No. 05-936

In the Supreme Court of the United States

MICHAEL O. LEAVITT, SECRETARY OF HEALTH & HUMAN SERVICES, PETITIONER

v.

BAYSTATE HEALTH SYSTEMS, D/B/A/ BAYSTATE MEDICAL CENTER, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

PAUL D. CLEMENT
Solicitor General
Counsel of Record

PETER D. KEISLER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

LISA S. BLATT
Assistant to the Solicitor General

ANTHONY J. STEINMEYER
ANNE M. MURPHY
Attorneys

Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

PAULA M. STANNARD
Acting General Counsel

THOMAS R. BARKER
Deputy General Counsel

KATHLEEN H. MCGUAN
Associate General Counsel

MARK D. POLSTON
Deputy Associate General Counsel for Litigation

GERARD KEATING
SYLVIA J. TRUJILLO
Attorneys

Department of Health and Human Services
Washington, D.C. 20201

QUESTION PRESENTED

Whether a federal court may, under 28 U.S.C. 1361, compel the Secretary of Health and Human Services to reopen and revise final Medicare payment determinations where the Secretary prospectively changed his interpretation of the Medicare Act to acquiesce in adverse circuit decisions and expressly ordered his fiscal intermediaries not to reopen and revise any final determinations.

PARTIES TO THE PROCEEDINGS

The petitioner in this Court is the Secretary of Health and Human Services, Michael O. Leavitt. The respondents are twenty-six Medicare providers: Baystate Health Systems d/b/a Baystate Medical Center, Berkshire Health Systems, Brockton Hospital, Carney Hospital, Cooley-Dickinson Hospital, Harrington Memorial Hospital, Holy Family Hospital, Holyoke Hospital, Jordan Hospital, Landmark Medical Center, Lawrence General Regional Health System, Inc., Lifespan, Lowell General Hospital, Memorial Hospital of Rhode Island, Morton Hospital and Medical Center, North Adams Regional Hospital, City of Quincy Hospital, Roger Williams Medical Center, Providence Health System, St. Anne's Hospital, Caritas Christi Health Care System, St. Joseph's Health Services of Rhode Island, Southcoast Hospitals Group, Sturdy Memorial Hospital, University of Massachusetts Memorial Medical Center, doing business as University of Massachusetts Memorial Hospital, and University of Massachusetts University Medical Center, doing business as University of Massachusetts University Hospital, which were appellees in the court of appeals.

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The Solicitor General, on behalf of the Secretary of Health and Human Services, Michael O. Leavitt, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-11a) is reported at 414 F.3d 7. The opinion of the district court (App., *infra*, 12a-30a) is reported at 309 F. Supp. 2d 89.

JURISDICTION

The judgment of the court of appeals was entered on July 1, 2005. A petition for rehearing was denied on September 28, 2005 (App., *infra*, 47a-48a). On December 19, 2005, Chief Justice Roberts extended the time within which to file a petition for a writ of certiorari to and including January 26, 2006. This Court's jurisdiction is invoked under 28 U.S.C. 1254(1).

REGULATORY PROVISION INVOLVED

The reopening regulation, 42 C.F.R. 405.1885 (1997), and Ruling 97-2 are reproduced at App., *infra*, 49a-55a.

STATEMENT

1. a. Title XVIII of the Social Security Act establishes the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered inpatient hospital and related post-hospital services. When patient beneficiaries receive covered services, the Secretary of Health and Human Services (HHS) reimburses the providers of those services under the Medicare Act and the implementing regulations. 42 U.S.C. 1395d, 1395ww(d).

A provider's total allowable Medicare payment is based on a "cost report" that it must prepare after the close of its fiscal year. 42 C.F.R. 405.1801(b)(1), 413.24(f). The cost report is filed with a "fiscal intermediary," generally a private insurance company that acts as the Secretary's agent and determines the amount of payments to be made pursuant to an agreement with the Secretary. 42 U.S.C. 1395h. The intermediary analyzes the cost report, audits it to the extent necessary, and issues the provider a written "notice of amount of program reimbursement" (NPR) containing the final determination of the total amount due the provider for Medicare services during the reporting period. *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 451 (1999) (*Your Home*); 42 C.F.R. 405.1803.

Congress specified in the Medicare Act a comprehensive scheme for administrative and judicial review of a fiscal intermediary's final determination. A "dissatisfied" provider may obtain a hearing before the Provider Reimbursement Review Board (PRRB) in HHS if the amount in controversy is at least $10,000 (or $50,000 for group appeals) and the provider requests a hearing within 180 days after notice

of the intermediary's final determination. 42 U.S.C. 1395*oo*(a)(1)(A)(i), (a)(2), (a)(3), (b), and (h); 42 C.F.R. 405.1835, 405.1845(a). See *Your Home*, 525 U.S. at 451; *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 403-404 (1988). The Board's decision is subject to review by the Secretary and to judicial review in federal district court if an action is brought within 60 days. 42 U.S.C. 1395*oo*(f)(1); 42 C.F.R. 405.1875 and 405.1877; *Your Home*, 525 U.S. at 451.

b. The Secretary has promulgated regulations governing "[r]eopening" of Medicare reimbursement determinations and decisions. 42 C.F.R. 405.1885; *Your Home*, 525 U.S. at 451. The regulations provide that a determination by the intermediary or a decision of the PRRB or the Secretary on administrative appeal may be reopened within three years with respect to specific "findings on matters at issue in such determination or decision," on the motion of either the affected provider or the relevant decision-maker—the intermediary, PRRB or Secretary. 42 C.F.R. 405.1885(a); see *Your Home*, 535 U.S. at 451. For the time period relevant to this case, the regulations further provided that "[a] determination * * * rendered by the intermediary shall be reopened and revised by the intermediary" if, "within the aforementioned 3-year period," the Health Care Financing Administration (HCFA) in HHS notifies the intermediary that such determination "is inconsistent with the applicable law, regulations, or general instructions issued by [HCFA] in accordance with the Secretary's agreement with the intermediary." 42 C.F.R. 405.1885(b) (1997).[1]

The Secretary's reopening regulations also provide that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R.

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[1] HCFA has been renamed the Centers for Medicare and Medicaid Services (CMS). 66 Fed. Reg. 35,437 (2001).

405.1885(c). This Court held in *Your Home* that an intermediary's denial of a request under 42 C.F.R. 405.1885(a) (1997) to reopen an intermediary's final determination was not subject to review by the PRRB or by a federal court under federal question jurisdiction, 28 U.S.C. 1331, or the mandamus statute, 28 U.S.C. 1361. 525 U.S. at 452-457.

2. In February 1997, HCFA issued Ruling 97-2, which prospectively acquiesced on a nationwide basis in the adverse decisions of four courts of appeals that had rejected the Secretary's method for calculating the "disproportionate share hospital" (DSH) adjustment to the rates applicable to those hospitals that serve a disproportionate percentage of low-income patients. App., *infra*, 49a-53a. In authorizing DSH adjustments, the Medicare Act requires calculation of a fraction whose numerator is "the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance" under Medicaid. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). In a preamble to the 1986 regulations implementing the DSH provision, the Secretary explained that he interpreted the Act to mean that "Medicaid covered days will include only those days for which benefits are payable," 51 Fed. Reg. 16,777 (1986); accord 51 Fed. Reg. 31,460 (1986), and thus to exclude days for which patients were not eligible under the terms of a State's Medicaid plan to receive payment for services.

Ruling 97-2 explained that, although HCFA "believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory language," HCFA recognized that its interpretation "is contrary to the applicable law in four judicial circuits." App., *infra*, 51a. Accordingly, HCFA announced that it would follow the adverse appellate decisions on a nationwide basis beginning on or after February 27, 1997, in order "to ensure national uniformity in calculation of DSH adjustments." *Ibid.* Ruling 97-2 stated that HCFA would begin to "count in the Medicaid fraction

the number of days of inpatient hospital services for patients eligible for Medicaid on that day, whether or not the hospital received payment for those inpatient hospital services." *Id.* at 51a- 52a. The Ruling expressly stated that it had only prospective application to cost reports that were still unsettled (or open) when the Ruling was issued and to cases in which a jurisdictionally proper appeal of the DSH payment issue was then pending. *Id.* at 52a. The Ruling expressly provided that HCFA "*will not reopen settled cost reports based on this issue.*" *Ibid.* (emphasis added).

Notwithstanding those explicit limitations in Ruling 97-2, the D.C. Circuit held in *Monmouth Medical Center* v. *Thompson*, 257 F.3d 807 (2001) (App., *infra*, 31a-46a), that Ruling 97-2 required intermediaries to reopen settled DSH reimbursement determinations for two providers and that mandamus relief was available to require it to do so. Those providers had failed to appeal the DSH determinations embodied in the NPRs issued to them by their respective intermediaries, but they had filed for reopening within three years of their respective NPRs, as required by 42 C.F.R. 405.1885(a). The intermediary denied reopening on the ground that it was barred by Ruling 97-2. App., *infra*, 35a. The court of appeals held, however, that the intermediaries were required by 42 C.F.R. 405.1885(*b*) to reopen the prior determinations, concluding that the Secretary, in Ruling 97-2, had "in effect" announced a finding that the determinations were inconsistent with applicable law within the meaning of that regulation, thereby triggering a mandatory duty to reopen. App., *infra*, 42a.

The court reached that result by the following reasoning: The court first observed that although Ruling 97-2 merely acquiesced prospectively in the result reached by four circuits, without stating that HCFA's prior interpretation was unlawful, the ruling did purport to change an existing interpretation by HCFA. App., *infra*, 42a-43a. The court then

noted that, although the Administrative Procedure Act (APA), 5 U.S.C. 553(a) and parallel provisions of the Medicare Act, 42 U.S.C. 1395hh(b) and (c), exempt interpretive rules from notice-and-comment requirements, circuit precedent nonetheless requires an agency to follow notice-and-comment procedures even for an interpretive rule when a different but valid interpretation exists. App., *infra*, 43a-44a (citing *Paralyzed Veterans of Am.* v. *D.C. Arena L.P.*, 117 F.3d 579, 586 (D.C. Cir. 1997), cert. denied, 523 U.S. 1003 (1998), and *Alaska Professional Hunters Ass'n* v. *Federal Aviation Admin.*, 177 F.3d 1030, 1033-1034 (D.C. Cir. 1999)). The court reasoned therefore that the new interpretation established by Ruling 97-2 would be unlawful absent notice-and-comment rulemaking, "unless the original interpretation was itself invalid." App., *infra*, 44a.

The court then concluded that Ruling 97-2 represented an implicit concession by HCFA that its 1986 interpretation was invalid, even though Ruling 97-2 expressly stated that "HCFA believes that its longstanding interpretation of the statutory language was a permissible reading" of that language. App., *infra*, 51a. Finally, treating the concession it attributed to HCFA as notice to intermediaries that HCFA's prior interpretation was "inconsistent with the applicable law" under 42 C.F.R. 405.1885(b), the court held that Ruling 97-2 imposed a "clear duty" on intermediaries to reopen DSH payment determinations for the hospitals, enforceable by mandamus, even though Ruling 97-2 expressly stated that such determinations would not be reopened. App., *infra*, 45a.

The court found it insignificant that, because of the three-year limitations in the regulations, "reopening would not be available if sought today." App., *infra*, at 45a. The court explained that the issuance of mandamus is largely controlled by equitable principles, and that "[s]ince both hospitals were within the three-year mark when they made their requests

for reopening, they are entitled to the reopening that was due them at that time." *Ibid.*

3. In 2002, in the wake of the *Monmouth* decision, the Secretary amended his reopening regulation to make clear that subsection (b) requires reopening only when the Secretary "[p]rovides notice to the intermediary that the intermediary determination * * * is inconsistent with the applicable law * * * in effect, and as [the Secretary] understood those legal provisions" when the intermediary made its determination. 42 C.F.R. 405.1885(b)(1)(i). The new regulation also states that reopening may occur only when the intermediary is "[e]xplicitly" directed by the Secretary to reopen, and it further clarifies that a "change of legal interpretation or policy[,] * * * whether made in response to judicial precedent or otherwise, is not a basis for reopening." 42 C.F.R. 405.1885(b)(1)(ii) and (2). The regulation's effective date is October 1, 2002. 67 Fed. Reg. 49,982 (2002).

4. Two years after *Monmouth*, the Tenth Circuit held, in conflict with *Monmouth*, that Ruling 97-2 does not impose any mandatory duty to reopen under the pre-2002 reopening regulation. *Bartlett Mem'l Med. Ctr., Inc.* v. *Thompson*, 347 F.3d 828, 838-841 (2003). The Tenth Circuit explained that "[t]he language of Ruling 97-2 clearly evinces both the Secretary's belief that his prior interpretation of the DSH provision was not inconsistent with the applicable law and his intent that no NPRs be reopened on that basis." *Id.* at 838. The Tenth Circuit also expressed its disagreement with the D.C. Circuit's *Monmouth* decision, observing that its reasoning was "unsound" because *Monmouth* "makes assumptions about the premises and intended effect of Ruling 97-2 that do not comport with fact or with the clear intention of the Secretary." *Id.* at 839.

5. In the meantime, eight months after the *Monmouth* decision and five years after the issuance of Ruling 97-2, 26 providers filed this action in the District of Columbia seeking

mandamus relief to compel the Secretary to reopen DSH calculations for the three years preceding Ruling 97-2, even though those providers never appealed their original DSH calculations and, unlike the providers in *Monmouth*, never sought reopening under the Secretary's regulations. Two-hundred seventy-five similar suits brought by 639 hospitals were filed in the same district court, which stayed the suits pending the resolution of this suit. The district court granted the 26 providers' motion for summary judgment. App., *infra*, 12a-30a.

The court of appeals affirmed. App., *infra*, 1a-11a. The court concluded that the providers' failure to appeal their DSH determinations to the PRRB did not bar mandamus relief because the two hospitals in *Monmouth* had likewise not appealed. *Id.* at 7a-9a. The court of appeals then extended *Monmouth* by holding that mandamus relief was available even for providers that failed to seek reopening from HHS within the three years allowed by the reopening regulation. *Id.* at 9a. The court explained that, even if the providers had filed timely motions to reopen, intermediaries would not have been at liberty to ignore the bar to reopening in Ruling 97-2, and the intermediaries' denial of reopening would have been unreviewable under *Your Home*. *Id.* at 7a-8a.

REASONS FOR GRANTING THE PETITION

The decision below is the product of two previous decisions of the D.C. Circuit. All three decisions are wrong, in conflict with decisions of other courts of appeals, and in tension with decisions of this Court. The combined effect of the three decisions is to make administrative acquiescence in adverse judicial decisions prohibitively expensive. Although the Secretary has amended his regulations to ameliorate the prospective effect of the decision below, the ruling below still threatens billions of dollars in liability from the reopening of closed cost years. Moreover, the mistaken principles of

administrative law established in the decision below will threaten further liability if left uncorrected.

The court of appeals plainly erred in *Monmouth* in holding that Ruling 97-2, which expressly acquiesced in the result reached by four courts of appeals only on a prospective basis, imposed a clear duty on fiscal intermediaries to reopen closed cost reports. Ruling 97-2 expressly *prohibits* reopening of such closed cost reports. And contrary to the court of appeals' view that Ruling 97-2 constitutes an implicit concession by the Secretary that his prior interpretation of the relevant statutory provisions was invalid all along (which, in turn, triggered a duty under the Secretary's regulation, 42 C.F.R. 405.1885(b), to reopen), Ruling 97-2 expressly states that the Secretary believes that his prior interpretation was based on a permissible interpretation of those provisions. *Monmouth* thus defied the plain text of the very administrative ruling it purported to construe and apply. It also improperly refused to defer to the Secretary's longstanding interpretation of the reopening regulation, which had always been understood to give the Secretary the ultimate control over reopening, not to give third parties a right, enforceable by mandamus, to force intermediaries to reopen against the express direction of the Secretary.

Now, in the decision below, the court of appeals has dramatically extended *Monmouth* by holding that Ruling 97-2 imposes a mandatory duty on the Secretary and intermediaries, enforceable by mandamus, to reopen closed cost reports even for providers that not only failed to appeal determinations by their intermediaries, but also (unlike the providers in *Monmouth*) failed even to seek reopening of those determinations within three years, as required by the only regulation that allows for reopening at the behest of a provider, 42 C.F.R. 405.1885(a). That holding compounds *Monmouth*'s conflict with Ruling 97-2 and the reopening regulations. The court of appeals imposed has broad retro-

active reopening obligations and monetary liability that would never have resulted if the Secretary had plowed ahead with further litigation and lost on the merits in other courts of appeals or this Court. The result is to penalize both the Secretary and the Trust Fund, held for the benefit of Medicare participants, for the Secretary's decision to try to save the providers, the government, and the courts the burdens of that further litigation. Acquiescence should not come at that high a price. Such a rule could not help but chill the sound and flexible administration of federal programs.

The D.C. Circuit's erroneous rulings in *Monmouth* and this case warrant review by this Court. The decision in *Monmouth*, which the panel below found to be controlling here, squarely conflicts with the Tenth Circuit's decision in *Bartlett Mem'l, Med. Ctr., Inc.* v. *Thompson*, 347 F.3d 828 (2003), which rejected the contention that intermediaries and the Secretary have a duty, enforceable by mandamus, to reopen closed cost reports in light of Ruling 97-2. In addition, the decisions in *Monmouth* and this case cannot be reconciled with decisions of this Court requiring deference to the plain text of an agency's rules and an agency's interpretation of its own regulations. They also are at odds with this Court's decisions holding that mandamus is unavailable where a party has failed to pursue available procedures for review; with the background rule established by this Court's cases that reopening decisions are discretionary with the agency; and with this Court's ruling in *Your Home*. And finally, both *Monmouth* and the decision below rest on the erroneous rule of the D.C. Circuit's *Paralyzed Veterans* decision—that notice-and-comment rulemaking is required for the issuance of an interpretative rule that changes an agency's existing interpretation—a decision that itself conflicts with the decisions of two other courts of appeals.

Quite aside from the legal errors in the court of appeals' decisions, the practical consequences of the decision below

would justify this Court's review, despite the Secretary's effort to limit the prospective damage by amending the reopening regulation. There are now approximately 275 additional suits pending in the district court raising the same issue, and HHS, in its latest public report on the financial status of the Medicare Program, estimates that the potential liability to the Trust Fund from the court of appeals' requirement that closed cost reports be reopened on the DSH issue is $2.8 billion. And additional mandamus actions have already been filed in the district court seeking to compel reopening on issues other than DSH. A decision resting on such mistaken principles of administrative law and having such enormous practical consequences should not be permitted to stand.

A. The Court Of Appeals' Decision Is Clearly Erroneous

The court of appeals clearly erred in holding that the extraordinary remedy of mandamus is available in this case. In the first place, Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), which has been incorporated into the Medicare Act by 42 U.S.C. 1395ii, provides that "[n]o findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as" provided in the Medicare Act itself. Thus, the intermediaries' determination of providers' DSH payments (like the intermediaries' denial of a motion to reopen) cannot be reviewed by any "tribunal," including a federal district court, except as provided in the Medicare Act itself. See *Califano* v. *Sanders*, 430 U.S. 99, 110-111 (1977) (Stewart, J., concurring in the judgment). Because the hospitals in this case unquestionably never invoked their right to direct review of their DSH payments and never even presented a request for reopening

of those determinations, the hospitals are precluded from seeking mandamus relief.[2]

Even were mandamus relief available in a case arising under Medicare, a federal court's exercise of mandamus jurisdiction under 28 U.S.C. 1361 is "a drastic [remedy], to be invoked only in extraordinary situations." *Allied Chem. Corp.* v. *Daiflon, Inc.*, 449 U.S. 33, 34 (1980) (per curiam). Mandamus relief is appropriate "for a plaintiff only if he has exhausted all other avenues of relief and only if the defendant owes him a clear nondiscretionary duty." *Heckler* v. *Ringer*, 466 U.S. 602, 616 (1984); see also *Gulf Stream Aerospace Corp.* v. *Mayacamas Corp.*, 485 U.S. 271, 289 (1988) (party seeking mandamus must show its "right to issuance of the writ is clear and indisputable") (internal quotation marks omitted); accord *Cheney* v. *United States Dist. Court*, 542 U.S. 367, 381 (2004). Respondents have satisfied neither of those conditions.

1. *The providers failed to exhaust their right to appeal the intermediaries' DSH determinations*

In this mandamus action, the providers seek recalculation of final DSH reimbursement determinations that were made by intermediaries in the 1994-1997 time period, despite the providers' failure to appeal those determinations to the PRRB within the 180-day period set forth in 42 U.S.C. 1395*oo*(a). App., *infra*, 7a; see 42 C.F.R. 405.1807 (intermediary's "determination shall be final and binding" absent a timely request for PRRB review). Because the providers unquestionably failed to exhaust their statutory right to appeal, the providers failed to establish that they "exhausted all other avenues of relief" (*Ringer*, 466 U.S. at 616) to ob-

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[2] This Court has reserved the question whether Section 405(h) altogether forecloses mandamus relief for claims arising under the Medicare Act. *Your Home*, 525 U.S. at 456-457 n.3; *Heckler* v. *Ringer*, 466 U.S. 602, 616-617 (1984).

tain the DSH payments to which they now claim they were entitled.

There was no obstacle to providers availing themselves of the statutory right to appeal to vindicate their claims to payment. Indeed, the four adverse circuit decisions that prompted Ruling 97-2 resulted from direct appeals of DSH payment determinations by providers that did not sleep on their rights but rather exhausted the review scheme set forth in the Medicare Act.[3] The failure of the providers here to appeal the fiscal intermediaries' original DSH payment determinations to the Board thus precludes mandamus relief. *Ringer*, 466 U.S. at 617 (mandamus unavailable where Medicare claimants failed to invoke right of direct appeal that provided "an adequate remedy * * * for challenging all aspects of the Secretary's denial of their claims for payment"); *Pittston Coal Group* v. *Sebben*, 488 U.S. 105, 123 (1988) (denying mandamus relief, noting that claimants seeking benefits "would have been vindicated if they had sought judicial review; they chose instead to accept incorrect adjudication"). That conclusion is only highlighted by the failure of the providers here, unlike those in *Monmouth*, to invoke the regulatory reopening mechanism in Section 405.1885(a) in a timely fashion.

2. *The Secretary has no clear duty to reopen reimbursement determinations*

There is no basis for concluding that the Secretary has a clear, non-discretionary duty to reopen and revise a payment determination that providers allowed to become final and binding against them when they elected to forgo a right of

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[3] *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984 (4th Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconess Health Servs. Corp.* v. *Shalala*, 83 F.3d 1041 (8th Cir. 1996); and *Jewish Hosp. Inc.* v. *Secretary of HHS*, 19 F.3d 270 (6th Cir. 1994).

direct appeal. The only subsection of the reopening regulation that directly affords an opportunity for reopening to providers is, by its terms, discretionary rather than mandatory. Section 405.1885(a) provides that an otherwise final reimbursement determination of an intermediary "may" be reopened and revised within three years of the determination if the provider requests reopening. Respondents concededly could not rely on this subsection—the only provision for reopening at the behest of a provider—because they never sought reopening, but its discretionary nature nonetheless underscores the lack of any mandatory duty running to the providers.

The court of appeals nonetheless found a mandatory duty by focusing on Section 405.1885(b), which provides that the intermediary "shall" reopen and revise a determination if HCFA "notifies the intermediary" that its determination "is inconsistent with the applicable law, regulations, or general instructions issued by [HCFA] in accordance with the Secretary's agreement with the intermediary." 42 C.F.R. 405.1885(b) (1997). The court of appeals held that "[t]he Secretary had a clear duty to require the intermediaries to reopen the hospitals' NPRs * * * because Ruling 97-2 amounted to a notice of inconsistency and because section 405.1885(b) mandates reopening when HCFA issues such a notice." App., *infra*, 6a; accord *id.* at 42a-46a. That analysis is flawed in four critical respects.

a. *The decision whether to reopen is committed to the Secretary's unreviewable discretion*

The first fundamental problem with the court of appeals' decision is that the Secretary's decision whether to order reopening under 42 C.F.R. 405.1885(b) based on an alleged error of law is entirely discretionary and unreviewable. That subsection does not create any mandatory duty on the part of the Secretary, but rather creates a mandatory duty on the

part of the intermediary if the Secretary has made a discretionary decision to order reopening. The text of the regulation plainly contemplates that in order to trigger reopening, there must be a notification specifically directed to an intermediary (the Secretary's agent) with respect to particular determinations that must be reopened. See 42 C.F.R. 405.1885(b) (reopening required if HCFA notifies the intermediary that "such determination" is inconsistent with applicable law).

Indeed, when the reopening rule was first promulgated in 1972 by the Social Security Administration (which then administered Medicare), the agency made clear that the regulations required intermediary reopening only upon "*the request of the Social Security Administration*" if the agency believed the intermediary's determination reflected an error of law. 37 Fed. Reg. 10,723 (1972) (emphasis added). The Secretary confirmed that long-standing interpretation when he amended the reopening regulation in 2002, stating: "We have always considered our notice, which is a precondition of mandatory intermediary reopening * * *, to be one in which we explicitly direct the intermediary to reopen." 67 Fed. Reg. at 50,096. Accordingly, as the Tenth Circuit correctly concluded in *Bartlett*, 347 F.3d at 840, the Secretary cannot "inadvertently notify the intermediaries to reopen and revise NPRs, contrary to his own clearly expressed intent not to allow reopening." See also *id.* at 839 ("Unlike the D.C. Circuit, we believe the concept of 'notification' requires some level of intent by the Secretary.").

Moreover, respondents cannot point to any clear statement in the regulation imposing a reopening duty *owed to them*. See 28 U.S.C. 1361 (duty of United States officer must be owed "*to the plaintiff*") (emphasis added).[4] Section

[4] In adopting the language in 28 U.S.C. 1361 that the governmental official must owe a duty "to the plaintiff," Congress rejected proposals to

405.1885(b), by its own terms, confers no duty on the Secretary, and confers no rights on providers. Rather, it reflects, at most, a conditional duty owed *to the Secretary* by fiscal intermediaries, acting as the Secretary's agents. Section 405.1885(b) directs that a determination "shall" be reopened and revised only "if" the Secretary, through HCFA, notifies the intermediary that a prior determination was inconsistent with applicable law, whether favorable or unfavorable to the provider. That rule simply requires intermediaries to follow the instructions of the Secretary. The text of the regulation reinforces that conclusion in yet another respect, since it states that the obligation to reopen stems from the intermediary's duty to act "in accordance with the Secretary's agreement with the intermediary." 42 C.F.R. 405.1885(b) (1997).

By contrast, the regulation imposes no duty (much less an indisputably clear duty) on the Secretary to afford reopening to a provider. Instead, it presupposes that the Secretary, in his sole discretion, has the authority to determine whether reopening is appropriate. That conclusion is confirmed when Section 405.1885(b) is read in light of Section 405.1885(a), which makes clear that, insofar as the provider is given an opportunity to seek reopening, relief is entirely discretionary with the Secretary. 42 C.F.R. 405.1885(a) (an intermediary's determination "may" be reopened at the request of the provider); *Your Home*, 525 U.S. at 457 ("The reopening regulations do not require reopening, but merely permit it."). For those reasons, "the Secretary has complete discretion as to when to employ the mandatory reopening regulation." *Bartlett*, 347 F.3d at 839. That has been the Secretary's

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extend Section 1361 to the enforcement of duties owed by government officials to the general public, rather than to an individual plaintiff. See S. Rep. No. 1992, 87th Cong., 2d Sess. 6 (1972); 108 Cong. Rec. 18,783-18,784, 20,079, 20,093-20,094 (1962).

long-standing interpretation. See 67 Fed. Reg. at 50,097, 50,099-50,100. The Secretary's interpretation is confirmed by the "traditional rule of administrative law" that an agency's refusal to reopen a final decision is unreviewable as committed to agency discretion by law. *Your Home*, 525 U.S. 455; *ICC* v. *Brotherhood of Locomotive Engineers*, 482 U.S. 270, 282 (1987) (refusal to reopen determination based on alleged "material error" is not subject to review). The court of appeals' decision cannot be reconciled with that background rule of non-reviewability of agency refusals to reopen.

The Secretary's reasonable and long-standing interpretation of the reopening regulation is entitled to substantial deference. *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994). Such deference is particularly warranted because the "right of a provider to seek reopening exists only by grace of the Secretary." *Your Home* 525 U.S. at 455; accord *Bartlett*, 347 F.3d at 839; *Auer v. Robbins*, 519 U.S. 452, 461 (1997) (where the applicable procedure is "a creature of the Secretary's own regulations, his interpretation of [the regulation] is * * * controlling unless plainly erroneous or inconsistent with the regulation") (internal quotation marks omitted).

b. *Ruling 97-2 neither notified fiscal intermediaries of an error of law nor ordered reopening*

The second fundamental flaw in the court of appeals' holding is that even if the reopening regulation could be read to create a mandatory duty for intermediaries to reopen when the Secretary has given the requisite notice, Ruling 97-2 manifestly did *not* notify respondents' fiscal intermediaries that prior DSH payment determinations were erroneous. Rather, the Ruling unequivocally states that HCFA "*believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory*

language," but that HCFA nonetheless was prospectively acquiescing in four adverse circuit precedents in order to "ensure national uniformity in calculation of DSH adjustments." App., *infra*, 51a (emphasis added). The mere fact that four circuits had rejected the Secretary's interpretation of the Act does not mean that the Secretary's interpretation was invalid, since other courts, including this Court, might well have reached a different conclusion. *E.g.*, *Brogan* v. *United States*, 522 U.S. 398, 400 (1998) (sustaining the government's interpretation of a statute despite the ruling of seven circuits). Moreover, any suggestion that Ruling 97-2 was an implicit order to reopen is inconsistent with the clear wording of the ruling: "Ruling 97-2, rather than notifying the fiscal intermediary to reopen and revise the challenged NPRs, expressly *forbade* it from doing so." *Bartlett*, 347 F.3d at 838 (emphasis added).

Thus, as the Tenth Circuit correctly concluded in *Bartlett*, 347 F.3d at 838, the "language of Ruling 97-2 clearly evinces both the Secretary's belief that his prior interpretation of the DSH provision was not inconsistent with the applicable law and his intent that no NPRs be reopened on that basis." There was thus no basis whatsoever for the holding in *Monmouth*, adhered to in this case, that the Secretary created a clear and indisputable duty for intermediaries to reopen long-settled cost reports by issuing an acquiescence ruling that announced that "*[w]e will not reopen settled cost reports*." App., *infra*, 52a (emphasis added).

In concluding that Ruling 97-2, contrary to its express terms, constituted a concession by the Secretary that his "original interpretation was itself invalid," the court of appeals in *Monmouth* reasoned that Ruling 97-2 would otherwise be invalid because it modified the Secretary's interpretation of the DSH regulation without notice-and-comment rulemaking, as required by the court's earlier decision in *Paralyzed Veterans*. App., *infra*, 44a. As explained below,

Paralyzed Veterans and its progeny are themselves incorrect and in conflict with decisions of other courts of appeals. But in any event, as the Tenth Circuit in *Bartlett* concluded, even were rulemaking required merely to acquiesce in adverse judicial precedent, "[o]ne would have assumed that the logical conclusion" of that requirement "would be to hold that Ruling 97-2 was invalid because of its failure to comply with notice and comment procedures." *Bartlett*, 347 F.3d at 839. Of course, invalidation of Ruling 97-2 would remove any basis for the providers' claim that Ruling 97-2 triggered a mandatory duty to reopen. And if Ruling 97-2 were removed from the equation, it would be crystal clear that the providers' opportunity to challenge the underlying NPRs would be foreclosed as no longer timely.

c. *The providers' failure to make a timely request for reopening nullifies any supposed right to obtain reopening*

Even if the Secretary could somehow be said to have established a novel mandatory and judicially reviewable reopening regime for providers that actually sought reopening within the three-year period allowed by the Secretary's regulation, the Secretary nonetheless would owe no clear duty enforceable by mandamus to the providers at issue in this case and the 275 related cases pending in the district court. Those providers never sought reopening within the time-period prescribed by 42 C.F.R. 405.1885(a), the only regulation that allows reopening at the behest of a provider. Under those circumstances, the equitable origins of the writ and the structure of the reopening regulation provide yet one more reason that the mandamus action must fail.

By contrast, the hospitals in *Monmouth* did seek administrative reopening within three years of receiving their NPRs from their intermediaries, and the panel in *Monmouth* found that fact significant. App., *infra*, 45a. Although that fact

does not provide a basis to overcome the first two fundamental obstacles to mandamus relief detailed above, those hospitals could at least claim an equitable toehold to invoke mandamus. But the providers in this case, by forgoing *both* a direct appeal *and* a timely motion to reopen, lack any basis whatsoever for claiming a personal and unmistakable right to reopening. Since the providers here unquestionably have never presented their claims for relief to the Secretary and did not even file suit until *five* years after the issuance of Ruling 97-2, the providers are not entitled to the extraordinary remedy of mandamus. Cf. *Mathews* v. *Eldridge*, 424 U.S. 319, 328 (1976) (presentment of claim to Secretary is required by Social Security Act and cannot be waived since provision for judicial review, 42 U.S.C 405(g), contemplates "some decision by the Secretary").

It is no answer to say, as did the court of appeals (App., *infra*, 8a), that this further default by the providers should be excused on the ground that Ruling 97-2 would have prohibited intermediaries from granting reopening if the providers had sought it and because any refusal to reopen would not, under *Your Home*, have been subject to review. The hospitals in *Monmouth*, when faced with the same circumstances, nonetheless filed timely motions to reopen rather than continuing to sleep on their rights, and the hospitals here could have done so as well. The court's rationale stands mandamus principles on their head by invoking limitations on obtaining reopening relief into a justification to bypass the agency's procedure and time limits altogether.

d. *The court of appeals' decision greatly undermines critical principles of finality*

As explained above, the Secretary has rejected the regulatory reopening regime suggested by the court of appeals, under which a provider would have a "personal right" to obtain reopening whenever it was "undercompensated due to

an erroneous interpretation of the law," despite its failure to appeal its NPRs. App., *infra*, 9a. The Secretary has properly concluded that it would be entirely "unworkable to reopen thousands of final, unappealed cost reports each time a judicial decision calls into question one of our many reimbursement policies." 67 Fed. Reg. at 50,100. The Secretary likewise has reasonably concluded that the regime embraced by the decision below would eviscerate the stringent 180-day statutory time limit for appealing NPRs under 42 U.S.C. 1395oo(a). 67 Fed. Reg. 50,099-50,100; accord *Brotherhood of Locomotive Engineers*, 482 U.S. at 282, 283 (time limits for direct appeal would be "entirely frustrated" and "nulli[fied]" if agency refusals to reopen were subject to review); *Sanders*, 430 U.S. at 108 (Congress's decision not to provide for review of refusal to reopen under Social Security Act "is a policy choice obviously designed to forestall repetitive or belated litigation of stale eligibility claims.").

For similar reasons, this Court in *Your Home*, 525 U.S. at 457, unanimously rejected the notion that providers had a right to mandamus relief to obtain reopening based on the provider's claim that an otherwise final NPR was erroneous. There is no reason for a different result in this case, in which providers likewise collaterally attack NPRs based on arguments that could have been pursued by exercising their right to appeal the NPRs. See also *Sebben*, 488 U.S. at 121-123.

Even an invalidation by this Court of the Secretary's interpretation of the Act or implementing regulations on any given payment issue would not impose a mandatory duty on the Secretary to reopen NPRs that were never appealed. When this Court decides a legal issue, the Court's "controlling interpretation of federal law" applies to "all cases still open on direct review," *Harper* v. *Virginia Dep't of Taxation*, 509 U.S. 86, 97 (1993), but the "[n]ew legal principles * * * do not apply to cases already closed." *Reynoldsville Casket Co.* v. *Hyde*, 514 U.S. 749, 758 (1995).

Consistent with that rule, it has never been the practice of the Secretary to order reopening and revision of closed determinations based on a subsequent change in the law, "in response to judicial precedent or otherwise." 67 Fed. Reg. at 50,096. The Secretary properly has concluded that his "policy of not reopening closed cost reports in response to decisions in other cases is essential for maintaining administrative finality in a program of extraordinary magnitude that is administered with limited resources." *Id.* at 50,100.

The same settled principles of finality apply equally to an acquiescence ruling, such as Ruling 97-2, in which the agency itself voluntarily agrees prospectively to follow adverse circuit precedent on a nationwide basis in order to bring about a prompt end to widespread litigation and ensure national uniformity in the administration of Medicare payment determinations. The purpose and effect of such an acquiescence ruling are to put in place for the agency the legal regime that would have existed if the Secretary had continued to litigate the issue and lost in every circuit or had lost in this Court—but without the burden and delay of subjecting the agency, private parties, and the courts to such litigation. As just explained, *actual* adverse judicial rulings do not require the reopening of closed cases. It follows that the Secretary's decision to pretermit such litigation does not require that extraordinary result. A contrary rule would create a powerful disincentive for agencies to acquiesce in adverse appellate decisions—a consequence that would be detrimental to the agency, private parties, and the courts.

B. The Court Of Appeals' Decision Warrants This Court's Review

1. *The court of appeals' decision conflicts with decisions of other courts of appeals and cannot be reconciled with decisions of this Court*

a. The decisions in *Monmouth* and this case squarely conflict with the decision of the Tenth Circuit in *Bartlett*, *su-*

pra. First, the Tenth Circuit held that Ruling 97-2 did not trigger a mandatory duty to reopen because Ruling 97-2 "clearly asserts the Secretary's belief that his DSH regulation was a permissible interpretation of the applicable statute" and the Ruling contains "unambiguous language" that evinces the Secretary's intent to acquiesce only prospectively and to prohibit reopening. 347 F.3d at 838. Thus, the Tenth Circuit found the reasoning in *Monmouth* "unsound because it makes assumptions about the premises and intended effect of Ruling 97-2 that do not comport with fact or with the clear intention of the Secretary." *Id*. at 839.

Second, the Tenth Circuit in *Bartlett* held that "the Secretary has complete discretion as to when to employ the mandatory reopening regulation," and "[u]nlike the D.C. Circuit," the court held that "the concept of 'notification' [in the reopening regulation] requires some level of intent by the Secretary." 347 F.3d at 839. Thus, *Bartlett*, in sharp contrast to the decision below and *Monmouth*, deferred to the Secretary's reasonable construction of his regulations as establishing an entirely discretionary reopening regime. That square conflict in the circuits on an important issue concerning the administration of the Medicare program—and more broadly on the deference owed to the Secretary in applying his own acquiescence ruling and interpreting his own reopening regulation—warrants this Court's review. *E.g.*, *Your Home*, 525 U.S. at 452; *Regions Hosp.* v. *Shalala*, 522 U.S. 448, 455 (1998); *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. at 402-403.

b. The court of appeals' decisions in *Monmouth* and this case also are in tension with this Court's understanding of the reopening regime under Medicare as set forth in *Your Home*, which held that reopening is discretionary with the Secretary when sought by the provider under 42 C.F.R. 405.1885(a)—the only provision for reopening at the behest of a hospital—and that mandamus will not lie to review a de-

nial of a request for reopening. The opportunities for wholesale evasion of subsection (a) and its three-year time limit opened up by the enforcement of subsection (b) via mandamus approved by the court of appeals is at least in considerable tension with the regime described in *Your Home*. Nor can the court of appeals' decisions be reconciled with *Ringer*, which held that mandamus will not lie under Medicare where the plaintiff has failed to pursue available administrative remedies, or with *Sebben*, which held that parties who declined to pursue direct appeals of the administrative denial of their claims were not entitled to mandamus relief to compel the reopening of adverse administrative decisions that they had allowed to become final and binding against them, even though the Court held that the rule of law applied in those closed decisions was erroneous.

c. Finally, review is warranted because the D.C. Circuit's decision in *Paralyzed Veterans*, on which the D.C. Circuit relied in *Monmouth*, is itself incorrect and in conflict with the decisions of two other courts of appeals. In *Paralyzed Veterans*, the court concluded that an agency must follow notice-and-comment procedures to change an interpretation of its own regulation.[5] In *Monmouth*, the court held that, because Ruling 97-2 changed the Secretary's interpretation, the issuance of that acquiescence ruling without formal notice-and-comment rulemaking would render the Ruling invalid unless the Secretary's original interpretation of the DSH provision was itself invalid. App., *infra*, 44a. Against that background, the court then concluded that the Ruling should be read as a concession by the Secretary that his prior interpretation was invalid, thereby triggering a supposed duty on the part of intermediaries to reopen closed

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[5] Although the statement of the requirement in *Paralyzed Veterans* was dictum, the court later elevated that requirement to a holding in *Alaska Professional Hunters* v. *FAA*, 177 F.3d 1030 (D.C. Cir. 1999).

cost reports on the ground that they were inconsistent with governing law. *Id.* at 44a-45a. That result does not follow from *Paralyzed Veterans* (which would suggest that Ruling 97-2 was invalid, see *supra*, p. 19), but the requirement of *Paralyzed Veterans* that set the whole case in motion is erroneous in any event.

Paralyzed Veterans cannot be reconciled with the APA, which expressly provides that agency interpretations need *not* be promulgated through notice and comment. See 5 U.S.C. 553(b)(A); accord, 42 U.S.C. 1395hh(a)(2) (parallel rulemaking provision of Medicare Act); see *Monmouth*, App., *infra*, 43a. That express statutory exception is dispositive, because under *Vermont Yankee Nuclear Power Corp.* v. *NRDC, Inc.*, 435 U.S. 519, 546 (1978), courts may not impose procedural requirements on an agency beyond those required by the APA or other governing statute. *Paralyzed Veterans* is also in conflict with the decision of other circuits. Compare *Warder* v. *Shalala*, 149 F.3d 73, 81-82 (1st Cir. 1998), and *Erringer* v. *Thompson*, 371 F.3d 625, 632 (9th Cir. 2004) (holding that an agency can change an interpretive rule without notice-and-comment rulemaking), with *Shell Offshore, Inc.* v. *Babbitt*, 238 F.3d 622, 629 (5th Cir. 2001) (endorsing *Paralyzed Veterans*). That circuit conflict warrants review by this Court.

This case in fact vividly confirms that courts should not hamper administrative agencies by imposing nonstatutory procedural requirements upon them. Faced with other pending litigation and the lack of a uniform nationwide DSH policy, HHS needed to act quickly when it acquiesced in the adverse DSH decisions. That acquiescence ruling thus was bound up with litigation judgments of the sort that have never been subject to public notice and comment or judicial review. Subjecting Ruling 97-2 to the time-consuming and cumbersome process of notice-and-comment rulemaking before it became effective also would have served little pur-

pose, since HHS sought not to impose burdens on providers but rather to abandon its own position and substitute one more *favorable* to providers, in accordance with judicial decisions adopting that position. "When acquiescence affects only the public fisc (when, for example, the IRS accepts a decision that reduces collection), the agency's decision is dispositive; it is an exercise of the President's power to execute the laws." *Atcheson, Topeka & Santa Fe Ry.* v. *Peña*, 44 F.3d 437, 447 (7th Cir. 1994) (Easterbrook. J., concurring), aff'd, 516 U.S. 152 (1996). The court of appeals' conclusion in *Monmouth*, without analysis, that an acquiescence ruling of this sort nonetheless must be issued through formal notice-and-comment rulemaking threatens to impose unnecessary burdens on agencies, regulated parties, and the courts, especially since suits may be brought under Medicare and most other programs in the District of Columbia.[6]

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[6] On July 31, 1998, as part of a much broader regulatory revision, HCFA in fact *did* amend the applicable DSH regulation to conform to the rule adopted by the four circuits. 63 Fed. Reg. 40,954, 40,984-40,985, 41,009 (1998). That amendment, like other changes made in the same rulemaking, was made applicable to all cost report periods beginning on or after October 1, 1998. *Id.* at 40,954. In proposing and adopting the regulation, HCFA explained that Ruling 97-2, which included the same provisions as the amended regulation, would continue to govern cost-reporting periods prior to October 1, 1998, *provided* that, as of the February 27, 1997, effective date of Ruling 97-2, the cost report for such a year was not yet settled or that a jurisdictionally proper appeal was pending. *Id.* at 40,985. HCFA reported that it received no comments on that proposal. *Ibid.* Thus, three years prior to *Monmouth* and almost four years prior to the filing of the instant mandamus action, HCFA adopted a prospective-only change in the law through notice-and-comment rulemaking, and preserved Ruling 97-2 (with its bar to reopening of closed cases) for cost reports still open or on appeal as of February 27, 1997. That rulemaking renders the decisions requiring reopening in *Monmouth* and this case all the more unwarranted.

2. *This Court's review is also warranted because of the fiscal and administrative impact of the court of appeals' decision*

Although the Secretary believes that the 2002 amendments to the reopening rule should prevent future mandamus actions to force reopening in cases governed by the amended rule, this Court's review of the decision below is nonetheless warranted for the additional reason that the amended rule does not ameliorate the staggering and immediate financial and administrative burdens imposed by the decision below. The court of appeals' decision requires the Secretary to review not only the 74 cost reports for the 26 providers in this case, but also approximately 2,306 cost reports for the 639 hospitals which are plaintiffs in the 275 related cases. For purposes of preparing CMS's public financial statement, the Office of Actuary and the Office of Financial Management within CMS have determined that, although "[a]ny potential payment of any funds" in response to the decision below "would be based on the providers' ability" to "provide adequate documentation to support their claims," "[t]he CMS expects that as of September 30, 2005, it is reasonably possible that *as much as $2.8 billion* could be owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals." HHS, *CMS Financial Report, Fiscal Year 2005* 48 (Nov. 2005) (emphasis added).[7]

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[7] HHS has informed this Office that the $2.8 billion figure is based on a comparison of the DSH payments to the affected hospitals before the issuance of Ruling 97-2 with the estimated additional payments that would be owed to those providers under Ruling 97-2 as adjusted for inflation. In seeking rehearing (Gov't Pet. 2), the Secretary had roughly estimated its potential liability to be at least $1.5 billion. But that estimate was based upon aggregate information about the DSH payment adjustment (as opposed to actual payments made to the plaintiff-hospitals), and the prior estimate was not prepared by CMS's Office of the Actuary and the Office

Moreover, quite aside from the great amount of money at stake, the decision below requires the Secretary to devote substantial administrative resources to reopen the cost reports on the DSH issue and to recalculate the DSH payment item. The Secretary has informed this Office that the DSH payment calculation is exceedingly complex and that fiscal intermediaries would need approximately 184,000 hours to audit the providers' claims. Fiscal intermediaries, which are responsible for ensuring the accuracy of *current* NPRs, should not have to divert their limited and valuable auditing efforts to recalculating and auditing stale reimbursement claims relating to decade-old NPRs that the providers never bothered to appeal—or even requested the intermediary to reopen under the governing regulations.

What is more, individual determinations by the fiscal intermediary on reopening would be subject to administrative review before the PRRB as well as judicial review in the district courts and the courts of appeals. 42 C.F.R. 405.1889; *Your Home*, 525 U.S. at 453. Given the amount of money at stake, the number of cost reports at issue, and the complexity of DSH payment calculations, many disputes could reasonably be expected to arise over the intermediary's final determination upon reopening that would yield substantial follow-on litigation, thereby unnecessarily draining the resources of the PRRB and the federal courts.

Finally, the consequences of the decision below extend beyond the DSH issue. The decision poses potentially far-reaching liability and administrative burdens on the Medicare program in many other contexts as well, given that program's breathtaking scope and complexity. The Secretary reports that there are 39,000 institutional providers participating in the Medicare program, and each of those providers

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of Financial Management in connection with CMS's annual public financial statement.

must file an annual cost report (see 42 C.F.R. 413.20(b), 413.24(f)). Any given cost report by one of those providers consists of between 3,000 and 27,000 discrete reimbursement matters. The agency also estimates that it typically changes or clarifies its reimbursement policies at least 1,000 times in any given year.

The holding announced in *Monmouth* and dramatically extended by the decision below opens the door for providers participating in Medicare to argue that a pre-2002 change in or clarification of the Secretary's reimbursement policies regarding literally thousands of discrete cost items imposes a mandatory duty to reopen for the three preceding years that is enforceable by way of mandamus. Although the government can try to resist those efforts by arguing that the passage of time makes mandamus inappropriate, the trajectory from *Monmouth* to this case does not suggest that such equitable considerations will necessarily carry the day. See App., *infra*, 9a-10a. Given the sheer magnitude and dimension of the Medicare program, reopening of a wide variety of final Medicare payment determinations would seriously disrupt the operations of the program as well as pose a significant drain on the Medicare Trust Fund.

Not surprisingly, there has already been substantial additional mandamus litigation instituted in the District Court for the District of Columbia that invokes *Monmouth* and the decision below in an effort to compel reopening of cost reports with respect to issues other than the particular DSH issue in this case. Nine lawsuits, which involve 100 providers and 825 fiscal period claims, have so far been filed seeking mandatory reopening on the theory that the Secretary, through a change in reimbursement policy, has effectively issued a notice that closed and final payment determinations were inconsistent with applicable law for purposes of the reopening regulation. See, *e.g.*, *Community Hosp.* v. *Leavitt*, No. 04-0504 (D.D.C.); *Bradley Mem'l Hosp.* v. *Leavitt*, No.

04-0416-EGS (D.D.C.); *Ball Mem'l Hosp.* v. *Leavitt*, No. 04-2254 (D.D.C.); *Berkshire Med. Ctr.* v. *Leavitt*, No. 04-1562 (D.D.C.). Absent this Court's intervention, there is every reason to believe that similar litigation will be filed by numerous other providers seeking retroactive reopening and revision of closed payment determinations. Because the court of appeals' decision is clearly wrong, at odds with other decisions and, at least for the foreseeable future, would impose substantial and unjustified deleterious effects on the operation of the Medicare program, this Court's review is warranted.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

PAUL D. CLEMENT
Solicitor General

PETER D. KEISLER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

LISA S. BLATT
Assistant to the Solicitor General

ANTHONY J. STEINMEYER
ANNE M. MURPHY
Attorneys

PAULA M. STANNARD
Acting General Counsel

THOMAS R. BARKER
Deputy General Counsel

KATHLEEN H. MCGUAN
Associate General Counsel

MARK D. POLSTON
Deputy Associate General Counsel for Litigation

GERARD KEATING
SYLVIA J. TRUJILLO
Attorneys

Department of Health and Human Services

JANUARY 2006

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 04-5203

IN RE: MEDICARE REIMBURSEMENT LITIGATION

BAYSTATE HEALTH SYSTEMS, D/B/A BAYSTATE MEDICAL CENTER, ET AL., APPELLEES

MICHAEL O. LEAVITT, SECRETARY, DEPARTMENT OF HEALTH & HUMAN SERVICES, APPELLANT

Argued: Apr. 11, 2005
Decided: July 1, 2005

OPINION

Before: SENTELLE, ROGERS, and TATEL, Circuit Judges.

Opinion for the Court filed by Circuit Judge TATEL.

TATEL, Circuit Judge.

In this case, the district court ordered the Secretary of Health and Human Services to make statutorily mandated payments to hospitals serving high percentages of low-income patients. Finding no error, we affirm.

I.

Pursuant to the Medicare Act, the Secretary of Health and Human Services reimburses hospitals for the "operating costs of inpatient . . . services" pro-

vided to Medicare and Medicaid beneficiaries. See 42 U.S.C. § 1395ww. At the end of each fiscal year, eligible hospitals file cost reports with their "fiscal intermediaries," see 42 C.F.R. § 413.20(b); *Monmouth Med. Ctr.* v. *Thompson*, 257 F.3d 807, 809 (D.C. Cir. 2001)—usually insurance companies that serve as the Secretary's agents for purposes of reimbursing health care providers, 42 C.F.R. §§ 421.1, 421.3; see generally *id.* § 421.100-421.128. After auditing the reports, intermediaries issue "Notice of Program Reimbursements" ("NPRs") in which they determine the amount owed to the hospitals for the fiscal year at issue. See *id.* § 405.1803(a)(2). Hospitals unhappy with their fiscal intermediary's award have 180 days to appeal to the Provider Reimbursement Review Board ("the Review Board"), 42 U.S.C. § 1395oo(a), which issues a decision that the Secretary may "reverse[ ], affirm[ ], or modif[y]" within 60 days, *id.* § 1395oo(f)(1). Hospitals remaining dissatisfied after the Review Board or Secretary issues a final decision may seek "judicial review" by filing suit in the appropriate U.S. District Court. *Id.*

Known at the time of the events at issue here as the Health Care Financing Administration ("HCFA"), the agency within HHS responsible for administering Medicare and Medicaid promulgated regulations that permit reopening of final NPRs. Two reopening provisions play central roles in this case. One, 42 C.F.R. § 405.1885(a) (1997), provides that an intermediary's payment determination or a decision by the Review Board or Secretary "may be reopened" if its issuer or the affected hospital moves to do so within three years of the date of the determination or decision. The other, 42 C.F.R. § 405.1885(b) (1997), provides (though it has been amended since the events at issue here) that an

intermediary's determination "shall be reopened and revised by the intermediary if, within the . . . 3-year period, the Health Care Financing Administration notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions."

The Medicare Act bases payments for "operating costs of inpatient hospital services" on preset nationally applicable rates, but those rates are subject to hospital-specific adjustments, 42 U.S.C. § 1395ww(d), one of which, the "Disproportionate Share Hospital" ("DSH") adjustment, increases payment rates for hospitals serving disproportionately high percentages of low-income patients, *id.* § 1395ww(d)(5)(F). Several years after creating the DSH adjustment, Congress enacted legislation that established detailed criteria for determining eligibility and the extent of a hospital's adjustment. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9105, 100 Stat. 82, 158-60 (1986) (codified at 42 U.S.C. § 1395ww(d)(5)(F)). HCFA promulgated interpretive regulations to implement these new statutory provisions, see 51 Fed. Reg. 16,772, 16,776-78 (May 6, 1986), but between 1994 and 1996 four circuits found the regulations inconsistent with one of these provisions, ruling that HCFA had improperly restricted DSH eligibility and reduced payments to eligible hospitals. *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984 (4th Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconess Health Servs. Corp.* v. *Shalala*, 83 F.3d 1041 (8th Cir. 1996) (per curiam); *Jewish Hosp., Inc.* v. *Sec'y of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994).

Responding to these decisions, HCFA issued Ruling 97-2, in which it announced it had "chang[ed] its interpretation of [the statutory provision at issue] to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits." Health Care Financing Administration Ruling 97-2, at 1 (Feb. 27, 1997) ("HCFAR 97-2" or "Ruling 97-2"). Significantly, however, HCFA's new interpretation would have prospective effect only. As the ruling explained, HCFA would "not reopen settled cost reports," and would instead apply its new interpretation only to cost reports settled thereafter, or to cost reports for which the hospital had a "jurisdictionally proper appeal pending on this issue." *Id.* at 2.

After HCFA issued Ruling 97-2, two DSH eligible hospitals, Monmouth Medical Center and Staten Island University Hospital, filed motions with their intermediaries pursuant to section 405.1885, seeking to reopen NPRs issued to them during the three years prior to the ruling. *Monmouth*, 257 F.3d at 808, 810. When the intermediaries denied these motions and the Review Board declined to order the proceedings reopened, the two hospitals sued in the U.S. District Court for the District of Columbia, which dismissed for lack of jurisdiction. *Id.* Reversing, we held in *Monmouth Medical Center* v. *Thompson*, 257 F.3d 807, that the district court had jurisdiction under the Mandamus Act, 28 U.S.C. § 1361, to order reopening of the hospitals' NPRs. *Id.* at 813-815. We explained that Ruling 97-2 amounted to a finding that HCFA's old method of calculating DSH entitlement was "inconsistent with the applicable law" for the purposes of section 405.1885(b). *Id.* (quoting 42 C.F.R. § 405.1885(b)). Pointing out that the regulation speaks in mandatory terms—inter-

mediaries "shall" reopen payment determinations when they receive notice the determinations are "inconsistent with the applicable law"—we held that Ruling 97-2 gave intermediaries a clear duty to reopen the NPRs even though the ruling said it had only prospective effect. *Id.*

Eight months later, plaintiffs in this case, twenty-six hospitals serving Medicare and Medicaid beneficiaries, filed suit under the Mandamus Act, seeking to compel reopening of NPRs issued to them in the three years preceding Ruling 97-2. Over 250 other hospitals filed similar suits, which (with some exceptions) the district court stayed pending resolution of the "core issue" in this case, *In re Medicare Reimbursement Litig.*, No. 03-0090 (D.D.C. July 1, 2003) (adopting case management plan staying actions other than this action). The court then denied the Secretary's motion to dismiss and granted plaintiffs' motion for summary judgment, relying on *Monmouth 's* holding that Ruling 97-2 triggered a duty to reopen NPRs pursuant to section 405.1885(b). *In re Medicare Reimbursement Litig.*, 309 F. Supp. 2d 89, 95, 97 (D.D.C. 2004).

The Secretary now appeals.

II.

Under the Mandamus Act, "[t]he district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." 28 U.S.C. § 1361. Pursuant to this act, a district court may grant mandamus relief if "(1) the plaintiff has a clear right to relief; (2) the defendant has a clear duty to act; and (3) there is no other adequate remedy available to the plaintiff."

Power v. *Barnhart*, 292 F.3d 781, 784 (D.C. Cir. 2002) (quoting *Northern States Power Co.* v. *U.S. Dep't of Energy*, 128 F.3d 754, 758 (D.C. Cir. 1997)). A district court's determination that a plaintiff has met these standards is reviewed de novo. See *Am. Cetacean Soc'y* v. *Baldrige*, 768 F.2d 426, 432 (D.C. Cir. 1985) (reviewing de novo district court's conclusion that claim passed three-prong test for mandamus jurisdiction), *rev'd on other grounds sub nom. Japan Whaling Ass'n* v. *Am. Cetacean Soc'y*, 478 U.S. 221, 106 S. Ct. 2860, 92 L. Ed. 2d 166 (1986). Even when the legal requirements for mandamus jurisdiction have been satisfied, however, a court may grant relief only when it finds "compelling . . . equitable grounds." *13th Reg'l Corp.* v. *U.S. Dep't of the Interior*, 654 F.2d 758, 760 (D.C. Cir. 1980). As to the equities, we review for abuse of discretion. See *Am. Cetacean Soc'y*, 768 F.2d at 444 (reviewing for abuse of discretion district court's determination that granting mandamus relief comports with equity).

We begin with *Monmouth*. There, we held that two hospitals, similar in all significant respects to the hospitals in this case, had satisfied the requirements for mandamus relief. The Secretary had a clear duty to require the intermediaries to reopen the hospitals' NPRs, we held, because Ruling 97-2 amounted to a notice of inconsistency and because section 405.1885(b) mandates reopening when HCFA issues such a notice. *Monmouth*, 257 F.3d at 813-15. In finding mandamus jurisdiction, we held implicitly that the hospitals had a clear right to relief, and we explained that they had no other adequate means of obtaining relief. *Id.* at 811-13, 815. To prevail in this case, then, the Secretary must identify some reason why the district court should have denied

mandamus relief notwithstanding our decision in Monmouth. The Secretary suggests five such reasons.

First, the Secretary devotes over half the argument section of his opening brief to a direct attack on *Monmouth*, arguing that contrary to *Monmouth*'s holding, Ruling 97-2 did not really constitute a notice of inconsistency. As "one three-judge panel . . . does not have the authority to overrule another . . . panel of the court," *LaShawn A.* v. *Barry*, 87 F.3d 1389, 1395 (D.C. Cir. 1996), we have no authority to consider this argument.

Second, the Secretary argues that the hospitals here failed to exhaust all avenues for administrative relief, as they never appealed to the Review Board when their NPRs first issued. This argument, too, is barred by *Monmouth*. Plaintiffs there likewise failed to bring such appeals, yet we found that the district court had mandamus jurisdiction. See 257 F.3d at 815.

Third, the Secretary argues that the hospitals cannot show an absence of alternate avenues for relief because, unlike the *Monmouth* plaintiffs, they never sought reopening pursuant to section 405.1885(a). Yet neither when we decided *Monmouth* nor when HCFA issued Ruling 97-2 did a motion for reopening offer any chance for the hospitals to obtain relief. Section 405.1885(a) provides that "[a]ny . . . request to reopen must be made within 3 years of the date of the notice of the intermediary," and by the time we decided *Monmouth*, the three-year period had long since passed for the NPRs at issue here. Hence, had the hospitals sought reopening following *Monmouth*, their intermediaries would have dismissed their motions as untimely. True, a motion filed in 1997—when HCFA issued Ruling 97-2—would have been timely with respect to these NPRs.

Ruling 97-2, however, purported to be prospective only: it barred intermediaries from reopening closed NPRs to recalculate DSH entitlement in accordance with the new interpretation of the statute. See HCFAR 97-2 at 2. As counsel for the Secretary conceded at oral argument, intermediaries were not at liberty to ignore this bar even if they believed the ruling amounted to a notice of inconsistency. Tr. of Oral Arg. at 4-5; see also *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 406, 108 S. Ct. 1255, 99 L. Ed. 2d 460 (1988) (noting that "[n]either the fiscal intermediary nor the [Review] Board has the authority to declare regulations invalid"). Moreover, hospitals may not seek judicial review of an intermediary's denial of a motion to reopen a payment determination. *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 456-57, 119 S. Ct. 930, 142 L. Ed. 2d 919 (1999). Consequently, the hospitals could not have obtained relief by seeking reopening in 1997.

The Secretary's fourth argument, like the second and third, focuses on the hospitals' failure to appeal or move for reopening. Conceding that section 405.1885(b) creates a duty to reopen NPRs of all affected hospitals when HCFA issues a notice of inconsistency, the Secretary argues that only those hospitals which either appealed to the Review Board or sought section 405.1885(a) reopening, as did the *Monmouth* hospitals, have a legally cognizable interest in the reopening of their NPRs. But given that section 405.1885(b) does not require hospitals to file anything at all to obtain relief, we see no basis for holding that only those hospitals that appealed or sought section 405.1885(a) reopening have a personal right to the reopening required by section 405.1885(b). Indeed, the fact that section 405.1885(b) contains no prerequisite for relief beyond a

notice of inconsistency suggests that all hospitals undercompensated due to an erroneous interpretation of the law have a personal right to section 405.1885(b) reopening.

Finally, the Secretary contends that the equities require denial of mandamus relief. Reviewing the district court's balancing of the equities for abuse of discretion, *Am. Cetacean Soc'y*, 768 F.2d at 444, we find none.

According to the Secretary, granting relief would be inequitable because the hospitals waited so long to file suit. The district court rejected this argument, reasoning that the hospitals had sued "just eight months [after *Monmouth*], hardly an inordinate time lag." *In re Medicare Reimbursement Litig.*, 309 F. Supp. 2d 89, 99 (D.D.C. 2004). While eight months would not constitute "an inordinate time lag" under the circumstances of this case, the hospitals slept on their rights far longer: like the *Monmouth* plaintiffs, they could have sued after HCFA issued Ruling 97-2. Asked at oral argument to explain why the hospitals had not done so, counsel claimed that Ruling 97-2 failed to give them "fair notice of their right to reopening." Tr. of Oral Arg. at 20. But the *Monmouth* plaintiffs had sufficient notice to sue, and when pressed, counsel admitted that his clients "could have" done so as well. *Id.* at 22. That said, we see no basis for concluding that the district court abused its discretion by rejecting the Secretary's timeliness argument, for the Secretary has failed to demonstrate that he suffered any prejudice due to the hospitals' unexplained delay. *Cf. Natural Res. Def. Council* v. *Pena*, 147 F.3d 1012, 1026 (D.C. Cir. 1998) (finding prejudice necessary for delay to warrant denial of injunctive relief).

The Secretary claims that reopening the NPRs "would be a very difficult and uncertain process, as well as being extraordinarily time-consuming to audit and verify." Appellant's Br. at 33 (quoting Decl. of Stephen Phillips). Yet the Secretary explains neither why reopening would be more burdensome now than it would have been five years ago nor why reopening would create more uncertainty now than it would have then. In fact, the hospitals assure us that they, not the Secretary, will "have to shoulder the burden of locating and presenting . . . data from prior years for the fiscal intermediaries" to use in recalculating DSH entitlement "upon reopening." Appellee's Br. at 32. Elaborating at oral argument, hospital counsel explained that under the terms of a ruling issued by the Secretary, in any reopening the "burden [rests] on the hospital to produce the data" needed to recalculate its DSH entitlement, and "the hospital takes nothing if it can't produce the information." Tr. of Oral Arg. at 29. Neither in his brief nor at oral argument did the Secretary challenge either of these assertions. On the record before us, then, we think it obvious that if the delay has increased the risk of lost evidence or the administrative burdens associated with reopening, only the hospitals will suffer. As the district court noted, moreover, even if the delay increased HCFA's administrative burden, the additional "burden [would] not outweigh the public's substantial interest in the Secretary's following the law." *In re Medicare Reimbursement Litig.*, 309 F. Supp. 2d 89, 99 (D.D.C. 2004).

The Secretary also invokes "important principles of finality and repose," asserting that they "would be greatly undermined" were we to uphold the district court. Appellant's Br. at 33. The Secretary adds that

"a substantial and unanimous body of law protect[s] the integrity of decisions that are closed and final, regardless of whether the rule of decision upon which they are based is invalidated . . . later." *Id.* at 33-34. Yet the Secretary's own regulations provide for reopening when HCFA "notifies an intermediary that [a] determination or decision is inconsistent with the applicable law." 42 C.F.R. § 405.1885(b) (1997). To show that the interest in finality warrants denying mandamus relief, then, the Secretary must explain why this interest became more important between 1997, when Ruling 97-2 triggered the hospitals' right to section 405.1885(b) reopening, and 2002, when the hospitals sued to enforce that right. The Secretary, however, has failed to do so. *See supra* at 11.

In his opening brief, the Secretary takes pains to point out the extraordinary sums at stake in the hundreds of cases now pending in the district court-more than $1 billion, according to the Secretary. Yet as his counsel rightly conceded at oral argument, Congress imposed on the Secretary a clear statutory duty to pay the hospitals these funds. Having to pay a sum one owes can hardly amount to an equitable reason for not requiring payment.

The judgment of the district court is affirmed.

So ordered.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 02-0601
MISC.NO. 03-0090(PLF)

IN RE: MEDICARE REIMBURSEMENT LITIGATION

BAYSTATE HEALTH SYSTEMS

v.

THOMPSON

Mar. 26, 2004

OPINION

PAUL L. FRIEDMAN, District Judge.

Plaintiff hospitals in *Baystate Heath System* v. *Thompson*, Civil Action No. 02-0601(PLF), bring suit for declaratory and injunctive relief in the nature of mandamus, asking the Court to compel defendant, the Secretary of Health and Human Services, through the Centers for Medicare and Medicaid Services ("CMS"), to reopen certain final payment decisions issued by the Secretary's payment agents that pertain to the Secretary's reimbursement of plaintiffs for services they rendered to indigent clients.[1] Defendant filed a motion

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[1] CMS is the component of the Department of Health and Human Services that is responsible for administering the Medicare

to dismiss and plaintiffs moved for summary judgment. These two motions are currently before the Court for consideration. The Court heard oral argument on the motions on August 11, 2003.

I. BACKGROUND

The Medicare statute, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, creates a federally funded health insurance program for the elderly and disabled, known as Medicare and Medicaid. This case arises under Part A of the Medicare program, which authorizes payments for, *inter alia*, certain inpatient hospital services and related post-hospital services. See 42 U.S.C. §§ 1395c, 1395d. A hospital may participate in the Medicare program as a provider by entering into a "provider agreement" with the Secretary of Health and Human Services. 42 U.S.C. § 1395cc. Plaintiffs here are not-for-profit acute care hospitals that participate as providers of inpatient hospital services in the federal Medicare program.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System ("PPS"). See 42 U.S.C. § 1395ww(d). The regulations governing the PPS require a provider of inpatient hospital services to file an annual cost report with a "fiscal intermediary." 42 C.F.R. § 413.20(b).[2] The fiscal intermediary-typically an insurance company that acts as the Secretary's agent-then audits the report and makes a final deter-

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program and was formerly known as the Health Care Financing Administration ("HCFA").

[2] Unless otherwise noted, citations to the Code of Federal Regulations are from that version of the regulations revised as of October 1, 1996.

mination of the total amount of payments owed by Medicare to the provider for that fiscal year. The total amount to which a provider is entitled is set forth by the intermediary in an initial Notice of Program Reimbursement ("NPR"). See 42 C.F.R. § 405.1803. Under the statute, a provider that is dissatisfied with any aspect of the total payment amount set forth in the initial NPR may timely request a hearing before the Provider Reimbursement Review Board ("Board"), an administrative body composed of five members appointed by the Secretary. See 42 U.S.C. § 1395oo(a) and (h). If the provider objects to the Board's conclusion, it may seek judicial review, provided that the provider files suit within 60 days of the Board's determination. See 42 U.S.C. § 1395oo(f)(1).

The PPS contains a number of provisions that adjust reimbursements based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves one of the hospital-specific adjustments, specifically, the disproportionate share adjustment. The "disproportionate share," or "DSH," adjustment requires the Secretary to provide increased PPS reimbursements to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage." *See* 42 U.S.C. § 1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," for a hospital's fiscal period. 42 U.S.C. § 1395ww(d)(5)(F)(vi).

The computation of the numerator of the "Medicaid" fraction is at the heart of this action. This numerator is calculated by determining the total number of a

hospital's inpatient days attributable to patients who "were eligible for medical assistance under a State plan approved under subchapter XIX [*i.e.*, eligible for Medicaid], but who were not entitled to benefits under Part A of this subchapter [Medicare]." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). From 1986 through 1997, the Secretary construed the first portion of this numerator calculation to include only those patients who were both eligible for Medicaid payments under the relevant state Medicaid plan *and* who actually received such payments from the state. See 42 C.F.R. § 412.106(b)(4). Providers challenged this interpretation, and every circuit court that considered the Secretary's interpretation rejected it. The courts of appeals uniformly concluded that the numerator calculation must include all patient days for which a patient was eligible for Medicaid assistance regardless of whether a state Medicaid program actually paid the hospital for services provided to the patient. *See Cabell Huntington Hospital, Inc.* v. *Shalala*, 101 F.3d 984, 988 (4th Cir. 1996); *Legacy Emanuel Hospital and Health Center* v. *Shalala*, 97 F.3d 1261, 1266 (9th Cir.1996); *Deaconess Health Services Corp.* v. *Shalala*, 83 F.3d 1041, 1041 (8th Cir. 1996); *Jewish Hospital, Inc.* v. *Sec'y of Health and Human Services*, 19 F.3d 270, 276 (6th Cir. 1994).

In February 1997, the then-Secretary of HHS issued a ruling that rescinded the original interpretation of the statutory provision and prospectively mandated that in calculating the disproportionate patient percentage, the Medicaid numerator must include all inpatient days of patients who were eligible for Medicaid "whether or not the hospital received payment for those inpatient hospital services." Defendant's Motion to Dismiss, Attach., Heath Care Financing Administrative Ruling 97-2 at 2

(Feb. 27, 1997) ("Ruling" or "Ruling 97-2"). In issuing the Ruling, the Secretary did not concede that the prior interpretation was incorrect. Instead, she stated that "[a]lthough HCFA believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory language, HCFA recognizes that, as a result of the adverse court rulings, this interpretation is contrary to the applicable law in four judicial circuits." *Id.* According to the Secretary, the changed interpretation would apply only prospectively, "[i]n order to ensure national uniformity in calculation of DSH adjustments." *Id.* The Ruling also expressly announced that the Secretary would not reopen past NPRs on the basis of this changed statutory interpretation. *See id.*

In response to the Ruling, two hospitals (the "*Monmouth* plaintiffs") sought to have their NPRs for the fiscal years ending in 1993 and 1994 reopened. *See Monmouth Medical Center* v. *Thompson*, 257 F.3d 807 (D.C. Cir. 2001). Under the regulations in effect at the time of the Ruling, there were two methods by which an intermediary had the authority to reopen a final determination. First,

> [a] determination or decision . . . may be reopened with respect to findings on matters at issue in such determination or decision . . . either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or where there has been no such decision, any such request to

> reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

42 C.F.R. § 405.1885(a). Second, the regulations directed that a determination or decision "shall be reopened and revised by the intermediary if, within the aforementioned 3-year period, the HCFA notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the HCFA in accordance with the Secretary's agreement with the intermediary." 42 C.F.R. § 405.1885(b).[3] These review methods are in

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[3] HHS amended Section 405.1885(b), which amendment took effect October 1, 2002, significantly changing the procedures whereby an intermediary must reopen a final decision. Section 405.1885(b) now reads:

> (b)(1) An intermediary determination or an intermediary hearing decision must be reopened and revised by the intermediary if, within the 3-year period specified in paragraph (a) of this section, CMS—
>
> (I) Provides notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary; and
>
> (ii) Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision.
>
> (2) A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a

addition to the direct appeals process of NPRs provided for by the statute. See 42 U.S.C. §§ 1395oo(a)-(f).

Although Ruling 97-2 expressly stated that closed decisions would not be reopened, the *Monmouth* plaintiffs sought recalculation of their DSH payments under Section 405.1885(a) within three years of the issuance of their original NPRs, but to no avail. *See Monmouth Medical Center* v. *Thompson*, 257 F.3d at 810. These plaintiffs also attempted to proceed through the vertical appeal procedures provided for in 42 U.S.C. § 1395oo, but again were denied. The *Monmouth* plaintiffs then filed suit, alleging three different bases for district court jurisdiction. The district court concluded that it had no jurisdiction and therefore found for defendant; the plaintiffs appealed. The court of appeals determined that jurisdiction existed only under 28 U.S.C. § 1361, the mandamus statute. See *id.* at 814. The court concluded that the Ruling constituted notice to the intermediaries that the Secretary's interpretation was inconsistent with applicable law, and that

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basis for reopening an intermediary determination or an intermediary hearing decision under this section.

(3) Notwithstanding paragraph (b)(1)(I) of this section, CMS may direct the intermediary to reopen a particular intermediary determination or intermediary hearing decision in order to implement, for the same intermediary determination or intermediary decision-

(I) A final agency decision under §§ 405.1833, 405.1871(b), 405.1875, or 405.1877(a) of this part;

(ii) A final nonappealable court judgment; or

(iii) An agreement to settle an administrative appeal or a lawsuit.

42 C.F.R. § 405.1885(b)(2002).

Section 405.1885(b) of the regulations therefore "imposed a clear duty on intermediaries to reopen DSH payment determinations for the hospitals." *Id.* Because Ruling 97-2's prohibition against retroactive reopening conflicted with the regulation's imposition of a clear duty to reopen, the prohibition was a "nullity," and mandamus lay to assure that the plaintiff providers' NPRs were reopened and recalculated. *Id.* at 814-15.

The court of appeals also reviewed the steps the *Monmouth* plaintiffs had taken in seeking relief under Subsection 405.1885(a), noting that "we think it insignificant that, because of the Secretary's own three year limitation, reopening would not be available if sought today. Although mandamamus [*sic*] is classified as a legal remedy, its issuance is largely controlled by equitable principles. Since both hospitals were within the three-year mark when they made their requests for reopening, they are entitled to the reopening that was due them at that time." *Monmouth Medical Center* v. *Thompson*, 257 F.3d at 815 (internal quotation and citation omitted). The court rejected as irrelevant the Secretary's contention that the hospitals had failed to exhaust their remedies by failing to file proper appeals of their final decisions under Section 1395oo(a) within 180 days of the decisions, concluding that the plaintiffs were challenging the reopening prohibition of the Ruling, which plaintiffs could not have pursued until the Ruling was issued, which occurred more than 180 days after the original NPRs. *See id.* The court expressly noted that "the question is whether [plaintiffs] have done all they can to vindicate their rights to reopening. We have already shown above how all other

avenues of relief [including appeal through Section 1395oo(a)] are either foreclosed or futile." *Id.*

In this action, plaintiffs filed suit for declaratory and injunctive relief in the nature of mandamus. Plaintiffs argue, *inter alia*, that the *Monmouth* decision requires this Court to direct the intermediaries to reopen and recalculate their NPR's for the three years prior to the Ruling, notwithstanding plaintiffs' failures (1) to request reopenings pursuant to Subsection 405.1885(a); and (2) to proceed through the administrative review channels provided for in the statute and regulations. Defendant filed a motion to dismiss under Rule 12(b)(1) and Rule 12(b)(6) of the Federal Rules of Civil Procedure, arguing that plaintiffs should be denied mandamus relief on timeliness and equitable grounds, thereby defeating plaintiffs' asserted basis of subject matter jurisdiction under the mandamus statute.[4] In response plaintiffs moved for summary judgment. Upon careful consideration of the pleadings and briefs filed by the parties and the arguments of counsel, the Court concludes that defendant's motion to dismiss should be denied and plaintiffs' motion for summary judgment should be granted. The writ of mandamus therefore will issue.

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[4] Defendant moved pursuant to both Rule 12(b)(1) (lack of subject matter jurisdiction) and Rule 12(b)(6) (failure to state a claim) on the ground that "[t]he question of whether mandamus jurisdiction exists frequently merges with the merits of the claim for relief." Defendant's Memorandum in Support of His Motion to Dismiss ("Def.'s Mem.") at 8.

II. DISCUSSION

A. *Standard for Relief in the Nature of Mandamus*

Disposition of the parties' motions rests on whether mandamus relief is available to plaintiffs. Section 1361 of Title 28 provides that "[t]he district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." 28 U.S.C. § 1361. The remedy of mandamus "is a drastic one, to be invoked only in extraordinary circumstances." *Allied Chemical Corp.* v. *Daiflon, Inc.*, 449 U.S. 33, 34, 101 S. Ct. 188, 66 L. Ed. 2d 193 (1980). Mandamus is available only if: "(1) the plaintiff has a clear right to relief; (2) the defendant has a clear duty to act; and (3) there is no other adequate remedy available to plaintiff." *Northern States Power Co.* v. *U.S. Dep't of Energy*, 128 F.3d 754, 758 (D.C. Cir. 1997) (quoting *Council of and for the Blind of Delaware Cty. Valley, Inc.* v. *Regan*, 709 F.2d 1521, 1533 (D.C. Cir. 1983) (en banc)). The party seeking mandamus "has the burden of showing that 'its right to issuance of the writ is clear and indisputable.'" *Northern States Power Co.* v. *U.S. Dep't of Energy*, 128 F.3d at 758 (quoting *Gulfstream Aerospace Corp.* v. *Mayacamas Corp.*, 485 U.S. 271, 289, 108 S. Ct. 1133, 99 L. Ed. 2d 296 (1988)).

B. *Plaintiffs' Clear Right to Relief*

It is undisputed that plaintiffs are providers of inpatient hospital services that received NPRs with DSH payment determinations calculated pursuant to the Secretary's prior incorrect interpretation of the Medicaid numerator. Plaintiffs therefore are entitled to a reopening of their NPRs for the three years prior to

Ruling 97-2 if plaintiffs meet the remaining prongs of the mandamus standard.

C. *A Clear Duty to Act: Mandatory Reopening Pursuant to Section 405.1885(b)*

Defendant argues that plaintiffs' request for mandamus relief "should be denied at the outset, because unlike the hospitals in *Monmouth*, plaintiffs did not move for reopening of their DSH-payment determinations within three years" of their original NPRs. Def.'s Mem. at 9. It is not disputed that Ruling 97-2 sufficed to serve as notice to the intermediaries that the Secretary's previous interpretation of the Medicaid numerator was inconsistent with the applicable law and that, under *Monmouth*, the Ruling itself imposed a clear, non-discretionary duty on the intermediaries to reopen the payment determinations issued within the three years prior to the Ruling. *See Monmouth Medical Center* v. *Thompson*, 257 F.3d at 814. As noted by defendant, however, unlike the plaintiffs in *Monmouth*, plaintiffs here did not request reopenings under Section 405.1885(a). The question before this Court therefore is whether Ruling 97-2 also imposed a clear, mandatory duty on Medicare intermediaries to reopen all intermediary determinations rendered in the three-year period prior to the Ruling *even in the absence of a provider's request to do so.* The Court concludes that such a duty does exist.

Under the plain language of Section 405.1885 of the Code of Federal Regulations in effect during the relevant time period there are two circumstances in which an NPR may be reopened. In one such circumstance reopening is discretionary and in the other, reopening is mandatory. Section 405.1885(a) provides that either a hospital provider or the intermediary may move to

reopen an NPR or Board Decision within three years of its issuance. See 42 C.F.R. § 405.1885(a). This window of opportunity closes after these three years unless the movant establishes that such determination "was procured by fraud or similar fault of any party to the determination or decision." 42 C.F.R. § 405.1885(d).[5] Section 1885.405(b), on the other hand, explicitly directs that reopening "shall" take place if the HCFA notifies the intermediary that an NPR was inconsistent with applicable law. 42 C.F.R. § 405.1885(b).[6] Under *Monmouth*, the mandatory duty to reopen under Section

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[5] Section 405.1885(e), also referenced by Subsection (a), provides that "[p]aragraphs (a) and (b) of this section apply to determinations on cost reporting periods ending on or after December 31, 1971. (See § 405.1801(c).) However, the 3-year period described shall also apply to determinations with respect to cost reporting periods ending prior to December 31, 1971, but only if the reopening action was undertaken after May 27, 1972 (the effective date of regulations which, prior to the publication of this subpart R, governed the reopening of such determinations)." 42 C.F.R. § 405.1885(e).

[6] The Court rejects defendant's assertion that the Court should apply the current regulation rather than the regulation in effect during the relevant time period. The recent amendment to Section 405.1885(b) requires an order from the CMS to intermediaries to reopen and revise the NPRs on the basis of a prior inconsistency with the applicable law. Application of this new regulation therefore would eliminate the right of plaintiffs to pursue their claim because in this instance CMS gave no such order. Retroactive application of the new regulation would be improper under established case law. *See National Mining Ass'n* v. *Department of Labor*, 292 F.3d 849, 859 (D.C. Cir. 2002) ("In the administrative context, a rule is retroactive if it takes away or impairs vested rights acquired under existing law, or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past.") (internal quotation omitted).

1885.405(b) was triggered by the Secretary's notice, Ruling 97-2, that the earlier interpretation was inconsistent with applicable law. *See Monmouth Medical Center* v. *Thompson*, 257 F.3d at 813-14. Reopening therefore was required.

There is no support in the *Monmouth* decision or in the language of the applicable regulations for defendant's position that, in effect, the "request for reopening" requirement of Section 1885.405(a) should be read into or made a condition precedent to the mandatory duty set out in Section 1885.405(b). Subsection (a) of Section 1885.405 provides individual hospitals or intermediaries an opportunity to move to request the reopening of individual NPRs. Subsection (b), by contrast, directs the mandatory retroactive implementation of a change in the regulatory scheme, which is necessary in order to ensure that NPR's are lawful. It would be incongruous to require individual providers to request the reopening of each file pursuant in Subsection (a) in order to implement a required global correction under the statute. Such a requirement would perpetuate an incorrect interpretation of the law because no intermediary would be under an obligation to reopen or revise an erroneous determination even though the Secretary has given notice that the determination was inconsistent with the applicable law. It also would deprive a provider of the application of the correct law to its case unless it formally moves to reopen in a timely fashion.[7]

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[7] The Court also rejects defendant's argument that if the Secretary had intended to exempt Section 405.1885(b) from the "request" requirement, she would have listed Subsection (b) as an exception to Section 405.1855(a), as she did with Subsections (d) and (e). See Defendant's Opposition to Plaintiff's Motion for Sum-

As defendant points out, the court of appeals in *Monmouth* did note that "under the Secretary's own three year limitation, reopening would not be available if sought today." *Monmouth Medical Center* v. *Thompson*, 257 F.3d at 815. The *Monmouth* plaintiffs originally brought their requests for reopening under Subsection (a), however, and, in making this comment on timeliness, the court of appeals concluded that reopening pursuant to Subsection (a) would be unavailable if sought three years after the original NPRs. In this action, by contrast, plaintiffs did not pursue relief under Subsection (a)—their claim is a stand-alone claim to enforce the intermediaries' existing duty to reopen under Subsection (b). Because the *Monmouth* plaintiffs brought their claims pursuant to Subsection (a), the court of appeals addressed the path those plaintiffs took. The court of appeals did not discuss the ramifications of its holding for providers who did not file requests for reopenings.

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mary Judgment and Reply in Support of His Motion to Dismiss at 12. Subsection (d) concerns fraud in the original determination of an individual reimbursement claim, the purview of Subsection (a). It therefore is logical that Subsection (d) is referenced in Subsection (a), and likewise that Subsection (d) expressly indicates its relationship to Subsection (a). See 34 C.F.R. § 405.1885(d) ("[n]otwithstanding the provisions of paragraph (a) of this section"). Subsection (b) makes no similar reference to Subsection (a) because it addresses global, not individual, changes to NPRs. Any argument based on Subsection (e) also fails to save defendant's claim; Subsection (e) simply indicates the NPRs to which both Subsections (a) and (b) first could have been applied. *See* note 5, *supra*.

D. *No Other Adequate Remedy Available*

The Court next concludes that plaintiffs lacked any alternative avenue of relief. Defendant argues that plaintiffs should have followed the *Monmouth* plaintiffs' path and filed requests for discretionary review under Subsection (a), but this argument does not withstand scrutiny. First, Ruling 97-2 itself expressly stated that the Secretary *would not* reopen past NPRs on the basis of her changed statutory interpretation. See Ruling at 2. Under defendant's logic, plaintiffs had a duty post-Ruling to exhaust their claims through an administrative process that the Secretary of HHS herself announced was unavailable. This argument is unconvincing.[8] Second, the court in *Monmouth* concluded that a request for review at the time of the original NPRs through the regular agency appeal process was futile. *See Monmouth Medical Center* v. *Thompson*, 257 F.3d at 815. *See also Bartlett Memorial Medical Center, Inc.* v. *Thompson*, 347 F.3d 828, 837 (10th Cir. 2003) ("[I]t would have been impossible for Plaintiffs to have resolved this issue through an initial appeal to the PRRB within 180 days after the issuance of the NPRs at issue because Ruling 97-2 was not in effect or applied

[8] At oral argument, counsel for the Secretary argued that plaintiffs have failed to exhaust their administrative remedies by failing to file for reopening under Section 405.1885(a)"[b]ecause it was procedurally available to them even though the intermediary probably would not have reopened because of 97-2." Transcript of Motions Hearing of August 11, 2003, at 35:19-21. Taken to its logical conclusion, the Secretary's argument is that providers should disregard HHS administrative rulings when they disagree with the mandate. The Court cannot conclude that the Secretary would endorse such an option, which likely would result in a significant increase in requests for re-openings even though many, if not most, would be futile.

to them until after the 180-day window for appeal had passed."). Finally, the Court rejects defendant's argument that plaintiffs should have requested reopening after the D.C. Circuit in *Monmouth* announced that the Ruling provided notice of the Secretary's prior inconsistent interpretation of the applicable law. While Subsection (b) requires the intermediaries to reopen NPRs in such circumstances, there is no corresponding duty to request reopening on the part of providers, the *Monmouth* plaintiffs' decision to pursue that avenue notwithstanding. *See* Section II(C), *supra*.

E. *No Denial of Mandamus Relief on Equitable Grounds*

Defendant argues that irrespective of any clear duty to act by the Secretary, plaintiffs should be denied mandamus relief on several equitable bases. First, defendant asserts that plaintiffs slept on their rights for five years from the time of Ruling 97-2 before filing suit, thereby justifying the Court's denial of the writ. Defendant relies on the D.C. Circuit's opinion in *13th Regional Corp.* v. *U.S. Dep't of Interior*, 654 F.2d 758, 763 (D.C. Cir. 1980), which affirmed the district court's denial of a writ of mandamus because those plaintiffs waited five years from the time the relevant regulation was promulgated to request a writ compelling the agency to conduct a time-sensitive evaluation under the regulation. In this case, however, the Court concludes that plaintiffs did not wait a protracted period of time in pursuing their claims. While the Ruling was issued in 1997, the court of appeals did not decide *Monmouth*—which announced for the first time that the Ruling constituted notice to the intermediaries of the inconsistency with applicable law of the Secretary's prior interpretation—until July 27, 2001.

Plaintiffs filed their suit just eight months later on March 29, 2002, hardly an inordinate time lag.

Defendant mixes apples and oranges when he claims that plaintiffs cannot argue both that the Ruling constituted notice to the intermediaries of an inconsistency with applicable law but that it did not give plaintiffs notice of a ground for having their NPRs reopened. As discussed in Section II(C), *supra*, the Secretary's intermediaries had a clear duty to act under Section 405.1885(b) to reopen the relevant NPRs once the intermediaries received notice through the Ruling. Plaintiffs, on the other hand, had no legal duty to request a reopening after the Ruling. Nor, according to the plain language of the Ruling itself, could plaintiffs successfully have requested reopening.

Second, defendant argues that reopening all the relevant NPRs would be prejudicial to the public's interest in finality in NPRs, relying on the Supreme Courts's decision in *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, 525 U.S. 449, 454, 119 S. Ct. 930, 142 L. Ed. 2d 919 (1999) (statutory interest in finality of NPRs manifested in limited period for direct appeal). But plaintiffs are not seeking the right to request reopening under Section 405.1885(a); they are seeking a writ compelling the Secretary to do what he is mandated under federal law to do. There is no public interest in maintaining legally infirm NPRs. Furthermore, the Secretary's compliance with applicable law constitutes a separate, compelling public interest. *See Wilkinson* v. *Legal Services Corp.*, 27 F. Supp. 2d 32, 48 (D.D.C. 1998) (stating in the context of the *Accardi* doctrine that agencies are bound by their own rules and federal law based on the "founding principle of this

Republic" that government officials are bound by the rule of law).

Third, defendant asserts that the writ would impose a serious administrative burden on the Secretary. The Court concludes, however, that any such potential burden does not outweigh the public's substantial interest in the Secretary's following the law. Nor does the potential burden outweigh the public's interest in the reimbursement of provider hospitals for services to indigent patients. *See Samaritan Health Center* v. *Heckler*, 636 F. Supp. 503, 518 (D.D.C. 1985). Finally, ordering reopening does not create a "perverse" disincentive for the Secretary to "acquiesce [in] adverse circuit court rulings." Def.'s Mem. at 16. Plaintiffs are not asserting that a new rule should be applied retroactively, thereby chilling the Secretary's motivation to make prospective rules that accord with circuit decisions. The original rule was an error of law that the intermediaries are required to remedy under Section 405.1885(b). See Ruling at 2.

III. CONCLUSION

The Court concludes that plaintiffs have met their burden of demonstrating that a writ of mandamus should issue in these circumstances. Section 405.1885(b) imposed a clear duty on the Secretary to reopen the relevant NPRs for the three years prior to Ruling 97-2. Plaintiffs have a right to this relief, and have no other avenue by which to pursue their claims. The Court therefore will deny defendant's motion to dismiss, will grant plaintiffs' motion for summary judgment, and will issue the writ of mandamus that plaintiffs seek. An Order consistent with this Opinion shall issue this same day.

SO ORDERED.

ORDER AND JUDGMENT

For the reasons stated in a separate Opinion issued this same day, it is hereby

ORDERED that Defendant's Motion to Dismiss [9-1] is DENIED; it is

FURTHER ORDERED that plaintiffs' Motion for Summary Judgement [14-1] is GRANTED; it is

FURTHER ORDERED that plaintiffs' petition for a writ of mandamus is GRANTED; it is

FURTHER ORDERED that defendant, the Secretary of Health and Human Services, shall cause his fiscal intermediaries to reopen and revise the Notices of Program Reimbursements issued to plaintiffs within the three-year period prior to February 27, 1997, to include in the Secretary's revised final determination for each affected fiscal year all Medicaid-eligible in-patient days in the numerator of the Medicaid fraction that is used in the calculation of the disproportionate share patient percentage, as defined in 42 U.S.C. § 1395ww(d)(5)(F); it is

FURTHER ORDERED that JUDGMENT is entered for plaintiffs; and it is

FURTHER ORDERED that this Order and Judgment shall constitute a FINAL JUDGMENT in this case. This is a final appealable order. See Fed. R. App. P. 4(a).

SO ORDERED.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

Nos. 00-5109, 00-5110

MONMOUTH MEDICAL CENTER, APPELLANT

v.

TOMMY G. THOMPSON, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
APPELLEE

Argued: March 23, 2001
Decided: July 27, 2001

Before: HARRY T. EDWARDS, STEPHEN F. WILLIAMS and SENTELLE, Circuit Judges.

Opinion for the Court filed by Circuit Judge STEPHEN F. WILLIAMS.

STEPHEN F. WILLIAMS, Circuit Judge:

Plaintiff-appellants Monmouth Medical Center and Staten Island University Hospital are acute-care facilities that receive payments under Medicare Part A for services to Medicare beneficiaries. Since 1983, the Secretary of Health and Human Services has made payments to cover hospital operating costs for inpatient care under the Prospective Payment System ("PPS"), which reimburses according to a uniform national rate schedule. See 42 U.S.C. § 1395ww(d). The two hospitals, because they serve a disproportionate share of

low-income Medicare recipients, are eligible for "disproportionate share hospital" ("DSH") adjustments to their PPS payments. See 42 U.S.C. § 1395ww(d)(5)(F). Monmouth and Staten Island sought the aid of the district court in an attempt to have their fiscal year ("FY") 1993 and FY 1994 DSH payments recalculated, asserting jurisdiction under 42 U.S.C. § 1395oo(a)(1)(a), 28 U.S.C. § 1331, and 28 U.S.C. § 1361. The district court decided that the hospitals failed to follow the statutorily mandated procedure for appealing their payments, that 42 U.S.C. § 1395ii precludes other review, and that, accordingly, it lacked subject matter jurisdiction. We reverse.

* * *

The Secretary of HHS has delegated authority to administer the Medicare Act to the Health Care Financing Administration ("HCFA").[1] Determinations of payment amounts are in turn often delegated to fiscal intermediaries, generally private insurers that manage the payments for the Secretary. See 42 U.S.C. § 1395h. Estimated payments are made periodically and an annual accounting is done by the intermediary in the form of a Notice of Provider Reimbursement ("NPR") based on a cost report submitted by the provider after the close of each fiscal year.

The Medicare Act has detailed instructions on the means for seeking review of payment determinations. Under 42 U.S.C. § 1395oo(a)(1)(A) a dissatisfied provider may appeal two types of "final determina-

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[1] HCFA was recently renamed and became the Centers for Medicare & Medicaid Services. We will continue to use the designation HCFA in this opinion to maintain consistency with the record below.

tions" to the Provider Reimbursement Review Board ("Board"). Clause (i) covers a fiscal intermediary's final reimbursement decision, commonly the NPR, and clause (ii) covers a final determination of the Secretary regarding payments under 42 U.S.C. §§ 1395ww(b) or (d), including the DSH payments. Appeals are to be filed within 180 days of notice of the final determination. *Id.* § 1395oo(a)(3). In either case, the decision of the Board is then reviewable by filing in district court within 60 days of notice of the decision, or by the Secretary's own motion. *Id.* § 1395oo(f). Section 1395ii generally forecloses other avenues of review by incorporating the review-limiting provision of the Social Security Act, 42 U.S.C. § 405(h):

> The findings and decision of the [Secretary of HHS] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary of HHS] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary of HHS], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h).

The Secretary's regulations provide three additional channels of administrative review. Under 42 CFR § 405.1841(b), a late-filed request for Board review may be considered by the Board, provided that good cause is shown and the request is filed no more than three years after the NPR. The regulations also provide two possibilities for the reopening of a determination, again with a three-year limit. 42 CFR § 405.1885(a) provides for

reopening, at the discretion of the decisionmaker, on the motion of the provider. Subsection (b) of that same regulation, which ultimately controls here, *mandates* reopening in one special circumstance. It directs that the decision

> *shall* be reopened and revised by the intermediary if . . . the [HCFA] notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the [HCFA].

42 CFR § 405.1885(b) (emphasis added).

Under the statute authorizing DSH adjustments, eligibility for and calculation of the payment require the summing of two fractions. The numerator of one of these fractions calls for the number of inpatient days of patients who "were *eligible* for medical assistance under a State plan [i.e., Medicaid]." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added). The Secretary promulgated a regulation on how to make the calculation and has repeatedly amended it. See 42 CFR § 412.106 (1993) (version in force when original DSH calculations were made). At the same time, the Secretary published an interpretation of that rule in the Federal Register as part of the notice and comment rulemaking implementing the PPS. See 51 Fed. Reg. 16,772, 16,777 (May 6, 1986); 51 Fed. Reg. 31,454, 31,460 (September 3, 1986). Reading "who were eligible" as "'who (for such days) were eligible' " the Secretary declared that "Medicaid covered days will include only those days for which benefits are *payable*." 51 Fed. Reg. at 16,777/2-3 (emphasis added). This interpretation had the effect of reducing payments by limiting adjustments for patients who were "eligible" for Medi-

caid benefits under the natural reading of the word, but who, because of a particular state's program, were not receiving such benefits on a given day.

Neither hospital timely availed itself of the right to appeal the NPRs in question. But other providers did. The Secretary's interpretation fared poorly, being struck down in four of our sister circuits. *See Cabell Huntington Hosp.* v. *Shalala*, 101 F.3d 984 (4th Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconess Health Serv. Corp.* v. *Shalala*, 83 F.3d 1041 (8th Cir. 1996); *Jewish Hosp., Inc.* v. *Secretary of Health and Human Services*, 19 F.3d 270 (6th Cir. 1994). In light of these decisions, the Administrator of HCFA issued a ruling that rescinded the Secretary's challenged interpretation nationwide. See Health Care Financing Administration Ruling 97-2 (February 27, 1997) ("HCFAR 97-2"). The ruling established a new interpretation more favorable to hospitals, providing that Medicaid eligible days would be counted "whether or not the hospital received payment for those inpatient hospital services." *Id.* The new interpretation was to be effective in the month of its publication and applied to all as yet unsettled cost reports and all cases in which "jurisdictionally proper" appeals were still pending. See *id.* The ruling explicitly foreclosed retrospective application: "We will not reopen settled cost reports based on this issue." See *id.* Like all such rulings, HCFAR 97-2 was issued without notice or opportunity for comment.

The hospitals nonetheless sought recalculation of their DSH payments, filing with their intermediaries for reopening well within the three years required by § 405.1885. Their respective intermediaries denied the requests, citing HCFAR 97-2. Both hospitals also

sought Board review in attempts to satisfy the jurisdictional requirements of 42 U.S.C. § 1395oo. They filed their appeals within 180 days of the publication of HCFAR 97-2, but the intermediaries objected that the trigger event was each hospital's NPR, not HCFAR 97-2. In response, the hospitals invoked § 405.1841(b), which allows extension of the time limit for "good cause." They argued that the delay was unavoidable because they could not have anticipated HCFAR 97-2's refusal to grant reopening. In separate letters to the providers, the Board stated that "your rationale for late filing does not constitute good cause" and that it lacked jurisdiction to hear the appeals. Both hospitals sought review in the district court. We review the district court's jurisdictional determination *de novo*. See *Moore* v. *Valder*, 65 F.3d 189, 196 (D.C. Cir. 1995). Although we eventually conclude that we have jurisdiction under 42 U.S.C. § 1361, we must first examine all other possible avenues of relief to ensure that the hospitals have fully exhausted those which were available.

* * *

The hospitals first invoke the jurisdiction of the district court under 42 U.S.C. § 1395oo(f) to review the Board's denial of their appeals. Having acknowledged that their appeals were untimely with respect to the NPRs, they frame the appeals here as challenges to the reopening prohibition in HCFAR 97-2. At issue is whether the Board could properly consider such an attack. As noted above, clause (i) of § 1395oo(a)(1)(A) gives the Board jurisdiction to review final reimbursement determinations by intermediaries. But it appears that neither of the hospitals framed its appeal as being from its intermediary's non-reopening decision, and an HCFA Ruling is *not* the action of an intermediary.

Staten Island did not even request reopening until three months after it sought Board review. And Monmouth, while it tried for reopening before making its appeal to the board, made absolutely no mention of its intermediary or its reopening request in its appeal to the Board.

Clause (ii), which applies to final determinations of the Secretary regarding a provider's PPS calculations, brings jurisdiction no nearer. In *Washington Hosp. Center* v. *Bowen*, 795 F.2d 139 (D.C. Cir. 1986), we determined that a pre-NPR challenge could be brought where the Secretary had firmly established "the only variable factor in the final determination as to the amount of payment under § 1395ww(d)." *Id.* at 147. There the Secretary had determined the individual hospitals' "target amount," the erstwhile variable factor, thereby fixing their payment amounts under the PPS. Even after concluding, as we do below, that HCFAR 97-2 triggered mandatory reopening under § 405.1885(b), we fail to see how an attempt by the Secretary to establish a general policy against reopening in any way resembles a final determination "as to the *amount of payment*," the only kind of determination for which clause (ii) creates a right of appeal to the Board. The hospitals argue that the blanket application of the ruling is irrelevant, because it directly affects their claims specifically. That may be true, but the effect is merely to purport to alter the procedures by which they may seek a new final determination; it does not itself either establish or alter their "disproportionate patient percentage" or the amount of payment they receive under PPS.

Our conclusion that the hospitals' appeals to the Board fit neither clause (i) nor clause (ii) is at least

consistent with, if not required by, the Supreme Court's recent opinion in *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, 525 U.S. 449, 119 S. Ct. 930, 142 L. Ed. 2d 919 (1999). In that case, the Court reviewed a discretionary decision under § 405.1885(a) not to reopen a clause (i) determination, finding that such a refusal did not itself qualify as a clause (i) determination. It relied on *Califano* v. *Sanders*, 430 U.S. 99, 97 S. Ct. 980, 51 L. Ed. 2d 192 (1977), in which it held that judicial review is not available for the Secretary's decision not to reopen a claim for benefits under the Social Security Act. *Sanders*, the Court pointed out, relied in turn on two factors: "that the opportunity to reopen a benefit adjudication was afforded only by regulation and not by the Social Security Act itself; and that judicial review of a reopening denial would frustrate the statutory purpose of imposing a 60-day limit on judicial review of the Secretary's final decision." *Your Home*, 525 U.S. at 454, 119 S. Ct. 930. The *Your Home* Court also concluded that the absence of Board review would not deprive petitioners there of a suitable opportunity for "'retroactive corrective adjustment[ ]'" because they had an initial opportunity to appeal their NPRs, plus a *chance* to secure discretionary reopening by the intermediary. *Id.* (citing 42 U.S.C. § 1395x(v)(1)(A)(ii)).

One might argue that where a provider is seeking reopening under § 405.1885(b), the *Sanders* concern about the finality of decision is lessened, inasmuch as such cases will be relatively few in number; they arise only if the HCFA determines that a prior decision or set of decisions is inconsistent with applicable law. But it would still remain unclear how this distinction would change the character of the reopening decision itself from "not a final determination" to "final determina-

tion." And of course it should make no difference if the analysis arises out of clause (i) or clause (ii). In any event, we reserve our own final determination on this issue for a case in which it is more clearly presented; here HCFAR 97-2 can in no way be mistaken for a final determination for the purposes of judicial review under §§ 1395oo(a) & (f).

The hospitals nonetheless argue that our opinion in *Washington Hospital Center* and the HCFA's application of it in *National Medical Enterprises Malpractice PPS Group Appeal*, Case No. 87-5050G, HCFA Adm. Dec. (Oct. 5, 1988), together compel the interpretation that clause (ii) creates a right to Board review 180 days after the "issuance, modification, or invalidation of a HCFAR." App. Open. Br. at 48. They do no such thing. *Washington Hospital Center* held invalid HCFAR 84-1, which had barred appeal of PPS determinations until after an NPR was issued. Providers in *National Medical Enterprises* sought Board review for their payments in the wake of that case, but submitted their appeal more than 180 days from the issuance of our decision. The Administrator's decision did indeed suggest that a more timely appeal would have been successful, but that conclusion was dependent on the peculiar operation of HCFAR 84-1, which had previously operated as a bar on properly filed appeals of right. See National Medical Enterprises at 3. In the absence of HCFAR 97-2 the hospitals would not have had recourse to the Board, as they have already acknowledged.

The hospitals next seek jurisdiction under 28 U.S.C. § 1331 for review of the reopening preclusion in HCFAR 97-2. Such review could not be more plainly off limits under 42 U.S.C. § 405(h), which explicitly

withholds § 1331 jurisdiction for "any claim arising under this title." The Supreme Court has consistently interpreted this phrase broadly, such that jurisdiction is barred when " 'both the standing and the substantive basis for the presentation' of the claims" is the Medicare Act. *Heckler* v. *Ringer*, 466 U.S. 602, 615, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984) (quoting *Weinberger* v. *Salfi*, 422 U.S. 749, 760-61, 95 S. Ct. 2457, 45 L. Ed. 2d 522 (1975)). Thus, in *Ringer*, the Court declared that plaintiffs seeking to overturn an HCFA ruling that would limit their recovery for a particular type of surgery could do so only in the context of the statutorily authorized process for review. This applied with equal force to the plaintiff who had not yet undergone the surgery and therefore had, as yet, no claim for reimbursement. See *id.* at 620. That the plaintiffs there were not seeking a specific monetary award was irrelevant. The ultimate goal for those plaintiffs, as for the hospitals here, was the recovery of additional sums under the Medicare Act. See *id.* at 615-16.

The hospitals make a plausible argument that jurisdiction may be had under the limited exception to § 405(h) carved out by *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667, 106 S. Ct. 2133, 90 L. Ed. 2d 623 (1986), as interpreted by *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 120 S. Ct. 1084, 146 L. Ed. 2d 1 (2000). In *Michigan Academy* the Court, concluding that Congress had incorporated § 405(h) *mutatis mutandis* into the Medicare Act, allowed a challenge to certain Medicare procedural regulations, reading § 405(h) as limiting review of determinations but not of "the Secretary's instructions and regulations." 476 U.S. at 680, 106 S. Ct. 2133. *Illinois Council*, however, clarified "*Michigan Academy* as

holding that § 1395ii does not apply § 405(h) where application of § 405(h) would not simply channel review through the agency, but would mean no review at all." 529 U.S. at 19, 120 S. Ct. 1084. The hospitals here argue that, because they no longer have jurisdictionally valid claims before the Board and because HCFAR 97-2 would not in any event apply to them if they did, they will never have the opportunity to challenge that ruling. That seems like a plausible outcome. But despite the intermediaries' reliance on HCFAR 97-2, the ruling is separate from their denials of reopening, and under the Secretary's regulations, only the intermediaries have the jurisdiction to reopen. 42 C.F.R § 405.1885(c). Jurisdiction to review the ruling would do nothing to provide jurisdiction over the intermediaries' denials, which would stand unchanged—and no longer susceptible to automatic reopening, given the expiration of the three-year period for reopenings under § 405.1885(b).

The hospitals lastly seek jurisdiction under 28 U.S.C. § 1361 and relief ordering the intermediaries to reopen their determinations. The Supreme Court has on several occasions expressly reserved the question of whether § 1361 jurisdiction is precluded by § 405(h). See *Your Home*, 525 U.S. at 456-57 n. 3, 119 S. Ct. 930; *Ringer*, 466 U.S. at 616-17, 104 S. Ct. 2013. But this court has previously determined that § 1361 jurisdiction is not barred, see *Ganem* v. *Heckler*, 746 F.2d 844, 850-52 (D.C. Cir. 1984), joining the virtual unanimity of circuit courts. See, e.g., *Burnett* v. *Bowen*, 830 F.2d 731, 737-38 (7th Cir. 1987); *Belles* v. *Schweiker*, 720 F.2d 509, 511-13 (8th Cir. 1983). Of course, to maintain an action under § 1361, a plaintiff must both exhaust administra-

tive remedies and show a clear non-discretionary duty. *Ringer*, 466 U.S. at 616-17, 104 S. Ct. 2013.

Neither party questions our ability to provide relief in the absence of the intermediaries as parties to this lawsuit, but we note that their non-joinder does not undermine our jurisdiction. The intermediaries are agents of the Secretary charged with the relevant duties under the Medicare Act and its regulations, and, as such, they may properly be bound by a writ of mandamus against the Secretary. See *United States ex rel. Rahman* v. *Oncology Associates*, 198 F.3d 502, 511 (4th Cir. 1999); Fed. R. Civ. P. 65(d).

The hospitals argue that 42 CFR § 405.1885(b) was triggered by HCFAR 97-2 and that the intermediaries therefore had a non-discretionary duty to reopen their determinations. The Secretary responds that the choice of whether or not to advise providers that a regulation is "inconsistent with the applicable law," thereby triggering the intermediaries' mandatory reopening duty under § 405.1885(b), is committed to the non-reviewable discretion of the Secretary. But the issue is not whether we may review the choice to advise or not advise as to consistency with applicable law; it is whether the Secretary, acting through the HCFA Administrator, in effect announced a finding of inconsistency (even while purporting to veto reopening).

To be sure, HCFAR 97-2 studiously avoided using the magic words "inconsistent with the applicable law," and instead called the earlier interpretation "contrary to the applicable law in four judicial circuits." HCFAR 97-2. The Secretary argues that HCFAR 97-2 merely "acquiesced prospectively," in the interests of national uniformity, without actually admitting its illegality. But HCFAR 97-2 also purports to change an existing

interpretation, and under the law of this circuit altering an interpretive rule (interpreting an agency regulation) requires notice and opportunity for comment unless, of course, the original interpretation was invalid and therefore a nullity (as discussed below).

The Medicare Act places notice and comment requirements on the Secretary's substantive rulemaking similar to those created by the APA. See 42 U.S.C. § 1395hh(b); 5 U.S.C. § 553(b). We have not had opportunity to decide whether the Medicare Act requirement of notice and comment for "changes [of] a substantive legal standard" creates a more stringent obligation or whether it somehow changes the dividing line between legislative and interpretive rules.[2] But it seems fair to infer that, as the Medicare Act was drafted after the APA, § 1385hh(c)'s reference to "interpretive rules" without any further definition adopted an exemption at least similar in scope to that of the APA. See *Warder* v. *Shalala*, 149 F.3d 73, 79 n. 4 (1st Cir. 1998). We see no reason to explore the possibility of a distinction here, as HCFAR 97-2 appears to have none of the indicia that would lead us to think it a legislative rule under the APA. See, generally, *American Mining Congress* v. *Mine Safety & Health Admin.*, 995 F.2d 1106, 1108-12 (D.C. Cir. 1993). In the absence of HCFAR 97-2 or its predecessor interpretation, there would still be an "adequate legislative basis for . . . agency action." *Id.* at 1112. The definition of eligible

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[2] Although no explicit exception to those requirements is made for "interpretive rules," an exception is implicit in the provision for periodic publication for such rules, see 42 U.S.C. § 1395hh(c), and courts generally have assumed the exception. See *Health Ins. Ass'n of America, Inc.* v. *Shalala*, 23 F.3d 412, 422-23 (D.C. Cir. 1994).

inpatient days is merely an "elucidation of rights and duties created by Congress" and the Secretary's legislative rule. *Health Ins. Ass'n of America, Inc.* v. *Shalala*, 23 F.3d 412, 423 (citing *American Mining Congress*, 995 F.2d at 1109-10)).

But characterization as an interpretive rule does not relieve the Secretary of notice and comment requirements when a valid interpretation exists. In *Paralyzed Veterans of America* v. *D.C. Arena L.P.*, 117 F.3d 579, 586 (D.C. Cir. (1997), we concluded that: "Once an agency gives its regulation an interpretation, it can only change that interpretation as it would formally modify the regulation itself: through the process of notice and comment rulemaking." See also *Alaska Professional Hunters Ass'n.* v. *Federal Aviation Administration*, 177 F.3d 1030, 1033-34 (D.C. Cir. 1999); *Shell Offshore Inc.* v. *Babbitt*, 238 F.3d 622, 629 (5th Cir. 2001). Here, a valid rule interpreting a regulation was clearly in play, and it was modified by HCFAR 97-2.

The new interpretation established by HCFAR 97-2 would therefore be unlawful absent notice and comment rulemaking, unless the original interpretation was itself invalid. See *Dixon* v. *United States*, 381 U.S. 68, 74, 85 S. Ct. 1301, 14 L. Ed. 2d 223 (1965) ("A regulation which . . . operates to create a rule out of harmony with the statute, is a mere nullity.") (internal citations omitted). As a general rule, it is for the courts to determine whether or not a regulation is invalid. As four circuits have already done so, it certainly can't have been improper for the Secretary to concede the invalidity nationally. See *Independent Petroleum Ass'n of America* v. *Babbitt*, 92 F.3d 1248, 1260 n. 3 (D.C. Cir. 1996).

Concluding that the Secretary *did* in fact give notice of the interpretation's inconsistency with applicable law, we also find that § 405.1885(b) imposed a clear duty on intermediaries to reopen DSH payment determinations for the hospitals. The portion of HCFAR 97-2 that conflicts with that duty is simply inapplicable. In addition, we think it insignificant that, because of the Secretary's own three year limitation, reopening would not be available if sought today. Although mandamus is classified as a legal remedy, its issuance is largely controlled by equitable principles. See *Duncan Townsite Co.* v. *Lane*, 245 U.S. 308, 312, 38 S. Ct. 99, 62 L. Ed. 309 (1917). Since both hospitals were within the three-year mark when they made their requests for reopening, they are entitled to the reopening that was due them at that time. *Cf. Burnett*, 830 F.2d at 736-41 & n. 7.

The Secretary argues that the hospitals have failed to exhaust their remedies, because they failed to file proper appeals of their NPRs under § 1395oo(a). But that fact is hardly relevant here. The question is whether they have done all they can to vindicate their right to reopening. We have already shown above how all other avenues of relief are either foreclosed or futile.

Finally, the Secretary half-heartedly suggests that the hospitals may have waived mandamus jurisdiction by failing to specify § 1361 as one of the bases for jurisdiction until their response to the Secretary's motion to dismiss. But the Secretary does not contend (apart from the arguments rejected above) that the hospitals failed to allege sufficient facts to support their mandamus claim, the essential test for legal sufficiency. *Richardson* v. *U.S.*, 193 F.3d 545, 549 (D.C. Cir. 1999). Nor does the Secretary argue that the government was in any way prejudiced by the trustees' failure to list

§ 1361 in their complaints. The government has at best identified a procedural failing that would easily have been remedied by a request to amend the complaints that in no way affects our authority to consider issuance of a writ. See *Caribbean Broadcasting System, Ltd.* v. *Cable & Wireless P.L.C.*, 148 F.3d 1080, 1083-84 (D.C. Cir. 1998); Fed. R. Civ. P. 15(a). Indeed courts can treat certain requests for mandatory injunctions as petitions for a writ of mandamus, see, e.g., *National Wildlife Federation* v. *U.S.*, 626 F.2d 917, 918 n.1 (D.C. Cir. 1980), and habeas petitions as ones for mandamus, see, e.g., *United States ex rel. Schonbrun* v. *Commanding Officer*, 403 F.2d 371, 374 (2d Cir. 1968); *Long* v. *Parker*, 390 F.2d 816, 818-19 (3d Cir. 1968).

Accordingly, the judgment of the district court is reversed and the case remanded for further proceedings consistent with this opinion.

So ordered.

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 04-5203

IN RE: MEDICARE REIMBURSEMENT LITIGATION

BAYSTATE HEALTH SYSTEMS, D/B/A BAYSTATE MEDICAL CENTER, APPELLEES

v.

BRIGHAM PLAINTIFFS, ET AL., APPELLEES

MICHAEL O. LEAVITT, SECRETARY, DEPARTMENT OF HEALTH & HUMAN SERVICES, APPELLANT

Filed: Sept. 28, 2005

ORDER

BEFORE: GINSBURG, Chief Judge, and EDWARDS,* SENTELLE, HENDERSON, RANDOLPH, ROGERS, TATEL, GARLAND,* ROBERTS,* BROWN and GRIFFITH, Circuit Judges

Upon consideration of appellant's petition for rehearing en banc, and the absence of a request by any member of the court for a vote, it is

* Circuit Judges Edwards, Garland, and Roberts did not participate in this matter.

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY:
Michael C. McGrail
Deputy Clerk

APPENDIX E

Ruling No. 97-2

Health and Human Services
HCFA Ruling No. 97-2
Date: February 1997

This Ruling states the policy of the Health Care Financing Administration concerning the determination to change its interpretation of section [1886(d)(5)(F)(vi)(II)] 1886(d)(5)(F)(vi)(II) of the Social Security Act (the Act) and [42 CFR 412.106(b)(4)] 42 CFR 412.106(B)(4) to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits. Under the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.

MEDICARE PROGRAM

Hospital Insurance (Part A).

INTERPRETATION OF MEDICAID DAYS INCLUDED IN THE MEDICARE DISPROPORTIONATE SHARE ADJUSTMENT CALCULATION

PURPOSE: This Ruling announces the Health Care Financing Administration's (HCFA) determination to change its interpretation of section [1886(d)(5)(F)(vi)(II)] 1886(d)(5)(vi)(II) of the Social Security Act (the Act)

and [42 CFR 412.106(b)(4)] 42 CFR 412.106(B)(4) to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits. Under the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.

CITATIONS: Section [1886(d)(5)(F)] 1886(d)(5)(F) of the Social Security Act and [42 CFR 412.106(b)(4)] 42 CFR 412.106(b)(4).

PERTINENT HISTORY: The Medicare disproportionate share hospital (DSH) adjustment calculation, which is set forth in section [1886(d)(5)(F)] 1886(d)(5)(F) of the Act, has been the subject of a substantial amount of litigation. The adjustment is calculated by determining a hospital's disproportionate patient percentage, which is the sum of two fractions, the Medicare fraction and the Medicaid fraction. In the Medicare fraction, the number of patient days for patients who (for those days) were entitled to both Medicare Part A and Supplemental Security Income (SSI) under Title XVI of the Act is divided by the total number of patient days for patients entitled to Medicare Part A for that same period. The Medicaid fraction consists of the number of patient days for patients who for those days "were eligible for medical assistance under a State plan approved under title XIX [Medicaid] but who were not entitled to benefits under Medicare Part A" (section [1886(d)(5)(F)(vi)(II)] 1886(d)(5)(F)(vi)(II) of the Act), divided by the total number of patient days for that

same period. The Medicaid fraction is the subject of this ruling.

In implementing the calculation of the Medicaid fraction, HCFA interpreted the statutory language to include as Medicaid patient days only those days for which the hospital received Medicaid payment for inpatient hospital services. This interpretation has been considered by the courts of appeals in four judicial courts. The initial issue in the litigation was whether HCFA should have counted days for patients who had been found to be Medicaid eligible, but who had exceeded Medicaid coverage limitations on inpatient hospital days of service (and, consequently, no Medicaid payment was made for those days). In later cases, plaintiffs challenged HCFA's exclusion of any days of inpatient hospital services for patients who met Medicaid eligibility requirements, regardless of the reason for which no Medicaid payment was made. In each of the cases, the court declined to uphold HCFA's interpretation, reasoning that the statutory language "eligible for medical assistance" would include days on which the patient meets Medicaid eligibility criteria regardless of whether payment is made.

Although HCFA believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory language, HCFA recognizes that, as a result of the adverse court rulings, this interpretation is contrary to the applicable law in four judicial circuits.

In order to ensure national uniformity in calculation of DSH adjustments, HCFA has determined that, on a prospective basis, HCFA will count in the Medicaid fraction the number of days of inpatient hospital services for patients eligible for Medicaid on that day,

whether or not the hospital received payment for those inpatient hospital services. This would not include days for which no Medicaid payment was made because of the patient's spenddown liability, because an individual was not eligible for Medicaid at that point.

Pursuant to this Ruling, Medicare fiscal intermediaries will determine the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claims. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

We will not reopen settled cost reports based on this issue. For hospital cost reports that are settled by fiscal intermediaries on or after the effective date of this ruling, these days may be included. For hospital cost reports which have been settled prior to the effective date of this ruling, but for which the hospital has a jurisdictionally proper appeal pending on this issue pursuant to either [42 CFR 405.1811] 42 CFR 405.1811 or [42 CFR 405.1835] 42 CFR 405.1835, these days may be included for purposes of resolving this appeal.

RULING: For all cost reporting period beginning on or after February 27, 1997, the Medicare disproportionate share adjustment will be determined by including IN

the calculation of the Medicaid fraction set forth in section [1886(d)(5)(F)(vi)(II)] 1886(d)(5)(vi)(II) of the Act of the additional days as set forth above.

IV. EFFECTIVE DATE

This Ruling is effective February 27, 1997.

Dated: 2/27/97

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Bruce C. Viadeck,
Administrator,
Health Care Financing Administration

APPENDIX F

CODE OF FEDERAL REGULATIONS
TITLE 42—PUBLIC HEALTH
CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCHAPTER B—MEDICARE PROGRAM
PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED
SUBPART R—PROVIDER REIMBURSEMENT DETERMINATIONS AND APPEALS

§ 405.1885 Reopening a determination or decision.

(a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

(b) A determination or a hearing decision rendered by the intermediary shall be reopened and revised by

the intermediary if, within the aforementioned 3-year period, the Health Care Financing Administration notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the intermediary.

(c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

(d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision.

(e) Paragraphs (a) and (b) of this section apply to determinations on cost reporting periods ending on or after December 31, 1971. (See § 405.1801(c).) However, the 3-year period described shall also apply to determinations with respect to cost reporting periods ending prior to December 31, 1971, but only if the reopening action was undertaken after May 27, 1972 (the effective date of regulations which, prior to the publication of this Subpart R, governed the reopening of such determinations).