

Medicare Provider Reimbursement Disputes: Mapping the Contorted Borders of Administrative and Judicial Review

I. INTRODUCTION

This nation spent 458 billion dollars—nearly eleven percent of the Gross National Product—on health care in 1986.¹ The federal government financed twenty-five percent of that amount through the Medicare and Medicaid programs.² Most of Medicare's expenditures were paid directly to health care providers, primarily hospitals, as reimbursement for providing care and treatment to Medicare beneficiaries.³ The Department of Health and Human Services [HHS] administers the Medicare program, and the Secretary of HHS has broad authority to promulgate rules and regulations affecting Medicare.⁴ Health care providers have an enormous stake in these rules, particularly those affecting reimbursement amounts. Recent figures indicate that the average acute-care hospital receives twenty-eight percent of its revenue directly from Medicare.⁵ Yet obtaining some form of review of the regulations and decisions relating to payment issues has proved to be difficult for Medicare providers. The jurisdictional grants of the Medicare act which provide for administrative and judicial review of provider disputes have been extensively litigated, often with conflicting results.⁶ If the present state of the availability of review is best described as being discordant, the future must be characterized as sharply restricted. Dramatic changes in the substantive law governing inpatient reimbursement have been specifically put beyond the scope of administrative and judicial oversight.⁷

The health care provider dissatisfied with its Medicare reimbursement must follow the procedures for obtaining review or face a collateral

¹*Currents*, HOSPITALS, August 5, 1987, at 22.

²*Id.*

³Hospitals receive approximately 70% of all Medicare reimbursements. UNITED STATES BUDGET IN BRIEF - FISCAL YEAR 1987, at 81 (1986).

⁴42 U.S.C. § 405(a) (1982).

⁵Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADM. L.J. 1, 5 (1987) (citing OFFICE OF MANAGEMENT AND BUDGET, BUDGET OF THE UNITED STATES, FY 1987, H.R. DOC. NO. 143, 99th Cong., 2d Sess. 5-108 (1986)).

⁶Informal research indicates that almost every federal case involving a challenge by a provider to a reimbursement determination has required some discussion as to the availability of jurisdiction. Many cases deal exclusively with jurisdiction. There are approximately 300 federal decisions interpreting 42 U.S.C. § 1395oo, the United States Code section governing appeal of reimbursement determinations.

⁷See *infra* notes 158-70 and accompanying text.

attack on his right to litigate. This Note examines the jurisdictional parameters governing administrative and judicial review of Medicare provider reimbursement disputes. The Note deals exclusively with the institutional provider⁸ receiving reimbursement under Medicare Part A.⁹ After an introductory overview to the Medicare program in general, the jurisdictional statutes and decisions will be reviewed, first for availability of administrative review, and then for access to judicial review. Fact patterns that have met with consistent jurisdictional results will be described, but the principal focus will be on those aspects of the statutes on which the courts have failed to reach agreement. Those statutory provisions that have been specifically precluded from administrative and judicial review will be explained. Building upon this analytical foundation of statutory interpretation and prior case law, the Note will assess the likely direction of future jurisdictional issues. The concluding section explains why a broad interpretation of Medicare jurisdictional statutes is both needed by Medicare service providers and consistent with recent Supreme Court holdings.

At issue in this analysis is the authority to challenge how billions of federal dollars are spent. At a practical level, the jurisdictional problems discussed herein are of critical importance to the fiscal well-being of the hospitals seeking review. One study indicated that the average size of a disputed Medicare payment at the administrative level of adjudication during 1986 was \$400,000.¹⁰ The Secretary has shown he intends to use the limited availability of review to his advantage against any claim where there may be a colorable jurisdictional issue. Given the sweeping nature of recent and proposed changes to Medicare reimbursement regulations, the health care provider must have an understanding of the jurisdictional roadblocks that may be encountered in litigation, and how to overcome them.

II. AN OVERVIEW OF MEDICARE FROM THE PROVIDER'S PERSPECTIVE

Medicare was enacted in 1965 as part of the Social Security Act.¹¹ It is essentially a federally subsidized health insurance program administered by the Department of Health and Human Services.¹² Generally,

⁸See 42 U.S.C. § 1395x(u) (Supp. III 1985) for the definition of a qualifying institutional provider.

⁹See *infra* notes 18-20 and accompanying text for an overview of Medicare Part A.

¹⁰See study reported in Burda, *Ganeles Braces the PRRB for Change*, HOSPITALS, January 5, 1987, at 44.

¹¹42 U.S.C. §§ 1395-1395zz (1982 & Supp. III 1985).

¹²In the interest of maintaining consistency with the nomenclature used in the cases, this Note will refer to either the HHS or the Secretary when discussing the administrative responsibility for Medicare.

enrollment in Medicare is limited to citizens aged sixty-five and older, and to certain disabled individuals.¹³ Medicare is divided into two distinct programs: Part A and Part B. The Part B program is made available on a voluntary basis, and is set up similarly to a commercial insurance company, providing insurance coverage primarily for physician fees.¹⁴ Although the jurisdictional borders of Part B regulations have been extensively litigated, that topic will not be addressed here.¹⁵ While some significant interpretations of the Medicare jurisdictional statutes have involved beneficiary claims, that category of claim will not be discussed.¹⁶ This Note focuses on Medicare Part A jurisdiction from the institutional health care provider perspective.¹⁷ Medicare Part A provides insurance for hospital and certain post-hospital expenses at no cost to the eligible enrollee.¹⁸ Only a hospital or other qualified provider of services is eligible to receive payments under the Part A program,¹⁹ and the provider must agree not to charge the Medicare beneficiary for services received.²⁰

Prior to 1983, hospitals were entitled to reimbursement from the government for the actual, reasonable costs of furnishing care to Medicare beneficiaries.²¹ At that time, and still today, each provider submitted a year-end "cost report" detailing the costs associated with treating Medicare patients.²² In 1983, Congress enacted provisions creating a prospective, rather than cost based system for reimbursing providers for inpatient services.²³ This new payment system²⁴ was phased in over a four year period ending in 1987.²⁵ For the most part, reimbursement for inpatient services is no longer based on the hospital's costs incurred in treating Medicare beneficiaries. However, reimbursement for psychiatric hospitals, outpatient services, capital expenses, bad debt and medical education is still based on the cost reporting system.²⁶

¹³42 U.S.C. §§ 1395c, 1395o (1982 & Supp. III 1985).

¹⁴*Id.* § 1395j, 1395k(a).

¹⁵Numerous decisions bantered around the availability of judicial review regarding Part B determinations until the recent Supreme Court decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). See *infra* notes 187-93 and accompanying text.

¹⁶*Heckler v. Ringer*, 466 U.S. 602 (1984); *Weinberger v. Salfi*, 422 U.S. 749 (1975).

¹⁷See *supra* note 8.

¹⁸42 U.S.C. § 1395d(a)-(c) (1982).

¹⁹42 U.S.C. § 1395f(a) (1982 & Supp. III 1985).

²⁰42 U.S.C. § 1395cc(a)(1) (1982).

²¹*Id.* § 1395f(b)(1).

²²42 C.F.R. §§ 413.20, 413.24(f) (1986). The cost report itself is a lengthy document often containing hundreds of pages in the form of schedules and worksheets.

²³42 U.S.C. § 1395ww(d) (Supp. III 1985).

²⁴See *infra* notes 158-62 and accompanying text for a brief overview to the prospective payment system.

²⁵42 U.S.C. § 1395ww(d)(1)(C) (Supp. III 1985).

²⁶*Id.* §§ 1395ww(a)(4), 1395ww(d)(1)(B).

Although the HHS administers the program and, through the Secretary, has the authority to promulgate rules and render decisions, the daily supervision of the Medicare program is performed at the local level by large insurance companies acting under contract as "fiscal intermediaries."²⁷ The intermediary is the first line of administrative authority for the resolution of any type of Medicare dispute.²⁸

The Medicare provider files the annual cost report with the assigned intermediary within three months following the end of the provider's fiscal year.²⁹ The intermediary audits the report and issues a Notice of Program Reimbursement, explaining any adjustments made to the provider's cost report.³⁰ A provider dissatisfied with the amount of reimbursement may request administrative review of his claim. A provider still dissatisfied following an administrative hearing may bring suit in federal court. Because all disputes must first begin at the administrative level, this Note's discussion begins with an analysis of the availability of administrative review. The inability to gain a jurisdictional foothold at this level will preclude the possibility of later judicial review.

III. ADMINISTRATIVE REVIEW

Provider dissatisfaction with some aspect of its Medicare reimbursement might be caused by a regulation thought to be invalid, or by a perceived inaccuracy in the application of a regulation by the intermediary. To obtain and preserve the right to dispute the issue, there are specific procedures and time-tables that the provider must observe.

In 1972, Congress created the Provider Reimbursement Review Board [Board] as a forum for administrative review of intermediary determinations.³¹ The Board adjudicates disputes arising from provider dissatisfaction with the amount of Medicare reimbursement due, or the timeliness of an intermediary determination.³² Section 139500 of title 42, United States Code, establishes the Board and delineates its authority.³³ It also

²⁷*Id.* § 1395h.

²⁸42 C.F.R. §§ 405.1803(a), 405.1809 (1986).

²⁹*See generally* 42 U.S.C. § 139500(a)(1) (1982 & Supp. III 1985).

³⁰*See generally id.* § 139500(f).

³¹*See* S. REP. No. 1230, 92d Cong., 2d Sess. 249 (1972).

³²42 U.S.C. § 139500(a)(1) (1982 & Supp. III 1985).

³³*Id.* §§ 139500(a) and (d), which establish the Board and delineate its authority are reproduced below:

(a) Establishment. Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2)

establishes the criteria for the availability of judicial review of provider disputes.³⁴

of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A) (i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is \$10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or, with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis. . . .

(d) Decisions of Board. A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

³⁴42 U.S.C. § 1395oo(f) (1982 & Supp. 1985) establishes the criteria for judicial review and is set out below:

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy.

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision

A. *The Jurisdiction of the Board*

The Board is authorized to act in an appellate capacity, in that it may "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report."³⁵ It also can act as a fact-

of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in the action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

- (2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of return on equity capital established by regulation pursuant to section 1395x(v)(1)(B) of this section and in effect at the time the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.
- (3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

³⁵42 U.S.C. § 1395oo(d) (1982).

finder, by examining witnesses and allowing the presentation of evidence at the Board hearing.³⁶ A determination by the Board is considered final, unless the Secretary exercises the statutory right to overrule the Board,³⁷ or unless the decision is overturned on appeal by a federal district court.³⁸ The Board is bound by the rulings of the Secretary in making its determinations.³⁹

The Board does not have the authority to consider questions of law regarding the validity of a rule or regulation promulgated by the Secretary or Congress.⁴⁰ Although provision has been made to allow for expedited judicial review when the Board has no authority to decide an issue, all claims still must be initially submitted to the Board, so that it can determine in the first instance whether it has authority to resolve the dispute.⁴¹ But the Board itself has other jurisdictional limitations, as well as some procedural requisites that have been interpreted as being jurisdictional in nature. These limitations are discussed in the following sections.

B. Amount in Controversy

The first relevant determination applicable to obtaining a hearing before the Board is the amount in controversy. Generally, the Board is not authorized to grant a hearing when the amount in controversy is less than \$10,000.⁴² However, review would be allowed even where the amount in controversy is less than \$10,000 if the provider can effectuate a group appeal. If all the providers' claims in the group "involve a common question of fact or interpretation of law or regulations," then a group appeal could be taken before the Board, as long as all the other jurisdictional requirements have been met and the aggregate amount in controversy exceeds \$50,000.⁴³

The courts would probably adopt a liberal interpretation of this amount in controversy requirement. This would be consistent with general

³⁶42 U.S.C. § 1395oo(c) (Supp. III 1985).

³⁷42 U.S.C. § 1395oo(f) (1982 & Supp. III 1985). See also note 34.

³⁸*Id.*

³⁹42 C.F.R. § 405.1867 (1986).

⁴⁰42 U.S.C. § 1395(f)(1) (Supp. III 1985); see also *Hospital Ass'n v. Secretary of HHS*, 820 F.2d 533, 539 (1st Cir. 1987).

⁴¹See *infra* notes 110-16 and accompanying text for a discussion of the 1980 amendments providing for expedited judicial review.

⁴²42 U.S.C. § 1395oo(a)(2) (Supp. III 1985). If the amount in controversy is less than \$10,000 but more than \$1000, the provider may obtain a hearing with the intermediary. 42 C.F.R. § 1809(b) (1986). The details of this type of administrative hearing are explained in 42 C.F.R. §§ 1809-1833 (1986).

⁴³42 U.S.C. § 1395oo(b) (Supp. III 1985).

federal law.⁴⁴ And in one of the few cases where the Secretary challenged the Board's jurisdiction on this point, the hospitals involved were permitted to aggregate cost reports for more than one year in order to meet the \$50,000 requirement.⁴⁵

C. *Timeliness of Request*

Section 1395oo also requires that the provider file a request for a hearing within 180 days following notice of the intermediary's final determination of total program reimbursement.⁴⁶ This provision has been generally accepted to be jurisdictional in nature.⁴⁷ Thus, a provider wishing to take advantage of a recent favorable court decision or in any way challenge his reimbursement for a given cost year must act promptly or lose the right to review.

This restriction seems simple enough, but has been made complicated by a federal regulation which gives the Board the authority to extend the time limit for accepting appeals for up to three years on a showing of "good cause."⁴⁸ This ruling conflicts with the general rule that administrative bodies do not have the authority to extend the jurisdictional limitations imposed by Congress.⁴⁹ For this reason, the appellate court in *St. Joseph's Hospital v. Heckler*⁵⁰ found the regulation to be illegal and without force. Thus, health care providers in the Eighth Circuit may not request an extension to appeal. But in the Ninth Circuit, the appellate court relied on the general rule that an agency interpretation will be given deference if found to be a permissible construction of the statute being construed,⁵¹ and upheld the validity of the rule in *Western*

⁴⁴The leading case on liberally construing federal amount in controversy requirements is *St. Paul Mercury Indem. v. Red Cab Co.*, 303 U.S. 283 (1938). In this oft-cited case, the Court stated that it must be apparent to a legal certainty that the claim is really for less than the jurisdictional amount in order to dismiss the case.

⁴⁵*Cleveland Mem. Hosp., Inc. v. Califano*, 594 F.2d 993 (4th Cir. 1979).

⁴⁶42 U.S.C. § 1395oo(a)(3) (Supp. III 1985). Notice, in this context, has been interpreted to occur when the provider actually receives notice of a determination, and not when the determination is made. *Sun Towers, Inc. v. Heckler*, 725 F.2d 315 (5th Cir.), *cert. denied*, 466 U.S. 936 (1984).

⁴⁷*See St. Joseph's Hosp. v. Heckler*, 786 F.2d 848, 853 (8th Cir. 1986); *V.N.A. of Greater Tift County v. Heckler*, 711 F.2d 1020 (11th Cir. 1983); *Miami Gen. Hosp. v. Bowen*, 652 F. Supp. 812, 814 (S.D. Fla. 1986).

⁴⁸42 C.F.R. § 1841(b) (1986).

⁴⁹*See generally Citizens State Bank v. FDIC*, 751 F.2d 209, 217 (8th Cir. 1984); *Atchison, T.&S.F. R.R. v. Interstate Commerce Comm'n*, 607 F.2d 1199, 1203 (7th Cir. 1979).

⁵⁰786 F.2d 848, 853 (1986).

⁵¹*See, e.g., Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984); *Blum v. Bacon*, 457 U.S. 132, 141 (1982); *Memorial Hosp. v. Heckler*, 706 F.2d 1130, 1134 (11th Cir. 1983).

Medical Enterprises, Inc. v. Heckler.⁵² Noting that the language of section 1395oo states that a provider "may" obtain a hearing if the jurisdictional requirements are met, the court found this language ambiguous enough to permit the Board to waive the 180 day requirement if it so chose.⁵³

Although the regulation does not seem unreasonable, the Eighth Circuit's holding that the 180 day limitation is not subject to discretionary extension is the better rule of law and makes more practical sense. As the *St. Joseph's* court noted, a House report discussing this provision states that an "appeal *must* be filed within 180 days. . . ." ⁵⁴ Congress could have avoided the use of the word "must" or inserted a clause indicating that appeal may be taken within such time as the Secretary may allow.⁵⁵ Further, it is axiomatic in federal courts that the issue of subject matter jurisdiction may not be waived.⁵⁶ There is no justification for not applying a similar rule to administrative bodies acting in a judicial capacity. From a practical standpoint given the extensive backlog of appeals now pending before the Board, it is unlikely that a provider could show convincing reasons for missing a filing deadline.⁵⁷

Because the Supreme Court will probably never entertain argument on this question, the issue will probably be adjudicated on a case by case basis. Clearly, there is a substantial risk involved in allowing the 180 day filing deadline to pass.

D. Matters Covered on a Cost Report

Another issue that has caused dissent among the courts is the question of what constitutes a matter covered on a cost report. Generally, section 1395oo provides that any health service provider who has filed a timely cost report may obtain a hearing before the Board "with respect to such cost report . . . [if the provider is] dissatisfied with a final determination of . . . [the intermediary] as to the amount of total program reimbursement due . . . for the period covered by the report"⁵⁸

⁵²783 F.2d 1376, 1379-80 (9th Cir. 1986).

⁵³*Id.* at 1380.

⁵⁴786 F.2d at 851 (quoting H.R. REP. NO. 231, 92d Cong., 2d Sess., reprinted in 1972 U.S. CODE CONG. & ADMIN. NEWS 4989, 5094).

⁵⁵*Id.*

⁵⁶FED. R. CIV. P. 12(h); see also *Laffey v. Northwest Airlines, Inc.*, 567 F.2d 429, 474 (D.C. Cir. 1976), cert. denied, 434 U.S. 1086 (1978).

⁵⁷In an interview early in 1987, Paul Morton Ganeles, the chairman of the Provider Reimbursement Review Board, stated that the Board was "set up to handle a caseload ten percent of what we have." At that time, the Board had 3,259 pending appeals. Burda, *Ganeles Braces the PRRB for Change*, HOSPITALS, January 5, 1987, at 44.

⁵⁸42 U.S.C. § 1395oo(a) (1982 & Supp. III 1985). The statute also authorizes the provider to obtain a hearing before the Board with respect to the cost report if the provider has not received a timely determination by the intermediary. See *supra* note 33 for a complete text of section 1395oo(a).

This section further provides that the Board has the authority to "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination."⁵⁹

In the routine Board dispute, then, a provider with a dispute involving an amount in controversy in excess of \$10,000 files for a hearing within 180 days of receiving the Notice of Program Reimbursement. The provider's complaint will center on some aspect of an expense claimed on the cost report but denied by the intermediary in its final reimbursement determination. But an important issue arises when a provider disagrees with a regulation, but files the cost report in accordance with the disputed rule. By strictly conforming to cost reporting regulations, many providers lost their right to administrative and judicial review. The general reasoning of the Board in these cases was that by not including the disputed cost on the cost report, there was no "final determination" of the intermediary "with respect to" a cost report for the Board to review.⁶⁰ In 1979, the Board began to refuse to accept jurisdiction to hear appeals concerning costs that had been "self-disallowed" from the cost report.⁶¹

Until April 4, 1988, when the Supreme Court decided *Bethesda Hospital v. Bowen*,⁶² the self-disallowance issue had been frequently litigated and with divergent results. The leading opinion on this issue since 1984 had been *Athens Community Hospital v. Schweiker*.⁶³ In that case, the provider group had argued unsuccessfully that section 1395oo(d) gave the Board the authority to review issues "even though such matters were not considered by the intermediary in making such final deter-

⁵⁹42 U.S.C. § 1395oo(d) (1982). See *supra* note 33 for the complete text.

⁶⁰42 U.S.C. § 1395oo(a) (1982 & Supp. III 1985). See *University of Cincinnati v. Secretary of HHS*, 809 F.2d 307, 310 (6th Cir. 1987); *Athens Community Hosp. v. Schweiker*, 743 F.2d 1, 8 (D.C. Cir. 1984).

⁶¹Tallahassee Mem. Regional Medical Center v. Bowen, 815 F.2d 1435 (11th Cir. 1987), involved a hospital that had "self-disallowed" costs. An attorney in that case has criticized the Board for penalizing hospitals that were attempting to comply with Medicare rules and regulations, especially since the hospitals were never made aware of the implications of omitting disputed costs from their cost reports. "The PRRB first used the policy in 1979 and acted like everyone knew about it. Hospitals were innocently led to slaughter." Burda, "Self-disallowed" Costs: Issue to High Court?, *HOSPITALS*, July 20, 1987 at 60.

⁶²108 S. Ct. 1255 (1988), *rev'g* 810 F.2d 558 (6th Cir. 1987).

⁶³743 F.2d 1 (D.C. Cir. 1984). This case is important for two reasons. First, the opinion, written by Judge Robert Bork, is carefully reasoned and well written. Second, District of Columbia Circuit decisions are highly influential because providers have the option of litigating either in their home district court or in the District of Columbia court. 42 U.S.C. § 1395oo(f) (1982 & Supp. III 1985).

mination.”⁶⁴ The District of Columbia Court of Appeals held that in order for jurisdiction to exist, a claim for reimbursement must be made either by directly claiming the disputed cost on the report or by appending a statement to the cost report claiming entitlement to reimbursement for the disputed cost.⁶⁵ This line of reasoning had been followed in decisions by the Courts of Appeals for the Fourth⁶⁶ and Sixth circuits.⁶⁷ But more recent appellate decisions had shown a willingness to find jurisdiction in these self-disallowed cost situations.⁶⁸ The Supreme Court granted certiorari in *Bethesda Hospital* to resolve what had become a conflict among the Courts of Appeals.⁶⁹

In the *Bethesda Hospital* case, a group of hospitals sought to challenge a regulation governing reimbursement for medical malpractice insurance costs.⁷⁰ But two of the plaintiff hospitals had filed their cost reports in accordance with the regulation they sought to challenge, and the Board refused to hear their claims.⁷¹ The district court ordered the Board to accept jurisdiction but that decision was reversed by the Sixth Circuit Court of Appeals.⁷²

The Supreme Court reversed, holding that when a provider self-allows a cost in accordance with a regulation, the right to challenge the validity of the rule and the reimbursement amount for that cost is not lost.⁷³ The decision was predicated on Justice Kennedy's interpretation of the language of section 1395oo(a)(1)(A)(i), which requires that a provider must be “dissatisfied with a final determination of . . . its fiscal intermediary”⁷⁴ The Court characterized as “strained” the Secretary's view that a provider cannot be dissatisfied with an intermediary's decision to reimburse the amount indicated in the cost report.⁷⁵ The Court stated:

It is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules does not, by itself, bar the provider from claiming dis-

⁶⁴*Athens*, 743 F.2d, at 5, (quoting 42 U.S.C. § 1395oo(d) (Supp. III 1985)). See *supra* note 33 for the complete text of this statute.

⁶⁵*Athens*, 743 F.2d at 10.

⁶⁶*Community Hosp. v. HHS*, 770 F.2d 1257 (4th Cir. 1985).

⁶⁷*Baptist Hosp. East v. Secretary of HHS*, 802 F.2d 860 (6th Cir. 1986).

⁶⁸See *Adams House Health Care v. Heckler*, 817 F.2d 587 (9th Cir. 1987); *Tallahassee Mem. Regional Medical Center v. Bowen*, 815 F.2d 1435 (11th Cir. 1987).

⁶⁹*Bethesda Hosp. v. Bowen*, 108 S. Ct. 1255, 1258 (1988).

⁷⁰*Id.* at 1257.

⁷¹*Id.*

⁷²*Id.*

⁷³*Id.* at 1258.

⁷⁴*Id.* (quoting 42 U.S.C. § 1395oo(a)(1)(A)(i) (Supp. III 1985)).

⁷⁵*Id.*

satisfaction with the amount of reimbursement allowed by those regulations We conclude that petitioners could claim dissatisfaction, within the meaning of the statute, without incorporating their challenge in the cost reports filed with their fiscal intermediaries.⁷⁶

The Court found further support for its position in section 1395oo(d), which permits the Board to "make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determinations."⁷⁷

While the *Bethesda Hospital* decision settled the question of self-disallowed costs when a regulation is being challenged, the Court did not address whether a provider could obtain Board review of reimbursement determinations when providers simply fail to request reimbursement to which they are entitled. But the Court did hint that a provider in that situation would "stand on different ground" than the petitioners in *Bethesda Hospital*.⁷⁸ Moreover, the Eleventh Circuit Court of Appeals had already taken the position that although self-disallowance in compliance with regulations does not create a jurisdictional bar,⁷⁹ failure to include allowable costs does preclude Board jurisdiction.⁸⁰ Following *Bethesda Hospital*, it seems likely that the other federal courts will adopt the same position.

E. A Final Determination of the Intermediary

The question of what constitutes a final determination by the intermediary has also caused conflict among federal courts. As a general rule, issuance of a Notice of Program Reimbursement satisfies the requirement of a final determination by the intermediary.⁸¹ However, instances have arisen in the past, and are likely to occur again, where an intermediary must make a determination affecting provider payment prior to the issuance of the reimbursement notice. The question then arises over whether the Board can hear an appeal on this intermediate determination, or whether the provider must await the formal issuance of the reimbursement notice. Although most courts which have addressed this question have allowed the Board to hear these appeals, some contrary

⁷⁶*Id.* at 1258-59.

⁷⁷*Id.* at 1259 (quoting 42 U.S.C. § 1395oo(d) (1982)).

⁷⁸*Id.*

⁷⁹Tallahassee Mem. Regional Medical Center v. Bowen, 815 F.2d 1435 (11th Cir. 1987).

⁸⁰North Broward Hosp. Dist. v. Bowen, 808 F.2d 1405 (11th Cir. 1987).

⁸¹See 42 U.S.C. § 1395oo(a)(1)(A) (Supp. III 1985); Charter Medical Corp. v. Bowen, 788 F.2d 728, 733 (11th Cir. 1986).

authority exists. This issue has arisen in the context of amendments to section 1395oo, adopted in 1983 as part of the shift to prospective reimbursement.⁸²

At the same time Congress was overhauling the substantive law governing Medicare reimbursement in 1983, conforming amendments were made to the jurisdictional provisions as well.⁸³ One of the amendments permitted a hearing before the Board if the provider was "dissatisfied with a final determination of the Secretary as to the amount of payment" under the new prospective reimbursement system.⁸⁴ Under the prospective payment system, intermediaries were required to make a preliminary determination of each hospital's current average cost of treatment of Medicare patients, so this amount could be blended into the prospective payment amount.⁸⁵ In reliance on the conforming amendments, the Board began accepting jurisdiction to review provider complaints regarding intermediary determinations of average cost.⁸⁶ The Secretary then issued a ruling [HCFAR 84-1] stating that an intermediary's estimation of base year costs is not a final determination of program reimbursement and accordingly, the Board is without jurisdiction to review the intermediary's determination until after the issuance of a reimbursement notice for the first year under the new system.⁸⁷ Pursuant to the Secretary's new rule, the Board began refusing to accept jurisdiction on this issue until after the filing of a cost report and issuance of a Notice of Program Reimbursement for the year in question. The hospitals that challenged the validity of HCFAR 84-1 in federal district court were all successful.⁸⁸ In five federal appeals, the providers have obtained affirmation in four cases.⁸⁹ Only the Eighth Circuit, in *Springdale Memorial Hospital v. Bowen*,⁹⁰ has been unwilling to require the Board to accept jurisdiction.

⁸²See *infra* notes 158-70 and accompanying text for an overview of the prospective payment system.

⁸³42 U.S.C. § 1395(a) (1982). See PUB. L. No. 98-21, § 602, 97 Stat. 65, 163-66 (1983).

⁸⁴42 U.S.C. § 1395oo(a)(1)(A)(ii) (Supp. III 1985). See *supra* note 33 for the complete text.

⁸⁵See 42 C.F.R. §§ 412.70 - 412.74 (1986); 42 U.S.C. § 1395ww(d)(1) (Supp. 1985).

⁸⁶In an appendix to one of the cases on this issue, the court indicated that the Board had accepted jurisdiction over 31 appeals prior to the issuance of HCFAR 84-1. *Washington Hosp. Center v. Bowen*, 795 F.2d 139, 142 (D.C. Cir. 1986).

⁸⁷49 Fed. Reg. 22,413, 22,415 (1984).

⁸⁸See *Doctors Hosp., Inc. v. Bowen*, 811 F.2d 1448, 1452 n.2 (11th Cir. 1987).

⁸⁹See *Doctors Hosp., Inc. v. Bowen*, 811 F.2d 1448 (11th Cir. 1987); *Sunshine Health Sys., Inc. v. Bowen*, 809 F.2d 1390 (9th Cir. 1987); *St. Francis Hosp. v. Bowen*, 802 F.2d 697 (4th Cir. 1986); *Washington Hosp. Center v. Bowen*, 795 F.2d 139 (D.C. Cir. 1986). Largely because it came from the District of Columbia court, the *Washington* case is considered to be the leading decision.

⁹⁰818 F.2d 1377 (1987).

Although the weight of authority favors finding HCFAR 84-1 to be an unlawful exercise of administrative authority, that finding is inconsistent with the plain language of the conforming amendments. In amending section 1395oo, Congress inserted the provision for review of prospective payment questions under subpart (a), rather than creating a separate subpart. Subpart (a) plainly anticipates that Board review is made "with respect to [a] cost report."⁹¹ The Secretary's interpretation is reasonable, and not arbitrary or capricious, as most courts have found.⁹² If Congress had expressly intended to exempt prospective payment determinations from the cost report requirement, the amendments could have been incorporated into a separate subpart. Further evidence that Congress did not intend the new review provisions to alter the cost report requirement can be found in Congress' use of the term "conforming amendments." The Supreme Court has implied that when Congress designates an amendment as being "conforming," this is evidence that it should be treated as a non-substantive reaction to related legislation.⁹³ Therefore, the Eighth Circuit's reasoning in *Springdale* offers the better analysis, based on strict statutory construction.

Yet whatever the merits of the arguments on this issue, HCFAR 84-1 is still a dubious exercise of administrative authority. At best, the ruling merely delayed the inevitable. By requiring providers to wait until the end of the year to file appeals, the Secretary created a situation where the Board was hit by a wave of appeals, rather than a continuous stream. This has the effect of slowing down an already overburdened review system.⁹⁴ If future changes in Medicare law require preliminary determinations by the fiscal intermediaries, the dissatisfied provider should look first to the language of any conforming amendments and legislative history for applicable changes in availability of review. If there are no accompanying changes in the jurisdictional provisions, current law favors the availability of administrative review prior to the issuance of the Notice of Program Reimbursement. Moreover, the Administrative Conference, an independent federal agency responsible for finding ways in which other agencies can be improved, has recently recommended to the HHS that the Board's jurisdictional authority be expanded to hear appeals in a more timely fashion.⁹⁵

⁹¹42 U.S.C. § 1395oo(a) (Supp. III 1985). See *supra* note 33 for the complete text.

⁹²Arbitrary and capricious is the standard used in determining if the actions of an administrative agency are in violation of the Administrative Procedure Act. 5 U.S.C. § 706(a)(A) (Supp. III 1985).

⁹³*CBS, Inc. v. FCC*, 453 U.S. 367, 381-82 (1981).

⁹⁴See *supra* note 57.

⁹⁵Burda, *Ganeles Braces the PRRB for Change*, HOSPITALS, January 5, 1987, at 44. This recommendation was based on a report submitted to the Administrative Conference

Finally, federal regulations permit the reopening and revision of a decision by the intermediary or the Board any time within three years of the date of notice of the determination.⁹⁶ A motion for reopening can be made by either the rendering body or the affected provider, and is permitted if new and material evidence has been submitted, an obvious error has been made, or the previous determination is inconsistent with the law.⁹⁷ However, only the authority rendering the decision has jurisdiction to reopen. Thus, a determination by the intermediary not to reopen is not reviewable by the Board.⁹⁸

After obtaining administrative review and being defeated on the merits, the provider must now look to the next available avenue of appeal—the federal courts.

IV. JUDICIAL REVIEW

The Social Security Act prohibits judicial review of any claim arising under Medicare through the usual jurisdictional channel of section 1331, title 28, United States Code: claims involving federal questions.⁹⁹ Judicial review is only available where provided in the Act itself.¹⁰⁰ For the Medicare provider, judicial review, like administrative review, is available only through section 1395oo.¹⁰¹

Except for certain statutory provisions that have been put beyond the reach of administrative or judicial scrutiny, judicial review of any final determination of the Board, or of any subsequent modification of a Board decision by the Secretary is generally available.¹⁰² Although this grant of authority seems straightforward, just as with administrative review, the courts have been called upon many times to discover the true intent of Congress. Moreover, just as with administrative review, the courts have not always achieved consistent results. The following sections examine the various prerequisites to judicial review in detail.

by Eleanor Kinney, Assistant Professor of Law and Director of the Center for Law and Health, Indiana University School of Law, Indianapolis. An updated version of that report was recently published: Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADM. L.J. 1 (1987).

⁹⁶42 C.F.R. § 405.1885(a) (1987).

⁹⁷*Id.*

⁹⁸*Id.* § 405.1885(c).

⁹⁹42 U.S.C. § 405(h) (1982), made expressly applicable to Medicare by 42 U.S.C. § 1395ii (1982).

¹⁰⁰*Id.* § 405(g).

¹⁰¹42 U.S.C. § 1395oo(f) (1982 & Supp. III 1985). See *supra* note 33 for the complete text.

¹⁰²*Id.* § 1395oo(f), (g).

A. *Timeliness of Request*

Civil actions against the Secretary must be commenced within 60 days of notice of a final determination.¹⁰³ Unlike the administrative timeliness requirement, however, this rule is considered to be a statute of limitations, rather than a jurisdictional bar.¹⁰⁴ This distinction is critical, in that statutory timeliness is a waivable requirement, whereas subject matter jurisdiction is not.¹⁰⁵ By way of illustration, in a 1984 suit in which the provider was late in filing, the court refused to dismiss the case because the Secretary was considered to have waived the timeliness issue by not raising it as an affirmative defense in his responsive pleading.¹⁰⁶ Courts have uniformly held that the 60 day period commences upon receipt of notice by the provider and not at the time of issuance of the final determination.¹⁰⁷

B. *Venue*

A civil action may be brought either in the district court for the district in which the provider is located or in the district court for the District of Columbia.¹⁰⁸ This provision is one of the reasons why the decisions of the District of Columbia Court of Appeals are so influential. If the District of Columbia court adopts a provider-favorable position, an incentive is created for providers to commence their actions there, rather than in their home jurisdiction.

When several providers aggregate their appeals, their "location" for the purpose of venue is considered to be the judicial district in which the greatest number of providers are located.¹⁰⁹

C. *Expedited Judicial Review and the Requirement of Exhaustion of Administrative Remedies*

Prior to 1980, a provider challenging the validity of a statute or regulation was required to bring an appeal before the Board, despite the Board's lack of authority to invalidate regulations promulgated by

¹⁰³*Id.* § 139500(f)(1).

¹⁰⁴*See* *Lloyd Nolan Hosp. & Clinic v. Heckler*, 762 F.2d 1561 (11th Cir. 1985); *Alexandria Hosp. v. Heckler*, 586 F. Supp. 581 (E.D. Va. 1984); *Bedford County Mem. Hosp. v. Heckler*, 583 F. Supp. 367 (W.D. Va. 1984).

¹⁰⁵*Laffey v. Northwest Airlines, Inc.*, 567 F.2d 429, 474 (D.C. Cir. 1976), *cert. denied*, 434 U.S. 1086 (1978). *See* FED. R. CIV. P. 12(h)(3).

¹⁰⁶*Alexandria Hosp.*, 586 F. Supp. 581 (E.D. Va. 1984).

¹⁰⁷*See* *Lloyd Nolan Hosp. & Clinic v. Heckler*, 762 F.2d 1561 (11th Cir. 1985); *Sun Towers, Inc. v. Heckler*, 725 F.2d 315 (5th Cir. 1984).

¹⁰⁸42 U.S.C. § 139500(f)(1) (Supp. 1985).

¹⁰⁹*Id.*

the HHS.¹¹⁰ Only after the Board renders a decision could the provider then bring his action in federal court. This requirement of "exhaustion of administrative remedy" is a cornerstone of judicial review of administrative action, and has been rigidly enforced in the Medicare context.¹¹¹ Resourceful providers have sought to circumvent this requirement in a number of ways: through mandamus jurisdiction,¹¹² through the Administrative Procedure Act,¹¹³ and through assertion that no other avenue of appeal exists.¹¹⁴ But the courts have consistently stated that resort to the administrative process, despite its prospective futility, was a prerequisite to federal jurisdiction. In 1980, however, Congress attempted to help providers avoid "time consuming and irrelevant administrative review merely to have the right to bring suit" by giving them "the right to immediate judicial review in instances where the Board determines it lacks jurisdiction to grant the relief sought."¹¹⁵ With these commendable intentions, section 1395oo was amended to provide for expedited judicial review.¹¹⁶

Despite the good intentions of Congress, the amendment has done little to make the appeals process more efficient. The statute still requires the provider to have met the jurisdictional requirements of subpart (a) of section 1395oo before the Board renders a determination of whether expedited judicial review is appropriate.¹¹⁷ Thus, the provider must file a cost report, obtain a determination by the intermediary, file an appeal for expedited review to the Board, and then obtain a ruling on whether the jurisdictional requirements of subpart (a) have been met, prior to the beginning of the 30 day period within which the Board must render a determination on the availability of expedited judicial review.¹¹⁸ The reality of expedited review is in stark contrast to the words of Congressman Heftel, in explaining the amendment:

¹¹⁰Hospital Ass'n v. Secretary of HHS, 820 F.2d 533, 539 (1st Cir. 1987).

¹¹¹See, e.g., Heckler v. Ringer, 466 U.S. 602, 617 (1984); Daniel Freeman Mem. Hosp. v. Schweiker, 656 F.2d 473 (9th Cir. 1981); Association of Am. Medical Colleges v. Califano, 569 F.2d 101 (D.C. Cir. 1977).

¹¹²See, e.g., Ohio Hosp. Ass'n v. Heckler, 654 F. Supp. 729 (S.D. Ohio 1986). Mandamus jurisdiction might be available if the matter in controversy was wholly procedural in nature, and the Secretary owed a clear, nondiscretionary duty. Ellis v. Blum, 643 F.2d 68 (2d Cir. 1981).

¹¹³See, e.g., Chelsea Community Hosp. v. Michigan Blue Cross, 630 F.2d 1131, 1133 (6th Cir. 1980). See generally Califano v. Sangers, 430 U.S. 99 (1977).

¹¹⁴Good Samaritan Medical Center v. Secretary of HHS, 776 F.2d 594, 597-98 (6th Cir. 1985).

¹¹⁵H.R. REP. No. 1167, 96th Cong., 2d Sess. 394 (1980).

¹¹⁶42 U.S.C. § 1395oo(f)(1) (Supp. III 1985). See *supra* note 33 for complete text.

¹¹⁷42 C.F.R. § 405.1842(b)(2) (1987).

¹¹⁸42 U.S.C. § 1395oo(f)(1) (Supp. III 1985).

Specifically, under current law providers may not seek judicial review of regulations of policies of [the HHS] until after the provider has gone through a long, tortuous process of preparing and filing cost reports; awaiting a decision by the fiscal intermediary; and appealing that decision to the PRRB, which must declare what everybody already knows—that the PRRB has no authority to decide the issues Our bill would change this situation by allowing the provider to obtain immediate judicial review in such cases—namely, those in which the PRRB has no authority to decide the case.¹¹⁹

If Congress is serious about improving the review process, then the law should be amended to allow providers to bypass the Board completely when challenging the validity of a statute or regulation, as long as the provider can show standing to sue.¹²⁰ The elimination of the Board from this type of proceeding would have the additional benefit of facilitating the use by providers of the class action suit. The Supreme Court has endorsed the use of certification of nation-wide classes to resolve actions involving administrative challenges.¹²¹ The class action is particularly appropriate in the Medicare context, where the filing of a multiplicity of individual suits has resulted in differing results for similarly situated individuals.¹²²

D. *The Mootness Problem*

One of the more complex and potentially consequential jurisdictional problems has arisen out of litigation involving a 1979 rule which substantially reduced Medicare reimbursement for a hospital's medical malpractice insurance costs. Every challenge to the legality of the 1979 rule was successful;¹²³ however, the HHS continued to litigate on a piecemeal basis until 1986, when the HHS finally conceded that the 1979 rule was invalid.¹²⁴ Although a battle was lost, the HHS had not surrendered the war. The Secretary promulgated a new rule that, from the provider

¹¹⁹126 CONG. REC. 22218 (1980) (introductory remarks of Rep. Heftel).

¹²⁰Standing, in this context, means that the amount in controversy requirements have been met, 42 U.S.C. § 1395oo(a)(2) (Supp. III 1985), and the provider is suffering from a legal wrong caused by agency action. 5 U.S.C. § 702 (1982).

¹²¹Califano v. Yamasaki, 442 U.S. 682, 701-703 (1979).

¹²²McClure v. Harris, 503 F. Supp. 409, 413 (N.D. Cal. 1980), *rev'd on other grounds sub nom.* Schweiker v. McClure, 456 U.S. 188 (1982).

¹²³See Tallahassee Mem. Regional Medical Center v. Bowen, 815 F.2d 1435, 1441 n.7 (11th Cir. 1987).

¹²⁴See 51 Fed. Reg. 11,142, 11,149 (April 1, 1986) (to be codified at 42 C.F.R. § 405).

viewpoint, was not much better than the old rule.¹²⁵ The new rule, by its own terms, was to be applied retroactively to all "open" cost reports.¹²⁶

By making the 1986 rule retroactive to all providers with open claims, the Secretary was now able to make a new jurisdictional challenge in new federal cases and in those coming up on appeal. The Secretary now has argued that the retroactive nature of the new rule renders any litigation on the old rule moot, thus eliminating federal jurisdiction.¹²⁷ The Medicare statutes authorize the Secretary to make retroactive adjustments to provider reimbursement under certain circumstances.¹²⁸ Yet the practical consequences of permitting retroactive rule-making in this situation would be that those providers with claims pending in the federal courts would not be entitled to reimbursement according to pre-1979 rules. They must either accept reimbursement under the 1986 rule or challenge the validity of the 1986 rule starting back at the beginning—at the administrative level. The long term consequences of the successful use of this strategy would be to potentially bind providers into a never-ending series of fruitless legal challenges. In finding that the new rule did not render the litigation moot, the Eleventh Circuit Court of Appeals commented:

[I]f this case is dismissed as moot, we would be creating a class of cases capable of evading judicial review by the very fact that, after years of litigation challenging an administrative regulation, an agency would be able to moot a given lawsuit by promulgating a new regulation. If we were to find this case moot, the hospitals would have to restart on a long and expensive litigation, only to be confronted again with the possibility that the Secretary could moot that litigation.¹²⁹

The district courts that have addressed this issue have reached conflicting results and are likely to continue to do so until the weight of appellate opinion becomes known.¹³⁰ Four appellate courts have rendered decisions to date. The Sixth and Eleventh Circuits have taken a provider-favorable position and have either expressly or implicitly assumed a

¹²⁵See *Tallahassee Mem. Regional Medical Center v. Bowen*, 815 F.2d 1435, 1441 n.19 (11th Cir. 1987).

¹²⁶51 Fed. Reg. 11,142, 11,149 (April 1, 1986) (to be codified at 42 C.F.R. § 405).

¹²⁷Mootness is jurisdictional. See *Tallahassee Mem. Regional Medical Center v. Bowen*, 815 F.2d 1435, 1448 n.22 (11th Cir. 1987).

¹²⁸42 U.S.C. § 1395x(v)(1)(A)(ii) (Supp. III 1985); see also *Tennessee v. Califano*, 631 F.2d 89 (6th Cir. 1980).

¹²⁹*Tallahassee*, 815 F.2d at 1451.

¹³⁰See *id.* at 1448 n.24.

limited degree of jurisdiction.¹³¹ Although both courts denied the Secretary's authority to promulgate retroactive regulations that would have the effect of mooting a present controversy, the courts invalidated only the retroactive aspect of the new rule, expressly finding themselves without jurisdiction to review the prospective validity of the rule.¹³² The First Circuit reached a different conclusion. That court also rejected the mootness argument, but found that the federal courts have the jurisdiction to review both the retroactive and the prospective aspects of the new rule.¹³³ The case was then remanded to the district court for a determination on both questions.¹³⁴ In the Seventh Circuit, however, the Secretary was able to gain a victory through an alternative argument.¹³⁵ The court refused to address the retroactivity question, instead finding that it was without jurisdiction to hear the appeal because the challenge to the retroactive application of the new rule amounts to an attack on the regulation itself.¹³⁶ Thus, the court found itself without jurisdiction until there has been a final determination of the Board with regard to the new regulation. The court reversed the district court's decision ordering reimbursement under the pre-1979 rule and remanded with instructions that the Secretary process the claims using the new regulation.¹³⁷ This "final determination" requirement will be examined in more detail in the following section.

The three appellate courts that rejected the Secretary's claims of mootness were obviously concerned about the public policy aspects of allowing an agency the unfettered ability to thwart the purposes of judicial review. However, the providers had some law to support their position as well. A supporting case for the providers is a 1984 Supreme Court ruling in which the Court held that when a party to a dispute has a monetary interest in the outcome of a litigation, the case cannot be dismissed as moot because of events subsequent to the action.¹³⁸ In *Tallahassee Memorial Regional Medical Center v. Bowen*,¹³⁹ the Eleventh Circuit, in a detailed and thorough analysis of the mootness question, applied the two-prong test for mootness adopted by the Supreme Court

¹³¹See *Mason General Hosp. v. Secretary of HHS*, 809 F.2d 1220 (6th Cir. 1987) (mootness denied implicitly without discussion); *Tallahassee Mem. Regional Medical Center v. Bowen*, 815 F.2d 1435 (mootness expressly denied).

¹³²*Mason*, 809 F.2d at 1231; see also *Tallahassee*, 815 F.2d at 1456-57.

¹³³*Hospital Ass'n v. Secretary of HHS*, 820 F.2d 533, 539 (1st Cir. 1987).

¹³⁴*Id.*

¹³⁵*Appleton Mem. Hosp. v. Bowen*, 814 F.2d 408 (7th Cir. 1987).

¹³⁶*Id.* at 410.

¹³⁷*Id.*

¹³⁸*Ellis v. Brotherhood of Ry. Clerks*, 466 U.S. 435 (1984), cited in *Hospital Ass'n v. Secretary of HHS*, 820 F.2d 533, 537 (1st Cir. 1987).

¹³⁹815 F.2d 1435 (11th Cir. 1987).

in *County of Los Angeles v. Davis*.¹⁴⁰ Under that standard, a case may be dismissed as moot only when the parties lack a legally cognizable interest in the outcome. Jurisdiction, once obtained, can abate only if two conditions have been met. First, there must be no reasonable expectation that the alleged violation will recur. Second, subsequent events must have “completely and irrevocably eradicated the effects of the alleged violation.”¹⁴¹

Although the weight of authority, and public policy mitigate against the success of the mootness argument, the Secretary will continue to confront providers still litigating the 1979 malpractice rule with this allegation. All this seemingly endless litigation over one rule could have been avoided had the HHS corrected the problems with the 1979 rule when it first became apparent that the rule was hopelessly invalid. The HHS policy of non-acquiescence in judicial rulings has been recently criticized in a report presented to the Administrative Conference of the United States:

Since the inception of the Medicare program, HHS has taken a very tough stance in provider challenges to payment levels under Part A. As guardian of the Medicare trust funds, and especially considering current budget pressures, this position is clearly appropriate.

At some point, however, a question of fairness is raised. This point may have been reached with respect to some Medicare payment issues in view of the fact that federal district and appellate courts have almost uniformly rejected these policies.

. . . HHS should develop a principled policy on when it will acquiesce to judicial decisions affecting the Medicare program and all other programs under the Social Security Act.¹⁴²

Given the amount of money at stake, the non-acquiescence problem is likely to remain, unless the statutory provisions can be amended to facilitate the use of binding class action litigation.

E. Final Determination

Section 1395oo(f)(1) states: “Providers shall have the right to obtain judicial review of any final decision of the Board, or any reversal, affirmance, or modification by the Secretary.”¹⁴³ With the statutory

¹⁴⁰440 U.S. 625 (1979).

¹⁴¹*Id.*

¹⁴²Kinney, *supra* note 5 at 98-99.

¹⁴³42 U.S.C. § 1395oo(f)(1) (Supp. III 1985). *See supra* note 34 for the complete text.

exception provided for expedited judicial review, the courts have been fairly uniform in requiring that all claims first have been submitted to the Board for a final decision prior to any judicial review.¹⁴⁴ This section will explore the various forms that a final determination has taken.

1. *The Effect of Retroactive Rule-making.*—Retroactive rule-making in the context of medical malpractice insurance costs discussed in the preceding section has provided one of the few controversies regarding the final determination requirement.¹⁴⁵ Along with the allegation of mootness, the Secretary has also argued in these cases that until the 1986 rule has actually been applied, and administrative review obtained, there has been no final determination of the Board, and therefore federal jurisdiction cannot exist.¹⁴⁶ This argument has proved problematic for providers. As mentioned in the preceding section, the Seventh Circuit Court of Appeals accepted this reasoning,¹⁴⁷ as has at least one district court.¹⁴⁸ Two other appellate courts faced with this argument found that the lack of final decision only precluded judicial review of the prospective, and not the retroactive application of the new rule.¹⁴⁹ The First Circuit Court of Appeals has been the only court willing to find federal jurisdiction to review both the prospective and retroactive aspects of the rule.¹⁵⁰ That court's reasoning—that the new rule simply raises another question of law "relevant to the matters in controversy" pursuant to the jurisdictional grant of section 139500(f)(1)—is persuasive.¹⁵¹ And the same policy arguments raised by the mootness problem are applicable here. Moreover, as the court pointed out, although the prospective futility of administrative remand is not a factor to be considered if the jurisdictional requirements have not been met, "it is a proper consideration . . . when those jurisdictional requirements have been met."¹⁵² In other words, once a court has properly assumed jurisdiction, subsequent events should not then demand an administrative remand. This is the proper interpretation of section 139500.

¹⁴⁴*See, e.g.,* *Mercy Hosp. of Laredo v. Heckler*, 777 F.2d 1038 (5th Cir. 1985); *Homewood Professional Care Center, Ltd. v. Heckler*, 764 F.2d 1242 (7th Cir. 1985); *Association of Am. Medical Colleges v. Califano*, 569 F.2d 101 (D.C. Cir. 1977).

¹⁴⁵*See supra* notes 123-37 and accompanying text.

¹⁴⁶*See* *Tallahassee Mem. Regional Medical Center v. Bowen*, 815 F.2d 1435, 1449 n.27 (11th Cir. 1987); *Hospital Ass'n v. Secretary of HHS*, 820 F.2d 533, 537 (1st Cir. 1987).

¹⁴⁷*Appleton Mem. Hosp. v. Bowen*, 814 F.2d 408 (7th Cir. 1987).

¹⁴⁸*St. Louis Univ. Medical Center v. Bowen*, 655 F. Supp. 72 (E.D. Mo. 1986).

¹⁴⁹*Mason General Hosp. v. Secretary of HHS*, 809 F.2d 1220, 1231 (6th Cir. 1987); *see also Tallahassee*, 815 F.2d at 1456-57.

¹⁵⁰*Hospital Ass'n v. Secretary of HHS*, 820 F.2d 533 (1st Cir. 1987).

¹⁵¹*Id.* at 538 (citing 42 U.S.C. § 139500(f)(1) (Supp. III 1985); 5 U.S.C. § 706 (1982)).

¹⁵²*Id.* at 539.

2. *Board Denial of Jurisdiction.*—Courts agree that a decision by the Board not to exercise jurisdiction is a final decision for the purpose of judicial review.¹⁵³ If the Board declines jurisdiction for failure to meet one of the threshold requirements of administrative review, that decision is subject to judicial review. If it were not, the Board could preclude any judicial review by simply denying jurisdiction to any claim viewed as non-meritorious.¹⁵⁴

3. *Preclusion of Availability to HHS.*—Interestingly, section 1395oo authorizes only a provider to seek judicial review of a Board decision.¹⁵⁵ However, there seems to be little practical consequence to this omission. The Secretary has the authority to affirm, modify, or reverse any decision of the Board, thus obviating the need for the Secretary to seek judicial review under section 1395oo.¹⁵⁶ Furthermore, if a district court reverses a Board decision in favor of the provider, the Secretary may now seek appellate review, because section 1291, title 28 of the Code governs the availability of appellate review.¹⁵⁷

V. MEDICARE PROVISIONS NOT SUBJECT TO REVIEW

Congress has made certain aspects of provider reimbursement under Medicare not available to any form of administrative or judicial review. An intermediary determination that an expense item is one of those listed in section 1395y, title 42, is not subject to review.¹⁵⁸ This section of the Code lists certain specific expenses that are excluded from Medicare coverage. More importantly, the major provisions of inpatient reimbursement under the prospective payment system adopted in 1983 and completely phased in by 1987 are excluded from any form of review.¹⁵⁹ To understand the significance of this exclusion, some background information on the prospective payment system is necessary.

In an effort to purchase health care services for the aged more efficiently, Congress in 1983 adopted provisions which made major changes in the way hospitals are reimbursed for providing inpatient

¹⁵³See *Saline Community Hosp. Ass'n v. Secretary of HHS*, 744 F.2d 517 (6th Cir. 1984); *Athens Community Hosp., Inc. v. Schweiker*, 686 F.2d 989, 994 (D.C. Cir. 1982), *modified on other grounds*, 743 F.2d 1 (D.C. Cir. 1984).

¹⁵⁴*Cleveland Mem. Hosp. v. Califano*, 444 F. Supp. 125, 128 (E.D.N.C. 1978), *aff'd*, 594 F.2d 993 (4th Cir. 1979).

¹⁵⁵42 U.S.C. § 1395oo(f)(1) (Supp. III 1985). See *supra* note 34 for complete text.

¹⁵⁶*Id.*

¹⁵⁷28 U.S.C. § 1291 (1982); see also *Daviess County Hosp. v. Bowen*, 811 F.2d 338, 342 (7th Cir. 1987).

¹⁵⁸42 U.S.C. § 1395oo(g)(1) (Supp. III 1985).

¹⁵⁹*Id.* § 1395oo(g)(2).

care.¹⁶⁰ Prior to 1983, hospitals were reimbursed for their costs incurred in the treatment of Medicare patients.¹⁶¹ After 1983, hospitals began being reimbursed at predetermined fixed rates which vary according to the type of services rendered.¹⁶² Approximately 470 categories were created, called Diagnosis Related Groups [DRGs].¹⁶³ Thus, a hospital which treats a patient that is classified in a DRG that entitles the hospital to \$7,000 reimbursement will receive that amount, regardless of whether the costs incurred were actually less or substantially greater. Although a complete discussion of the impact of this system is beyond the scope of this Note, it is worth noting that prospective reimbursement creates an enormous change in the financial incentives of inpatient care, and substantially diminishes the significance of the cost report in determining provider reimbursement.¹⁶⁴

At the same time these major amendments were being adopted, Congress amended the jurisdictional provisions of section 1395oo.¹⁶⁵ Neither administrative nor judicial review is available to resolve controversies involving the establishment of DRGs,¹⁶⁶ the methodology used in classifying patients into DRG groups,¹⁶⁷ or the weighting factors attached to each DRG which is used to calculate reimbursement.¹⁶⁸ Nor is review available for disputes involving budget neutral adjustments to the prospective payment rates.¹⁶⁹ Thus, the regulations governing the largest source of hospital Medicare revenue, inpatient services, have been specifically withheld from the overview of a neutral judiciary.¹⁷⁰

VI. FUTURE JURISDICTIONAL LITIGATION

The significance of the cost report and, by implication, the need for administrative and judicial review, was greatly diminished by the advent of prospective reimbursement for inpatients. However, medical

¹⁶⁰See H.R. REP. NO. 25, 98th Cong., 1st Sess. 132 (1983) (discussing the reasoning for adopting prospective reimbursement as codified in 42 U.S.C. § 1395ww(d) (Supp. III 1985)).

¹⁶¹42 U.S.C. § 1395x(v)(1)(A) (1982).

¹⁶²42 U.S.C. § 1395ww(d) (Supp. III 1985).

¹⁶³*Id.*; see also 49 Fed. Reg. 34,728, 34,780-90 (1984).

¹⁶⁴*But see supra* note 26 and accompanying text.

¹⁶⁵42 U.S.C. § 1395oo(g)(2) (Supp. III 1985).

¹⁶⁶42 C.F.R. § 405.1804(b)(1) (1986).

¹⁶⁷*Id.* at § 405.1804(b)(2).

¹⁶⁸*Id.* at § 405.1804(b)(3).

¹⁶⁹*Id.* at § 405.1804(a).

¹⁷⁰Congress created the Prospective Payment Assessment Commission to determine the various factors used to determine the reimbursement factors for each DRG. These factors are updated yearly and published in the Federal Register. 42 U.S.C. §§ 1395ww(d)(4)(D), (e)(2)-(3) (Supp. III 1985).

education expenses, outpatient service costs, capital expenditures, and loss attributable to bad debt are all still significant reimbursements determined by the cost report.¹⁷¹ Not coincidentally, reimbursement methods for all these items have been targeted for change by the HHS or Congress.¹⁷²

In all likelihood, these changes will be opposed by health care providers. While the specific case holdings discussed in the preceding sections will be relied upon extensively, the general doctrines from which much of the case law has developed will be of value. The following sections touch briefly on the major themes which emerge from an assimilation of case law interpreting the jurisdictional parameters of Medicare provider initiated litigation. The doctrines discussed were selected not only for their recurrence in the case law, but because of their general applicability to a variety of jurisdictional issues.

A. *Judicial Deference*

The most frequently occurring theme in provider reimbursement disputes is that of "judicial deference." This doctrine requires courts to defer to the agency's interpretation of a statute the agency is charged with administering.¹⁷³ In other words, this doctrine creates a presumption in cases involving statutory interpretation that the Secretary's interpretation is to be given substantial deference by the courts. However, the "judicial deference" doctrine has limitations in its application. The Supreme Court has taken the position that deference is only appropriate where the statute is ambiguous or silent on a particular issue.¹⁷⁴ Of course, the courts do not always agree as to whether a statute is ambiguous.¹⁷⁵ Further, courts will not defer to an agency interpretation when the interpretation cannot be reconciled with congressional intent.¹⁷⁶ In this respect, the statutory interpretation urged by the Secretary has

¹⁷¹See *supra* note 26.

¹⁷²See 51 Fed. Reg. 6755 (February 26, 1986) (Proposed rule on changes to medical education payment); 52 Fed. Reg. 20,623 (June 2, 1987) (Proposed rule on changes in outpatient payment); 52 Fed. Reg. 18,840 (May 19, 1987) (Proposed rule on capital payments); *Currents*, HOSPITALS, August 5, 1987, at 26 (HCFA circulation of a proposal draft that would halt Medicare payments for bad debt).

¹⁷³*Blum v. Bacon*, 457 U.S. 132, 141 (1982).

¹⁷⁴*Chevron U.S.A. v. Natural Res. Defense Council*, 467 U.S. 837, 842-43 (1984).

¹⁷⁵In their respective interpretations of section 1395oo(f), compare *St. Luke's Hosp. v. Secretary of HHS*, 810 F.2d 325, 331 (1st Cir. 1987) ("[W]e interpret the language literally, and we find no initial ambiguity.") with *Athens Community Hosp. v. Schweiker*, 743 F.2d 1, 8 (D.C. Cir. 1984) ("[T]he statute is unclear (to put it mildly in the context of this case) . . .").

¹⁷⁶*Securities Industry Ass'n v. Board of Governors*, 468 U.S. 137, 143 (1984).

often been found to be at odds with the plain language of the statute.¹⁷⁷ Providers have also argued that the weight to be given the agency interpretation will depend on the consistency of the agency's position with prior actions.¹⁷⁸ Hospitals have thus been able to take advantage of prior inconsistencies in the Board's actions.¹⁷⁹

Moreover, the Supreme Court has recently explained that the "judicial deference" rule is applicable only where the agency is applying an agreed upon legal standard to a set of facts, and not where there is a question of interpretation of a contested legal standard.¹⁸⁰ Thus, it would appear that courts need not show deference when the matter is one of pure statutory construction.¹⁸¹ Similarly, providers have successfully argued that while HHS may have special expertise in administering the substantive provisions of Medicare, it has no special expertise in interpreting jurisdictional statutes, and thus deference is not necessarily required when the contested issue involves jurisdiction.¹⁸²

B. Congressional Intent

Another critical aspect of provider jurisdictional disputes has been the relationship of the action to congressional intent, as discerned through the legislative history of section 1395oo. Congress has been careful to amend the statute when necessary, and the legislative history, though brief, has been frequently invoked. Congressional intent has proved to be dispositive of provider disputes, both for and against the providers.¹⁸³ A review of the legislative history indicates a trend toward broadening the jurisdictional borders of provider disputes, at least until 1983. The original statute, which only permitted judicial review where the Secretary reversed or modified a Board decision, was modified in 1974 to permit

¹⁷⁷See, e.g., *Doctor's Hosp., Inc. v. Bowen*, 811 F.2d 1448, 1452 (11th Cir. 1987); *Hospital Ass'n v. Secretary of HHS*, 820 F.2d 533, 537-38 (1st Cir. 1987).

¹⁷⁸*INS v. Cardoza-Fonseca*, 107 S. Ct. 1207, 1221 n.30 (1987). *Accord* *Bowen v. American Hosp. Ass'n*, 106 S. Ct. 2101, 2122 n.34 (1986).

¹⁷⁹*St. Luke's Hosp. v. Secretary of HHS*, 810 F.2d 325 (1st Cir. 1987).

¹⁸⁰107 S. Ct. at 1221.

¹⁸¹*Id.*

¹⁸²*Adams House Health Care v. Heckler*, 817 F.2d 587, 594 (9th Cir. 1987); *St. Luke's Hosp. v. Secretary of HHS*, 810 F.2d 325 (1st Cir. 1987).

¹⁸³See *Tallahassee Mem. Regional Medical Center v. Bowen*, 815 F.2d 1435, 1463 (11th Cir. 1987) (In ruling for the provider, the court noted, "The clear language of the statute and the legislative history of the PRRB lead us to conclude. . ."); *Springdale Mem. Hosp. Ass'n v. Bowen*, 818 F.2d 1377, 1386 (8th Cir. 1987) (In ruling for the HHS, the court noted, "Nothing in the legislative history indicates that Congress intended this conforming amendment to [eliminate the NPR] This, coupled with our reading of section 1395oo(a) leads us to conclude. . .").

review of a decision of the Board.¹⁸⁴ Then, in 1980, the statute was again amended to provide for expedited judicial review.¹⁸⁵ Sharp limitations on review were then adopted as part of prospective reimbursement in 1983.¹⁸⁶ How subsequent legislative history will affect provider claims will largely depend on the nature of the dispute. While Congress seems willing to provide for more access to review of minor matters, the new trend with regard to the major provisions of payment methodologies is toward precluding review.

C. *The Michigan Academy Case*

Congress and courts have spoken often of a strong presumption of the availability of judicial review.¹⁸⁷ The Supreme Court has underscored this presumption in the Medicare context in the recent case of *Bowen v. Michigan Academy of Family Physicians*.¹⁸⁸ In this case, a group of physicians challenged the method by which certain payments were made under Medicare Part B.¹⁸⁹ Although prior case law tended to indicate that judicial review was not available for Part B payment determinations, the Court held that review is only foreclosed from determinations of benefit amounts, and not from the method by which the determinations are made.¹⁹⁰ Providers have been quick to incorporate this theme into their arguments. Some courts have found the *Michigan Academy* holding supportive of the provider viewpoint,¹⁹¹ but others have not.¹⁹² The implication of *Michigan Academy*—that the methods by which Medicare payments are made should be available to judicial review—does not square with the 1983 amendments foreclosing review of payment methodologies affecting health care providers. As yet, no challenge has been made to the jurisdictional limitations of the 1983 amendments. It has been argued that the lack of challenge to the statute may be attributable to the fact that hospitals have been doing reasonably well financially under prospective payment, and that it would be difficult to show that the methodology is arbitrary or capricious.¹⁹³ At some point, however,

¹⁸⁴42 U.S.C. § 1395oo(f)(1) (Supp. 1985). PUB. L. No. 93-484, 88 Stat. 1459 (1974).

¹⁸⁵See *supra* text accompanying note 115.

¹⁸⁶See *supra* text accompanying notes 165-70.

¹⁸⁷See, e.g., *Abbott Laboratories v. Gardner*, 387 U.S. 136, 140 (1987) (citing cases); S. REP. No. 752, 79th Cong., 1st Sess. 26 (1945).

¹⁸⁸476 U.S. 667 (1986).

¹⁸⁹*Id.* at 668.

¹⁹⁰*Id.* at 678.

¹⁹¹*Tallahassee Mem. Regional Medical Center v. Bowen*, 815 F.2d 1435, 1463-64 n.54 (11th Cir. 1987).

¹⁹²*Bethesda Hosp. v. Secretary of HHS*, 810 F.2d 558, 561 (6th Cir. 1987).

¹⁹³Kinney, *supra* note 5 at 88.

financial incentives will force a provider group to challenge the preclusion of review, and when that happens, the providers will rely heavily on the *Michigan Academy* holding.

VII. CONCLUSION

The burdensome backlog of pending appeals to the Board¹⁹⁴ and the voluminous number of court decisions¹⁹⁵ are evidence that the health care providers are willing to litigate when the Secretary or Congress makes decisions affecting their interests. Providers are frustrated, however, by the HHS policy of non-acquiescence.¹⁹⁶ Furthermore, despite the pronouncements of the Supreme Court favoring the class action in the administrative context, the rigid timing requirements of administrative and judicial review make it virtually impossible for providers to get certification to mount class action challenges to offensive regulations.¹⁹⁷ The piecemeal litigation of the same issues, and the conflicting results that are frequently obtained, have made the resolution of provider disputes a highly technical, time-consuming, and expensive process. By insulating certain aspects of the Medicare program from judicial scrutiny,¹⁹⁸ Congress has foreclosed any possibility of recourse for health care providers who believe that the provisions are unfair or otherwise invalid.

These are volatile times for the health care industry. Prospective reimbursement and other regulatory changes are a response to what has been perceived as a runaway escalation of health care costs.¹⁹⁹ As Congress and the HHS look for new ways to limit Medicare expenditures, any

¹⁹⁴See *supra* note 57.

¹⁹⁵See *supra* note 6.

¹⁹⁶See *supra* note 142 and accompanying text.

¹⁹⁷In order to obtain class certification, Fed. R. Civ. P. 23 requires, *inter alia*, numerosity of class, common questions of law or fact, and that the representative parties typify and be able to adequately protect the interests of the entire class. If the problems of coordinating the appeals process among hundreds of hospitals all in the different jurisdictions, and all winding their way through the administrative appeal process at varying speeds could be overcome statutorily, the next task would be to determine to what extent certification would extend to other similarly situated providers. In making this decision, the courts must weigh the costs and burdens of unsettling previously decided claims against the potential injustice of not doing so. *McClure v. Harris*, 503 F. Supp. 409, 413 (N.D. Cal. 1980), *rev'd on other grounds sub nom. Schweiker v. McClure*, 456 U.S. 188 (1982).

¹⁹⁸See *supra* notes 158-70 and accompanying text.

¹⁹⁹See, e.g., Schramm, *State Hospital Cost Containment: An Analysis of Legislative Initiatives*, 19 IND. L. REV. 919, 920 (1986); Kinney, *Making Hard Choices Under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1151 (1986).

gains made will probably come at the expense of the health care providers rather than the health care beneficiaries. In light of these inevitable changes, the time has come for a more expansive interpretation of the jurisdictional parameters that govern Medicare provider reimbursement disputes, or perhaps even legislative reform. In *Michigan Academy*, the Supreme Court spoke of a strong presumption of administrative and judicial review in the Medicare context.²⁰⁰ That viewpoint has been underscored by the more recent *Bethesda Hospital*²⁰¹ case as well. Since Congress has sharply restricted significant aspects of Medicare reimbursement from judicial oversight,²⁰² it has become even more imperative that the Board and the federal judiciary interpret the jurisdictional statutes broadly in disputes over the provisions still subject to review. What is needed is statutory constructions that will allow Medicare providers the widest access to review of the regulatory changes that affect both their ability to function in the health care marketplace and the delivery of health care services.

DOUGLAS E. CRESSLER

²⁰⁰See *supra* note 187 and accompanying text.

²⁰¹See *supra* notes 69-80 and accompanying text.

²⁰²See *supra* notes 158-70 and accompanying text.

