005. Nevertheless, CMS applied that same 2004 position to the LIP adjustment for rehabilitation hospitals for periods prior to 2005. Despite this, the D.C. Circuit has now held that CMS's pre-2005 LIP adjustment is beyond review. Assuming that this decision withstands further possible review by the D.C. Circuit sitting *en banc* or by the Supreme Court (both unlikely occurrences), hospitals' sole recourse, it appears, is to persuade Congress or CMS to alter its position. Neither approach seems likely to yield a favorable outcome.