No. 11-1231

In the Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

AUBURN REGIONAL MEDICAL CENTER, ET AL.

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

BRIEF FOR THE PETITIONER

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QUESTIONS PRESENTED

1. Whether the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U.S.C. 1395*oo*(a)(3), is subject to equitable tolling.

2. Whether the 180-day statutory time limit for filing an appeal with the Provider Reimbursement Review Board from a final Medicare payment determination made by a fiscal intermediary, 42 U.S.C. 1395*oo*(a)(3), may be extended for any period.

PARTIES TO THE PROCEEDING

Petitioner is Kathleen Sebelius, Secretary, United States Department of Health and Human Services.

Respondents are Auburn Regional Medical Center, Chalmette Regional Medical Center, Doctors' Hospital of Staten Island, Edinburg Regional Medical Center, Forest Hills Hospital, Franklin Hospital, Hackensack University Medical Center, Inland Valley Regional Medical Center, Long Island Jewish Medical Center, McAllen Medical Center, Northern Nevada Medical Center, River Parishes Hospital, Southside Hospital, Staten Island University Hospital, UHS of New Orleans, Universal Health Services, Inc., Valley Hospital Medical Center, and Wellington Regional Medical Center.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-10a) is reported at 642 F.3d 1145. The order of the court of appeals denying rehearing en banc (Pet. App. 63a-64a), and an opinion concurring in the denial of rehearing (Pet. App. 65a-66a), are reported at 685 F.3d 1059. The amended opinion of the district court (Pet. App. 11a-50a) is reported at 686 F. Supp. 2d 55. The decision of the Administrator of the Centers for Medicare & Medicaid Services declining to review the decisions of the Provider Reimbursement Review Board (Pet. App. 57a-58a) is unreported. The decisions of the Provider Reimbursement Review Board (*e.g.*, Pet. App. 51a-56a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 24, 2011. Petitions for rehearing were denied on December 20, 2011 (Pet. App. 61a-66a). On March 13, 2012, the Chief Justice extended the time within which to file a petition for a writ of certiorari to and including April 13, 2012, and the petition was filed on that date. The petition was granted on June 25, 2012. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant statutory and regulatory provisions are set forth in an appendix to this brief. App., *infra*, 1a-33a.

STATEMENT

1. The Medicare program, established in 1965 by Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq*. (Medicare Act), pays for certain medical services provided to elderly and disabled patients entitled to benefits under the program. Part A of the program provides insurance for covered inpatient hospital and related post-hospital services. Under the Prospective Payment System (PPS), hospitals providing inpatient Medicare services are paid at a fixed amount for each patient discharged, regardless of actual costs incurred. 42 U.S.C. 1395ww(d) (2006 & Supp. IV 2010).

Hospitals and other Part A providers submit cost reports at the end of each fiscal year to contractors, known during the relevant time period as fiscal intermediaries, which are generally private insurance companies acting on behalf of the Department of Health and Human Services (HHS). See 42 U.S.C. 1395h; 42 C.F.R.

405.1801(b)(1), 413.1(a)(2), 413.20(b), 413.24(f).[1] The fiscal intermediary determines the total payment due and issues a Notice of Program Reimbursement (NPR), informing the provider how much it will be paid for the fiscal year at issue. 42 C.F.R. 405.1803.

a. As originally enacted, the Medicare Act did not provide for any administrative or judicial review of the fiscal intermediary's payment determination. See H.R. Rep. No. 231, 92d Cong., 1st Sess. 108 (1971) (*1971 House Report*); S. Rep. No. 1230, 92d Cong., 2d Sess. 51 (1972). Pursuant to agreements, the intermediary itself provided certain review procedures, but there was no process for appealing to the Secretary.[2] See *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 349, 350 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977); *1971 House Report* 108. On May 27, 1972, HHS formalized those procedures in regulations promulgated through notice-and-comment rulemaking. The regulations afforded providers an opportunity to request a hearing before an intermediary hearing officer if (1) the provider was dissatisfied with the intermediary's payment determination; (2) the amount in controversy was $1000 or more; and (3) the request was filed within 60 days after issu-

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[1] Unless otherwise indicated, all references to Title 42 of the Code of Federal Regulations are to the 2007 version. As relevant here, subsequent amendments to Part 405, Subpart R, 42 C.F.R. 405.1801 *et seq.*, apply only to "appeals pending as of, or filed on or after[,] August 21, 2008." See 73 Fed. Reg. 30,190 (May 23, 2008). Accordingly, those amended regulations do not directly apply to this case. See Pet. App. 15a n.3.

[2] At that time, fiscal intermediaries entered into contracts with the Secretary of the Department of Health, Education, and Welfare (HEW), which was HHS's predecessor agency. References to the "Secretary" throughout the brief are either to the Secretary of HEW or the Secretary of HHS, depending on the relevant time period.

ance of the NPR. See 37 Fed. Reg. 10,724 (adopting 20 C.F.R. 405.492(a) (1973)). If the provider's request for a hearing was untimely, the intermediary hearing officer was required to dismiss the request—unless the provider could demonstrate "good cause" and the request was filed within three years of the NPR. See *ibid.* (adopting 20 C.F.R. 405.493 (1973)); see also *id.* at 10,725 (adopting 20 C.F.R. 405.499g (1973)) (providing for, *inter alia*, discretionary reopening "within 3 years" of the NPR).

Shortly thereafter, Congress enacted legislation establishing an administrative and judicial review process governing provider payment under the Medicare Act. See Social Security Amendments of 1972 (1972 SSA Amendments), Pub. L. No. 92-603, § 243(a), 86 Stat. 1420 (42 U.S.C. 1395*oo*).[3] To effectuate the new statutory scheme, the Secretary was charged with establishing a Provider Reimbursement Review Board (PRRB or Board). 42 U.S.C. 1395*oo*(a). The Board was to be composed of five members "appointed by the Secretary" and "knowledgeable in the field of payment of providers of services"; two of the members were to be "representative of providers of services" and one "a certified public accountant." 42 U.S.C. 1395*oo*(h).

In 1974, after notice and comment, the Secretary published regulations implementing Section 1395*oo*. See 39 Fed. Reg. 34,514 (Sept. 26, 1974) (final rule); 39 Fed. Reg. 8166 (Mar. 4, 1974) (proposed rule). The final rule included, in modified form, the intermediary-hearing regulations promulgated two years prior, 39 Fed. Reg. at 34,515, as well as newly promulgated (though often-

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[3] Initial legislative proposals to afford providers an opportunity to appeal an adverse payment determination by a fiscal intermediary dated back to the 91st Congress. See S. Rep. No. 1431, 91st Cong., 2d Sess. 176-177 (1970).

times similar) regulations governing Board hearings, *id.* at 34,517-34,519.

b. Under the review scheme established by Section 1395*oo* and the Secretary's regulations, a provider that has filed a timely cost report is entitled to a hearing before the PRRB "if" the provider is dissatisfied with the final determination of the intermediary; the amount in controversy is $10,000 or more; and the request is filed within 180 days of the NPR. 42 U.S.C. 1395*oo*(a)(1)(A)(i), (2) and (3); see 42 C.F.R. 405.1835(a)-(b), 405.1839(a), 405.1841(a)(1). A provider is also entitled to a hearing "if" the intermediary's final determination is not rendered within 12 months after receipt of the provider's cost report; the amount in controversy requirement is met; and the request is filed within 180 days after the determination would have issued had it been timely rendered. 42 U.S.C. 1395*oo*(a)(1)(B)-(C), (2) and (3); see 42 C.F.R. 1835(c), 1841(a)(1). And a provider is entitled to a hearing "if" it is dissatisfied with the Secretary's determination of the "amount of payment" to be received during a fiscal year under the PPS. 42 U.S.C. 1395*oo*(a)(1)(A)(ii). Again, the amount in controversy requirement must be met and the request must be filed within 180 days of the Secretary's final determination. 42 U.S.C. 1395*oo*(a)(2) and (3); see 42 C.F.R. 405.1801(a)(3), 405.1835(a)-(b), 405.1839(a), 405.1841(a)(1). The statute and regulations additionally allow group appeals by providers raising the same legal or factual issues, if the amount in controversy is $50,000 or more in the aggregate and the providers satisfy the other criteria for an individual appeal. 42 U.S.C. 1395*oo*(b); see 42 C.F.R. 405.1837.

Pursuant to a regulation first adopted in 1974, "[a] request for a Board hearing filed after the [180-day time

limit] shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider." 42 C.F.R. 405.1841(b); cf. 42 C.F.R. 405.1813 (parallel good-cause exception for intermediary hearings).

That regulation was amended in 2008 to further specify and narrow the circumstances in which an extension may be granted. See 42 C.F.R. 405.1836 (2011). As amended and recodified, the regulation now provides that "[t]he Board may find good cause * * * only if the provider demonstrates * * * [that] it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike)." 42 C.F.R. 405.1836(b) (2011). The request must be "received by the Board within a reasonable time" after "expiration" of the 180-day limit, and the Board may not grant an extension request if received "later than 3 years after" the NPR. 42 C.F.R. 405.1836(b) and (c)(2) (2011). The Board is also prohibited from granting an extension for good cause if "[t]he provider relies on a change in the law, regulations, [Rulings of the Centers for Medicare & Medicaid Services (CMS)],[4] or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the

[4] CMS is the component of HHS that administers the Medicare program for the Secretary. CMS was formerly the Health Care Financing Administration (HCFA). The Secretary has delegated her review authority to the Administrator of HCFA (now CMS). 49 Fed. Reg. 35,248 (Sept. 6, 1984). For ease of reference, this brief refers to both components interchangeably as CMS.

extension request." 42 C.F.R. 405.1836(c)(1) (2011). A finding "that the provider did or did not demonstrate good cause * * * is not subject to judicial review." 42 C.F.R. 405.1836(e)(4) (2011).

The Board has the authority to affirm, modify, or reverse the final determination of the intermediary. 42 U.S.C. 1395*oo*(d). The Board also has "full power and authority to make rules and establish procedures, not inconsistent with the provisions of [the Medicare Act] or regulations of the Secretary, which are necessary and appropriate to carry out the provisions of [Section 1395*oo*]." 42 U.S.C. 1395*oo*(e); see 42 C.F.R. 405.1867. The decision of the Board is final unless the Secretary reverses, affirms, or modifies it within 60 days. 42 U.S.C. 1395*oo*(f)(1). A provider may seek judicial review of "any final decision of the Board," or of "any reversal, affirmance, or modification by the Secretary," by filing suit in federal district court within 60 days. *Ibid.* That suit is governed by the Administrative Procedure Act (APA), 5 U.S.C. 701 *et seq.* 42 U.S.C. 1395*oo*(f)(1).

Apart from the administrative appeal process, a provider may also obtain administrative relief from an intermediary's final payment determination by requesting that the intermediary "reopen" its determination. See 42 C.F.R. 405.1885(a). The provider's request "must be made within 3 years of the date of the [NPR]," and "[n]o [intermediary] determination * * * may be reopened after such 3-year period." *Ibid.*[5] An interme-

[5] The reopening regulation requires the reopening of an intermediary's determination beyond the three-year period "if it is established that such determination * * * was procured by fraud or similar fault of any party to the determination." 42 C.F.R. 405.1885(d). Because neither the Secretary nor CMS nor the intermediary is a "par-

diary's denial of a provider's reopening request is not subject to administrative review by the PRRB or to judicial review. See *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 452-457 (1999).

2. The PPS provides for certain payment adjustments based on hospital-specific factors. One such add-on is available to hospitals "serv[ing] a significantly disproportionate number of low-income patients," referred to as a "disproportionate share hospital," or "DSH," adjustment. 42 U.S.C. 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the Medicare DSH adjustment and the amount of any such adjustment depend on the particular hospital's "disproportionate patient percentage." 42 U.S.C. 1395ww(d)(5)(F)(v).

The disproportionate patient percentage for a given hospital is the sum of two components, commonly known as the "Medicaid" fraction and the "Medicare/SSI" or "SSI" fraction. See 42 U.S.C. 1395ww(d)(5)(F)(vi). The Medicaid fraction reflects the number of hospital inpatient days attributable to patients eligible for medical assistance under a state Medicaid plan, but not entitled to Medicare Part A benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). The numerator consists of the number of hospital inpatient days for patients eligible for Medicaid but *not* entitled to Medicare Part A; the denominator consists of all hospital inpatient days. *Ibid.* The SSI fraction, at issue in this case, reflects the number of hospital inpatient days attributable to patients entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits. 42 U.S.C.

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ty" to the fiscal intermediary's determination, reopening under that subsection is required only when the provider (or a related organization of the provider) has itself "procured" the determination by "fraud or similar fault." 42 C.F.R. 405.1805, 405.1885(d).

1395ww(d)(5)(F)(vi)(I).[6] The numerator consists of the number of hospital inpatient days for patients entitled to Medicare Part A *and* SSI; the denominator consists of all hospital inpatient days for patients entitled to Medicare Part A. *Ibid.*

Computation of the SSI fraction requires the matching of individual Medicare billing records (submitted to CMS by the hospital) to individual SSI records (maintained by the Social Security Administration (SSA)). During the relevant time period, "the data sources for the computation of the SSI fraction included approximately 11 million billing records from the Medicare inpatient discharge file, and over 5 million records from the SSI file compiled by SSA." *Baystate Med. Ctr.* v. *Leavitt*, 545 F. Supp. 2d 20, 23 (D.D.C.), amended in part, 587 F. Supp. 2d 37 (D.D.C. 2008) (*Baystate*). For that reason, it was determined that CMS would calculate the SSI fraction for each hospital. *Ibid.*; 42 C.F.R. 412.106(b)(2). CMS provides the SSI fraction to the responsible intermediary; the intermediary then calculates the Medicaid fraction based on data submitted by the provider and, using both fractions, determines the disproportionate patient percentage. 42 C.F.R. 412.106(b)(4)-(5).

3. This case arises against the background of litigation brought by Baystate Medical Center (Baystate), which is not a party to this action. Baystate timely appealed its DSH adjustment determinations by the intermediary for fiscal years 1993 through 1996, and challenged CMS's calculation of the numerator of the SSI

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[6] The SSI program is a federal assistance program, administered by the Social Security Administration, for low-income individuals who are aged, blind, or disabled. See 42 U.S.C. 1381 *et seq.*; *Sullivan* v. *Zebley*, 493 U.S. 521, 524 (1990).

fraction. On appeal, the Board concluded, among other things, that the SSI data used to calculate the SSI fraction were incomplete or inaccurate in certain respects; that there were flaws in the data-matching process; and that those errors "tended to deflate the overall DSH payment," Pet. App. 17a-18a. See *Baystate Med. Ctr.*, PRRB Dec. No. 2006-D20, 2006 WL 752453, at *33-*34 (Mar. 17, 2006). The CMS Administrator (Administrator) reversed the Board's decision, in relevant part, and affirmed CMS's determination of the SSI fraction. See *Baystate Med. Ctr.*, 2006 WL 1684639 (CMS Adm'r May 11, 2006). The district court, in turn, concluded that CMS did not rely on the "best available data" to compute the SSI fraction, and it reversed, in part, the Administrator's decision. See 545 F. Supp. 2d at 57-58.

4. Each of the respondent hospitals in this case received NPRs, which included determinations regarding their DSH adjustments, for fiscal years between 1987 and 1994. J.A. 17-19, 34 ¶¶ 4-11, 50, 52. In contrast to Baystate, respondents did not appeal those determinations to the Board within 180 days. See 42 U.S.C. 1395*oo*(a)(3); Pet. App. 17a. Nor did they seek a discretionary extension of the 180-day deadline within three years for "good cause shown," 42 C.F.R. 405.1841(b), or request reopening by the intermediary within three years, 42 C.F.R. 405.1885(a). See Pet. App. 18a, 29a & n.9, 45a, 52a, 55a.

In September 2006, nearly six months after the Board's *Baystate* decision and more than a decade after the statutory appeal deadlines had expired, respondents attempted to appeal the intermediaries' determinations of their DSH adjustments. Pet. App. 2a, 18a.[7] Re-

[7] Several of the respondents filed individual appeals, and others filed group appeals. See J.A. 34 ¶ 52. Because the Board's decisions

spondents acknowledged that their appeals to the Board were untimely, but urged that equitable tolling was appropriate "because the hospitals' failure to file an appeal within 180 days of issuance of the NPRs was the result of CMS's refusal to inform the hospitals that their SSI percentages were incorrectly understated for the fiscal years at issue." *Id.* at 18a-19a. In respondents' view, "the appeals were timely [under an equitable-tolling theory] because they were filed within 180 days of the Board's *Baystate* decision." *Id.* at 19a.

The Board dismissed respondents' appeals, concluding that it lacked jurisdiction to decide them. Relying in part on its earlier decision in *Anaheim Memorial Hospital*, PRRB Dec. No. 2000-D72, 2000 WL 1146514 (July 3, 2000), the Board held that it could not grant "equitable relief" such as "equitable tolling." Pet. App. 55a. The Board explained that it "is an administrative forum and, unlike the courts, [it] does not have general equitable powers but rather only the powers granted to it by statute and regulation." *Ibid.* The Secretary, acting through the Administrator, declined to review the Board's decision. *Id.* at 57a-58a.

5. Respondents then filed this action arguing, among other things, that the Board should have equitably tolled the 180-day appeal deadline. See J.A. 31-37. The district court held, *inter alia*, that the Medicare Act does not authorize equitable tolling of the 180-day administrative appeal period, and granted the government's motion to dismiss. Pet. App. 11a-50a.

6. The court of appeals reversed. Pet. App. 1a-10a. Relying on *Irwin* v. *Department of Veterans Affairs*, 498

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are substantively the same, the appendix to the certiorari petition contains a representative decision in one of the group appeals. See Pet. App. 51a-56a; J.A. 36 ¶ 57.

U.S. 89 (1990), the court applied a presumption that equitable tolling is available. Pet. App. 5a-6a. The court reasoned that such a presumption was appropriate because, *inter alia*, a hospital's claim for payment under the Medicare Act is "familiar to private litigation," in which tolling is generally available, "because it is analogous to a contract claim." *Id.* at 5a-6a & n.1 (citation omitted).

The court of appeals then concluded that the presumption had not been rebutted. Contrasting Section 1395*oo*(a)(3) with the statutory time limit for tax refund claims at issue in *United States* v. *Brockamp*, 519 U.S. 347 (1997), the court observed that, here, the statutory language is "fairly simple"; there are no statutory exceptions; and the timing provision is not itself complex. Pet. App. 9a-10a. The court recognized that there is a "good cause" exception provided under the Secretary's regulations, but concluded that the regulatory exception is immaterial to the equitable-tolling inquiry and, in any event, not sufficiently technical to rebut the presumption. *Id.* at 9a. The court also acknowledged that the Medicare Act "is quite complex," but nevertheless concluded that Section 1395*oo*(a)(3) is "amenable to tolling" because "its timing scheme is straightforward." *Id.* at 10a. The court therefore held that the 180-day period for requesting a Board hearing is subject to equitable tolling, and remanded to the district court for "further factual development" to determine whether tolling is "appropriate" in this case. *Ibid.*

SUMMARY OF ARGUMENT

The Secretary of Health and Human Services and the Court-appointed amicus curiae agree on the most fundamental point: the 180-day administrative appeal deadline in Section 1395*oo*(a)(3) is not subject to judi-

cially imposed equitable tolling. In the view of the Secretary, the Medicare Act grants her authority to determine whether and when to allow the Board to extend the filing deadline, and her considered judgment of the limits to be imposed on the Board's authority to do so must be respected by the courts. In the view of amicus, neither the courts nor the Secretary can extend the filing deadline for any reason. Either way, the court of appeals' decision must be reversed.

A. The Secretary has broad authority to interpret and implement Section 1395*oo*. Through notice-and-comment rulemaking contemporaneous with the enactment of that section, the Secretary determined that the Board has no authority to hear untimely appeals filed beyond the 180-day deadline in 42 U.S.C. 1395*oo*(a)(3), except as provided by regulation: for "good cause" shown *if* the request is filed within three years of the NPR. 42 C.F.R. 405.1841(b), 405.1867. An equitable-tolling regime superimposed on the long-established procedures for provider appeals under Medicare would conflict with the limitations in the Secretary's regulation. The court of appeals' decision to do so contravenes settled principles of administrative law, which preclude courts from imposing extra-statutory procedural requirements on an administrative tribunal, see *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519 (1978), and from setting aside a duly promulgated regulation that is neither arbitrary nor capricious.

B. Neither precedent nor logic suggests that the Court should apply a presumption in favor of equitable tolling to a statutory deadline governing an administrative appeal scheme of the sort at issue here. That presumption should not override fundamental principles of administrative law. Any presumption is, moreover, inap-

plicable here on its own terms because a provider's claim for Medicare payment is not comparable to any suit that can be brought against a private litigant in federal court. And, even if it were to apply, any such presumption would be substantially weakened in this context, where equitable principles do not traditionally govern the substantive law and where Congress enacted the time deadline eighteen years before this Court's decision in *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89 (1990).

In any event, a presumption in favor of equitable tolling would be rebutted here because the statutory text, structure, and history, and the underlying subject matter and purpose, make clear that Congress did not authorize courts to engraft an open-ended equitable tolling exception onto Section 1395*oo*(a)(3). The 180-day time limit in the statute does not contain its own exceptions that could be enforced directly by a court. From the Board's inception, the Secretary has consistently prohibited it from extending that deadline, except as provided by regulation. For nearly four decades, Congress has acquiesced in that interpretation. An equitable-tolling regime would place substantial administrative burdens on the agency, its contractors, and on the Medicare Trust Fund that Congress did not envision and could not have intended.

C. The Secretary agrees with the Court-appointed amicus curiae that the courts have no authority to engraft extra-textual equitable exceptions onto Section 1395*oo*(a)(3). She also agrees that the 180-day deadline is in some sense "jurisdictional," in that it constrains the Board's authority to adjudicate a provider's appeal. The Secretary, however, parts company with amicus on one issue: her authority to promulgate a regulation estab-

lishing the scope of the Board's jurisdiction within the administrative review process and allowing an extension of the 180-day appeal period in limited circumstances. In the Secretary's view, the Board's adjudicatory authority is defined by statute and by regulation, but not by the courts.

ARGUMENT

THE 180-DAY TIME LIMIT FOR A PROVIDER TO APPEAL TO THE PROVIDER REIMBURSEMENT REVIEW BOARD IS NOT SUBJECT TO EQUITABLE TOLLING

Respondents contend (and the court of appeals held) that the 180-day statutory time limit for a provider to file an administrative appeal with the Board is like an ordinary statute of limitations for filing a suit in court and for that reason is subject to judicially fashioned principles of equitable tolling. Br. in Opp. 13, 14-21; Pet. App. 5a-10a. The Court-appointed amicus curiae, by contrast, argues that the 180-day administrative appeal period is a jurisdictional limit on the PRRB's adjudicatory authority and cannot be extended for *any* reason, even pursuant to the Secretary's "good cause" regulation. Amicus Br. 14-47. As is often the case, the answer lies somewhere in between.

The Secretary stands at the center of the exceedingly complex statutory and regulatory program that governs Medicare claims, processing, and payment. The comprehensive and self-contained administrative and judicial review scheme that governs provider payment is also a product of both statute and regulation. The 180-day administrative appeal deadline is a critical part of that scheme, and the Secretary's implementing regulations reinforce the importance of timely filing and of finality. The Secretary determined, after notice and comment, that an extension of the 180-day filing period

could be warranted, but only if requested within three years and only if "good cause" is shown.

Judicially imposed equitable tolling is inconsistent with that statutory and regulatory review scheme. As we argue below and as respondents do not dispute, the Secretary had authority to promulgate the good-cause regulation. Her considered judgment that an extension of the 180-day period should be permitted *only* in the limited circumstances allowed by that regulation is entitled to substantial deference and cannot be overridden unless arbitrary and capricious. The regulation is plainly valid under that standard, and open-ended equitable tolling is therefore inconsistent with the statute as implemented by the Secretary. But if the Court were to conclude that the Secretary did not have authority to permit *any* extensions (as amicus argues), a court likewise has no authority to craft equitable exceptions. Accordingly, although the Secretary and amicus disagree about whether the Secretary has authority to craft any exceptions to the 180-day filing deadline, they agree on the most fundamental point: a court does not have authority to do so through imposition of judicially fashioned equitable-tolling principles on the Board's administrative procedures. The court of appeals' unprecedented decision to the contrary, rendered after almost 40 years of established practice since the enactment of 42 U.S.C. 1395*oo*, should be reversed.

A. Well-Established Principles Of Administrative Law Preclude Equitable Tolling Of The 180-Day Administrative Appeal Deadline

Fundamental principles of administrative law preclude courts from imposing extra-statutory procedural requirements on an administrative tribunal and from setting aside a regulation, duly promulgated through

notice-and-comment rulemaking pursuant to an express grant of rulemaking authority, that is neither arbitrary nor capricious. The equitable-tolling regime imposed on the Board by the court of appeals violates both precepts.

1. a. When a statutory deadline addresses matters to be resolved by an administrative agency, the implementation of that deadline is entrusted to agency discretion. "[T]he very basic tenet of administrative law [is] that agencies should be free to fashion their own rules of procedure." *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519, 543-544 (1978) (*Vermont Yankee*); see *FCC* v. *Pottsville Broad. Co.*, 309 U.S. 134, 143 (1940). While "[a]gencies are free to grant additional procedural rights in the exercise of their discretion, * * * reviewing courts are generally not free to impose them if the agencies have not chosen to grant them." *Vermont Yankee*, 435 U.S. at 524. The reason for affording agencies procedural autonomy is simple: "administrative agencies and administrators will be familiar with the industries which they regulate and will be in a better position than federal courts or Congress itself to design procedural rules adapted to the peculiarities of the industry and the tasks of the agency involved." *Id.* at 524-525 (quoting *FCC* v. *Schreiber*, 381 U.S. 279, 290 (1965)). When an agency adopts procedural rules pursuant to a statutory grant of rulemaking authority to implement a program entrusted to it for administration, those procedures are entitled to substantial deference and they cannot be set aside unless they are arbitrary, capricious, or contrary to law. See *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 21 (2000) (*Illinois Council*); *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 417-418 (1993); *Sullivan* v. *Zebley*, 493 U.S. 521, 528 (1990); *Commodity Futures Exch.*

Comm'n v. *Schor*, 478 U.S. 833, 844 (1986); *Heckler* v. *Chaney*, 470 U.S. 821, 832 (1985); *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. 837, 843-844 (1984).

Those well-established principles apply with particular force to the statutory and regulatory regime governing Medicare. As this Court has often recognized, the Medicare program is exceedingly "complex and highly technical," and its administration requires "significant expertise," as well as "the exercise of judgment grounded in policy concerns." *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994) (*Thomas Jefferson*) (citation omitted); see *Illinois Council*, 529 U.S. at 13 (describing Medicare program as "a massive, complex health and safety program * * * , embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations"). The Secretary has broad rulemaking authority to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs under [Medicare]." 42 U.S.C. 1395hh(a)(1); accord 42 U.S.C. 1302(a); 42 U.S.C. 1395ii (incorporating 42 U.S.C. 405(a)). That includes the authority to adopt rules and procedures to govern the administrative appeal process. See *Illinois Council*, 529 U.S. at 20-21; *Weinberger* v. *Salfi*, 422 U.S. 749, 763-767 (1975). Section 1395*oo* itself confers broad authority on the Secretary with respect to the Board: the Secretary establishes the Board and appoints its members, see 42 U.S.C. 1395*oo*(a) and (h); she may review its decisions, 42 U.S.C. 1395*oo*(f)(1); and the Board may adopt its own rules and procedures only if they are "not inconsistent" with the Medicare Act or "regulations of the Secretary," 42 U.S.C. 1395*oo*(e).

b. Pursuant to that broad rulemaking authority, the Secretary, following notice and comment, promulgated

regulations to implement Section 1395*oo*. See 39 Fed. Reg. at 34,514, 34,515 (final rule); 39 Fed. Reg. at 8166 (proposed rule). The regulations (as first promulgated and as amended) set forth detailed criteria for filing a group appeal (42 C.F.R. 405.1837), calculating the amount in controversy (42 C.F.R. 405.1839), requesting a Board hearing (42 C.F.R. 405.1841), disqualifying Board members (42 C.F.R. 405.1847), scheduling and conducting a Board hearing (42 C.F.R. 405.1849-.1861), and issuing a decision (42 C.F.R. 405.1871). The regulations specify the parties to a Board hearing (42 C.F.R. 405.1843), the composition of the Board (42 C.F.R. 405.1845), and the scope of the Board's decision-making authority (42 C.F.R. 405.1869).

With respect to the administrative appeal deadline, the regulations provide that a request for a Board hearing must be filed "within 180 days" of the intermediary's issuance of the NPR, 42 C.F.R. 405.1841(a)(1), and that a request filed after 180 days "shall be dismissed" unless the provider demonstrates "good cause" for an extension and the request is made no more than three years after the NPR, 42 C.F.R. 405.1841(b). The three-year limit on that narrow exception to the 180-day appeal period, as in effect when respondents sought review by the Board, is emphatic:

> A request for a Board hearing filed after the [180-day time limit] *shall be dismissed* by the Board, except that for good cause shown, the time limit may be extended. However, *no such extension shall be granted* by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

Ibid. (emphases added); accord 42 C.F.R. 405.1836(b)-(c) (2011). Indeed, a parallel provision governing hearings

before a fiscal intermediary preceded the creation of the Board, see 37 Fed. Reg. at 10,724 (adopting 20 C.F.R. 405.493 (1973)), and remains in effect, 42 C.F.R. 405.1813 (2011). Cf. 37 Fed. Reg. at 10,725 (adopting 20 C.F.R. 405.499g (1973)) (reopening regulation); 42 C.F.R. 405.1885(a) (2011) (current reopening regulation). The regulation governing the 180-day filing period for appeals to the Board and allowance of an extension only for good cause was promulgated in 1974. See 39 Fed. Reg. at 34,514; pp. 5-6, *supra*. It has remained in effect ever since, and was amended in 2008 to specify and further narrow the circumstances in which an extension may be granted. See pp. 6-7, *supra*. Since 1974, Congress has amended Section 1395*oo* six times, without altering the 180-day administrative appeal period or the Secretary's rulemaking authority, and without overriding the three-year outer time limit adopted by the Secretary for an extension upon a showing of "good cause." See *Schor*, 478 U.S. at 846.[8]

c. The Board and the Administrator have consistently held that the Board has no inherent authority to toll the 180-day appeal deadline for equitable reasons. That conclusion necessarily follows from the Act itself, which provides that the Board may adopt its own procedures only if they are "not inconsistent with the [Medicare

[8] See Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13503(c)(1)(B), 107 Stat. 579; Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4161(a)(6) and (b)(4), 104 Stat. 1388-94, -95; Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, Div. B, Tit. III, §§ 2351(a)(1) and (b)(1), 2354(b)(39) and (40), 98 Stat. 1098, 1099, 1102; Social Security Amendments of 1983, Pub. L. No. 98-21, § 602(h), 97 Stat. 165; Medicare and Medicaid Amendments of 1980, Pub. L. No. 96-499, Tit. IX, § 955, 94 Stat. 2647; Act of Oct. 26, 1974, Pub. L. No. 93-484, § 3(a), 88 Stat. 1459.

Act] or regulations of the Secretary." 42 U.S.C. 1395*oo*(e); see 42 C.F.R. 405.1867. And as explained above, the Secretary's regulations *prohibit* the Board from granting a request for a hearing filed more than 180 days after an NPR issues *unless* the provider can demonstrate good cause for the delay *and* the request is filed within three years. See 42 U.S.C. 1395*oo*(a)(3); 42 C.F.R. 405.1841(a)(1) and (b). Deference to an agency's interpretation of its own regulation is required unless it is contrary to the plain language of the regulation, particularly where, as here, "the regulation concerns 'a complex and highly technical regulatory program.'" *Thomas Jefferson*, 512 U.S. at 512 (citation omitted).

In *Anaheim Memorial Hospital*, PRRB Dec. No. 2000-D72, 2000 WL 1146514 (July 3, 2000) (*Anaheim*), the Board explained that "it does not have general equitable powers," but only those "powers granted to [it] by statute and regulation." *Id.* at *13. The Board observed that, to the extent applicable, the good-cause and reopening regulations provide "limited regulatory authority to grant relief from time limits in factual situations that could constitute grounds for equitable tolling." *Id.* at *15.[9] But, the Board explained, outside of the specific circumstances identified in those regulations it has no residual authority to "grant equitable relief such as equitable tolling." *Id.* at *13. The Board (and the Administrator) have reiterated that interpretation in a number of subsequent adjudications, including in the decisions below. See, *e.g.*, *Medical Coll. of Ga. Hosp.*, PRRB Dec. No. 2010-D30, 2010 WL 4214222, at *3 (May 25, 2010), aff'd, 2010 WL 5570990, at *3 (CMS

[9] Since the decision in *Anaheim*, the regulation has been revised to expressly set forth a narrow definition of "good cause." See pp. 6-7, *supra*.

Adm'r July 13, 2010); *Valley Presbyterian Hosp.*, PRRB Dec. No. 2009-D18, 2009 WL 1973490, at *3 (Apr. 9, 2009); *SKI 1987-1994 DSH SSI% Group*, PRRB Dec. No. 2009-D12, 2009 WL 981317, at *4 (Mar. 5, 2009) (*SKI Group*); Pet. App. 51a-56a.[10]

d. Rather than respecting the Secretary's considered judgment, the court of appeals engrafted a judge-made exception onto that carefully crafted administrative review scheme, imposing its own open-ended procedural rule of equitable tolling. Cf. *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 455 (1999) (*Your Home*) (describing the reopening regulation as providing an appropriate "procedure" for making retroactive corrective adjustments). The court thereby granted providers a right to seek an untimely Board hearing by the simple expedient of invoking judicially fashioned notions of equitable tolling, requiring a fact-intensive inquiry broader than the agency's own assessment of "good cause." See *Credit Suisse Sec. (USA) LLC* v. *Simmonds*, 132 S. Ct. 1414, 1419 (2012) (*Credit Suisse Sec.*); 42 C.F.R. 405.1836(b) (2011). In so doing, the court of appeals impermissibly intruded on the Secretary's discretion to determine the rules and procedures

[10] The Board and the Administrator have similarly held that the Board lacks authority to equitably toll certain regulatory deadlines. See *Newman Mem. County Hosp.*, PRRB Dec. No. 2001-D41, 2001 WL 1023208, at *11 (Aug. 20, 2001) (180-day regulatory time limit for requesting exception to routine cost limit); *Mercy Gen. Hosp.*, PRRB Dec. No. 2000-D87, 2000 WL 1460704, at *11 (Sept. 22, 2000) (same); cf. *Bradford Reg'l Med. Ctr.*, PRRB Dec. No. 99-D19, 1999 WL 10149, at *8 (Jan. 9, 1999) (90-day time limit for submitting supporting documentation relating to capital-related costs), rev'd, 1999 WL 398034, at *12-*14 (HCFA Adm'r Mar. 12, 1999), rev'd, *Bradford Hosp.* v. *Shalala*, 108 F. Supp. 2d 473 (W.D. Pa. 2000).

governing the Board. See *Vermont Yankee*, 435 U.S. at 524.

Importing an equitable-tolling regime into an administrative appeals process that has functioned appropriately for almost four decades would also work a fundamental shift in the agency's operations at every level. Under the current administrative review scheme, the Board must simply dismiss all appeals filed more than 180 days after the NPR, unless the provider can demonstrate good cause for the delay. See 42 C.F.R. 405.1836(a) (2011); see also 42 C.F.R. 405.1841(a)(1) and (b). And it must in all events dismiss any hearing request filed more than three years after the NPR. See 42 C.F.R. 405.1836(c)(2) (2011); see also 42 C.F.R. 405.1841(b). Under these governing standards, an intermediary need only inform the Board that a hearing request is untimely or, in certain circumstances, respond to a provider's request for an extension for good cause under the regulation. 42 C.F.R. 405.1843(a) (2011); CMS, *Medicare: Provider Reimbursement Manual*, Pt. 1, ch. 29, § 2900(B)(6)(b), at 29-6 (2011) (*PRM*).[11] The Secretary (acting through the Administrator) may review good-cause extensions granted or denied by the Board when appropriate. See 42 C.F.R. 405.1836(e)(2)-(3), 405.1875 (2011); see also, *e.g.*, *St. Joseph Reg'l Health Ctr.*, 2007 WL 1004399 (CMS Adm'r Feb. 6, 2007) (*St. Joseph*). But otherwise, CMS has little (if any) involvement in the administrative adjudication of untimely claims. See 42 C.F.R. 405.1843(b) (2011). And a finding "that the provider did or did not demonstrate good cause * * * is not subject to judicial review." 42

[11] http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html (last visited Sept. 10, 2012).

C.F.R. 405.1836(e)(4) (2011); cf. *Your Home*, 525 U.S. at 452-457 (denial by intermediary of request to reopen not subject to administrative or judicial review); but see *Western Med. Enters., Inc.* v. *Heckler*, 783 F.2d 1376, 1380-1381 & n.3 (9th Cir. 1986).

In practice, then, HHS currently need not devote significant resources to adjudicating or litigating untimely appeals. This Office has been informed by HHS that no good-cause extensions of the appeal deadline have been granted under the regulation as amended in 2008, see 42 C.F.R. 405.1836 (2011), and that, under the prior version, the Board found good cause to extend the deadline in approximately three dozen appeals from 1986 through 2007.[12] In three of those cases, the Board's decision was reversed by the Administrator. See *St. Joseph*, 2007 WL 1004399, at *4-*6; *St. Vincent's Hosp. FY 1986 Outlier Group*, 2000 WL 1146583, at *2-*10 (HCFA Adm'r Jan. 3, 2000); *Independent Outlier Group II*, 1999 WL 649069, at *3-*9 (HCFA Adm'r July 23, 1999).

Affording providers a new procedural right to invoke equitable tolling to override that carefully circumscribed statutory and regulatory framework would fundamentally alter the treatment of untimely appeals at great cost to the agency, to the Medicare program, and to the Medicare Trust Fund. Under an equitable-tolling regime, the Board could no longer dismiss untimely appeals outright (or, for those filed within three years of the NPR, after a limited inquiry into good cause, espe-

[12] HHS has informed this Office that, to compile the data, the PRRB searched its electronic case management system, which includes records for cases dating back to 1986, as well as certain earlier cases that were still open in 1988-1989 when the system was manually updated.

cially as now narrowly defined), but instead would have to consider in every instance whether the provider had established more open-ended equitable grounds for the late filing. "[T]he Board is burdened by an immense caseload," and "procedural rules requiring timely filings are indispensible devices for keeping the machinery of the reimbursement appeals process running smoothly." *High Country Home Health, Inc.* v. *Thompson*, 359 F.3d 1307, 1310 (10th Cir. 2004) (*High Country*).

For intermediaries, which appear as parties before the Board to defend their NPRs, 42 C.F.R. 405.1843(a), the availability of equitable tolling would mean an entirely new docket of stale cases, in which they would have to inquire into and defend against arguments for equitable tolling. If equitable tolling were then allowed, intermediaries would have to defend payment claims on their merits for cost years that had long since been closed. CMS too would have additional responsibilities, both before the Board (actively participating in Board hearings where, as here, the provider's equitable-tolling arguments are based on CMS's actions), and in court (litigating untimely claims). Beyond the increased caseload, CMS and intermediaries would have to confront the challenges of defending against stale claims when documents and records may no longer exist (pursuant to valid record-retention policies), when witnesses may be unavailable, and when memories have faded. The courts, in turn, would experience an increased number of cases raising equitable-tolling arguments and seeking adjudication of stale claims on their merits.

e. The scenario illustrated by this case vividly demonstrates why HHS declined to confer broader authority on the Board to equitably toll the 180-day appeal deadline. One provider (here, Baystate) brings a *timely*

appeal challenging one aspect of its final payment determination (here, calculation of the numerator of the SSI fraction for purposes of computing the DSH adjustment) for one or more cost reporting years (here, 1993 through 1996). That provider argues that it is entitled to additional payment for those cost years because the underlying data were flawed, or there was a mathematical error in making the calculations, or the agency misinterpreted the statutory formula. The Board or a reviewing court agrees with that one provider and remands for the intermediary to recalculate that provider's payment amount for the challenged cost reporting years. Hundreds of other providers then learn of the Board (or court) decision and believe that the intermediary may have used similarly flawed data, or calculations, or interpretations to calculate their payment for cost reporting years that have long since been closed. They then file *untimely* appeals with the Board invoking equitable tolling.

This case, for example, is only the first of more than a dozen post-*Baystate* suits in the District Court for the District of Columbia filed on behalf of approximately 200 hospitals for more than 2000 fiscal years—all invoking equitable tolling and relying on *Baystate* to seek recalculation of payment determinations made many years (and oftentimes, as in this case, a decade or more) ago. See Pet. App. 11a-12a; App., *infra*, 34a-37a. Hospice providers raising other payment issues have similarly invoked equitable tolling in suits currently pending in federal court. App., *infra*, 34a-37a. And HHS informs this Office that approximately 450 providers have invoked equitable tolling in more than 80 cases now pend-

ing before the PRRB, involving claims for more than 4000 cost reporting years.[13]

More than 35,000 institutional providers participate in the Medicare program, including more than 6100 hospitals, and each of those providers must file an annual cost report. See 42 C.F.R. 413.1(a)(2), 413.20(b), 413.24(f); see HHS, *2012 CMS Statistics* 21, 22 (June 2012) (*2012 Statistics*) (Tbls. II.3, II.5).[14] There is a very real potential for an equitable-tolling regime to seriously disrupt the Medicare provider payment process and take time and resources away from processing claims and appeals filed in compliance with the statutory and regulatory requirements, to the detriment of other Medicare providers. Cf. *Your Home*, 525 U.S. at 454 ("[T]he statutory purpose of imposing a 180-day limit * * * would be frustrated by permitting requests to reopen to be reviewed indefinitely."); *High Country*, 359 F.3d at 1311 ("The danger is that the deadline, which is supposed to help manage the burdens of a heavy caseload, will become a new (and less productive) font of litigation; instead of focusing on timely raised substantive claims, the adjudicator must expend resources on litigation about whether a party's excuse for missing the deadline was good enough."). That practical reality

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[13] HHS arrived at these figures based on the PRRB's search of its electronic database, decisions, and working files. The "approximately 450 providers" figure is an aggregate calculation; some providers may be involved in more than one of the pending appeals.

[14] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html (last visited Sept. 10, 2012).

reinforces the Secretary's judgment to adopt strict limitations on extending the appeal deadline.[15]

f. A judicially imposed equitable-tolling rule would also allow providers to circumvent the Secretary's limited reopening procedures that this Court sustained in *Your Home*. In that case, the Court held that reopening is discretionary when sought by the provider under 42 C.F.R. 405.1885 (1997), and that "[t]he right of a provider to seek reopening exists only by grace of the Secretary." *Your Home*, 525 U.S. at 454. The Court explained that, "given the administrative realities," it "would not be shocked by a system in which underpayments could *never* be the basis for reopening." *Id.* at 455. Indeed, the Court noted, "[t]he few dozen fiscal intermediaries often need three years within which to discover overpayments in the tens of thousands of NPRs that they issue, while each of the tens of thousands of sophisticated Medicare-provider recipients of these NPRs is generally capable of identifying an underpayment in its own NPR within the 180-day time period specified in 42 U.S.C. § 1395*oo*(a)(3)." *Id.* at 455-456.

An equitable-tolling rule would allow those "tens of thousands of sophisticated Medicare-provider recipients" to evade the carefully circumscribed limits in the reopening regulation. It would transform a provider's

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[15] Even if provider appeals to equity ultimately fall short in most cases, substantial resources would have to be devoted to adjudicating (before the Board) and litigating (in court) untimely claims. See *Credit Suisse Sec.*, 132 S. Ct. at 1419, 1421 (explaining that equitable tolling involves "fact-intensive disputes" about whether a litigant has diligently pursued his rights and whether "some extraordinary circumstances stood in his way") (citation omitted); *High Country*, 359 F.3d at 1311 ("[F]or every plaintiff whose substantive claim or reason for default leads an adjudicator to excuse the default, ten less sympathetic plaintiffs are likely to demand similar treatment.").

ability to seek reopening from a time-limited opportunity existing solely by grace of the Secretary into an open-ended regime fashioned by the courts using their own sense of what an equitable administrative process should look like. The same "administrative realities" that caused this Court in *Your Home* to envision a Medicare payment scheme without any opportunity for provider reopening, render such a judicially fashioned equitable-tolling regime contrary to the statutory and regulatory framework, as well as highly disruptive and burdensome. Cf. *Califano* v. *Sanders*, 430 U.S. 99, 108 (1977) ("limit[ing] judicial review to the original decision denying benefits is a policy choice obviously designed to forestall repetitive or belated litigation of stale eligibility claims").

2. In addition to imposing new and very burdensome procedures on HHS, in violation of *Vermont Yankee*, applying principles of equitable tolling to the 180-day administrative appeal deadline would effectively invalidate the Secretary's regulation allowing extensions only in narrow circumstances. That respondents do not formally challenge that regulation is of no consequence. Accepting their argument that the Board must consider untimely appeals invoking equitable tolling, regardless of when they are filed, would be tantamount to abolishing the Secretary's longstanding requirement that an appeal to the Board "shall be dismissed" if filed more than 180 days after the NPR, unless the provider shows "good cause" and requests an extension *no later than* three years after the NPR. Unless respondents can demonstrate that those limitations in the Secretary's regulation are "arbitrary, capricious, or manifestly contrary to the statute," that regulation must be sustained. *Chevron*, 467 U.S. at 843-844; see *Zebley*, 493

U.S. at 528; *Schreiber*, 381 U.S. at 291; *High Country*, 359 F.3d at 1313; see also 42 U.S.C. 1395*oo*(f)(1) (incorporating APA standards of review). For the reasons discussed in Part B, *infra*, the limitations in the good-cause regulation are not "manifestly contrary to the statute." And for the reasons set forth above, neither are they arbitrary and capricious.

Principles of finality and repose are critical to the administration of the Medicare program and to the Medicare Trust Fund. See *Palisades Gen. Hosp., Inc.* v. *Leavitt*, 426 F.3d 400, 404 (D.C. Cir. 2005); *Methodist Hosp.* v. *Shalala*, 38 F.3d 1225, 1232-1233 (D.C. Cir. 1994); see also 42 C.F.R. 405.1807. Absent fixed time limits, HHS and providers would have to stand ready to reassess and litigate any one of the hundreds of calculations that go into an annual determination of the amount due a provider for any given cost reporting period, and the Medicare Trust Fund would remain exposed to enormous and unpredictable liabilities that might be imposed many years (or even a decade or more) later. As HHS has explained, "[i]t is in the interest of providers and the program that, at some point, intermediary determinations and the resulting amount of program payment due the provider or the program become no longer open to correction." *PRM*, Pt. 1, § 2930, at 29-73.

Indeed, experience has caused the agency to expressly delineate and further narrow the limitations even on its own good-cause regulation. In 2004, the Secretary explained that "the case backlog at the Board * * * necessitate[d] revision" of the good-cause regulation because it added additional cases "to the backlog" and because the "lengthy 3-year period for requesting a good cause extension makes increases in the backlog more likely." 69 Fed. Reg. 35,725 (June 25, 2004); *id.* at

35,717 (noting backlog of approximately 10,000 cases); see 73 Fed. Reg. 30,205 (May 23, 2008); *id.* at 30,192 (noting backlog of approximately 6800 cases); see also *ibid.* (explaining that proposed amendments were designed to "lead to a more effective and efficient appeal process" and to reduce the "huge backlog of cases before the Board"). The Secretary "considered eliminating altogether any extensions of the 180-day period for requesting a hearing," but ultimately decided to retain the regulation while allowing untimely requests "only in extraordinary circumstances beyond [a provider's] control (for example, fire, catastrophe or strike) that existed prior to the expiration of the 180-day appeal period." *Id.* at 30,206. Again, the Secretary reiterated that three years is the absolute "outside limit" for extension requests, 73 Fed. Reg. at 30,206, and further specified that any such appeal must be filed "within a reasonable time (as determined by the Board under the circumstances) after the expiration of the 180-day limit," 42 C.F.R. 405.1836(b) (2011). See 42 C.F.R. 405.1836(c)(2) (2011). The Secretary's longstanding judgment—refined and strengthened based on practical experience—that the Board should not have authority to consider an untimely hearing request if the conditions specified in the good-cause regulation are not met cannot be said to be arbitrary or capricious.

B. Congress Did Not Intend To Subject The 180-Day Administrative Appeal Deadline To Equitable Tolling

Respondents nevertheless argue, and the court of appeals held, that the Medicare Act itself provides for equitable tolling of the 180-day administrative appeal deadline. They do not rely on the express terms of Section 1395*oo*(a)(3), which does not speak to equitable tolling or indeed mention any grounds for extending the

deadline. Nor do they rest on any other generally applicable tools of statutory interpretation. Instead, they rely heavily on a presumption in favor of the availability of equitable tolling. No such presumption applies here and, without a presumption, the statute is at best silent or ambiguous and the Secretary's considered judgment and reasonable regulations are controlling. See Part A, *supra*. But even if such a presumption applied in some form, it would be rebutted by the text, structure, and history of the statute, as well as its underlying subject matter and purpose.

1. In *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89 (1990), this Court considered whether the then-30 day time period for filing suit against a federal agency under Title VII of the Civil Rights Act of 1964, 42 U.S.C. 2000e-16(c) (1988), was subject to equitable tolling. Seeking to reconcile its prior cases involving "the effect of time limits in suits against the Government," *Irwin*, 498 U.S. at 94, the Court started with the proposition that "[t]ime requirements in lawsuits between private litigants are customarily subject to 'equitable tolling,'" *id.* at 95. The Court acknowledged that statutory filing deadlines for suits against the government are conditions on Congress's waiver of sovereign immunity, and that waivers of sovereign immunity must be "unequivocally expressed." *Id.* at 94-95 (citation omitted). But the Court ultimately concluded that "the same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States." *Id.* at 95-96.

a. Before and after *Irwin*, the equitable-tolling cases before this Court have generally involved limitations periods for filing a suit in federal court. See, *e.g.*, *Holland* v. *Florida*, 130 S. Ct. 2549 (2010) (one-year

period for filing application for writ of habeas corpus); *Rotella* v. *Wood*, 528 U.S. 549 (2000) (four-year period for filing civil RICO suit); *United States* v. *Beggerly*, 524 U.S. 38 (1998) (12-year period to bring suit under Quiet Title Act); *Lampf, Pleva, Lipkind, Prupis & Petigrow* v. *Gilbertson*, 501 U.S. 350 (1991) (one- and three-year periods for commencing suit under Section 10(b) of the Securities Exchange Act of 1934); *Honda* v. *Clark*, 386 U.S. 484 (1967) (60-day period for filing suit under Trading with the Enemy Act); *Burnett* v. *New York Cent. R.R.*, 380 U.S. 424 (1965) (three-year period for filing suit under Federal Employers' Liability Act (FELA)); *Soriano* v. *United States*, 352 U.S. 270 (1957) (six-year period for filing suit in Court of Federal Claims); *Kendall* v. *United States*, 107 U.S. 123 (1883) (same). This Court has never applied the *Irwin* presumption to equitably toll a time limit governing the action of an administrative agency. The few cases that involved an administrative deadline are quite distinct from this case.

In *Zipes* v. *Trans World Airlines, Inc.*, 455 U.S. 385 (1982), the Court concluded that the statutory time limit for filing charges with the Equal Employment Opportunity Commission (EEOC) as a prerequisite to filing a suit under Title VII was not a "jurisdictional prerequisite to suit" in district court, but rather was subject to equitable doctrines such as waiver, estoppel, and tolling. *Id.* at 393. Although the case was about waiver and estoppel, not tolling, the Court concluded that permitting "waiver as well as tolling when equity so requires" would further "the remedial purpose" of Title VII "without negating the particular purpose of the filing requirement, to give prompt notice to the employer." *Id.* at 398. The Court further explained that applying

equitable principles was consistent with the statutory scheme, wherein "laymen, unassisted by trained lawyers, initiate the process." *Id.* at 397 (citation omitted); see *National R.R. Passenger Corp.* v. *Morgan*, 536 U.S. 101, 113 (2002).

In *Zipes*, the EEOC (and the United States) argued in favor of equitable modification of the charge-filing period. See U.S. Amici Br. at 10-21, *Zipes*, *supra* (Nos. 78-1545 and 80-951). And Title VII suits in federal court following EEOC proceedings are de novo actions. See *Chandler* v. *Roudebush*, 425 U.S. 840, 844, 864 (1976). In marked contrast, the considered judgment of the Secretary with respect to Medicare providers is that equitable tolling would be incompatible with the statutory and regulatory scheme. The task of applying equitable principles here would fall to an administrative tribunal expert "in the field of payment of providers of services," 42 U.S.C. 1395*oo*(h), and judicial review would proceed under the deferential standards of the APA, 42 U.S.C. 1395*oo*(f)(1). In addition, unlike the filing of charges under Title VII, the payment system under the Medicare Part A program applies to sophisticated providers which are often assisted by "trained lawyers."

United States v. *Brockamp*, 519 U.S. 347 (1997), involved the time period for filing a tax refund claim with the Internal Revenue Service (IRS). A tax refund suit, however, "is not an appellate review of the administrative decision that was made by IRS," but a de novo proceeding. *Wells Fargo & Co.* v. *United States*, 91 Fed. Cl. 35, 75 (2010) (citation omitted), aff'd, 641 F.3d 1319 (Fed. Cir. 2011); compare 42 U.S.C. 1395*oo*(f)(1) (applying APA standards). The Court in *Brockamp*, moreover, only "assume[d]," "for argument's sake," that the *Irwin* presumption applied, 519 U.S. at 350, and ultimately

held that tolling was unavailable. The Court's conclusion that the statutory text and structure, as well as the underlying subject matter and history, conclusively precluded equitable tolling was in full accord with the IRS's denial of the requested refunds as untimely. See U.S. Br. at 5, 10, *Brockamp*, *supra* (No. 95-1225).[16]

Respondents also rely (Br. in Opp. 19-20) on *Bowen* v. *City of New York*, 476 U.S. 467 (1986), but the Court there allowed equitable tolling of the 60-day limitations period for seeking *judicial* review of the Secretary's Social Security benefits determination. *Id.* at 478-482. The Court did discuss the administrative appeal deadline as well, but only in the section of the opinion addressing administrative exhaustion. *Id.* at 482-486. Moreover, even with respect to the 60-day period for filing a suit in court, the Court did not apply any presumption, but rather focused on whether equitable tolling was "consistent with Congress' intent." *Id.* at 479-480. Because the disability benefits scheme was "designed to be 'unusually protective' of claimants," *id.* at 480 (citation omitted), the Court concluded that equitable tolling was appropriate. The same cannot be said of the 180-day administrative appeal period for "sophisticated" institutional providers, *Your Home*, 525 U.S. at 456, to seek Medicare payment. The *City of New York* Court also observed that Congress had "authorized the Secretary to toll the 60-day limit, thus expressing its clear intention to allow tolling in some cases." 476 U.S.

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[16] *Young* v. *United States*, 535 U.S. 43 (2002), involved the "three-year lookback period" in the Bankruptcy Code. Although not involving a time limit for filing suit in court, that case does not directly inform how the Court should treat an administrative appeal deadline that the expert agency has determined should not be subject to equitable tolling.

at 480 (citing 42 U.S.C. 405(g) (1982)).[17] That indicium of congressional intent is absent here. See Amicus Br. 37-38; pp. 48-49, *infra* (addressing amicus argument).

b. Neither precedent nor logic suggests that the Court should mechanically apply the *Irwin* presumption to a statutory deadline governing an administrative appeal scheme of the sort at issue here. This Court has long recognized that there are functional differences between judicial and administrative tribunals, and that the failure to recognize those differences would cause courts to "read the laws of Congress through the distorting lenses of inapplicable legal doctrine." *Pottsville Broad.*, 309 U.S. at 144. The Court should heed that caution here.

The presumption of equitable tolling was adopted in part on the premise that "[s]uch a principle is likely to be a realistic assessment of legislative intent." *Irwin*, 498 U.S. at 95; see *John R. Sand & Gravel Co.* v. *United States*, 552 U.S. 130, 137 (2008) (purpose of rebuttable presumption is "to produce a set of statutory interpretations that will more accurately reflect Congress' likely meaning in the mine run of instances where it enacted a Government-related statute of limitations"). No such premise supports applying a presumption of equitable tolling in this case. Congress was concerned enough about finality to enact a statutory time deadline to

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[17] The Secretary exercised that delegated authority and issued regulations permitting extensions of time for good cause. See *City of N.Y.*, 476 U.S. at 480 n.12 (citing 20 C.F.R. 404.911, 416.1411 (1985)). Unlike the good-cause regulation governing appeals to the PRRB, see 42 C.F.R. 405.1841(b), the regulations at issue in *City of New York* imposed no outer time limit for seeking an extension and defined "good cause" broadly. In those circumstances, the Court concluded that the regulations additionally supported application of tolling principles. 476 U.S. at 480 n.12.

govern an appeal to the Board that does not on its face provide for extending the appeal time, whether based on equitable tolling or otherwise. See 42 U.S.C. 1395*oo*(a)(3). Rather, the Medicare Act confers on the Secretary extensive rulemaking and other authority with respect to the Board. Under established principles of administrative law, the Act thus delegates to the Secretary the authority to determine whether Section 1395*oo*(a)(3) may be construed to allow any extensions of the 180-day appeal period and, if so, whether and what sort of power should be conferred on the Board to allow extensions. Likewise under established principles of administrative law, the Secretary's interpretation and implementation of her authority under such statutory provisions after notice-and-comment rulemaking can be set aside only if arbitrary and capricious. See pp. 29-30, *supra*. It would be fundamentally inconsistent with these principles for the Court to nonetheless presume that Congress intended to *divest* the Secretary of her delegated authority and instead to confer authority on federal courts to impose equitable tolling. Indeed, the presumption should be precisely to the contrary, and neither the court of appeals nor respondents have pointed to any indication that Congress intended for courts to have that authority, rather than the Secretary.

The situation is the same as if Congress had enacted Section 1395*oo* in identical form, but without any time limit for filing an appeal with the Board, and the Secretary had adopted the very same regulations to govern Board proceedings. In that hypothetical, there would still be a 180-day appeal deadline (by regulation) and there would still be a limited opportunity to extend that deadline for good cause within three years. Under well-settled principles of administrative law, and under this

Court's equitable-tolling precedents, the "emphatic" regulatory time restrictions would not be subject to equitable tolling, cf. *Kontrick* v. *Ryan*, 540 U.S. 443, 458 (2004) (citation omitted)—especially where the responsible agency has construed the regulations to bar tolling, see *Thomas Jefferson*, 512 U.S. at 512. There is no reason for a different result here, where Section 1395*oo*(a)(3) is silent and the Secretary has been given authority to interpret and implement it.

2. The factors considered by this Court in cases discussing a presumption of equitable tolling also demonstrate that such a presumption is out of place here, or at the very least substantially weakened.

a. Although a "precise private analogue" to the particular type of suit against the government at issue is not required in order to invoke the *Irwin* presumption, *Scarborough* v. *Principi*, 541 U.S. 401, 422 (2004), the Court's reasoning in *Irwin* rested on the proposition that a rule in favor of equitable tolling should be "applicable to suits against the Government[] in the same way that it is applicable to private suits," 498 U.S. at 95. In *Brockamp*, the Court recognized the need to identify a private analogue, and assumed "only for argument's sake" that "a tax refund suit and a private suit for restitution" were sufficiently similar to warrant application of the *Irwin* presumption. 519 U.S. at 350. Unlike tort actions or employment disputes, however, claims for provider payment under the Medicare program are not comparable to any suit that can be brought against a private litigant. The court of appeals was of the view that a Medicare provider's administrative appeal seeking payment is sufficiently analogous to a private contract action, Pet. App. 6a n.1, but Medicare provider payments depend on the statute and the regulations, not

on independent contractual undertakings.[18] Respondents' claim that the Secretary should recalculate their Medicare payments under complex statutory and administrative standards is "so peculiarly governmental that there is no basis for assuming [that the] customary ground rules apply." *Chung* v. *United States Dep't of Justice*, 333 F.3d 273, 277 (D.C. Cir. 2003).

b. Moreover, a presumption in favor of equitable tolling, even if one applied at all, would be substantially weakened in this context. In *Holland*, this Court explained that the presumption of equitable tolling was "reinforced" and "strength[ened]" by two factors: (1) "the fact that equitable principles have traditionally governed the substantive law of habeas corpus," and (2) "the fact that Congress enacted [the Antiterrorism and Effective Death Penalty Act of 1996 (AEDPA)] after the Court decided *Irwin* and therefore was likely aware that courts, when interpreting AEDPA's timing provisions, would apply the presumption." 130 S. Ct. at 2560-2561 (internal quotation marks and citation omitted); *id.* at 2569 (Scalia, J., dissenting) (agreeing that the presumption is particularly strong when the underlying action is "traditionally governed by equitable principles"). Similarly, in *Young* v. *United States*, 535 U.S. 43 (2002), the Court noted that the *Irwin* presumption is appropriate "when [Congress] is enacting limitations periods to be applied by bankruptcy courts, which are courts of equity and apply the principles and rules of

[18] The court of appeals suggested that *Holland* casts doubt on the need to search for a comparable private suit. Pet. App. 6a n.1. But in *Holland*, a state prisoner filed a habeas corpus petition against his custodian; it was not a suit against the United States, or one that implicated sovereign-immunity considerations.

equity jurisprudence." *Id.* at 50 (internal quotation marks, brackets, and citations omitted).

Neither factor is present here. First, unlike habeas corpus and bankruptcy litigation, and the Title VII discrimination claim presented in *Irwin*, general "equitable principles," unrooted in statutory or regulatory text, have not "traditionally governed" the "substantive law" of Medicare provider payment, let alone the administrative appeals process. Cf. *Brockamp*, 519 U.S. at 352 (noting that tax law "is not normally characterized by case-specific exceptions reflecting individualized equities"). Thus, the question here is not whether Congress has divested a court of its traditional equitable authority, *Holland*, 130 S. Ct. at 2560, but whether a court may impose on an administrative tribunal equitable powers that Congress and the Secretary declined to confer. See Pet. App. 55a-56a (holding that the Board has no residual equitable powers with respect to the 180-day deadline); see also pp. 17-29, *supra*. Second, the 180-day administrative appeal period was first enacted in 1972, 1972 SSA Amendments § 243(a), 86 Stat. 1420—18 years before this Court decided *Irwin*. Accordingly, Congress plainly was not "aware that courts, when interpreting" even federal statutes governing the filing of a suit against the United States in court, much less the Medicare Act's administrative-appeal "timing provisions, would apply the presumption." *Holland*, 130 S. Ct. at 2561.

3. In the end, the touchstone must be congressional intent. See *Brockamp*, 519 U.S. at 350 (whether there is "good reason to believe that Congress did *not* want the equitable-tolling doctrine to apply"); *City of N.Y.*, 476 U.S. at 480 (whether equitable tolling "is consistent with Congress' intent"); *Honda*, 386 U.S. at 501 (whether

equitable tolling is "[c]onsistent with the overall congressional purpose"); *Burnett*, 380 U.S. at 427 (whether equitable tolling "effectuates" the "congressional purpose"). Here, the statutory text, structure, and history, and the underlying subject matter and purpose, make clear that Congress "did not intend courts to read other unmentioned, open-ended 'equitable' exceptions into the statute that it wrote." *Brockamp*, 519 U.S. at 352. Any presumption in favor of equitable tolling therefore is rebutted.

The Court-appointed amicus curiae argues that many of the same indicia of congressional intent demonstrate that the statutory 180-day appeal period is an absolute limit on the Board's jurisdiction. See Part C, *infra*. Whether or not Section 1395*oo*(a)(3) standing alone is "jurisdictional" in that "strict sense of the term," *Hallstrom* v. *Tillamook County*, 493 U.S. 20, 31 (1989), the statute leaves no room for judicially imposed equitable tolling outside the controlling statutory and regulatory framework.

a. Section 1395*oo*(a) establishes several mandatory preconditions to obtaining a hearing before the PRRB. *First*, the appealing party must be a "provider of services" that "has filed a required cost report within the time specified in regulations," or a hospital that receives payments under the PPS and that "has submitted such reports within such time as the Secretary may require." 42 U.S.C. 1395*oo*(a). *Second*, the provider must either be "dissatisfied" with the final determination of the intermediary or the Secretary, or must not have received a final determination from the intermediary on a timely basis. 42 U.S.C. 1395*oo*(a)(1). *Third*, the amount in controversy must be $10,000 or more. 42 U.S.C. 1395*oo*(a)(2). *Fourth*, the provider must request a hear-

ing within 180 days after receiving notice of the intermediary's (or the Secretary's) final determination, or within 180 days after notice of the intermediary's determination should have been received if it had been made on a timely basis. 42 U.S.C. 1395*oo*(a)(3); see *1971 House Report* 108 ("The appeal must be filed within 180 days after notice of the fiscal intermediary's final determination."). Nothing in the statutory text suggests that any of the preconditions to a Board hearing are amenable to judicially imposed equitable exceptions.

Although not as technical and repetitive as the time limit at issue in *Brockamp*, 519 U.S. at 350-352, the 180-day time limit is itself stated in absolute and unqualified terms. A provider is entitled to a hearing before the Board "*if*," among other things, it files a request within 180 days. 42 U.S.C. 1395*oo*(a)(3) (emphasis added). Unlike the judicial review deadline at issue in *City of New York*, Section 1395*oo* does not expressly provide for any exceptions to the 180-day deadline. See 476 U.S. at 476. "Under a literal reading of the statute, compliance with the" administrative appeal deadline is a "mandatory, not optional, condition precedent" to a hearing before the Board, and a "district court may not disregard" the deadline "at its discretion." *Hallstrom*, 493 U.S. at 26, 31.[19]

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[19] The statutory time limit also has substantive, as well as procedural, effects. See *Brockamp*, 519 U.S. at 352. Section 1395*oo*(f)(2) provides that, when a provider seeks judicial review, interest will accrue "beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section." 42 U.S.C. 1395*oo*(f)(2); see Amicus Br. 35 n.22. Tolling the 180-day deadline would seem to require a court to judicially alter the starting date for interest accrual—"a kind of tolling for which" there is "no direct precedent." *Brockamp*, 519 U.S. at 352.

The history of Section 1395*oo*(a)(3), as detailed above, reinforces the statutory text. Until 1972, the Medicare Act provided no avenue for providers to obtain administrative or judicial review. When Congress first directed the Secretary to establish the Board, it simultaneously imposed the 180-day deadline, with no express exceptions. For nearly forty years, the Secretary (through regulations, formal adjudications, and interpretive guidance) has prohibited the Board from extending that deadline, except as provided by regulation. And until the court of appeals' decision in this case, no court had ever superimposed extra-textual equitable tolling principles onto Section 1395*oo*(a)(3) and the Secretary's regulations implementing that provision. Against that backdrop, Congress amended Section 1395*oo* on numerous occasions and never expressed any disapproval of the Secretary's interpretation. See p. 20 & n.8, *supra*. "It is well established that when Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended by Congress." *Schor*, 478 U.S. at 846 (internal quotation marks and citation omitted). Accordingly, Congress may be understood to have acquiesced in the Secretary's interpretation. Cf. *John R. Sand & Gravel Co.*, 552 U.S. at 138-139 (requiring sua sponte consideration of timeliness where Congress had "long acquiesced" in the Court's interpretation of a statutory time deadline).

b. Section 1395*oo*(a)(3)'s underlying subject matter and purpose further confirm that equitable tolling is inconsistent with the statutory and regulatory scheme.

Section 1395*oo* is qualitatively different from the remedial statutes at issue in many of this Court's equitable-tolling cases. See *Irwin*, 498 U.S. at 91 (Title VII); *City of N.Y.*, 476 U.S. at 480 (Social Security disability benefits); *Zipes*, 455 U.S. at 398 (Title VII); *Honda*, 386 U.S. at 486, 495 (Trading with the Enemy Act); *Burnett*, 380 U.S. at 427 (FELA); cf. *Henderson* v. *Shinseki*, 131 S. Ct. 1197, 1204 (2011) (veterans disability benefits). The statutory scheme is not designed to be "'unusually protective' of claimants," *City of N.Y.*, 476 U.S. at 480 (citation omitted), nor is it one "in which laymen, unassisted by trained lawyers, initiate the process," *Zipes*, 455 U.S. at 397 (citation omitted). The payment system under Medicare Part A applies to "sophisticated" institutional providers that are assisted "by trained lawyers," and that are "generally capable of identifying an underpayment in [their] own NPR within the 180-day time period specified in 42 U.S.C. § 1395*oo*(a)(3)." *Your Home*, 525 U.S. at 455-456; see *Hallstrom*, 493 U.S. at 28.

The administrative appeal deadline also "relate[s] to an 'underlying subject matter[]' * * * with respect to which the practical consequences of permitting equitable tolling would [be] substantial." *Holland*, 130 S. Ct. at 2561 (quoting *Brockamp*, 519 U.S. at 352). In *Brockamp*, the Court concluded that "[t]he nature of the underlying subject matter" (tax collection) "underscore[d]" its conclusion that equitable-tolling principles could not be read into the statutory time limit. 519 U.S. at 352-353. In *Beggerly*, the Court held that the statutory time limit in the Quiet Title Act could not be equitably tolled because, among other things, "the underlying claim 'deal[t] with ownership of land' and thereby implicated landowners' need to 'know with certainty what their

rights are, and the period during which those rights may be subject to challenge.'" *Holland*, 130 S. Ct. at 2561 (brackets in original) (quoting *Beggerly*, 524 U.S. at 49). By contrast, the Court emphasized in *Holland* in allowing equitable tolling under AEPDA that, "unlike the subject matters at issue" in *Brockamp* and *Beggerly*, "AEDPA's subject matter, habeas corpus, pertains to an area of the law where equity finds a comfortable home." *Ibid.*; cf. *id.* at 2562 (considering whether equitable tolling would "undermine[]" the statute's "basic purposes").

Medicare Part A is far more analogous to the subject matter in *Brockamp* (tax collection) and *Beggerly* (land claims) than to the subject matter in *Holland* (habeas corpus) or *Irwin* (Title VII). The Medicare system is one of the most detailed and complex federal administrative programs ever created. See p. 18, *supra*. It is akin to tax collection in terms of its sheer size and complexity. Medicare contractors annually process millions of claims for more than 35,000 providers under Medicare Part A, see p. 27, *supra*, resulting in annual expenditures of more than $250 billion. *2012 Statistics* 29 (Tbl. III.5); cf. *Brockamp*, 519 U.S. at 352 ("The IRS processes more than 200 million tax returns each year" and "issues more than 90 million refunds."). More than $139 billion in Medicare Part A benefit payments are made annually for inpatient hospital services alone. *2012 Statistics* 30 (Tbl. III.6).

As explained in detail above (see Part A, *supra*), an equitable-tolling regime would place substantial administrative burdens on the agency, on its contractors, and on the Medicare Trust Fund that Congress did not envision and could not have intended. Thus, just as "read[ing] an 'equitable tolling' exception into [Section]

6511 [of the Internal Revenue Code] could create serious administrative problems by forcing the IRS to respond to, and perhaps litigate, large numbers of late claims, accompanied by requests for 'equitable tolling' which, upon close inspection, might turn out to lack sufficient equitable justification," *Brockamp*, 519 U.S. at 352, imposing equitable tolling on provider payment determinations under Medicare Part A would create similar administrative problems for HHS. And just as in *Brockamp*, "Congress would likely have wanted to decide explicitly"—or, as it did here, to delegate to the Secretary the authority to decide explicitly—"whether, or just where and when, to expand the statute's limitations periods, rather than delegate to the courts a generalized power to do so wherever a court concludes that equity so requires." *Id.* at 353. The result of imposing an equitable-tolling regime here would be to require a five-member administrative review body (the PRRB) created for its expertise in resolving technical hospital cost and payment issues to divine and apply judicially fashioned equitable-tolling principles far removed, both factually and legally, from the areas of its technical expertise. In the end, the "nature and potential magnitude of the administrative problem suggest that Congress decided to pay the price of occasional unfairness in individual cases * * * in order to maintain a more workable" payment system. *Id.* at 352-353; see *Taylor* v. *Freeland & Kronz*, 503 U.S. 638, 644 (1992) ("Deadlines may lead to unwelcome results, but they prompt parties to act and they produce finality."); *Your Home*, 525 U.S. at 455 (noting that the Court "would not be shocked by a system in which [Medicare] underpayments could *never* be the basis for reopening").

C. The 180-Day Administrative Appeal Deadline Is Not "Jurisdictional" In The Strictest Sense Of That Term

The Court-appointed amicus curiae argues that Section 1395*oo*(a)(3)'s timely filing requirement is "jurisdictional" because the 180-day appeal deadline limits the Board's adjudicatory authority. Amicus is correct to a point. The Board has no authority to adjudicate any appeal filed more than 180 days after the NPR—except as provided by regulation. Section 1395*oo*(a)(3) limits the Board's jurisdiction; it does not preclude the Secretary from adopting a narrow and time-limited good-cause regulation in the exercise of her broad authority under the Medicare Act. If the good-cause regulation did not exist, however, the Secretary agrees that any hearing request filed more than 180 days after the NPR would be jurisdictionally barred.

1. The 180-day filing deadline is a critical limitation on a provider's ability to obtain a hearing before the Board. It is therefore reasonable for amicus to characterize that time limit as "jurisdictional" in the sense that it constrains the Board's adjudicative powers. The Secretary, however, has authority to interpret and implement Section 1395*oo*. The Secretary has permissibly interpreted Section 1395*oo*(a)(3) to permit her to extend the time limit in certain circumstances, and the good-cause regulation is a proper exercise of that authority. As a result, Section 1395*oo*(a)(3) and the regulations implementing it *together* establish the time limits on the Board's adjudicative powers.

Nothing in the statutory text or history suggests that Congress intended to prohibit the Secretary from implementing Section 1395*oo*(a)(3) in this manner. The Medicare Act directed the Secretary to "establish[]" the Board, 42 U.S.C. 1395*oo*(a), and the scope of the Board's

adjudicatory authority is set forth in that same section. Shortly before Congress enacted Section 1395*oo*(a)(3), the Secretary promulgated regulations affording providers a right to administrative review, *i.e.*, an intermediary hearing, that included a virtually identical good-cause exception. See 37 Fed. Reg. at 10,724. And in implementing regulations promulgated immediately after Congress created a new avenue of administrative review through a Board hearing, the Secretary adopted a parallel good-cause regulation to govern those proceedings. See 39 Fed. Reg. at 34,517; *id.* at 34,516 (retaining good-cause exception for intermediary hearings); *Schor*, 478 U.S. at 844 (agency's "contemporaneous interpretation of the statute it is entrusted to administer" is entitled to "considerable weight"). The good-cause regulation remained unchanged for more than thirty years, until it was narrowed further in 2008. See 73 Fed. Reg. at 30,205-30,207. Congress has never altered the Secretary's rulemaking authority or questioned her implementation of Section 1395*oo*(a)(3). See *Schor*, 478 U.S. at 845-846; pp. 20, 43, *supra*.

Amicus points to (Br. 36-37) provisions governing administrative and judicial review for Medicare beneficiaries and contrasts them with 42 U.S.C. 1395*oo*(a)(3), which governs review for Medicare providers. Amicus notes that those provisions were enacted (for Medicare providers) or amended (for Medicare beneficiaries) by Congress in 1972, but only the latter "gave the Secretary explicit discretion over the time requirements." Br. 36. As amicus acknowledges (Br. 36 n.25), however, Congress first adopted the provisions governing Medicare *beneficiary* appeals at the inception of the Medicare program in 1965. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1869, 79 Stat. 330. In doing

so, Congress simply incorporated the preexisting procedures governing Social Security benefit claims. *Ibid.* While it is true that the incorporated procedures explicitly afforded the Secretary discretion to adopt certain time requirements to govern both judicial and administrative review, those provisions were enacted in 1939 and 1956, respectively. See Social Security Act Amendments of 1939, ch. 666, § 205(g), 53 Stat. 1370; Social Security Act Amendments of 1956, ch. 836, § 111, 70 Stat. 831. The 1972 amendments to the Medicare Act did not alter those incorporated provisions. See 1972 SSA Amendments § 299O, 86 Stat. 1464. Thus, Congress expressly gave the Secretary authority to adopt time limits (or allow an extension of statutory time limits) governing the review process for another government program decades before establishing Medicare; incorporated those provisions into the Medicare Act to govern beneficiary appeals at a time when the statute afforded providers no review; and amended that provision as part of the 1972 amendments that also directed the Secretary to establish the Board. That is too thin a reed on which to base an inference that Congress's silence in Section 1395*oo*(a)(3) was intended to prevent the Secretary, exercising her otherwise broad authority to administer the Medicare program, from allowing limited extension of the appeal deadline for "good cause" shown.

2. That the Secretary's good-cause regulation concerns the Board's adjudicatory jurisdiction does not diminish the deference that it is due. "[I]t is settled law that the rule of deference applies even to an agency's interpretation of its own statutory authority or jurisdiction." *Mississippi Power & Light Co.* v. *Mississippi ex rel. Moore*, 487 U.S. 354, 381 (1988) (Scalia, J., concur-

ring in the judgment) (citing cases); accord *Schor*, 478 U.S. at 845 (substantial deference due to regulation defining scope of agency jurisdiction); *NLRB* v. *City Disposal Sys., Inc.*, 465 U.S. 822, 830 n.7 (1984). And, in *Your Home*, this Court recognized the Secretary's authority to determine the bounds of the Board's jurisdiction. See 525 U.S. at 453 (deferring to Secretary's interpretation that a "final determination" subject to review by the Board under Section 1395*oo*(a)(1)(A)(i) did not include an intermediary's refusal to reopen a prior determination); cf. *Salfi*, 422 U.S. at 764, 766-767 (holding that Secretary had authority to "determin[e] in particular cases that full exhaustion of internal review procedures is not necessary for a decision to be [a] 'final' [decision] within the language of [Section] 405(g)," a requirement "central to the requisite grant of subject-matter jurisdiction").

Indeed, the regulations providing for reopening of closed payment determinations—a procedure not provided for in the Medicare Act at all, see *Your Home*, 525 U.S. at 454—are a prime example of the Secretary's authority to confer (and divest) the Board of jurisdiction over particular appeals. See 42 C.F.R. 405.1885(a). In *Your Home*, the Court deferred to the Secretary and held that the Board lacks jurisdiction to review a fiscal intermediary's refusal to reopen a final determination. The parties disputed whether the Secretary had clearly divested the Board of jurisdiction, but the Court found the answer to that question immaterial because the provider "would still have to establish that the Board's appellate jurisdiction is somewhere *conferred*." 525 U.S. at 453. To answer that question, the Court looked first to the Secretary's regulations, and second to the Medicare Act. *Ibid.* One regulation, the Court explained,

granted the Board jurisdiction over an "intermediary's affirmative decision to reopen and revise" a final determination, but it said "nothing about appeal of a refusal to reopen." *Ibid.* (citing 42 C.F.R. 405.1889 (1999)). Implicit in the Court's reasoning is the understanding that the regulations *could* have conferred jurisdiction on the Board to review an intermediary's refusal to reopen. If the Secretary could amend the reopening regulations to grant providers a right to an administrative appeal in those circumstances (*i.e.*, to challenge an intermediary's refusal to reopen after expiration of the 180-day period for requesting a Board hearing), it is difficult to understand why the Secretary cannot afford providers a limited opportunity to seek an extension of the 180-day appeal deadline from the Board directly.

To be sure, the Secretary's discretion to construe and implement the jurisdictional requirements in Section 1395*oo*(a), including the 180-day time limit, is not boundless. Cf. *United States* v. *Locke*, 471 U.S. 84, 102 n.14 (1985) (noting, without deciding, that an agency may have been "well within its authority to promulgate regulations construing" a "December 30" deadline as allowing "December 31 filings"). But the Secretary's carefully circumscribed and rarely applied good-cause regulation hardly upsets Congress's clear intent to limit the Board's authority to timely filed claims.

3. Amicus contends (Br. 42-47) that HHS has not adopted a consistent position on the jurisdictional status of Section 1395*oo*(a)(3). But as this Court has recognized, the word "jurisdiction" has often been used to convey "many, too many, meanings." *Steel Co.* v. *Citizens for a Better Env't*, 523 U.S. 83, 90 (1998) (citation omitted). Properly understood, the good-cause regula-

tion is entirely consistent with HHS's statements regarding the jurisdictional nature of Section 1395*oo*(a)(3).

As amicus explains (Br. 43-44), the Board's general practice (evidenced by this case, Pet. App. 55a) is to dismiss untimely requests for a hearing, or requests that fail to satisfy other Section 1395*oo*(a) prerequisites, for want of "jurisdiction." Similarly, the Administrator's practice is to affirm such "jurisdictional" dismissals or to vacate in cases where the Board lacked "jurisdiction." When relevant, however, both the Board and the Administrator have explained that the Board's adjudicative authority (*i.e.*, its "jurisdiction") is defined by Section 1395*oo*(a) *and* by the Secretary's regulations. In this case, for example, the Board explained that its adjudicatory authority is limited to the "powers granted to it by statute and regulation." Pet. App. 55a; see also, *e.g.*, *Medical Coll. of Ga. Hosp.*, 2010 WL 4214222, at *3 (PRRB); *SKI Group*, 2009 WL 981317, at *4 (PRRB); *QRS 96 DSH MediKan Days Grp.*, 2007 WL 1804053, at *5 & n.9 (CMS Adm'r May 25, 2007); *Sacred Heart Med. Ctr.*, 1998 WL 1064771, at *2 & n.5 (HCFA Adm'r Dec. 21, 1998).[20]

Amicus also relies (Br. 45) on the 2008 amendments to the regulations that now refer specifically to the timely filing requirement under the heading "Board

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[20] The Board has, at times, cited to *Alacare Home Health Services* v. *Sullivan*, 891 F.2d 850, 855-856 (11th Cir. 1990), and *St. Joseph's Hospital* v. *Heckler*, 786 F.2d 848, 852-853 (8th Cir. 1986), when denominating the Section 1395*oo*(a)(3) requirement as "jurisdictional." *E.g.*, *SKI Group*, 2009 WL 981317, at *5-*6 & n.11 (citing decisions favorably but noting that the courts had held the Secretary's good-cause regulation invalid). Both cases held that Section 1395*oo*(a)(3) is "jurisdictional" in nature and admits of no exceptions, and on that basis declared invalid the Secretary's regulation permitting extension of the 180-day period for "good cause."

jurisdiction." See 42 C.F.R. 405.1840(a)(2) (2011); cf. 42 C.F.R. 405.1873 (pre-2008 regulation addressing "Board jurisdiction" without specific mention of 180-day filing deadline). That regulation provides that "[t]he Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy has been met)." 42 C.F.R. 405.1840(a)(2) (2011). But the parenthetical's reference to whether a request for a hearing was "timely" obviously encompasses the provision elsewhere in the regulations governing Board hearings that permit an extension beyond 180 days in narrow circumstances.[21]

* * * * *

In the end, however, the Secretary and the Court-appointed amicus agree on the most fundamental point: the 180-day administrative appeal deadline is not subject to judicially imposed equitable tolling, and the court of appeals' decision should be reversed.

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[21] The same parenthetical is included in 42 C.F.R. 405.1814 (2011), which requires an "intermediary hearing officer[]" to make a similar determination as to "its jurisdiction." 73 Fed. Reg. at 30,207 (explaining that the parenthetical was added to both sections to add "clarity"). That is significant because an intermediary hearing officer's "jurisdiction" is entirely the product of regulation, not statute. Referring to the Board's "jurisdiction" in the same terms as the intermediary hearing officer's "jurisdiction" is consistent with HHS's understanding of its authority.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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APPENDIX A

1. 42 U.S.C. 405(a) provides:

Evidence, procedure, and certification for payments

(a) Rules and regulations; procedures

The Commissioner of Social Security shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

2. 42 U.S.C. 405(g) provides in pertinent part:

Evidence, procedure, and certification for payments

(g) Judicial review

Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. * * *

3. 42 U.S.C. 1302(a) provides:

Rules and regulations; impact analyses of Medicare and Medicaid rules and regulations on small rural hospitals

(a) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter.

4. 42 U.S.C. 1395x(v)(1)(A) provides:

Definitions

For purposes of this subchapter—

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the

amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) 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.

5. 42 U.S.C. 1395hh(a)(1) provides:

Regulations

(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

6. 42 U.S.C. 1395ii provides:

Application of certain provisions of subchapter II

The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k), and *(l)* of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

7. 42 U.S.C. 1395*oo* provides:

Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

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

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

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

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

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

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

(b) Appeals by groups

The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) Decisions of Board

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

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II of this chapter.

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

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secre-

tary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) of this section or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5 governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) "Provider of services" defined

In this section, the term "provider of services" includes a rural health clinic and a Federally qualified health center.

8. 42 U.S.C. 1395ww(d)(5) provides in pertinent part:

Payments to hospitals for inpatient hospital services

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

* * * * *

(F)(i) For discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

* * * * *

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a

disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to

supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

* * * * *

9. 20 C.F.R. 405.492(a) (1973) provides:

Right to hearing on a notice of program reimbursement determination.

(a) A provider who has been furnished a notice of amount of program reimbursement may request an intermediary hearing if (1) he is dissatisfied with the intermediary's determination contained in such notice and (2) the amount of program reimbursement in issue is $1,000 or more. Such request must be in writing and be filed with the intermediary within 60 calendar days after the date of the notice of program reimbursement.

10. 20 C.F.R. 405.493 (1973) provides:

Failure to timely request a hearing on a notice of program reimbursement determination.

Where a provider requests a hearing on a notice of amount of program reimbursement determination after the time limit prescribed in § 405.492(a), the designated individual(s) of the intermediary responsible for the hearing procedure shall dismiss the request and furnish the provider a written notice which explains the time limitation, except that for good cause shown the time limit prescribed in § 405.492(a) may be extended. However, no such extension shall be granted if such request is filed more than 3 years after the date of the notice of program reimbursement.

11. 42 C.F.R. 405.1801(b)(1) (2007) provides:

Introduction.

* * * * *

(b) *General rule—(1) Providers.* The principles of reimbursement for determining reasonable cost and prospective payment are contained in parts 413 and 412, respectively, of this chapter. In order to be reimbursed for covered services furnished to Medicare beneficiaries, providers of services are obliged to file cost reports with their intermediaries as specified in § 413.24(f) of this chapter. Where the term "provider" appears in this subpart, it includes hospitals paid under the prospective payment system for purposes of applying the appeal procedures described in this subpart to those hospitals.

12. 42 C.F.R. 405.1803 (2007) provides:

Intermediary determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the intermediary's determination of total program reimbursement due the provider on the ba-

sis of reasonable cost for the reporting period covered by the cost report or amended cost report; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

(2) *Prospective payment.* With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (see part 412 of this chapter), the intermediary must include in the notice its determination of the total amount of the payments due the hospital under that system for the cost reporting period covered by the notice. The notice must explain (with appropriate use of the applicable money amounts) any difference in the amount determined to be due, and the amounts received by the hospital during the cost reporting period covered by the notice.

(b) *Requirements for intermediary notices.* The intermediary must include in each notice appropriate references to law, regulations, CMS Rulings, or program instructions to explain why the intermediary's determination of the amount of program reimbursement for the period differs from the amount the provider claimed. The notice must also inform the provider of its right to an intermediary or Board hearing (see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of the notice.

(c) *Use of notice as basis for recoupment of overpayments.* The intermediary's determination contained in its notice is the basis for making the retroactive adjustment (required by § 413.64(f) of this chapter) to any program payments made to the provider during the period to which the determination applies, including re-

coupment under § 405.373 from ongoing payments to the provider of any overpayments to the provider identified in the determination. Recoupment is made notwithstanding any request for hearing on the determination the provider may make under § 405.1811 or § 405.1835.

13. 42 C.F.R. 405.1805 (2007) provides:

Parties to intermediary determination.

The parties to the intermediary's determination are the provider and any other entity found by the intermediary to be a related organization of the provider under § 413.17 of this chapter.

14. 42 C.F.R. 405.1813 (2007) provides:

Failure to timely request an intermediary hearing.

If a provider requests an intermediary hearing on an intermediary's determination after the time limit prescribed in § 405.1811, the designated intermediary hearing officer or panel of hearing officers will dismiss the request and furnish the provider a written notice that explains the time limitation, except that for good cause shown, the time limit prescribed in § 405.1811 may be extended. However, an extension may not be granted if the extension request is filed more than 3 years after the date of the original notice of the intermediary determination.

15. 42 C.F.R. 405.1835 (2007) provides:

Right to Board hearing.

(a) *Criteria.* The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if:

(1) An intermediary determination has been made with respect to the provider; and

(2) The provider has filed a written request for a hearing before the Board under the provisions described in § 405.1841(a)(1); and

(3) The amount in controversy (as determined in § 405.1839(a)) is $10,000 or more.

(b) *Prospective payment exceptions.* Except with respect to matters for which administrative or judicial review is not permitted as specified in § 405.1804, hospitals that are paid under the prospective payment system are entitled to hearings before the Board under this section if they otherwise meet the criteria described in paragraph (a) of this section.

(c) *Right to hearing based on late intermediary determination about reasonable cost.* Notwithstanding the provisions of paragraph (a)(1) of this section, the provider also has a right to a hearing before the Board if an intermediary's determination concerning the amount of reasonable cost reimbursement due a provider is not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report or amended cost report (as permitted or as required to furnish sufficient data for purposes of making such determination—

see § 405.1803(a)) provided such delay was not occasioned by the fault of the provider.

16. 42 C.F.R. 405.1836 (2011) provides:

Good cause extension of time limit for requesting a Board hearing.

(a) A request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in § 405.1835(a)(3) of this subpart must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.

(b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).

(c) The Board may not grant a request for an extension under this section if—

(1) The provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request; or

(2) The date of receipt by the Board of the provider's extension request is later than 3 years after the date of the intermediary or other determination that the provider seeks to appeal.

(d) If an extension request is granted or denied under this section, the Board must give prompt written notice to the provider, and mail a copy of the notice to each party to the appeal. The notice must include a detailed explanation of the reasons for the decision by the Board and the facts underlying the decision.

(e)(1) If the Board denies an extension request and determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a Board dismissal decision dismissing the appeal for lack of Board jurisdiction. This decision by the Board must be in writing and include the explanation of the extension request denial required under paragraph (d) of this section, in addition to specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal (as described in § 405.1840(c) of this subpart). A copy of the Board's dismissal decision must be mailed promptly to each party to the appeal (as described in § 405.1843 of this subpart).

(2) A Board dismissal decision under paragraph (e)(1) of this section is final and binding on the parties, unless the decision is reversed, affirmed, modified, or remanded by the Administrator under § 405.1875(a)(2)(ii) and § 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision.

(i) This Board decision is inoperative during the 60-day period for review of the decision by the Administra-

tor, or in the event the Administrator reverses, affirms, modifies, or remands that decision, within the period.

(ii) A Board decision under paragraph (e)(1) of this section that is otherwise final and binding may be reopened and revised by the Board in accordance with § 405.1885 through § 405.1889 of this subpart.

(3) The Administrator may review a Board decision granting an extension request solely during the course of an Administrator review of one of the Board decisions specified as final, or deemed final by the Administrator, under § 405.1875(a)(2) of this subpart.

(4) A finding by the Board or the Administrator that the provider did or did not demonstrate good cause for extending the time for requesting a Board hearing is not subject to judicial review.

17. 42 C.F.R. 405.1837 (2007) provides:

Group appeal.

(a) *Criteria for group appeals.* Subject to paragraph (b) of this section, a group of providers may bring an appeal before the Board but only if—

(1) Each provider in the group is identified as one which would, upon the filing of a request for a hearing before the Board, but without regard to the $10,000 amount in controversy requirement, be entitled to a hearing under § 405.1835;

(2) The matters at issue involve a common question of fact or of interpretation of law, regulations or CMS Rulings; and

(3) The amount in controversy is, in the aggregate, $50,000 or more.

(b) *Providers under common ownership or control.* Effective April 20, 1983, any appeal filed by providers that are under common ownership or control must be brought by the providers as a group appeal in accordance with the provisions of paragraph (a) of this section with respect to any matters involving an issue common to the providers and for which the amount in controversy is, in the aggregate, $50,000 or more (see § 405.1841(a)(2)). A single provider involved in a group appeal that also wishes to appeal issues that are not common to the other providers in the group must file a separate hearing request (see § 405.1841(a)(1)) and must separately meet the requirements in § 405.1811 or § 405.1835, as applicable.

18. 42 C.F.R. 405.1839 (2007) provides:

Amount in controversy.

(a) *Single appeals.* The $1,000 amount in controversy required under § 405.1809 for an intermediary hearing and the $10,000 amount in controversy required under § 405.1835 for a Board hearing is, as applicable to the matters for which the provider has requested a hearing, the combined total of the amounts computed as follows:

(1) *Providers under prospective payment.* For providers that are paid under the prospective payment system, by deducting—

(i) The total of the payment due the provider on other than a reasonable cost basis under the prospective

payment system from the total amount that would be payable after a recomputation that takes into account any exclusion, exception, adjustment, or additional payment denied the provider under part 412 of this chapter, as applicable;

(ii) The total of the payment due the provider on a reasonable cost basis under the prospective payment system from the total reimbursable costs claimed by the provider; and

(iii) The adjusted total reimbursable costs due the provider on a reasonable cost basis under other than the prospective payment system from the total reimbursable costs claimed by the provider.

(2) *Providers not under prospective payment.* For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due the provider on a reasonable cost basis from the total reimbursable costs claimed by the provider.

(b) *Group appeals.* The $50,000 amount in controversy required under § 405.1837 for group appeals to the Board is, as applicable to the common matters for which the group of providers have requested a hearing, the combined total of the amounts computed as follows:

(1) *Providers under prospective payment.* For providers that are paid under the prospective payment system, by deducting—

(i) The total of the payment due the providers (in the aggregate) on other than a reasonable cost basis under the prospective payment system from the total amount that would be payable to the providers (in the aggregate) after a recomputation that takes into account

any applicable exception, exclusion, adjustment, or additional payment denied the providers under part 412 of this chapter.

(ii) The total of the payment due the providers (in the aggregate) on a reasonable cost basis under the prospective payment system from the total reimbursable costs claimed in the aggregate by the providers; and

(iii) The adjusted total reimbursable costs due the providers (in the aggregate) on a reasonable cost basis under other than the prospective payment system from the total reimbursable costs claimed in the aggregate by the providers.

(2) *Providers not under prospective payment.* For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due the providers (in the aggregate) on a reasonable cost basis from the total reimbursable costs claimed in the aggregate by the providers.

19. 42 C.F.R. 405.1841 (2007) provides:

Time, place, form, and content of request for Board hearing.

(a) *General requirements.* (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the pro-

vider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

(2) Effective April 20, 1983, any request for a Board hearing by providers that are under common ownership or control (see § 413.17 of this chapter) must be brought by the providers as a group appeal (see § 405.1837(b)) with respect to any matters at issue involving a question of fact or of interpretation of law, regulations, or CMS Rulings common to the providers and for which the amount in controversy is $50,000 or more in the aggregate. If a group appeal is filed, the provider seeking the appeal must be separately identified in the request for hearing, which must be prepared and filed consistently with the requirements of paragraph (a)(1) of this section.

(b) *Extension of time limit for good cause.* A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

20. 42 C.F.R. 405.1843 (2007) provides:

Parties to Board hearing.

(a) The parties to the Board hearing shall be the provider, the intermediary (including the Centers for Medicare & Medicaid Services when acting directly as intermediary) that rendered the determination being appealed (see § 405.1833), and any other entity found by the intermediary to be a related organization of such provider.

(b) Except as provided in paragraph (a), neither the Secretary nor the Centers for Medicare & Medicaid Services may be made a party to the hearing. However, the Board may call as a witness any employee or officer of the Department of Health and Human Services having personal knowledge of the facts and the issues in controversy in a hearing pending before the Board and may call as a consultant to the Board in connection with any such hearing any individual designated by the Secretary for such purpose. (See § 405.1863.)

21. 42 C.F.R. 405.1867 (2007) provides:

Sources of Board's authority.

In exercising its authority to conduct the hearings described herein, the Board must comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator of the Centers for Medicare & Medicaid Services (see § 401.108 of this subchapter). The Board shall afford great weight to interpretive rules, general statements of policy, and rules

of agency organization, procedure, or practice established by CMS.

22. 42 C.F.R. 405.1869 (2007) provides:

Scope of Board's decisionmaking authority.

The Board shall have the power to affirm, modify, or reverse a determination of an intermediary with respect to a cost report and to make any other modifications on matters covered by such cost report (including modifications adverse to the provider or other parties) even though such matters were not considered in the intermediary's determination. The opinion of the majority of those Board members deciding the case will constitute the Board's decision.

23. 42 C.F.R. 405.1873 (2007) provides:

Board's jurisdiction.

(a) *Board decides jurisdiction.* The Board decides questions relating to its jurisdiction to grant a hearing, including (1) the timeliness of an intermediary determination (see § 405.1835(c)), and (2) the right of a provider to a hearing before the Board when the amount in controversy is in issue (see §§ 405.1835(a)(3) and 405.1837).

(b) *Matters not subject to board review.* (1) The determination of a fiscal intermediary that no payment may be made under title XVIII of the Act for any expenses incurred for items and services furnished to an individual because such items and services are excluded from coverage pursuant to section 1862 of the Act, 42 U.S.C. 1395y (see subpart C of this part), may not be reviewed by the Board. (Such determination shall be re-

viewed only in accordance with the applicable provisions of subpart G or H of this part.)

(2) The Board may not review certain matters affecting payments to hospitals under the prospective payment system as provided in § 405.1804.

24. 42 C.F.R. 405.1885 (2007) provides:

Reopening a determination or decision.

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

(b)(1) An intermediary determination or an intermediary hearing decision must be reopened and revised by the intermediary if, within the 3-year period specified in paragraph (a) of this section, CMS—

(i) Provides notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary; and

(ii) Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision.

(2) A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.

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

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

(ii) A final nonappealable court judgment; or

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

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

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

(e) Notwithstanding an intermediary's discretion to reopen or not reopen an intermediary determination or an intermediary hearing decision under paragraphs (a) and (c) of this section, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section.

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

25. 42 C.F.R. 412.106(b) (2007) provides:

Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(b) *Determination of a hospital's disproportionate patient percentage—(1) General rule.* A hospital's dis-

proportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A (or Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A (or Medicare Advantage (Part C)).

(3) *First computation: Cost reporting period.* If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

(5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a per-

centage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.

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APPENDIX B[1]

1. *St. Joseph Med. Ctr.* v. *Sebelius*, No. 11-1381 (D.D.C. filed July 27, 2011) (2 providers; 18 cost reporting years (1987-1995)). The case has been stayed pending the outcome of this case. See 5/3/12 Minute Order.[2]

2. *Deaconess Med. Ctr.* v. *Sebelius*, No. 11-1335 (D.D.C. filed July 20, 2011) (2 providers; 13 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 5/3/12 Minute Order.

3. *Carrolton Home Care, Inc.* v. *Sebelius*, No. 10-1697 (D.D.C. filed Oct. 5, 2010) (4 providers; 5 cost reporting years (2006-2008)). The case has been stayed for reasons unrelated to this case. See 4/6/11 Minute Order. [3]

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[1] HHS provided this Office with a list of civil actions by providers challenging the PRRB's refusal to excuse their untimely administrative appeals. Those cases are summarized in this appendix. Each item contains the number of providers and the number of cost reporting years at issue in the case. The number of cost reporting years captures every appeal by a provider for the fiscal years in question. All information in this appendix can be found in documents available at Public Access to Court Electronic Records (PACER).

[2] The cases listed in items 1-2, 5, 7, 9-19 involve suits by providers relying on *Baystate* and invoking equitable tolling to seek recalculation of payment determinations.

[3] The cases listed in items 3-4, 6, and 8 involve challenges by hospice providers to repayment demands that invoke equitable tolling to excuse untimely administrative appeals. With the exception of item 6, all of these cases involve both timely and untimely appeals. The entries in this appendix capture only cost reporting years for the untimely appeals.

4. *Russell-Murray Hospice, Inc.* v. *Sebelius*, No. 10-5326 (D.C. Cir. filed Sept. 30, 2010) (1 provider; 1 cost reporting year (2006)). The appeal has been held in abeyance pending the outcome of this case. See 6/25/12 Clerk's Order.

5. *Bon Secours Health Sys., Inc.* v. *Sebelius*, No. 10-1406 (D.D.C. filed Aug. 20, 2010) (10 providers; 80 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 11/3/10 Order.

6. *Heaven & Earth Hospice, LLC* v. *Sebelius*, No. 10-1166 (D.D.C. filed July 12, 2010) (1 provider; 2 cost reporting years (2006-2007)). The case has been stayed pending the outcome of this case. See 8/29/12 Minute Order.

7. *Forsyth Med. Ctr.* v. *Sebelius*, No. 10-1038 (D.D.C. filed June 17, 2010) (3 providers; 30 cost reporting years (1987-1996)). The case has been stayed pending the outcome of this case. See 8/27/10 Minute Order.

8. *Hospice Advantage* v. *Sebelius*, No. 10-845 (D.D.C. filed May 21, 2010) (1 provider; 1 cost reporting year (2007)). The case has been stayed for reasons unrelated to this case. See 4/6/11 Minute Order.

9. *Alameda County Med. Ctr.* v. *Sebelius*, No. 09-1465 (D.D.C. filed Aug. 4, 2009) (29 providers; approximately 500 cost reporting years (1986-2003)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

10. *Fremont Med. Ctr.* v. *Sebelius*, No. 09-1449 (D.D.C. filed July 31, 2009) (2 providers; 20 cost reporting years (1986-1993, 1996, 1998-1999)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

11. *Haw. Pac. Health* v. *Sebelius*, No. 09-1448 (D.D.C. filed July 31, 2009) (2 providers; 30 cost reporting years (1986-2003)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

12. *Alta Bates Med. Ctr.* v. *Sebelius*, No. 09-1447 (D.D.C. filed July 31, 2009) (25 providers; approximately 300 cost reporting years (1986-2003)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

13. *Daughters of Charity Health Sys.* v. *Sebelius*, No. 09-1446 (D.D.C. filed July 31, 2009) (5 providers; 48 cost reporting years (1986-1993, 2000-2003)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

14. *Regents of Univ. of Cal.* v. *Sebelius*, No. 09-1445 (D.D.C. filed July 31, 2009) (6 providers, 60 cost reporting years (1986-2000)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

15. *Casa Grande Cmty. Hosp.* v. *Sebelius*, No. 09-1443 (D.D.C. filed July 31, 2009) (21 providers; approximately 168 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

16. *Arroyo Grande Cmty. Hosp.* v. *Sebelius*, No. 09-1441 (D.D.C. filed July 31, 2009) (42 providers; approximately 580 cost reporting years (1986-2005)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

17. *Columbia Hosp.* v. *Sebelius*, No. 09-1093 (D.D.C. filed June 15, 2009) (21 providers; approximately 168 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

18. *Valley Presbyterian Hosp.* v. *Sebelius*, No. 09-1034 (D.D.C. filed June 3, 2009) (1 provider; 11 cost reporting years (1987-1997)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.

19. *Aurora Sinai Med. Ctr.* v. *Sebelius*, No. 09-823 (D.D.C. filed May 5, 2009) (14 providers; approximately 112 cost reporting years (1987-1994)). The case has been stayed pending the outcome of this case. See 5/21/10 Minute Order.