No. 97-1489

In the Supreme Court of the United States

OCTOBER TERM, 1997

YOUR HOME VISITING NURSE SERVICES, INC.,
PETITIONER

v.

DONNA E. SHALALA, SECRETARY OF
HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Whether a fiscal intermediary's denial of a Medicare provider's request to reopen an annual reimbursement determination under Part A of the Medicare program is subject to administrative and judicial review under 42 U.S.C. 1395*oo* and, if not, whether the denial is subject to judicial review under 28 U.S.C. 1331, 28 U.S.C. 1361, or the Administrative Procedure Act, 5 U.S.C. 706.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-15) is reported at 132 F.3d 1135. The opinion of the district court (Pet. App. 17-33) is unreported. The decision of the Provider Reimbursement Review Board (J.A. 14-24) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 38-39) was entered on December 22, 1997. The petition for a writ of certiorari was filed on March 11, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The provisions of 5 U.S.C. 706, 28 U.S.C. 1331 and 1361, and 42 U.S.C. 405(h), 1395x(v)(1)(A), and 1395*oo* are set forth at Pet. App. 40-50. The provisions of 42 C.F.R. 405.1885 are set forth at Pet. App. 51-52.

STATEMENT

1. In Title XVIII of the Social Security Act, Congress established 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, including certain home health services that are provided to an individual on a visiting basis at the individual's place of residence. 42 U.S.C. 1395x(m).[1] When patient beneficiaries receive covered home health services, the Secretary reimburses the providers of those services under the Medicare Act and the Secretary's implementing regulations. 42 U.S.C. 1395f(b)(1), 1395x(v)(1)(A).

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), 413.24(f). The cost report is filed with a "fiscal intermediary," generally a private insurance company that is nominated by a group or association of providers and determines the amount of payments to be reimbursed by the Secretary pursuant to an agreement with the Secretary. 42 U.S.C. 1395h. The cost report shows the provider's costs and the percentage of those costs allocated to Medicare services. 42 C.F.R. 413.20(b), 413.24(f). The

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[1] Part B is a voluntary supplementary insurance program covering physicians' charges and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s). This case arises under the Part A program. See pp. 39-40, *infra.*

intermediary analyzes the cost report, audits it if 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. 42 C.F.R. 405.1803. See *Regions Hosp.* v. *Shalala*, 118 S. Ct. 909, 913 (1998). During the provider's fiscal year, the Secretary makes advance interim payments reflecting the provider's pre-audited estimated costs of anticipated services. 42 U.S.C. 1395g(a); 42 C.F.R. 413.60. As a result, the NPR reflects any adjustments that are necessary to reconcile the aggregate amount of interim payments paid to the provider during the course of the fiscal year with the provider's reimbursable costs as reflected in the NPR. 42 U.S.C. 1395x(v)(1)(A)(ii); 42 C.F.R. 405.1803(c), 413.64(e)-(f); *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402 (1993).

Congress has specified in the Medicare Act itself a comprehensive scheme for administrative and judicial review of "a final determination of [a fiscal intermediary] as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under [Medicare] for the period covered by [the provider's cost] report." 42 U.S.C. 1395*oo*(a)(1)(A)(i).[2] A "dissatisfied" provider may obtain a hearing before the Provider Reimbursement Review Board (PRRB), whose members are appointed by the Secretary, if the amount in controversy equals or exceeds $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),

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[2] Congress also has established administrative and judicial review procedures for claimants who are denied Medicare benefits under Part A or B of the Medicare program. See 42 U.S.C. 1395ff (incorporating procedures under 42 U.S.C. 405(b) and (g)); see also pp. 26-27, 38-41, *infra*.

(a)(3), (b), and (h); 42 C.F.R. 405.1835, 405.1837, 405.1845(a). See *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 403-404 (1988).

The Board has authority to "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to [the] cost report and to make any other revisions on matters covered by such cost report * * * even though such matters were not considered by the intermediary in making [its] final determination." 42 U.S.C. 1395*oo*(d). The Board's decision may be reversed, affirmed, or modified by the Secretary within 60 days after the provider is notified of the Board's decision. Unless reviewed by the Secretary, the Board's decision is final, and is subject 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. 405.1877.[3]

The Secretary has promulgated regulations governing "[r]eopening[s]" of Medicare reimbursement determinations. 42 C.F.R. 405.1885. Under those regulations, a determination by the intermediary may be reopened within three years (or at any time in the case of fraud) with respect to specific "findings on matters at issue in [the intermediary's] determination," by motion of either the intermediary or the provider affected by the intermediary's determination. 42 C.F.R. 405.1885(a) and (d); see *Regions Hosp.*, 118 S. Ct. at

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[3] Providers may also obtain expedited judicial review of any action taken by a fiscal intermediary "which involves a question of law or regulations relevant to the matters in controversy," if the PRRB has jurisdiction and determines that "it is without authority to decide the question" or fails to make a timely determination of its authority to decide the question. 42 U.S.C. 1395*oo*(f)(1); 42 C.F.R. 405.1842(b). The Board is authorized by regulation to deny expedited judicial review if it finds that the issue on which review is sought is intertwined with disputed factual or legal issues that it is authorized to decide. 42 C.F.R. 405.1842(g)(2).

913.[4] An intermediary's determination "shall be reopened and revised by the intermediary" if the Health Care Financing Administration (HCFA) notifies the intermediary that the determination "is inconsistent with the applicable law, regulations, or general instructions issued by [HCFA]." 42 C.F.R. 405.1885(b). The Secretary's Provider Reimbursement Manual (PRM) also states that "[w]hether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions" of the Secretary. PRM § 2931.2.

The Secretary's regulations 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. 405.1885(c). The PRM explains that "[a] provider has no right to a hearing on a finding by an intermediary * * * that a reopening * * * of a determination * * * is not warranted." PRM § 2932.1. The PRM similarly states that "[a] refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 C.F.R. § 405.1885(c)." PRM § 2926, App. A, ¶ B.4. In the event the intermediary does reopen the prior determination, however, a provider may appeal to the Board any adjustments made by the intermediary in a revised NPR, if the amount in controversy and filing requirements are satisfied. 42 C.F.R. 405.1889. The Board's final decision concerning the revised NPR would then be subject to judicial review under 42 U.S.C. 1395*oo*(f)(1).

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[4] The regulations also authorize the Board and the Secretary to reopen their respective decisions. 42 C.F.R. 405.1885(a).

Finally, the second and third sentences of Section 205(h) of Title II of the Social Security Act, 42 U.S.C. 405(h), made applicable to the Medicare Act by 42 U.S.C. 1395ii, provide:

> No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], 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).

2. Petitioner provides home health care services to Medicare beneficiaries and is reimbursed on a reasonable cost basis. Pet. App. 2; see 42 U.S.C. 1395f(b)(1)(A). For its 1989 fiscal year, petitioner submitted four cost reports for its four constituent home health agencies. Pet. App. 3. The reports included requests for payment for certain compensation to its owners as an allowable cost reimbursable under the Medicare program. See 42 C.F.R. 413.102(a). Petitioner prepared those cost reports after receiving the fiscal intermediary's NPR for fiscal year 1987, which had disallowed a portion of the provider's claimed owners' compensation costs. As a result, petitioner did not claim reimbursement for $48,890 in owners' compensation on its 1989 cost reports, and attached a schedule of "[p]rotested" amounts. J.A. 32, 50, 52; cf. *Bethesda Hosp. Ass'n*, 485 U.S. at 401-402. On March 29, 1991, petitioner's fiscal intermediary issued four NPRs that determined the total amount of program reimbursement due to petitioner; the NPRs did not include payments for the protested amounts. J.A. 34-56. The NPRs notified petitioner of its right under Section 1395*oo*(a) to seek review of the intermediary's determination within 180 days of the notice. J.A. 37, 41, 45, 49. Petitioner did not appeal any of the four NPRs to the PRRB within the statutory time

period. Pet. 23; Pet. App. 3. By contrast, petitioner did administratively appeal the intermediary's determination as to allowable owners' compensation costs for fiscal years 1987, 1990, 1991, 1992, 1993, and 1994. Pet. 23.

On March 28, 1994, less than three years from the date of the issuance of the NPRs for petitioner's fiscal year 1989, petitioner requested its intermediary to reopen the final reimbursement determinations for 1989 for petitioner's four agencies under the Secretary's reopening regulations. J.A. 31-34. Petitioner claimed that during the course of appealing the intermediary's denial of certain owners' compensation costs for fiscal years other than 1989, petitioner discovered that the intermediary had failed to compare petitioner's costs to salary data for officers of home health agency chains, and that the intermediary accordingly should "recompute" the provider's allowable owners' compensation costs. J.A. 32. On April 21, 1994, the intermediary denied the request for reopening, finding that the cost reports were "not inconsistent with the law, regulations and rulings or general instructions"; that a "clear and obvious error was not made when these cost reports were filed"; and that "new and material evidence has not been presented to establish that the compensation claimed was inappropriate." J.A. 28-29. On October 14, 1994, petitioner sought to appeal the intermediary's denial to the PRRB. J.A. 25-27. On January 10, 1995, the PRRB dismissed petitioner's appeal on the ground that, under 42 C.F.R. 405.1885(c), it lacked jurisdiction to review the reopening denial. J.A. 15. The PRRB concluded that, because "the Intermediary was the administrative body that rendered the last determination [on petitioner's reimbursement], it is the Intermediary's decision whether or not to reopen the cost report." *Ibid.*

3. Petitioner filed suit in the United States District Court for the Eastern District of Tennessee, requesting that the court order the PRRB to review the intermediary's de-

nial of the request to reopen its final determinations for petitioner's 1989 fiscal year or, in the alternative, order the intermediary to reopen petitioner's NPRs to make additional payments for the claimed costs regarding owners' compensation. J.A. 61. The district court dismissed petitioner's complaint on the ground that the PRRB does not have jurisdiction under 42 U.S.C. 1395*oo*(a) over an intermediary's denial of a request to reopen a provider's NPR. Pet. App. 16-33. The court reasoned that "the Secretary's determination as reflected in the Medicare regulations and Provider Reimbursement Manual that denials of reopening requests are unreviewable is a reasonable interpretation of the Medicare statute." *Id.* at 26. The court also rejected petitioner's alternative contention that the court could review the intermediary's reopening denial through the exercise of either general federal question jurisdiction under 28 U.S.C. 1331 or mandamus jurisdiction under 28 U.S.C. 1361. Pet. App. 30-32.

4. The court of appeals affirmed. Pet. App. 1-15. It concluded that the operative language in 42 U.S.C. 1395*oo*(a) triggering a provider's right of review before the Board—"a final determination * * * of the intermediary * * * as to the amount of total program reimbursement due the provider"—does not clearly encompass an intermediary's denial of a request to reopen a prior determination, and that the Secretary's reopening regulations and interpretative guidelines reasonably interpret the Medicare Act not to grant the PRRB jurisdiction over an intermediary's denial of a request to reopen. Pet. App. 4-7. The court found its conclusion "bolstered" by *Califano* v. *Sanders*, 430 U.S. 99, 108 (1977), in which this Court concluded that the Social Security Act, 42 U.S.C. 405(g), does not authorize federal courts to review a denial of reopening of a Social Security disability claim based on an alleged abuse of agency discretion. Pet. App. 7-8.

The court of appeals further concluded that 42 U.S.C. 405(h) precludes a district court from exercising its general federal question jurisdiction under 28 U.S.C. 1331 to review an intermediary's denial of a request to reopen, because petitioner's claims for additional reimbursement arise under the Medicare Act. Pet. App. 11-12. Finally, reasoning that a fiscal intermediary's "decision not to reopen [i]s discretionary," the court of appeals rejected petitioner's contention that the intermediary's denial of reopening is reviewable under the mandamus statute, 28 U.S.C. 1361. Pet. App. 14-15.

SUMMARY OF ARGUMENT

I. The familiar two-step analysis of *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984), requires that, if Congress has not "directly spoken to the precise question at issue," a court must sustain an agency's interpretation of an Act of Congress so long as it is "based on a permissible construction of the statute." Moreover, where, as here, the Act confers legislative rulemaking authority on the Secretary (see 42 U.S.C. 405(a) (as incorporated into the Medicare Act by 42 U.S.C. 1395(ii)), 1302(a), 1395x(v)(1)(A), 1395hh), the regulations "are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." See *Sullivan* v. *Zebley*, 493 U.S. 521, 528 (1990), quoting *Chevron*, 467 U.S. at 843-844. Here, the Secretary's reopening regulations are not "arbitrary, capricious, or manifestly contrary" to the Act.

A. The text of Section 1395*oo*(a) requires the PRRB to conduct an administrative hearing with respect to an intermediary's "final determination * * * as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under [Medicare] for the period covered by [the provider's cost] report." That language refers to an intermediary's NPR, which constitutes the intermediary's final de-

termination of the total amount of annual reimbursement owed to the provider. The statutory phrase, however, does not clearly encompass an intermediary's refusal to revisit reimbursement determinations already made in a closed NPR. Neither the Act itself nor its history speaks to reopenings. The Secretary therefore permissibly exercised her broad rulemaking authority to allow a provider to seek reopening, but not to seek further review of a decision denying reopening. The Secretary's approach furthers Congress's intent to require providers to challenge substantive reimbursement determinations within the 180-day time period prescribed by 42 U.S.C. 1395*oo*(a)(3).

The Secretary's position also rests on a reasonable construction of her reopening regulations, which vest the "exclusive[]" "[j]urisdiction" for reopening with "that administrative body that rendered the last determination," 42 C.F.R. 405.1885(c), and provide for further review only "[w]here a revision is made * * * after [a] determination * * * has been reopened," 42 C.F.R. 405.1889. The plain text of those provisions fully supports the Secretary's conclusion that the Board lacks jurisdiction to review intermediary decisions denying reopening.

B. The Secretary's reopening regulations are reasonable and not arbitrary or capricious. The regulations are consistent with the Secretary's established treatment of reopening denials with respect to other payment determinations under the Medicare program. The regulations do not authorize intermediaries to deny reimbursement requests in an arbitrary fashion. Intermediaries frequently grant providers' requests to reopen, and intermediaries are subject to continuing oversight by the Secretary to ensure that reopening requests are considered in accordance with the Secretary's regulations and interpretive guidance. The regulations, moreover, rationally balance the Secretary's interest in administrative finality with the need to provide a limited

means for the correction of errors after the intermediary's determination in the NPR has become final.

II. Federal courts do not have subject matter jurisdiction under 28 U.S.C. 1331 to review intermediary decisions denying reopening. The third sentence of 42 U.S.C. 405(h), incorporated into the Medicare Act by 42 U.S.C. 1395ii, expressly bars federal question jurisdiction under 28 U.S.C. 1331 over actions "to recover on any claim" arising under the Medicare Act. Section 405(h) consequently precludes federal question jurisdiction over petitioner's claim to recover additional reimbursement for owners' compensation costs under the Secretary's reopening regulations. That result is entirely consistent with this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), which permitted a federal court under 28 U.S.C. 1331 to consider an attack on the validity of the Secretary's regulation under Part B of the program when such challenge otherwise would be altogether immune from judicial review. Petitioner's claims for additional reimbursement do not raise such a facial attack, and 42 U.S.C. 1395*oo* provided petitioner with an adequate opportunity to challenge the intermediary's substantive reimbursement determination.

III. The federal mandamus statute, 28 U.S.C. 1361, is not a basis for reviewing reopening denials. Review by mandamus is barred by 42 U.S.C. 405(h). In any event, mandamus relief is not available unless the plaintiff has exhausted all other avenues of relief and the defendant owes the plaintiff a clear nondiscretionary duty. *Heckler* v. *Ringer*, 466 U.S. 602, 616 (1984). Those requirements are not met in this case, because an intermediary's decision to reopen is discretionary. Likewise, petitioner has not stated a claim for mandamus relief with respect to the underlying calculation of the amount of owners' compensation costs owed to petitioner. Petitioner did not exhaust that claim by appealing its NPR under 42 U.S.C. 1395*oo*, and the determination of petitioner's

reasonable owners' compensation costs under the Act and the Secretary's implementing regulations is discretionary.

IV. This Court held in *Califano* v. *Sanders*, 430 U.S. 99, 105-107 (1977), that the Administrative Procedure Act (APA), 5 U.S.C. 701-706, is not an independent basis of subject matter jurisdiction to review agency action. Petitioner offers no basis for reconsidering that decision, and *Califano* v. *Sanders* consequently forecloses jurisdiction under the APA to hear challenges to reopening denials by intermediaries.

ARGUMENT

I. 42 U.S.C. 1395*oo* DOES NOT PROVIDE A RIGHT OF REVIEW OF AN INTERMEDIARY'S DENIAL OF A REQUEST TO REOPEN A FINAL REIMBURSEMENT DETERMINATION

A provider of services under Part A of the Medicare program has a right to a hearing before the Provider Reimbursement Review Board (PRRB) with respect to a "cost report" filed by the provider if it is "dissatisfied with a final determination of [a fiscal intermediary] as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under [Medicare] for the period covered by [the provider's cost] report." 42 U.S.C. 1395*oo*(a). The provider then has a right to judicial review of the "final decision" of the Board following such a hearing. 42 U.S.C. 1395*oo*(f)(1). The principal issue in this case is whether Section 1395*oo*(a) confers on providers a right to administrative review by the Board of an intermediary's refusal to revisit prior reimbursement determinations. In the Secretary's view, the phrase "final determination * * * as to the amount of total program reimbursement due the provider" refers to the notice of amount of program reimbursement (NPR), not to a refusal to reconsider the NPR. Petitioner, in contrast,

contends that the statutory language must be read to encompass an intermediary's decision denying a provider's request under the Secretary's regulations to reopen a specific finding in a prior NPR.

The starting point in any case of statutory construction is, of course, the language of the Act itself. If a court determines that an Act of Congress speaks clearly "to the precise question at issue," the court "must give effect to the unambiguously expressed intent of Congress." *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984). If "the statute is silent or ambiguous with respect to the specific issue," however, the court must sustain the agency's interpretation and implementing regulations if they are "based on a permissible construction of the statute." *Id.* at 843; see also *Regions Hosp.* v. *Shalala*, 118 S. Ct. 909, 915 (1998) ("[i]f the agency's reading fills a gap or defines a term in a reasonable way in light of the Legislature's design, we give that reading controlling weight"). In this case, moreover, Congress has conferred legislative rulemaking authority on the Secretary in the implementation of the Medicare Act, including the authority to issue regulations that govern reimbursement determinations under the Act. See 42 U.S.C. 405(a) (as incorporated into the Medicare Act by 42 U.S.C. 1395ii), 1302(a), 1395x(v)(1)(A), 1395hh; *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 418-419 & n.13 (1993); *Sullivan* v. *Zebley*, 493 U.S. 521, 525 n.2, 528 (1990); *Heckler* v. *Campbell*, 461 U.S. 458, 466 (1983). In that situation, the regulations "are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Sullivan* v. *Zebley*, 493 U.S. at 528 (quoting *Chevron*, 467 U.S. at 843-844).[5] Here, far from being

[5] Petitioner's amici contend (Br. 25-26) that the Secretary's interpretation is not entitled to deference because the question in this case pertains not to "the complexities of the Medicare program," but a jurisdic-

arbitrary, capricious, or manifestly contrary to the Act, the Secretary's construction of Section 1395*oo*(a) is fully consistent with the Act and is plainly reasonable.

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tional question over which courts are more familiar. In *Commodity Futures Trading Commission* v. *Schor*, 478 U.S. 833, 845 (1986), however, this Court rejected the notion that a court has "superior expertise" with respect to an agency's adjudicatory jurisdiction and concluded that an agency's position is due "substantial deference" whenever "a dispute centers on whether a particular regulation is 'reasonably necessary to effectuate any of the provisions or to accomplish any of the purposes' of the Act the agency is charged with enforcing." The Court, on numerous occasions, has deferred to an agency's interpretation of its adjudicatory jurisdiction. See, *e.g.*, *Reiter* v. *Cooper*, 507 U.S. 258, 269 (1993); *EEOC* v. *Commercial Office Prods. Co.*, 486 U.S. 107, 115 (1988); *NLRB* v. *United Food & Commercial Workers Union*, 484 U.S. 112, 123 (1987); see also *Mississippi Power & Light Co.* v. *Moore*, 487 U.S. 354, 380-382 (1988) (Scalia, J., concurring in the judgment) (collecting cases on question of deference to agency's interpretation of statute concerning its jurisdiction). Here, the Medicare Act confers broad authority on the Secretary to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs" under the Act. 42 U.S.C. 1395hh(a)(1); accord 42 U.S.C. 405(a), 1302(a), 1395x(v)(1)(A); see also 42 U.S.C. 1395*oo*(e) (authorizing PRRB to make rules "not inconsistent with the * * * regulations of the Secretary" to carry out provisions of Section 1395*oo*). The Secretary's rulemaking authority therefore encompasses the ability to prescribe regulations defining the type of agency decision subject to administrative review. See *Weinberger* v. *Salfi*, 422 U.S. 749, 766 (1975) (noting Secretary's rulemaking authority to define agency's "final decision" triggering right of judicial review under 42 U.S.C. 405(g)). Moreover, the administrative process by which intermediaries make reimbursement determinations that are subject to review by the Board, and ultimately the Secretary, necessarily relates to the "complex and highly technical regulatory program" over which the Secretary has particular expertise. *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994) (quoting *Pauley* v. *BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991)).

A. The Text Of Section 1395*oo*(a) Supports The Secretary's Construction

1. Section 1395oo(a) Is Most Naturally Read To Confer A Right To Review Of A Notice Of Amount Of Program Reimbursement Issued By An Intermediary

Section 1395*oo*(a) states that "[a]ny provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by [the] Provider Reimbursement Review Board" if each of three conditions is satisfied. The first condition is that "such provider * * * is dissatisfied with a final determination of the * * * intermediary * * * as to the amount of total program reimbursement due the provider * * * for the period covered by [the provider's cost] report." 42 U.S.C. 1395*oo*(a)(1)(A)(i). The remaining two conditions are that the amount in controversy is $10,000 or more, and that the provider files a "request for a hearing" within 180 days after notice of the intermediary's final determination. 42 U.S.C. 1395*oo*(a)(2) and (3).

The language quoted above is most naturally read to confer a right to Board review of the intermediary's substantive reimbursement determination at the end of each cost year, but not of the intermediary's mere refusal to revisit that determination. That conclusion is especially evident from the fact that Section 1395*oo*(a) confers a right to a "hearing" by the Board, which includes the right to present evidence and cross-examine witnesses. See 42 U.S.C. 1395*oo*(c). Such a hearing is of course appropriate on review of the NPR, but even petitioner does not contend that it is entitled to the sort of evidentiary hearing specified by Section 1395*oo*(c) concerning an intermediary's denial of a motion to reopen a prior determination. Compare *Califano* v. *Sanders*, 430 U.S. 99, 108 (1977).

Moreover, to the extent the Act itself does not define the operative statutory terms, "[their] meaning is left to the Secretary to flesh out by regulation." *Weinberger* v. *Salfi*, 422 U.S. 749, 766 (1975); see also n. 5, *supra*. The Secretary's regulations make clear that providers have a right to obtain Board review of an intermediary's annual determination as reflected in the NPR, but not its decision denying a request to reopen a prior NPR.

The Secretary has defined an intermediary's "final determination" under Section 1395*oo*(a)(1)(A)(i) to mean a "determination of the amount of total reimbursement due the provider, *pursuant to [42 C.F.R.] 405.1803* following the close of the provider's cost reporting period." 42 C.F.R. 405.1801(a)(1) and (3) (emphasis added). Section 405.1803 of the regulations, in turn, specifically requires the intermediary to issue a "notice of amount of program reimbursement"—the NPR—by "furnish[ing] the provider * * * a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider." 42 C.F.R. 405.1803(a); see also *Regions Hosp.* v. *Shalala*, 118 S. Ct. at 913 ("[t]he [NPR] determines the total amount payable to the provider for Medicare services during the reporting period"); *HCA Health Servs., Inc.* v. *Shalala*, 27 F.3d 614, 617 (D.C. Cir. 1994) ("it is fairly straightforward to conclude that the NPR is the intermediary's 'final determination . . . as to the amount of total program reimbursement'"). The Secretary had promulgated similar regulations even before Congress created the PRRB. See 37 Fed. Reg. 10,722, 10,724 (May 27, 1972) (the NPR "shall * * * explain the intermediary's determination of total program reimbursement due the provider for the reporting period covered by the cost report"). The NPR also is a "final and binding" determination as to the total amount of reimbursement owed to a provider in a given cost year, unless the provider timely appeals the NPR within the 180-day

time period under Section 1395*oo*(a), or the intermediary in fact has revised its determination through a reopening. 42 C.F.R. 405.1807.

Accordingly, under the statutory and regulatory framework, the operative "final determination * * * as to the total amount of program reimbursement" in this case is the intermediary's issuance of four NPRs on March 29, 1991, J.A. 34-56, and not the intermediary's denial, three years later, of petitioner's request to reconsider petitioner's allowable owners' compensation costs, J.A. 28-29. Thus, petitioner was required under Section 1395*oo*(a) to seek administrative review before the PRRB within 180 days of its NPRs or not at all.[6]

2. Section 1395oo(a) Does Not By Its Terms Confer A Right To Review Of An Intermediary's Refusal To Revisit Its Final Determination

a. Petitioner and its amici do not dispute that Section 1395*oo*(a) refers to an intermediary's issuance of the NPR, or that providers must seek administrative review of that determination by the intermediary within 180 days after receiving notice of the determination. Rather, petitioner and

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[6] Amici are incorrect in asserting (Br. 7) that the Secretary's interpretation is inconsistent with the Court's decision in *Bethesda Hospital Association* v. *Bowen*, 485 U.S. 399 (1988). That case involved the interpretation of the word "dissatisfied" in Section 1395*oo*(a)(1)(A)(i) upon a provider's *direct* appeal of an NPR. Amici similarly err in suggesting (Br. 14) that the Secretary's interpretation conflicts with 42 U.S.C. 1395*oo*(d), which authorizes the Board to revise matters covered by a cost report "even though such matters were not considered by the intermediary in making [its] final determination." This Court explained in *Bethesda Hospital Association*, 485 U.S. at 406, that Section 1395*oo*(d) applies "once [the Board] obtains jurisdiction pursuant to subsection (a)." Thus, whether the PRRB has jurisdiction to review a denial of a provider's reopening request "ultimately must rest upon [Section] 1395oo(a)." *HCA Health Servs., Inc.*, 27 F.3d at 617.

its amici argue (Pet. Br. 6-12, 17-18; Amici Br. 6-7) that Section 1395*oo*(a) inevitably must also extend to any subsequent decision by the intermediary denying a provider's request to revisit a final NPR. See also *State of Oregon* v. *Bowen*, 854 F.2d 346, 349 (9th Cir. 1988) (concluding a reopening denial falls within Section 1395*oo*(a)(1)(A)(i) because it "directly implicate[s]" the total amount of Medicare reimbursement owed in a given cost year). That interpretation, however, is compelled by neither the text of Section 1395*oo*(a) nor its history.

As an initial matter, the Act makes no mention of reopenings; the intermediary's ability to reopen its previous final determination is purely a creature of the Secretary's regulations. The Secretary first promulgated reopening regulations shortly before Congress created the PRRB in Section 1395*oo*, 37 Fed. Reg. at 10,725, and did so under the Secretary's general rulemaking authority, *HCA Health Servs., Inc.* v. *Shalala*, 27 F.3d at 618-619. Nothing in the language of Section 1395*oo* compels an intermediary, much less the PRRB, to consider a provider's request for additional reimbursement if the provider fails to challenge the intermediary's NPR within 180 days of receiving notice of its issuance. See *Good Samaritan Hosp. Reg'l Med. Ctr.* v. *Shalala*, 85 F.3d 1057, 1062 (2d Cir. 1996) ("42 U.S.C. § 1395oo, read by itself, leaves us in a 'quandary' as to the availability of PRRB review over a reopening decision") (quoting *HCA Health Servs., Inc.*, 27 F.3d at 618-619). The Act's silence as to reopenings therefore confirms that the Secretary may permissibly construe Section 1395*oo*(a) to grant providers a right to administrative review of substantive reimbursement determinations by intermediaries,

but not of intermediaries' subsequent refusals to reopen and reconsider such determinations.[7]

The history of Section 1395*oo*(a) is fully consistent with the Secretary's interpretation. Before Congress created the PRRB in 1972, the Act did not provide for administrative or judicial review of Medicare reimbursement determinations, but simply directed the Secretary to "periodically determine the amount which should be paid * * * to each provider of services with respect to the services furnished by it" and to pay "at such time or times as the Secretary believes appropriate (but not less often than monthly) * * * the amounts so determined." Pub. L. No. 89-97, § 102(a), 79 Stat. 297 Social Security Act § 1815, 42 U.S.C. 1395g(a)). In response to provider complaints that there was "no specific

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[7] Amici contend (Br. 10) that the Secretary's interpretation is inconsistent with the Board's authority to review intermediary determinations other than the NPR. See, *e.g.*, 42 C.F.R. 405.1889 (intermediary determinations revising an NPR upon a reopening); 42 C.F.R. 413.30(c) (denial of routine cost limit exception requests); 42 C.F.R. 413.40(e)(4) (denial of rate-of-increase ceiling adjustment requests); 42 C.F.R. 413.86(e)(1)(v) (cited in *Regions Hosp.*, 118 S. Ct. at 918) (per-resident amount determinations under 42 U.S.C. 1395ww(h)). Unlike a mere refusal to revisit a prior "final determination," however, the Secretary has recognized that the Board may review certain *new* substantive reimbursement determinations by an intermediary that affect an initial or revised NPR. See generally PRM § 2926, App. A. In any event, the Secretary has authority under the Act to interpret and amplify the Board's jurisdiction so long as her regulations are not otherwise precluded by statute. See n.5, *supra*. Amici similarly suggest (Br. 9 n.5) that the Act's express preclusion of PRRB review in 42 U.S.C. 1395*oo*(g) and 1395yy(e)(8) necessarily means that Congress intended to mandate a right to PRRB hearing with respect to any decision by an intermediary relating to a reimbursement determination. Sections 1395*oo*(g) and 1395yy(e)(8), however, relate to payment determinations specified *by statute*, and therefore do not reflect an intent by Congress to require review of an intermediary's decision denying a reopening request under a procedure bestowed solely by the Secretary's regulations.

provision for an appeal * * * of a fiscal intermediary's final reasonable cost determination," H.R. Rep. No. 231, 92d Cong., 1st Sess. 108 (1971), Congress, in 1972, established the PRRB to afford a hearing with respect to such final determinations upon a provider's request for a hearing within 180 days after notice of the intermediary's final determination. Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1420; see also S. Rep. No. 1230, 92d Cong., 2d Sess. 248 (1972). Although Congress plainly intended Section 1395*oo* to authorize an administrative hearing on the intermediary's annual final determination as to the total amount of program reimbursement, nothing in the Act's history suggests that Congress intended to afford providers a right to a hearing by the PRRB whenever an intermediary denies a request to revisit that final determination.

b. Petitioner argues (Br. 11-14) that a right to review by the PRRB is mandated by 42 U.S.C. 1395x(v)(1)(A)(ii), which requires the Secretary to establish regulations to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." Petitioner contends that Section 1395x(v)(1)(A)(ii) requires the Secretary to provide for reopening of closed cost reports and that Section 1395x(v)(1)(A)(ii)'s "plain language" and purpose "to provide a fair method to make retroactive adjustments" conflict with the Secretary's position of "unreviewability." Br. 12-13 (quoting *State of Oregon*, 854 F.2d at 349-350); see also Amici Br. 9-10 n.6.

In *Good Samaritan Hospital* v. *Shalala*, 508 U.S. 402 (1993), however, this Court specifically rejected the contention that Section 1395x(v)(1)(A)(ii) requires the Secretary to alter retroactively her substantive determinations as to the amount of Medicare reimbursement due to providers. Rather, the Court held that the Secretary reasonably con-

strued Section 1395x(v)(1)(A)(ii) narrowly to refer only to the year-end book balancing of advance monthly estimated payments to providers (see 42 U.S.C. 1395g) with the final amounts determined by the intermediary in the NPR to be reimbursable under the Act and the Secretary's implementing regulations. *Good Samaritan Hosp.*, 508 U.S. at 414-420; see also p. 3, *supra*; J.A. 36, 40, 44, 48 (computing the "net amount due provider" by comparing difference between petitioner's "total Medicare reimbursable cost" and its "total interim payments"). The final year-end reconciliation in the NPR is entirely distinct from a later decision by the intermediary denying a provider's request to *re*determine the NPR. Accordingly, Section 1395x(v)(1)(A)(ii) is wholly consistent with the Secretary's conclusion that Section 1395*oo* does not require the Board to review an intermediary's denial of a reopening request.[8]

c. The fact that reopening is not mandated by the Act is significant for another reason as well. The Secretary's regulations authorize reopening only "with respect to findings on matters at issue" in a prior determination by the intermediary. 42 C.F.R. 405.1885(a). The regulations therefore permit a provider, like petitioner, to request an intermediary to reconsider its previous final determination with respect to one or more particular cost items covered by the NPR. See J.A. 32 (petitioner's request for "re-opening of the 1989 cost report to recompute the allowable owners' compensation"). An intermediary's denial of a request to revisit one or more of those specific "findings," however, does not

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[8] In light of *Good Samaritan Hospital*, the Ninth Circuit has acknowledged that its conclusion in *State of Oregon*, 854 F.2d at 349, that Section 1395x(v)(1)(A)(ii) is the source of statutory authority for a reopening procedure has been substantially "undercut." *French Hosp. Med. Ctr.* v. *Shalala*, 89 F.3d 1411, 1418 n.8 (9th Cir. 1996); accord *Mt. Diablo Hosp.* v. *Shalala*, 3 F.3d 1226, 1231 (9th Cir. 1993).

determine "the amount of *total* program reimbursement" within the meaning of Section 1395*oo*(a). As the court of appeals explained, "a decision not to reopen * * * does not, in and of itself, establish an amount of total program reimbursement as required by the statute." Pet. App. 7 (quoting *Good Samaritan Hosp. Reg'l Med. Ctr.*, 85 F.3d at 1061). Accordingly, the Secretary has reasonably concluded that the denial of a request to reopen under her regulations merely constitutes the intermediary's decision not to alter its previous "final determination * * * as to the amount of total program reimbursement." See *Good Samaritan Hosp. Reg'l Med. Ctr.*, 85 F.3d at 1061 ("a reopening denial is a refusal to revisit the final determination"). Such a decision is not the "final determination" itself, and therefore does not trigger a right to hearing before the Board.

3. The Secretary's Interpretation Furthers Congress's Intent To Require Providers To Appeal Their NPRs Within 180 Days

Under 42 U.S.C. 1395*oo*(a)(3), a provider must challenge an intermediary's NPR within 180 days of receiving notice of the final determination embodied in the NPR. That requirement supports the Secretary's conclusion that Section 1395*oo*(a) does not extend to reopening denials. It would largely defeat the congressional goal of finality reflected in Section 1395*oo*(a)(3) to construe the Act to require the Secretary to confer a right of review by the Board with respect to all refusals by intermediaries to reopen reimbursement determinations in final NPRs, each of which would, under petitioner's reading of the Act, constitute a new "final determination" subject to a mandatory Board hearing and subsequent judicial review. The Secretary's interpretation therefore "avoid[s] frustrating the congressional purpose to impose a 180-day limitation upon [PRRB] review of a fiscal

intermediary's final determination on an initial cost report." Pet. App. 8.

This Court in *Califano* v. *Sanders*, 430 U.S. 99 (1977), reached a similar conclusion in holding that 42 U.S.C. 405(g) does not authorize judicial review of the Secretary's refusal to reopen a decision on a claim for Social Security benefits. The Court observed at the outset that "the opportunity to reopen final decisions and any hearing convened to determine the propriety of such action are afforded by the Secretary's regulations and not by the Social Security Act." *Sanders*, 430 U.S. at 108. The Court further explained (*ibid.*) that 42 U.S.C. 405(g) provides for judicial review only with respect to a "final decision of the Secretary made after a hearing," and that "a petition to reopen a prior final decision may be denied without a hearing as provided in * * * 42 U.S.C. § 405(b)."[9] The Court also reasoned that "an interpretation that would allow a claimant judicial review simply by filing—and being denied—a petition to reopen his claim would frustrate the congressional purpose, plainly evidenced in [42 U.S.C. 405(g)], to impose a 60-day limitation upon judicial review of the Secretary's final decision on the initial claim for benefits." *Ibid.*[10]

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[9] Lower courts had concluded that 42 U.S.C. 405(b), which requires a hearing upon request with respect to "decisions as to the rights of any individual applying for a payment under this subchapter," did not apply to refusals to reopen such decisions pursuant to the Secretary's regulations. See, *e.g.*, *Cappadora* v. *Celebrezze*, 356 F.2d 1, 4-5 (2d Cir. 1966) (Friendly, J.); *Filice* v. *Celebrezze*, 319 F.2d 443, 445-446 (9th Cir. 1963). The Secretary's interpretation of Section 1395*oo*(a) in this case is no different.

[10] Amici contend (Br. 12-13) that *Sanders* is distinguishable on the grounds that the Secretary's regulations in that case had no time limit; that the claimant filed a reopening request seven years after the original decision denying benefits; that the claimant did not proffer any new evidence; and that an ALJ reviewed the reopening denial. The regulations at issue in *Sanders*, however, "specified time limits after the date of initial determination" for seeking reopening unless certain conditions were satis-

That same analysis applies here. The Secretary's interpretation furthers "Congress' determination * * * to limit judicial review to the original decision denying benefits" in order to "forestall repetitive or belated litigation of stale eligibility claims." *Sanders*, 430 U.S. at 108. By contrast, petitioner's construction of Section 1395*oo*(a) would nullify the 180-day time period prescribed by Section 1395*oo*(a)(3) and burden the Board and ultimately the courts with repetitive requests to reopen administratively settled matters.

4. The Secretary's Reopening Regulations Confirm That There is No Right To Review By The Board

The Secretary's regulations 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. 405.1885(c) (emphasis added). The Secretary has construed that provision to preclude further review of intermediary decisions denying reopening. The PRM, which provides interpretive guidance to providers and intermediaries, see *Shalala* v. *Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995), states that "[a] refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 C.F.R. § 405.1885(c)." PRM § 2926, App. A, ¶ B.4; accord PRM § 2932.1 ("A provider has no right to a hearing on a finding by an intermediary * * * that a reopening * * * of a determination * * * is not warranted.").

This Court has stated that it "must give substantial deference to an agency's interpretation of its own regulations." *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994). Thus, courts do not "decide which among several competing

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fied. 430 U.S. at 102. In any event, the Court did not rest its decision on the length of time that elapsed before the claimant requested reopening, or on the fact that an ALJ had reviewed the reopening request and denied it for lack of new evidence.

interpretations best serves the regulatory purpose. Rather, the agency's interpretation must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation." *Ibid.* (internal quotation marks omitted). Here, the Secretary reasonably has construed her reopening regulations not to provide for administrative review by the Board of reopening denials by intermediaries.

That interpretation is fully consistent with the text of 42 C.F.R. 405.1885(c), which vests "exclusive[]" "[j]urisdiction" over a reopening request with the "administrative body that rendered the last determination or decision." In this case, the intermediary—"that administrative body that rendered the last determination" with respect to petitioner's 1989 NPRs—had the "exclusive[]" "[j]urisdiction" to determine whether to reopen the NPRs on the owners' compensation issue. Petitioner argues (Br. 7-8) that Section 405.1885(c) simply confirms the intermediary's "discretion" to reopen and that the regulation "says nothing about reviewability" by the Board for alleged abuses of that discretion. The regulation prohibits such review, however, because it would divest the intermediary of its "exclusive[]" jurisdiction to reopen its own prior determination. At a minimum, that construction is not "plainly erroneous or inconsistent with the regulation." *Thomas Jefferson Univ.*, 512 U.S. at 512.

The Secretary's interpretation is further confirmed by the regulations' *express* authorization for administrative review when an intermediary affirmatively reopens and revises its prior determination. 42 C.F.R. 405.1889 (permitting Board review "[w]here a revision is made in a determination * * * on the amount of program reimbursement after such determination * * * has been reopened as provided in § 405.1885"). The regulations do not likewise grant providers a right to appeal when the intermediary declines to reconsider its prior determination. In light of the express provision for review of the revised NPR if the prior final

determination *is* reopened, "this omission provides persuasive evidence that [the Secretary] deliberately intended to foreclose further review of such claims." *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 (1982). The regulations as a whole therefore support the Secretary's conclusion that the Board lacks jurisdiction to review reopening denials. See Pet. App. 5.

B. The Secretary's Interpretation Of Section 1395*oo*(a) Is Reasonable

1. The Secretary's Interpretation Is Consistent With The Absence Of A Right To A Statutory Hearing And Judicial Review Of Other Reopening Denials Under the Medicare Program

The Secretary's conclusion that providers do not have a right under Section 1395*oo*(a) to administrative review by the Board of reopening denials by intermediaries is fully consistent with her longstanding interpretation that reopening denials of other Part A and Part B benefit determinations are unreviewable. Just as Part A providers may seek to reopen NPRs under 42 C.F.R. 405.1885, the Secretary has promulgated similar regulations permitting individual beneficiaries under Part A, and physicians (and other suppliers of services) and individual beneficiaries under Part B, to request reopening of intermediary or carrier determinations denying claims for benefits. 42 C.F.R. 405.750(b), 405.841-405.842. Those regulations do not, however, permit administrative review of decisions denying requests to reopen. See Medicare Intermediary Manual § 3799.16; Medicare Carrier Manual § 12100.16. Moreover, because 42 U.S.C. 405(g) governs individual claims for benefits under Parts A and B (and physician claims under Part B), see 42 U.S.C. 1395ff and n.2, *supra*, this Court's decision in *Califano* v. *Sanders*, *supra*, forecloses any statutory right to a hearing concerning a reopening denial and precludes those

claimants from seeking judicial review of such denials. Thus, by construing Section 1395*oo*(a) not to confer a right to further review of reopening denials affecting providers under Part A, the Secretary rationally has determined that the Act should afford similar treatment with respect to all decisions denying reopening under the Medicare Act.

2. The Reopening Regulations Do Not Permit Unchecked Or Arbitrary Action By Intermediaries

Petitioner asserts (Br. 31-34, 36-38) that PRRB review is necessary to ensure that intermediary reopening decisions are not arbitrary or capricious. That contention is unwarranted. The Secretary has set forth detailed criteria to guide an intermediary's exercise of discretion in considering a reopening request. The Provider Reimbursement Manual states that "[w]hether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions" of the Secretary. PRM § 2931.2. HCFA also may instruct an intermediary to reopen a prior determination when HCFA concludes that the determination "is inconsistent with the applicable law, regulations, or general instructions issued by [HCFA]." 42 C.F.R. 405.1885(b). We have been informed by the Secretary that intermediaries frequently grant providers' reopening requests[11] and that HCFA regularly imparts guidance to intermediaries as needed to promote consistent application of, and adherence to, the reopening standards set forth in the Secretary's regulations and PRM.

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[11] Although HCFA does not maintain nationwide statistics on reopening decisions, it estimates that intermediaries grant at least 30%-40% of providers' requests to reopen.

Petitioner's amici further contend (Br. 14-21) that the Secretary has conferred unlimited discretion on intermediaries that have an incentive to deny reopening requests in order to meet performance standards set by the Secretary. Amici also refer (Br. 17-18) to the Secretary's notice of proposed rulemaking to establish conflict-of-interest regulations with respect to Medicare Integrity Program contractors (42 U.S.C. 1395ddd (Supp. II 1996)), in which the Secretary recognized the "potential" for conflicts of interest "[w]hen a Medicare contractor owns a provider or supplier." 63 Fed. Reg. 13,590, 13,592 (Mar. 20, 1998). Those contentions, however, all ignore the salient fact that providers suspecting an intermediary of bias may challenge an intermediary's underlying substantive reimbursement determination by timely compliance with the review procedures set forth by Congress in Section 1395*oo*(a). Indeed, had petitioner pursued its statutory appeal rights with respect to its NPRs for 1989, petitioner would have been entitled to a full evidentiary hearing during which it could have raised any basis for contending that the intermediary's action was erroneous or arbitrary.

In any event, the Secretary has not delegated unbridled discretion to biased fiscal intermediaries. As an initial matter, petitioner offers no basis for inferring that intermediaries are predisposed against providers when considering requests to reopen. *Schweiker* v. *McClure*, 456 U.S. 188, 195 (1982) ("We must start * * * from the presumption that the hearing officers [designated by private carriers] who decide Part B claims are unbiased."). Indeed, intermediaries are nominated by *providers*, 42 U.S.C. 1395h(a) and (d); 42 C.F.R. 421.104, and providers are free to request a change in their intermediary, 42 C.F.R. 421.106. The Secretary also has general oversight authority over intermediaries, 42 U.S.C. 1395h, and has established performance criteria to assure that intermediaries make "[c]orrect coverage and

payment determinations"; are "[r]esponsive[] to beneficiary concerns"; and "[p]roper[ly] manage[] * * * administrative funds." 42 C.F.R. 421.120(a)(1)-(3); see also 42 C.F.R. 421.122. In the event of nonperformance or noncompliance with the Secretary's directives, the Secretary may take adverse action against an intermediary, including termination of its agreement. 42 U.S.C. 1395h; 42 C.F.R. 421.124, 421.126. Far from providing "strong incentives" to make decisions unfavorable to providers (Amici Br. 17), those regulations ensure that intermediaries properly perform their duty to make accurate determinations. Compare *Schweiker* v. *McClure*, 486 U.S. at 197.

Petitioner and its amici also argue (Pet. Br. 37; Amici Br. 13-14, 22) that the absence of review of reopening denials is inconsistent with this Court's decision in *Interstate Commerce Commission* v. *Brotherhood of Locomotive Engineers*, 482 U.S. 270, 279 (1987), which held that a denial by the Interstate Commerce Commission of a request to reopen a prior order was subject to judicial review under the Hobbs Administrative Orders Review Act (Hobbs Act), 28 U.S.C. 2344, to the extent that the reopening request was based on "new evidence" or "substantially changed circumstances." The Court found that reopening decisions based on alleged "material error" were committed to agency discretion and therefore unreviewable by virtue of 5 U.S.C. 701(a)(2) and that a contrary interpretation would be inconsistent with the Hobbs Act's 60-day limit upon judicial review. 482 U.S. at 277-284; see also *id.* at 280 ("If a judicial panel or an en banc court denies rehearing, no one supposes that that denial, as opposed to the panel opinion, is an appealable action."). The Court distinguished reopening requests based on "new evidence" or "changed circumstances," however, because otherwise the party seeking reopening "will have been deprived of all opportunity for judicial consideration—even on a 'clearest abuse of discretion' basis—of facts which,

through no fault of his own, the original proceeding did not contain." *Id.* at 279.

The Court's conclusion in *Brotherhood of Locomotive Engineers* that reopening requests based on new evidence or changed circumstance were subject to judicial review does not invalidate the Secretary's interpretation of the Medicare Act in this case. In *Brotherhood of Locomotive Engineers*, Congress expressly had authorized parties to petition the Commission to reopen its prior decisions based on "new evidence[] or * * * substantially changed circumstances," 49 U.S.C. 10327(g)(1), and Congress further had authorized judicial review in the court of appeals over any "final order" of the Commission, 28 U.S.C. 2344. By contrast, the Medicare Act does not address reopening, and the issue in this case is whether there is a right to administrative review of an intermediary's denial of a request to reopen a "final determination * * * as to the total amount of program reimbursement." 42 U.S.C. 1395*oo*(a). Moreover, this Court has concluded that courts lack subject matter jurisdiction to review reopening denials when that result is supported by the statutory scheme. See, *e.g.*, *Sanders*, 430 U.S. at 102, 108 (no judicial review of reopening denials under 42 U.S.C. 405(g) even though reopening regulations permitted reopening upon discovery of new and material evidence); *SEC* v. *Louisiana Public Serv. Comm'n*, 353 U.S. 368, 371-372 (1957) (court of appeals lacked jurisdiction to review a Commission order denying a petition to reopen proceedings under 15 U.S.C. 79k(b), because that provision did "not include an order merely denying a petition to reopen").[12]

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[12] Amici also err in relying (Br. 22) on the availability of judicial review of refusals to reopen deportation proceedings under the Immigration and Nationality Act. In *Giova* v. *Rosenberg*, 379 U.S. 18 (1964), this Court directed the court of appeals to review a denial of a motion to reopen a deportation proceeding. The government had conceded in that case, however, that a "final order[] of deportation" under 8 U.S.C. 1105a(a) as it

Petitioner is in any event incorrect in contending (Br. 34-37) that its reopening request is necessary to present "new evidence" supporting its claims for additional reimbursement. Petitioner alleges that, after submitting its 1989 cost reports, it discovered that the intermediary had used an informal survey for the 1987 cost year to determine the allowable owners' compensation costs for some home health agency chains, but not for petitioner. J.A. 32, Pet. Br. 34-35. Petitioner was not prevented, however, from raising that contention before the Board and ultimately the courts. Petitioner was fully aware of its "protested" owners' compensation costs even before the intermediary issued the NPRs for the 1989 cost year, J.A. 50, and petitioner in fact sought a hearing before the PRRB with respect to the amount of its owners' compensation reimbursement for 1987 and the years subsequent to 1989. See Pet. 23. Moreover, had petitioner timely sought PRRB review of the 1989 NPRs, petitioner could have sought discovery of any salary surveys used by the intermediary to determine allowable owners' compensation costs for home health agency chains. 42 C.F.R. 405.1853(b); cf. 42 C.F.R. 405.1853(a) (requiring intermediary to present to the Board "all available documentary evidence in support of [the intermediary's] position," as well as "all relevant documents which formed the basis for its determination of the amount of program reimbursement").

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then existed should encompass an order denying reopening. The government argued that, although "[l]iterally" a reopening denial was not a "final order of deportation" under the Act, Congress nonetheless intended in that statute to "provide a single, unitary review procedure * * * for every litigable issue that might arise in a deportation proceeding." No. 64-23 U.S. Br. at 15 (emphasis omitted); see also 8 U.S.C. 1105a(a)(6) (discussed in *Stone* v. *INS*, 514 U.S. 386 (1995)) and 8 U.S.C. 1252(b)(6) (Supp. II 1996) (recent authorization of judicial review of motions to reopen deportation proceedings under certain circumstances).

3. The Reopening Regulations Reasonably Further The Goal Of Administrative Finality Under The Act

The Secretary's interpretation of Section 1395*oo*(a) as not providing for PRRB review of intermediary reopening denials also reflects a reasonable balancing of the interests in preserving administrative finality with those of providing a limited procedure for correction of errors after the intermediary's determination in the NPR has become final. See PRM § 2930. By establishing in Section 1395*oo*(a)(3) a 180-day time period for providers to appeal the total amount of program reimbursement determined in the NPR, Congress afforded providers a limited period to challenge the lawfulness and accuracy of its program reimbursement. But "[i]f a provider permits that deadline to lapse, the Statute envisions no further appeal of the intermediary's decision." *HCA Health Servs., Inc.*, 27 F.3d at 620. At that point, the cost report is closed and final. 42 C.F.R. 405.1807(c); PRM § 2930.1A.

Balanced against the interests of finality is the Secretary's recognition of the appropriateness of making available a reopening procedure for the correction of errors in an otherwise final NPR if the provider requests or the intermediary initiates reopening within three years of the NPR and the criteria for reopening are satisfied. 42 C.F.R. 405.1885(a); PRM §§ 2930, 2931.A, 2931.2. The Secretary informs us that reopening often results in payment of additional program reimbursement to the provider. In the event the provider is dissatisfied with the result of a reopening, however, the regulations grant the provider 180 days to appeal the specific reimbursement matters that are actually reopened and addressed in a revised NPR. 42 C.F.R. 405.1889; *HCA Health Servs., Inc.*, 27 F.3d at 615; *French Hosp. Med. Ctr.*, 89 F.3d at 1422.

By contrast, since an intermediary's denial of a request to reopen does not alter the provider's total program reim-

bursement, the Secretary reasonably found no need to provide for PRRB review of an intermediary's decision denying reopening. As a result, the Secretary's interpretation rationally precludes the "belated litigation" of "stale" claims that could have been appealed within Section 1395*oo*(a)(3)'s 180-day period. *Califano*, 430 U.S. at 108.

Petitioner and its amici argue (Pet. Br. 14-17; Amici Br. 11-12; 19-21) that the Secretary's interpretation of the Act imposes an arbitrary double standard because the Secretary may require intermediaries to reopen a prior determination and, if necessary, to recoup reimbursement, if such determination is "inconsistent with the applicable law, regulations, or general instructions issued by [HCFA]." 42 C.F.R. 405.1885(b). They also refer to this Court's decision in *Regions Hospital*, 118 S. Ct. at 914, which upheld the Secretary's graduate medical education (GME) costs regulation that instructed intermediaries to apply a newly calculated "per-resident amount" in a base year to recoup overpayments made for GME costs in fiscal years still subject to reopening under 42 C.F.R. 405.1885. See 42 C.F.R. 413.86(e)(1)(iii). Petitioner and its amici accordingly contend that principles of administrative finality similarly must yield when providers seek to obtain additional reimbursement for cost reports still subject to reopening. That contention lacks merit.

In balancing the goal of administrative finality against the interest in affording a limited means to correct errors after finality has attached, the Secretary reasonably provided for reopenings at the direction of HCFA in order to protect the public fisc from unauthorized and wasteful expenditures. Each year, the Secretary makes total payments of approximately $120 billion to approximately 38,000 providers participating in Part A of the Medicare program. See 1997 HCFA Statistics, HCFA Pub. No. 03403, at 27 (Table 30). Each of those providers submits an annual cost report

containing thousands of cost items for which reimbursement is sought. See *Athens Community Hosp., Inc.* v. *Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984) (The cost report is "a lengthy document consisting of numerous schedules, worksheets, and supplemental worksheets. * * * [A] cost report, when completed, is approximately three-quarters of an inch thick."). It is neither administratively feasible nor efficient for the 37 intermediaries that currently service Part A providers to perform a detailed field audit of each item claimed on a cost report. Thus, the Secretary reasonably promulgated her reopening regulations in light of the practical need to reopen prior NPRs when there is reason to believe that intermediaries made payments that are not reimbursable under the Act. See *Regions Hosp.*, 118 S. Ct. at 917 (GME reaudit regulation reasonably permits Secretary "to carry out [her] official[] responsibility to reimburse only reasonable costs" and "prevent[s] payment of uncovered, improperly classified, or excessive costs"). Furthermore, if a prior determination *is* reopened, any new determination by the intermediary that requires the provider to repay sums it previously received is subject to administrative and judicial review. 42 U.S.C. 405.1889. That regulatory scheme fairly and sensibly permits the Secretary expeditiously to administer the program with a safety net that ensures that only reimbursable payments are made.

It is also rational for the Secretary to grant providers the right to request reopening but not the right to seek review of an intermediary's denial of a request to reopen. As sophisticated entities that "rely on Medicare as a major source of revenue to assure their financial survival" (Amici Br. 1), providers generally submit accurate cost reports each year. Cf. 42 U.S.C. 1395g(a) (prohibiting Medicare reimbursements unless provider submits adequate documentation); 42 C.F.R. 413.24(f)(2) (giving providers five months following close of fiscal year to submit cost report). Similarly, provid-

ers ordinarily scrutinize their annual NPRs and raise any challenges to them within the 180-day time period specified under 42 U.S.C. 1395*oo*(a)(3). The Secretary's reopening regulations recognize, however, that providers should be permitted "a reasonable period of time within which to seek or make corrections wherever an error has been discovered." PRM § 2930. Yet because of the enormous administrative costs to the program that would result from PRRB and judicial review of reopening denials by intermediaries with respect to any cost item reimbursed within the three years following an NPR, the Secretary has reasonably limited further administrative review of reopening decisions to only those instances when the intermediary has actually reopened and revised a prior determination.[13] Indeed, a contrary con-

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[13] Amici contend (Br. 19-21) that providers should be entitled to reap the benefit of any judicial decision that, if applied retroactively to NPRs issued within the preceding three years, would result in additional reimbursement. They therefore fault the Secretary's general policy to apply judicial decisions prospectively and to all pending administrative challenges, but not to settled cost reports. See, *e.g.*, HCFA Ruling 97-2, Medicare and Medicaid Guide (CCH) ¶ 45,105 (1997) (Amici Br. a3-a4) (applying corrected adjustment methodology under "prospective payment system" to pending and future cases); see also 42 C.F.R. 405.850 (change in law does not warrant reopening under Part B). That criticism is unfounded. In cases in which the law has changed by a judicial ruling after the administrative decision becomes final and binding, the Secretary may decline to accord retroactive relief when the law applicable at the time of the intermediary's decision comported with the Secretary's construction of the Medicare Act, which the provider never challenged on direct appeal. Cf. *Bousley* v. *United States*, 118 S. Ct. 1604, 1609 (1998) (noting rule of *Teague* v. *Lane*, 489 U.S. 288, 310 (1989), that "new constitutional rules of criminal procedure will not be applicable to those cases which have become final before the new rules are announced"); *Reynoldsville Casket Co.* v. *Hyde*, 514 U.S. 749, 758 (1995) ("New legal principles, even when applied retroactively, do not apply to cases already closed."). The Secretary's decision to deny review of reopening denials based on subsequent judicial decisions therefore can hardly be declared arbitrary. See *Broth-*

clusion could dissuade agencies in a similar position from authorizing claimants to seek reopening in the first instance.[14]

II. FEDERAL COURTS DO NOT HAVE JURISDICTION UNDER 28 U.S.C. 1331 TO REVIEW REOPENING DENIALS BY INTERMEDIARIES

A. 42 U.S.C. 405(h) Prohibits Review Of Reopening Denials Under 28 U.S.C. 1331

Petitioner and its amici argue (Pet. Br. 18-23; Amici Br. 21-23) that, in the event the Court upholds the Secretary's interpretation of Section 1395*oo*(a), the Court should rely on a general presumption in favor of judicial review and hold that federal courts have federal question subject matter jurisdiction under 28 U.S.C. 1331 to review reopening

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*erhood of Locomoti*ve Eng'rs, 482 U.S. at 286 (petition for reconsideration that "merely urged the Commission to correct what [the moving party] thought to be a serious error of law * * * should have been sought many months earlier, by an appeal from the original order"); *Federated Dep't Stores, Inc.* v. *Moitie*, 452 U.S. 394, 400 (1981) (rejecting "equitable doctrine" that "countenances an exception to the finality of a party's failure to appeal merely because his rights are 'closely interwoven' with those of another party" that chose to appeal).

[14] In light of the practical differences between the Secretary (who administers the Act with limited resources and without ready access to all the records of thousands of providers) and providers (which obtain reimbursement under the program based on evidence of their own operations to which they have full access), the Secretary could provide for different reopening rules with respect to each. Under her broad authority to issue regulations to establish procedures and methods of proof for determining reimbursable costs under the Act (42 U.S.C. 405(a) (as incorporated by 42 U.S.C. 1395ii), 1302(a), 1395x(v)(1)(A), 1395hh), the Secretary rationally could determine that the interests of finality and effective administration of the Medicare program support a regulatory scheme under which NPRs are subject to reopening only upon the Secretary's initiative. The Secretary permissibly could even conclude that those interests warrant complete elimination of reopening procedures.

denials by intermediaries. Such jurisdiction, however, is specifically precluded by the third sentence of 42 U.S.C. 405(h), incorporated into the Medicare Act by 42 U.S.C. 1395ii, which provides that "[n]o action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 * * * of title 28 to recover on any claim arising under this subchapter."

This Court has made clear that the preclusive language of Section 405(h) is "sweeping and direct." *Salfi*, 422 U.S. at 757. In *Heckler* v. *Ringer*, 466 U.S. 602 (1984), this Court held that Section 405(h) bars federal courts from exercising federal question jurisdiction to hear "all 'claim[s] arising under' the Medicare Act." 466 U.S. at 615 (quoting 42 U.S.C. 405(h)); see also *Sanders*, 430 U.S. at 103 n.3, 109. The Court in *Ringer* further explained that Section 405(h) "broadly" extends to "any claims in which 'both the standing and substantive basis for the presentation' of the claims" is the Medicare Act. 466 U.S. at 615 (quoting *Salfi*, 422 U.S. at 760-761).[15]

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[15] Petitioner and its amici attempt to diminish the force of the Court's decisions in *Ringer* and *Salfi* by arguing (Pet. Br. 21-22; Amici Br. 22) that those decisions involved the exhaustion of administrative remedies, whereas providers here lack an administrative process to exhaust challenges to reopening denials. The availability of administrative review procedures, however, was irrelevant to the Court's conclusions in those decisions that Section 405(h) precludes federal question jurisdiction under 28 U.S.C. 1331 over claims under the relevant provisions of the Social Security Act, including its Medicare title. Rather, the question whether the claimants had exhausted their administrative remedies pertained solely to the availability of judicial review under other statutes. *Ringer*, 466 U.S. at 616-617 (28 U.S.C. 1361 and 42 U.S.C. 405(g)); *Salfi*, 422 U.S. at 763-766 (42 U.S.C. 405(g)); see also *Sanders*, 430 U.S. at 103 n.3 (Section 405(h) "has been held to require the exhaustion of available administrative procedures, to foreclose jurisdiction under the general grant of federal-question jurisdiction, * * * *and* to route review through [42 U.S.C. 405(g)]") (emphasis added) (citing *Salfi*, 422 U.S. at 757, 761).

Those principles foreclose federal question jurisdiction over petitioner's claims. Petitioner seeks review of the intermediary's refusal to reopen the reimbursement determination for owners' compensation costs in petitioner's NPRs for 1989 or, alternatively, an increase in its reimbursement for owners' compensation costs. J.A. 61. The court of appeals properly found that "both the standing and substantive basis for the presentation of [those] claims comes from the plain language of the Medicare Act." Pet. App. 12. Accordingly, the third sentence of Section 405(h) bars a federal court from exercising jurisdiction under 28 U.S.C. 1331 to hear petitioner's claims for additional Medicare reimbursement.[16]

B. Preclusion of Judicial Review Under 28 U.S.C. 1331 Is Consistent With *Bowen* v. *Michigan Academy of Family Physicians*

In *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), this Court concluded that a federal court had jurisdiction under 28 U.S.C. 1331 to review a challenge to the validity of a Medicare regulation governing payments to physicians under Part B of the Medicare program. At that time, 42 U.S.C. 1395ff provided for a hearing and judicial review of challenges to the amount of payments made under Part A but not Part B of the program. See 476 U.S. at 674 n.5 (quoting 42 U.S.C. 1395ff (1982)); *Erika, Inc.*, 456 U.S. at 207-208. Relying on the "strong presumption that

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[16] Such review is also barred by the second sentence of Section 405(h), discussed at pp. 42-43, *infra*. Only one court has held that reopening denials are reviewable under Section 1331. *Memorial Hosp.* v. *Sullivan*, 779 F. Supp. 1410 (D.D.C. 1991). In that case, however, the district court did not mention Section 405(h) and found jurisdiction also present under 28 U.S.C. 1361, discussed *infra*, pp. 42-45. Moreover, "critical" to the court's decision was its finding that the Secretary specifically had directed the provider to seek reopening instead of directly appealing the NPR. 779 F. Supp. at 1412.

Congress intends judicial review of administrative action," the Court concluded that neither 42 U.S.C. 405(h) nor 42 U.S.C. 1395ff (as it then existed) precluded "challenges mounted against the *method* by which [the] amounts [of Part B benefits] are to be determined rather than [challenges to] the [amount] *determinations* themselves." 476 U.S. at 670, 675. Thus, the Court found that because the claimants had sought review not of an "'amount determination' which decides 'the amount of the Medicare payment to be made on a particular claim,'" but a facial attack on the validity of the Secretary's regulations, the district court had federal question jurisdiction to hear the claims. *Id.* at 676.

Petitioner argues (Br. 20) that *Michigan Academy* supports federal question jurisdiction in this case because petitioner contests the intermediary's application of 42 C.F.R. 413.102(b)(2)(i), which governs the reimbursement of owners' compensation costs. That claim, however, does not attack the underlying validity of a regulation; it simply avers that the intermediary misapplied a regulation when determining the amount of reimbursable owners' compensation costs owed to petitioner. Thus, petitioner's contentions do not resemble the sort of facial challenge that the Court in *Michigan Academy* found to be beyond the scope of Section 405(h)'s preclusive effect.[17]

Moreover, unlike the situation presented in *Michigan Academy* in which there was no other jurisdictional basis for obtaining judicial review of administrative action under Part

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[17] Petitioner additionally argues (Br. 20) that its challenge to the validity of the Secretary's reopening regulations is the type of "collateral" methodology dispute that the Court in *Michigan Academy* found subject to review under 28 U.S.C. 1331. The parties concede, however, that the district court below had subject matter jurisdiction under *Section 1395oo(f)(1)* to review the final decision of the Board concluding that it lacks jurisdiction to review reopening denials. See Pet. Br. 20; Pet. App. 22; Gov't C.A. Br. 1.

B of the program as it then existed, see n.18, *infra*, Section 1395*oo* explicitly affords Part A providers, such as petitioner, an avenue to challenge both the amount of Medicare payments and the methods by which those payments are calculated. When such review is available, the presumption of judicial review underlying the Court's decision in *Michigan Academy* is not "implicate[d]." *Thunder Basin Coal Co.* v. *Reich*, 510 U.S. 200, 207 n.8 (1994); see also *McNary* v. *Haitian Refugee Ctr., Inc.*, 498 U.S. 479, 498 (1991) ("Inherent in our analysis [in *Michigan Academy*] was the concern that absent such a construction of the * * * statute, there would be 'no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program.'") (quoting *Michigan Academy*, 476 U.S. at 680). Thus, under Section 405(h) and this Court's decisions in *Ringer*, *Salfi*, and *Sanders*, Section 1395*oo* is the sole means of obtaining judicial review of provider reimbursement claims arising under the Medicare Act. See, *e.g.*, *St. Francis Med. Ctr.* v. *Shalala*, 32 F.3d 805, 812-813 (3d Cir. 1994), cert. denied, 514 U.S. 1016 (1995); *Westchester Mgmt. Corp.* v. *HHS*, 948 F.2d 279, 282 (6th Cir. 1991), cert. denied, 504 U.S. 909 (1992).[18]

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[18] Subsequent legislative changes have eliminated the basis for continuing application of the holding in *Michigan Academy* even under Part B of the Medicare program. In 1986, Congress amended Section 1395ff to provide for administrative and judicial review of challenges to carrier determinations concerning the amount of payments made under Part B of the program. Pub. L. No. 99-509, § 9341(a)(1)(B), 100 Stat. 2037. In light of that amendment, lower courts have held that federal courts lack jurisdiction under 28 U.S.C. 1331 to review claims arising under Part B, including the type of "methodology" disputes at issue in *Michigan Academy*. See *American Academy of Dermatology* v. *HHS*, 118 F.3d 1495, 1500 (11th Cir. 1997) ("the amount/methodology distinction established in *Michigan Academy* is no longer viable"); *Martin* v. *Shalala*, 63 F.3d 497, 503 (7th Cir. 1995) ("the *Michigan Academy* distinctions drawn between 'amount of payment' and 'validity of the statute and regulations' chal-

The foregoing conclusion is not altered by the argument of petitioner and its amici (Pet. Br. 23; Amici Br. 21-23) that, if district courts lack jurisdiction under 42 U.S.C. 1395*oo* to review intermediary decisions denying reopening, federal question jurisdiction under 28 U.S.C. 1331 is necessary to provide some route for judicial review of that type of agency action. Under that contention, any party could file multiple suits in federal courts under Section 1331 to challenge an agency's decision denying reopening notwithstanding the party's initial failure to seek review of the agency's underlying decision—and, here, notwithstanding the fact that Section 405(h) specifically channels all judicial review of agency action affecting provider claims under Part A of the Medicare program through the procedures set forth in 42 U.S.C. 1395*oo*. This Court should reject that contention. Petitioner is no different from the claimant in *Sanders*: petitioner had a right to administrative and judicial review of the intermediary's substantive determination of the amount it would be reimbursed, but petitioner failed to exercise that right. See also *Sanders*, 430 U.S. at 109 (recognizing that "federal question jurisdiction under 28 U.S.C. § 1331 is precluded by [Section 405(h)]"). In these circumstances, there is no basis for disregarding the express terms of Section 405(h) that bar federal question jurisdiction over "all 'claim[s] arising under'

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lenges are no longer meaningful or necessary"); *Farkas* v. *Blue Cross & Blue Shield of Mich.*, 24 F.3d 853, 860 (6th Cir. 1994) (amount/methodology distinction is no longer "good law"); *Abbey* v. *Sullivan*, 978 F.2d 37, 42 (2d Cir. 1992) (*Michigan Academy*'s distinction "relegat[ed] to irrelevancy"); *National Kidney Patients Ass'n* v. *Sullivan*, 958 F.2d 1127, 1132 (D.C. Cir. 1992) ("the special treatment of part B [claims], based on the pre-October 1986 statutory differences, cannot survive the elimination of those differences"), cert. denied, 506 U.S. 1049 (1993); but see *Illinois Council on Long Term Care, Inc.* v. *Shalala*, 143 F.3d 1072, 1075 (7th Cir. 1998) (relying on *Michigan Academy* and concluding that Section 405(h) does not preclude "pre-enforcement review of a regulation's validity").

the Medicare Act." *Ringer*, 466 U.S. at 615 (quoting 42 U.S.C. 405(h)).

III. THE MANDAMUS STATUTE, 28 U.S.C. 1361, DOES NOT FURNISH A BASIS FOR REVIEWING AN INTERMEDIARY'S DECISION DENYING REOPENING

Petitioner further argues (Br. 24-29) that federal courts may review an intermediary's denial of a provider's reopening request by the exercise of mandamus jurisdiction under 28 U.S.C. 1361. That argument, too, is foreclosed by 42 U.S.C. 405(h).

The second sentence of Section 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided"—*i.e.*, except as provided in the Medicare Act itself. There can be no dispute that the decision of the intermediary denying petitioner's request to reopen is a "decision of the Secretary" for these purposes. See *Erika*, 456 U.S. at 206 n.4. Thus, that decision cannot be reviewed by any "tribunal," including a federal district court, except as provided in the Medicare Act itself. See *Sanders*, 430 U.S. at 110-111 (Stewart, J., concurring in the judgment). As we have explained, however, 42 U.S.C. 1395*oo*(f) provides no right of review here.[19]

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[19] The third sentence of Section 205(h) of the Social Security Act (42 U.S.C. 405(h)), as originally enacted in 1939, provided that no action to recover on any claim arising under Title II of the Social Security Act could be brought "under section 24 of the Judicial Code" (53 Stat. 1371), which at that time contained all of the general grants of jurisdiction to the district courts. See 28 U.S.C. 41 (Supp. V 1934); *Salfi*, 422 U.S. at 756 n.3. When the mandamus statute was enacted in 1962, Congress placed it in Chapter 85 of Title 28 (see Act of Oct. 5, 1962, Pub. L. No. 87-748, 76 Stat. 744), which likewise contains all of the general grants of jurisdiction to the district courts and therefore is the successor to the prior 28 U.S.C. 41.

In any event, the Court made clear in *Ringer* that mandamus relief is an appropriate remedy "only if [the plaintiff] has exhausted all other avenues of relief and only if the defendant owes him a clear nondiscretionary duty." 466 U.S. at 616. Those requirements are not met in this case.

As explained above (see p. 18, *supra*), an intermediary's authority to reopen its prior final determination derives exclusively from the Secretary's reopening regulations. Those regulations provide that the decision whether to grant a provider's request to reopen is discretionary with the intermediary. Thus, the regulations provide that "[a] determination of an intermediary * * * *may* be reopened * * * by such intermediary * * * on motion of the provider affected by such determination." 42 C.F.R. 405.1885(a) (emphasis added). Moreover, as petitioner and its amici concede (Pet. Br. 8; Amici Br. 24), the regulations elsewhere recognize the discretionary nature of the reopening decision by

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The 1962 amendment thereby placed the mandamus statute within the scope of the jurisdictional bar in the third sentence of 42 U.S.C. 405(h).

In the 1976 version of the United States Code, the codifiers revised the third sentence of 42 U.S.C. 405(h) to refer to "sections 1331 or 1346 of title 28," instead of "section 24 of the Judicial Code." That change was intended to reflect the 1948 revision of Title 28 (see 42 U.S.C. 405 note, at 518 (1976)) and, because it was not enacted by Congress, it had no legal effect. *North Dakota* v. *United States*, 460 U.S. 300, 311 n.13 (1983). In *Ringer*, which was decided in May 1984, the Court reserved the question whether the third sentence of 405(h), as then in effect, foreclosed mandamus jurisdiction. See 466 U.S. at 616.

Later in 1984, in Section 2663(a)(4)(D) of the Deficit Reduction Act of 1984 (Pub. L. No. 98-369, 98 Stat. 1162), Congress amended Section 205(h) of the Social Security Act to refer to "section 1331 or 1346 of title 28," instead of "section 24 of the Judicial Code." That amendment was one of a number of "technical corrections" that did not "chang[e] or affect[] any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date." 98 Stat. 1160, 1171-1172; see also H.R. Conf. Rep. No. 861, 98th Cong., 2d Sess. 1413-1415 (1984).

providing that the "[j]urisdiction for reopening a determination * * * rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R. 405.1885(c). Thus, because the Secretary does not have a "clear nondiscretionary duty" (*Ringer*, 466 U.S. at 616) to reopen petitioner's NPRs for 1989, petitioner has failed to satisfy the requirements for mandamus relief.

Petitioner nonetheless argues for the first time in its merits brief in this Court (Br. 25-27) that the Secretary owed petitioner a nondiscretionary "procedural" duty to pay it reasonable costs in accordance with 42 U.S.C. 1395x(v)(1)(A) and to follow her regulations governing owners' compensation costs, which provide that "[r]easonablness requires that the compensation allowance * * * [b]e such an amount as would ordinarily be paid for comparable services by comparable institutions." 42 C.F.R. 413.102(b)(2)(i). That claim, however, fails both requirements for mandamus relief. First, petitioner failed to appeal its NPRs for 1989 under 42 U.S.C. 1395*oo*. Pet. 23; Pet. App. 3. Thus, petitioner did not "exhaust[] all other avenues" (*Ringer*, 466 U.S. at 616) to remedy the alleged error by the intermediary in determining the amount of petitioner's reimbursement for owners' compensation in 1989. See *id.* at 617 (mandamus relief not available when claimants "have an adequate remedy * * * for challenging all aspects of the Secretary's denial of their claims for payment"); Pet. App. 13 (petitioner's "failure to appeal the initial determination would preclude mandamus review of that determination"). Mandamus review in that situation would flout "the purpose of the exhaustion requirement * * * to prevent 'premature interference with agency processes' and to give the agency a chance 'to compile a record which is adequate for judicial review.'" *Ringer*, 466 U.S. at 619 n.12 (quoting *Salfi*, 422 U.S. at 765).

Second, the Secretary does not owe a clear nondiscretionary duty to pay petitioner a specific amount of owners' com-

pensation determined to be "reasonable" and "comparable" to other like institutions. Pet. Br. 26. By their nature, determinations of reasonableness and comparability necessarily require the discretionary exercise of the Secretary's expertise under the Act. See *Ringer*, 466 U.S. at 617 ("The Secretary's decision as to whether a particular medical service is 'reasonable and necessary' and the means by which she implements her decision * * * are clearly discretionary decisions."); *Anderson* v. *Bowen*, 881 F.2d 1, 5 (2d Cir. 1989) (noting "considerable HCFA and carrier discretion in determining whether a charge is 'inherently reasonable'"). For those reasons, petitioner has failed to state a claim for mandamus relief under 28 U.S.C. 1361.

IV. THE APA DOES NOT PROVIDE A BASIS FOR SUBJECT MATTER JURISDICTION TO REVIEW AGENCY ACTION

Petitioner and its amici finally assert (Pet. Br. 29-38, 40; Amici Br. 24) that the Administrative Procedure Act (APA), 5 U.S.C. 706(2)(A), provides federal courts with subject matter jurisdiction to review an intermediary's decision denying reopening. This Court in *Sanders*, however, specifically held that Section 10 of the APA, 5 U.S.C. 701-706, does not vest federal courts with subject-matter jurisdiction to review agency action, including decisions denying reopening requests. 430 U.S. at 105-107. The Court explained that "the actual text of [Section] 10 * * * nowhere contains an explicit grant of jurisdiction to challenge agency action in the federal courts," *id.* at 105-106, and that reading Section 10 as an implied grant of subject matter jurisdiction with respect to matters under the Social Security Act would be inconsistent with Congress's decision to retain Section 405(h) when it eliminated the amount-in-controversy requirement under 28 U.S.C. 1331(a) for suits against federal agencies and their officers and employees, 430 U.S. at 106-107.

"Considerations of *stare decisis* have special force in the area of statutory interpretation, for * * * Congress remains free to alter what [the Court] ha[s] done." *Patterson* v. *McClean Credit Union*, 491 U.S. 164, 172-173 (1989). This Court therefore will not overrule precedent construing a federal statute unless intervening law has undercut the "conceptual underpinnings" of the decision; "later law has rendered the decision irreconcilable with competing legal doctrines or policies"; or there is "compelling evidence bearing on Congress' original intent." *Neal* v. *United States*, 516 U.S. 284, 295 (1996). None of those conditions is satisfied here. Indeed, petitioner does not even cite *Sanders*, much less contend that it is in error. Thus, under *Sanders*, the APA does not provide a jurisdictional basis for judicial review of reopening denials.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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SEPTEMBER 1998