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

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

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.

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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St. Joseph's Hosp. v. *Heckler*, 786 F.2d 848 (8th Cir. 1986) 23

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42 U.S.C. 1395ww(d) (2006 & Supp. IV 2010) 2, 19
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49 Fed. Reg. (Sept. 6, 1984):

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p. 35,251 3

69 Fed Reg. 35,725 (June 25, 2004) 25, 29

73 Fed. Reg. (May 23, 2008):

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p. 30,192 . . . . 13, 29

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CMS, *The Provider Reimbursement Manual*, 2011, http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html (last visited Apr. 13, 2012) 29

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HHS, *2011 CMS Statistics*, June 2011, https://www.cms. gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html (last visited Apr. 13, 2012) 22, 29

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PETITION FOR A WRIT OF CERTIORARI

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

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-10a) is reported at 642 F.3d 1145. The amended opinion of the district court (App., *infra*, 11a-50a) is reported at 686 F. Supp. 2d 55. The decision of the Provider Reimbursement Review Board (App., *infra*, 51a-56a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 24, 2011. Petitions for rehearing were denied on December 20, 2011 (App., *infra*, 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. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant statutory and regulatory provisions are reproduced in the appendix to this petition. App., *infra*, 67a-83a.

STATEMENT

1. The Medicare program, established by Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.* (Medicare statute), pays for certain medical services provided to elderly and disabled patients entitled to benefits under the program. Under the Prospective Payment System (PPS) for reimbursement of providers under Part A of Medicare, hospitals providing inpatient Medicare services are paid prospectively at a fixed amount for each patient discharged, regardless of actual costs incurred. 42 U.S.C. 1395ww(d) (2006 & Supp. IV 2010). Hospitals 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 C.F.R. 405.1801(b)(1), 413.24(f) (2011). The intermediary determines the total payment (including any hospital-specific adjustments) 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 (2011).

If a provider is dissatisfied with its NPR and meets the amount-in-controversy requirement, it may appeal to the Provider Reimbursement Review Board (PRRB or Board) "if * * * [it] files a request for a hearing within 180 days after notice of the intermediary's final determination." 42 U.S.C. 1395*oo*(a)(3). The Board is composed of five members "knowledgeable in the field of payment of providers of services" and appointed by the Secretary of Health and Human Services (Secretary), 42 U.S.C. 1395*oo*(a) and (h), and it has the authority to affirm, modify, or reverse the final determination of the intermediary, 42 U.S.C. 1395*oo*(d). The decision of the Board is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. 42 U.S.C. 1395*oo*(f)(1).[1] A provider may seek judicial review of "any final decision of the Board" by filing suit in federal district court within 60 days. *Ibid.*

HHS regulations provide the Board with limited discretion to extend the time limit for filing an appeal of the intermediary's final determination, but only in circumscribed instances in which "good cause [is] shown," and the request is filed within three years after issuance of the NPR. 42 C.F.R. 405.1841(b) (2007).[2] Specifically,

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[1] The Secretary's review authority has been delegated to the Administrator of the Centers for Medicare & Medicaid Services (CMS), 49 Fed. Reg. 35,248 (Sept. 6, 1984), and may be redelegated to the Deputy Administrator of CMS, *id.* at 35,251.

[2] Unless otherwise indicated, all references to Title 42, C.F.R., are to the 2007 version. Subsequent amendments apply only to administrative "appeals pending as of, or filed on or after, August 21, 2008," see 73

during the relevant time period, HHS regulations provided that "[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.*[3]

Apart from the administrative appeal process, a provider may also obtain administrative relief from an intermediary's final reimbursement determination by requesting that the intermediary "reopen" its determination. See 42 C.F.R. 405.1885(a). Such a request, however, "must be made within 3 years of the date of the notice of the intermediary" determination, and "[n]o such determination * * * may be reopened after such

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Fed. Reg. 30,190 (May 23, 2008), and, accordingly, do not directly apply to this case. See App., *infra*, 15a n.3.

[3] The "good cause" regulation was subsequently amended and is now codified at 42 C.F.R. 405.1836 (2011). As amended, "[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, 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." 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).

3-year period" absent a specified exception. *Ibid.*[4] An intermediary'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) (*Your Home*).

2. This case arises against the background of litigation brought by Baystate Medical Center (Baystate), which is not a party to this action. See *Baystate Med. Ctr.* v. *Leavitt*, 545 F. Supp. 2d 20, amended in part, 587 F. Supp. 2d 37 (D.D.C. 2008) (*Baystate*). Like *Baystate*, this case involves an adjustment to the Medicare payment that 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 amounts of any adjustment depend on the hospital's "disproportionate patient percentage." 42 U.S.C. 1395ww(d)(5)(F)(v). As defined by statute, the "disproportionate patient percentage" consists of two components, commonly known as the "Medicare/SSI fraction" and the "Medicaid fraction." See 42 U.S.C. 1395ww(d)(5)(F)(vi). The numerator of the Medicare/SSI fraction, which is at issue here, "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 [Medicare Part A]" and who were also entitled to Supplemental Security Income (SSI) benefits; the denominator consists of the number

[4] One exception 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).

of patient days which were made up of patients who (for such days) were entitled to Medicare Part A benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I); cf. 42 U.S.C. 1381 *et seq.* (establishing national program to provide SSI benefits to aged, blind, or disabled individuals whose income falls below a certain level); *Sullivan* v. *Zebley*, 493 U.S. 521, 524 (1990). The Centers for Medicare & Medicaid Services (CMS) determines the Medicare/SSI fraction for each hospital and provides that information to the responsible intermediary. 42 C.F.R. 412.106(b). The intermediary then determines the total payment amount a hospital is due (including any DSH adjustment) and issues an NPR.

Each of the respondent hospitals received an NPR, which included its DSH adjustment determination, for fiscal years 1987 through 1994. Respondents did not appeal those determinations to the Board within 180 days as required by statute. See 42 U.S.C. 1395*oo*(a)(3); App., *infra*, 17a. Nor did they seek discretionary relief from 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 App., *infra*, 18a, 29a & n.9, 45a, 52a, 55a. By contrast, Baystate did timely appeal its DSH adjustment determinations for fiscal years 1993 through 1996, and the Board found that certain errors in CMS' calculation of the Medicare/SSI fraction "tended to deflate the overall DSH payment." *Id.* at 17a-18a.

In September 2006, several 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 for fiscal years 1987 through 1994, to the Board. App., *infra*, 2a, 18a. Respondents

acknowledged that their appeals to the Board were untimely, but urged that equitable tolling is 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 authority to decide them. Relying in part on its earlier decision in *Anaheim Memorial Hospital* v. *Blue Cross & Blue Shield Ass'n*, Nos. 93-1920 and 94-0007, 2000 WL 1146514 (July 3, 2000), the Board held that it could not grant "equitable relief" such as "equitable tolling." App., *infra*, 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 declined to review the Board's decision. *Id.* at 57a-60a.

3. Respondents then filed this action in the District Court for the District of Columbia arguing, among other things, that the Board should have equitably tolled the 180-day time limit. The district court granted the government's motion to dismiss. App., *infra*, 11a-50a.

As relevant here, the district court held that the Medicare statute does not authorize equitable tolling of the 180-day administrative appeal period. The court explained that the presumption in favor of equitable tolling recognized in *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89, 95-96 (1990), does not apply to the Medicare limitations period because no sufficiently

"similar" private suit had been identified and "the programmatic reimbursement at issue is not familiar to private litigation." App., *infra*, 32a. "Based on the statutory language, the regulations granting only limited exceptions to the 180-day limitations period, and the Supreme Court's determination in *Your Home* that the 180-day limit may not be circumvented by expanding Board (and hence, district court) jurisdiction to review requests to reopen," the court concluded that "equitable tolling of the 180-day limitations period is not available under 42 U.S.C. § 1395*oo*." *Id.* at 38a-39a. That conclusion, the court explained, was "buttressed by the scope and complexity of the Medicare program." *Id.* at 40a.

4. The court of appeals reversed. App., *infra*, 1a-10a. Concluding that the 180-day period for requesting a hearing is subject to equitable tolling, the court of appeals remanded to the district court for "further factual development" to determine whether tolling is "appropriate" in this case. *Id.* at 10a.[5]

The court of appeals applied a presumption in favor of equitable tolling based, in part, on its conclusion that a claim for Medicare payment is "'familiar to private litigation' because it is analogous to a contract claim." App., *infra*, 5a-6a & n.1. The court then concluded that the presumption had not been rebutted because, in the court's view, the statutory language imposing the time limit for appeal of Medicare payment determinations is "fairly simple," there are no statutory exceptions, and the timing provision is not itself complex. *Id.* at 9a-10a. The court recognized that there is a "good cause" excep-

[5] Although the court of appeals remanded to the district court, we assume (consistent with ordinary principles of administrative law) that the court intended the district court to first remand to the Board for any "further factual development."

tion provided under the Secretary's regulations, but it concluded that such regulatory exceptions are immaterial to the equitable tolling inquiry and, in any event, not sufficiently technical to rebut the presumption. *Id.* at 9a. The court also concluded that, although the Medicare statute "is quite complex," it is nevertheless "amenable to tolling" because "its timing scheme is straightforward." *Id.* at 10a.

REASONS FOR GRANTING THE PETITION

The court of appeals has held that the 180-day statutory time limit for a provider to file an administrative appeal with the PRRB from a final payment determination by a fiscal intermediary is subject to equitable tolling. That decision is wrong; it is unprecedented in the nearly 40-year existence of the Board; it cannot be reconciled with decisions of other courts of appeals; and it is in considerable tension with this Court's decision in *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, 525 U.S. 449 (1999). If allowed to stand, the decision would impose a substantial administrative and financial burden on the Medicare program.

At the outset, the presumption in favor of judicially fashioned principles of equitable tolling of limitations periods for filing a suit in court is inapplicable in the quite distinct context of administrative proceedings for adjudicating claims before a tribunal like the PRRB. The exceedingly complex substantive and procedural framework for resolving Medicare payment claims through an administrative process has no analogue in the filing of a private suit in court, and it is not traditionally governed by general equitable principles that go beyond the specific terms and limitations in the Medicare statute and implementing regulations. Moreover,

the mandatory administrative appeal process was enacted by Congress long before this Court applied any presumption in favor of the availability of equitable tolling even in suits against the United States in court.

Assuming arguendo, however, that a presumption in favor of equitable tolling not provided for by statute or regulation is appropriate, any such presumption is rebutted here. Congress affords Medicare providers a right to appeal the intermediary's final determination to the PRRB, but only "if," among other things, the appeal is filed within 180 days of issuance of the NPR. The statutory language on its face provides no basis for judicially fashioned exceptions. "[T]he tens of thousands of sophisticated Medicare-provider recipients of these NPRs [are] generally capable of identifying an underpayment in [their] own NPR[s] within the 180-day time period specified in 42 U.S.C. § 1395*oo*(a)(3)." *Your Home*, 525 U.S. at 455-456. And the Secretary, who is charged with administering the Medicare program has, as a matter of "grace," *id.* at 454, prescribed only two circumscribed exceptions to that limitation—neither of which is applicable here. See 42 C.F.R. 405.1841(b), 405.1885(a). The court of appeals' imposition of an open-ended equitable tolling regime on top of this carefully crafted procedural framework established by the Medicare statute and regulations is contrary to basic principles of judicial review of agency action under this Court's decision in *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519 (1978) (*Vermont Yankee*).

The court of appeals' decision also cannot be reconciled with decisions in the Eighth and Eleventh Circuits, and with this Court's understanding of the Medicare reimbursement regime in *Your Home*. If allowed to stand, the decision would impose a considerable adminis-

trative burden on HHS and would expose the Medicare Trust Fund to substantial and unpredictable liabilities for past cost years that have long since been closed.

Because all Medicare providers may seek judicial review of any final decision of the Board in the District Court for the District of Columbia, the D.C. Circuit's decision in this case, unless reversed by this Court, can be expected to have a broad effect on the nationwide administration of the Medicare program going forward. Review by this Court is warranted.

A. The 180-Day Administrative Appeal Period Is Not Subject To Equitable Tolling

The court of appeals erred by holding that the Medicare statute requires the 180-day period for requesting an administrative appeal to be subject to general principles of equitable tolling, even where the Secretary has not so provided. That holding cannot be squared with this Court's decisions concerning judicial review of agency action, with the factors for determining when equitable tolling is available, with the Medicare provider payment scheme, or with the considered judgment of the expert agency charged with administering the Medicare program.

1. In *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89 (1990), this Court held 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. The court of appeals held that such a presumption is applicable to the time limit in 42 U.S.C. 1395*oo*(a)(3) because a provider's Medicare claim for additional payment is "analogous to a contract claim." App., *infra*, 6a n.1. That conclusion is fundamentally mistaken.

a. As an initial matter, the presumption in favor of judicially fashioned principles of equitable tolling of limitations periods for filing a suit in court is inapplicable in the quite distinct context of a statutory and regulatory framework for adjudicating claims before an administrative tribunal such as the PRRB. When a statutory provision like 42 U.S.C. 1395*oo*(a)(3) speaks to substantive or procedural matters to be resolved by an administrative agency, the interpretation and implementation of that provision are presumptively entrusted to that agency in the first instance, not to the courts. Here, the statutory and regulatory review scheme limits the Board's authority to hear appeals from final determinations of the fiscal intermediary to those appeals filed within 180 days of the NPR, or three years from that date if the provider is able to demonstrate "good cause." See 42 U.S.C. 1395*oo*(a)(3); 42 C.F.R. 405.1841(b); App., *infra*, 55a-56a. That carefully calibrated administrative appeal process should not be set aside (or modified by court-imposed equitable principles) unless a court concludes that the limits imposed by the Secretary on any extension of the 180-day deadline are arbitrary and capricious. See *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 418-419 (1993). There is no basis for any such conclusion.

The Medicare statute confers broad authority on the Secretary to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs" under the statute. 42 U.S.C. 1395hh(a)(1); accord 42 U.S.C. 405(a), 1302(a). The Secretary's rulemaking authority encompasses the authority to prescribe regulations governing the timeliness of provider appeals to the Board. See 73 Fed. Reg. 30,206 (May 23, 2008); cf. *Weinberger* v. *Salfi*, 422 U.S. 749, 766 (1975)

(noting Secretary's rulemaking authority to define agency's "final decision" triggering right of judicial review under 42 U.S.C. 405(g)).[6]

In 1974 and 2008, the Secretary engaged in notice-and-comment rulemaking implementing the statutory administrative review provisions, including the 180-day appeal deadline. See 39 Fed. Reg. 34,517 (Sept. 26, 1974); 73 Fed. Reg. at 30,191 (discussing history of regulations). As the Secretary explained in the preamble to the 2008 revisions to the "good cause" regulation, the agency's "longstanding policy has permitted extensions of the timeframe for requesting hearings only in limited circumstances." *Id.* at 30,206.[7] Through those regulations, the Secretary has consistently prohibited the Board from entertaining an untimely appeal *unless* (1) the provider demonstrates "good cause," and (2) the request is made no more than three years after the NPR. See 39 Fed. Reg. at 34,517. The limitation on that narrow exception to the 180-day appeal period 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*

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[6] Although Congress has amended 42 U.S.C. 1395*oo* several times since 1974, see, *e.g.*, Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, Tit. IX, § 955, 94 Stat. 2647, it has never altered the 180-day administrative appeal period or the Secretary's rulemaking authority, nor has it overridden the Secretary's three-year outer time limit on the "good cause" exception.

[7] The amendments to the regulations, see notes 2-3, *supra*, were designed to "lead to a more effective and efficient appeal process," and to reduce the "huge backlog of cases before the Board." 73 Fed. Reg. at 30,192.

> *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) (emphases added); cf. *Kontrick* v. *Ryan*, 540 U.S. 443, 458 (2004) (relevant question for nonjurisdictional time limit in procedural rule is "whether the time restrictions in th[e] Rules are in such emphatic form as to preclude equitable exceptions") (internal quotation marks omitted; brackets in original).

In *Your Home,* this Court recognized that "[t]he right of a provider to seek reopening exists only by grace of the Secretary, and the statutory purpose of imposing a 180-day limit on the right to seek Board review of NPRs, see 42 U.S.C. § 1395*oo*(a)(3), would be frustrated by permitting requests to reopen to be reviewed indefinitely." 525 U.S. at 454. The same is true of the regulatory "good cause" exception to the 180-day deadline for administrative appeals. That exception exists solely "by grace of the Secretary," and the Secretary reasonably concluded that allowing administrative appeals to be filed in an open-ended manner, more than three years after issuance of an NPR, would frustrate "the statutory purpose of imposing a 180-day limit on the right to seek Board review." *Ibid.*

The "good cause" regulation reflects the Secretary's "belie[f that] it is fair and appropriate that, absent extraordinary circumstances, providers should be expected to file their appeals within the 180-day period," and should not be permitted to "depend on a right to file late if there is a favorable change in the law at some point after the 180-day appeal period." 73 Fed. Reg. at 30,206. The Secretary has broad authority to administer the Medicare program. Her considered judgment as to

whether and when the 180-day administrative appeal deadline should be extended, which was rendered through notice-and-comment rulemaking, is entitled to substantial deference. See *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 21 (2000); see also *Good Samaritan Hosp.*, 508 U.S. at 417-418 (noting that the Court "should be especially reluctant to reject the agency's" interpretation when it "so closely fits the design of the statute as a whole," as well as "its object and policy") (internal quotation marks and citations omitted); *Methodist Hosp.* v. *Shalala*, 38 F.3d 1225, 1235 (D.C. Cir. 1994) (upholding as reasonable Secretary's decision "that the interests in finality and administrative efficiency outweighed the value of increased accuracy"). By engrafting a judge-made equitable tolling requirement onto the 180-day administrative appeal period, the court of appeals has effectively created a "good cause" exception of its own without any temporal limit and governed by judicially fashioned equitable tolling principles, rather than the standards in the Secretary's "good cause" regulation. The court of appeals' decision thus is contrary to "the very basic tenet of administrative law that agencies should be free to fashion their own rules of procedure." *Vermont Yankee*, 435 U.S. at 543-544.[8]

[8] In *Zipes* v. *TWA, Inc.*, 455 U.S. 385 (1982), the Court concluded that the statutory time limit for filing charges with the Equal Employment Opportunity Commission (EEOC) under Title VII of the Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 253, was not a "jurisdictional prerequisite to suit" in district court, but rather was subject to equitable doctrines such as waiver, estoppel, and tolling. 455 U.S. at 393. The Court found that such equitable principles were consistent with the statutory scheme, wherein "laymen, unassisted by trained lawyers, initiate the process." *Id.* at 397. The EEOC (and the United States) argued in favor of equitable modification of the charge-filing period, and did not suggest that the EEOC lacked authority to apply

b. Even if the factors considered by the Court in cases concerning equitable tolling of limitations periods for judicial actions did have some application here, a presumption in favor of equitable tolling would be inappropriate.

Although a "precise private analogue" is not required in order to invoke the *Irwin* presumption, *Scarborough* v. *Principi*, 541 U.S. 401, 422 (2004), the court of appeals erred in holding that a Medicare provider's administrative appeal seeking payment is sufficiently analogous to a private contract action to trigger a presumption in favor of equitable tolling. Medicare provider payments depend on the statute and regulations, not on independent contractual terms. 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).

But even if respondents' Medicare reimbursement claims were deemed similar in some respects to a private suit in court for breach of contract, any presumption in favor of equitable tolling would nonetheless be misplaced in this context. In *Holland* v. *Florida*, 130 S.

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equitable tolling. See Gov't Amici Br., *Zipes*, *supra* (Nos. 78-1545 and 80-951). By contrast, the considered judgment of the agency charged with administering the Medicare program is that judicially (or Board) fashioned equitable tolling is incompatible with the statutory and regulatory scheme. And, again in contrast to *Zipes*, the reimbursement system under the Medicare Part A program applies to sophisticated providers which *are* assisted by "trained lawyers," and thus presents no such justification for a court to impose a doctrine of equitable tolling on the program and the Board that decides administrative appeals under it.

Ct. 2549 (2010), which involved the statute of limitations for filing habeas corpus petitions, this Court explained that the presumption in favor 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 (AEDPA)] after the Court decided *Irwin* and therefore was likely aware that courts, when interpreting AEDPA's timing provisions, would apply the presumption." *Id.* at 2560-2561 (internal quotation marks and citations omitted). Similarly, in *Young* v. *United States*, 535 U.S. 43 (2002), which involved the "three-year lookback period" in the Bankruptcy Code, 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 equity jurisprudence." *Id.* at 50 (internal quotation marks and citations omitted; brackets omitted).

Neither factor is present here. 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 appeal process. Cf. *United States* v. *Brockamp*, 519 U.S. 347, 352 (1997) (noting that tax law "is not normally characterized by case-specific exceptions reflecting individualized equities"). The Board has thus concluded that it has no residual equitable powers with respect to the 180-day deadline unless provided by the Medicare statute or an implementing regulation. See App., *infra*, 55a-56a; *Anaheim Mem'l Hosp.* v. *Blue Cross & Blue*

Shield Ass'n, No. 93-1920 and 94-0007, 2000 WL 1146514 (P.R.R.B. July 3, 2000) (*Anaheim*). And the 180-day administrative appeal period was first enacted in 1972, Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1420—many 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 statute's administrative-appeal "timing provisions, would apply the presumption." *Holland*, 130 S. Ct. at 2561.[9]

2. Even if a presumption in favor of equitable tolling were to apply in some way in this very different context, the relevant inquiry under *Irwin* would be whether "there [is] good reason to believe that Congress did *not* want the equitable tolling doctrine to apply." *Brockamp*, 519 U.S. at 350. Here, there is more than ample reason.

a. Section 1395*oo*(a)(3) establishes an administrative appeal deadline in unambiguous terms. A provider may

[9] The Court's decision in *Bowen* v. *City of New York*, 476 U.S. 467 (1986), is readily distinguishable. In that case, the Court 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; cf. *id.* at 482-486 (dispensing with exhaustion requirement for plaintiffs who failed to timely pursue claims before the agency). The Court did not apply any presumption in favor of equitable tolling, but rather focused on whether equitable tolling was "consistent with Congress' intent." *Id.* at 479-480. Because the benefits scheme was "designed to be 'unusually protective' of claimants," *id.* at 480, the Court concluded that equitable tolling was appropriate. The same plainly cannot be said of the 180-day *administrative* appeal period for "sophisticated" institutional providers, *Your Home*, 525 U.S. at 456, to seek Medicare reimbursement.

appeal an intermediary's reimbursement determination to the Board only

> if— * * * (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.

42 U.S.C. 1395*oo*(a)(3);[10] see H.R. Rep. No. 231, 92d Cong., 1st Sess. 108 (1971) ("The appeal *must* be filed within 180 days after notice of the fiscal intermediary's final determination.") (emphasis added). The 180-day appeal period is reiterated three times in this provision, and the time deadline is just one of three mandatory preconditions to invoking administrative review. See 42 U.S.C. 1395*oo*(a). Neither of the other two preconditions—provider dissatisfaction and a $10,000 amount-in-controversy requirement—is readily amenable to equitable exceptions. See 42 U.S.C. 1395*oo*(a)(1) and (2); *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 404 (1988) ("[A] provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction."); cf. *Hallstrom* v. *Tillamook County*, 493 U.S.

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[10] Paragraph (1)(A)(i) applies to circumstances in which a provider is dissatisfied with a final determination of the intermediary; Paragraph (1)(A)(ii) applies to circumstances in which a provider is dissatisfied with a final determination of the Secretary under 42 U.S.C. 1395ww(b) or (d) (2006 & Supp. IV 2010); and Paragraph (1)(B) and (C) addresses circumstances in which a provider has not received a final determination from the intermediary on a timely basis after filing a compliant cost report, or supplemental cost report, respectively.

20, 31 (1989) (identifying "mandatory conditions precedent to commencing suit" that the "district court may not disregard * * * at its discretion").[11]

b. The court of appeals failed to appreciate the significance of the fact that Section 1395*oo*(a)(3) prescribes a time deadline for filing an administrative appeal with the PRRB, not a statute of limitations for filing suit in federal court. Unlike a court, the PRRB is "established by the Secretary" and is "composed of five members appointed by the Secretary," two of whom "shall be representative of providers of services," "at least one" of whom "shall be a certified public accountant," and all of whom must be "knowledgeable in the field of payment of providers of services." 42 U.S.C. 1395*oo*(a) and (h). Whereas the providers and the intermediary are parties to the proceedings before the Board, 42 C.F.R. 405.1843(a) (2011), HHS itself cannot be a party, 42 C.F.R. 405.1843(b) (2011). In short, the PRRB and its procedures were not established and are not suited for the adjudication of the sort of fact-specific equitable tolling claims that would now routinely be asserted as a result of the D.C. Circuit's decision.

c. Finally, and significantly, "the statute at issue * * * relate[s] to an 'underlying subject matter[]' * * * with respect to which the practical consequences of permitting tolling would [be] substantial." *Holland*, 130 S. Ct. at 2561. The court of appeals readily conceded that "the Medicare statute * * * is quite complex," App., *infra*, 10a, and "that the complex Medicare

[11] The statutory time limit has substantive, as well as procedural, effects. See *Brockamp*, 519 U.S. at 352. Section 1395*oo*(f)(2) provides for the accrual of 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." 42 U.S.C. 1395*oo*(f)(2).

reimbursement scheme will be more difficult to administer with equitable tolling available to claimants," *id.* at 66a (Griffith and Williams, JJ., concurring in the denial of rehearing en banc). Yet the court of appeals rejected the Secretary's reliance on this Court's discussion of similar considerations in *United States* v. *Brockamp*, *supra*, which held that the time limit for seeking a tax refund under the Internal Revenue Code was not subject to equitable tolling. The court of appeals reasoned that *Brockamp* was focused not on "the complexity of tax law per se, but rather the complexity of the provisions governing whether and when a claim could be filed." App., *infra*, 9a. The court misread *Brockamp* and this Court's equitable tolling cases.

In *Brockamp*, the Court defined the "underlying subject matter" as "tax collection" and focused on the number of tax returns filed each year and the number of refunds issued. 519 U.S. at 352-353. In *United States* v. *Beggerly*, 524 U.S. 38 (1998), 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 (quoting *Beggerly*, 524 U.S. at 48-49). And, in *Holland*, the Court broadly described the relevant subject matter in *Brockamp* as "tax collection" and in *Beggerly* as "land claims." *Ibid.* As the Court emphasized in *Holland* in allowing equitable tolling under AEPDA, "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[]" statute's "basic purposes").

The Medicare statute 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 *Illinois Council on Long Term Care*, 529 U.S. at 13; *Methodist Hosp.*, 38 F.3d at 1229. It is akin to tax collection in terms of its sheer size and complexity. Medicare contractors annually process claims for approximately 6000 hospitals, 15,000 skilled nursing facilities, and other providers of care under Medicare Part A, resulting in annual expenditures of approximately $250 billion. HHS, *2011 CMS Statistics*, Tbls. II.1, II.3, III.5, June 2011, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html (last visited Apr. 13, 2012) (*2011 Stats*); 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. *2011 Stats*, Tbl. III.6.

As explained in detail below (see Part B.3, *infra*), an equitable tolling regime would place substantial additional 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 § 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 inspec-

tion, might turn out to lack sufficient equitable justification," *Brockamp*, 519 U.S. at 352, a requirement that equitable tolling be imposed on the Medicare program could create similar administrative problems for HHS. Just as in *Brockamp*, "Congress would likely have wanted to decide explicitly whether, or just where and when, to expand the statute's limitations period, rather than delegate to the courts a generalized power to do so wherever a court concludes that equity so requires," *id.* at 353—or to impose that task on a five-person administrative review body (the PRRB) created for its expertise in resolving technical hospital cost and reimbursement issues. 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.

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

1. The court of appeals' decision cannot be reconciled with the Eleventh Circuit's decision in *Alacare Home Health Services, Inc.* v. *Sullivan*, 891 F.2d 850 (1990) (*Alacare Home Servs.*), or the Eighth Circuit's decision in *St. Joseph's Hospital* v. *Heckler*, 786 F.2d 848 (1986). In both cases, the courts of appeals concluded that the 180-day administrative appeal period set forth in 42 U.S.C. 1395*oo*(a)(3) is "jurisdictional" in nature and admits of no exceptions, and on that basis declared invalid the agency's regulation permitting extension of the 180-day period for "good cause." See *Alacare Home Servs.*, 891 F.2d at 855-856 (concluding that the Secretary was not authorized to create exceptions to the mandatory 180-day time limit); *St. Joseph's Hosp.*, 786 F.2d at 852-853 (concluding that "the 180 day time pe-

riod for filing claims with the Board is a jurisdictional prerequisite to the Board's authority to review a claim," and that the agency therefore lacked authority to extend the time limit). But see *Western Med. Enters., Inc.* v. *Heckler*, 783 F.2d 1376, 1379-1380 (9th Cir. 1986) (upholding "good cause" regulation). The issue presented in the Eighth and Eleventh Circuit cases was whether the agency properly concluded that the provider had failed to demonstrate "good cause" and, accordingly, neither court specifically considered the question of equitable tolling. Nevertheless, the courts' conclusion that the time limit is jurisdictional, and their rejection of even the Secretary's own "good cause" regulation allowing a limited extension, necessarily preclude recognition of an equitable tolling exception in those circuits. See *Bowles* v. *Russell*, 551 U.S. 205, 214 (2007) (court "has no authority to create equitable exceptions to jurisdictional requirements").

Thus, after the D.C. Circuit's decision, there are now three different (and irreconcilable) regimes governing the time limits on administrative appeals: (1) the 180-day statutory time limit is jurisdictional and administrative appeals filed after 180 days are categorically barred, regardless of the reason for the delay and the Secretary's "good cause" regulation (Eighth and Eleventh Circuits); (2) the 180-day statutory time limit governs unless the provider seeks an extension within three years and can demonstrate "good cause" as defined by regulation (HHS); and (3) the 180-day statutory time limit is subject to open-ended equitable tolling as defined by the courts (D.C. Circuit).[12] Medicare is a na-

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[12] Although the Ninth Circuit has clearly rejected the approach of the Eighth and Eleventh Circuits, see *Western Med. Enters.*, 783 F.2d at 1379-1380, it has not squarely addressed the equitable tolling issue. In

tionwide program and it should be governed by a uniform rule. At the same time, because any provider may seek judicial review of any final decision of the Board in the District Court for the District of Columbia, see 42 U.S.C. 1395*oo*(f)(1), the D.C. Circuit's decision in this case, if allowed to stand, would in itself have a broadly disruptive impact on the nationwide administration of the program. Cf. *Vermont Yankee*, 435 U.S. at 537 n.14 (noting that, because "the vast majority of challenges to administrative agency action are brought to the Court of Appeals for the District of Columbia Circuit, the decision[s of that court] serve as a precedent for many more proceedings for judicial review of agency actions than would the decision of another Court of Appeals").[13]

2. The court of appeals' decision is also in considerable tension with this Court's understanding and approval of the circumscribed reopening regime for Medicare providers as set forth in *Your Home*. In that case,

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Anaheim Memorial Hospital v. *Shalala*, 130 F.3d 845 (9th Cir. 1997), the court held that it lacked jurisdiction to review a provider's contention that the 180-day limit should be equitably tolled because the Board had not addressed that issue, and the court therefore remanded the case to the Secretary for a "final decision on the merits of [the plaintiff's] equitable tolling claim." *Id.* at 853. On remand, the PRRB determined that it lacked authority to equitably toll the statutory appeal period. See *Anaheim*, 2000 WL 1146514, at *13-*16; see p. 7, *supra* (noting that Board in this case relied in part on its decision in *Anaheim*).

[13] In its rulemaking leading to the 2008 amendment to the "good cause" regulation, HHS noted the "split among the Federal circuit courts of appeals on the threshold question of [the agency's] authority to authorize the Board to extend the 180-day period for hearing requests" pursuant to the regulation. 69 Fed. Reg. 35,725 (June 25, 2004). Although HHS considered "eliminating" the "good cause" regulation "altogether," it decided to "retain and revise" the regulation instead. *Ibid.*; see 73 Fed. Reg. at 30,205-30,207.

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. "[G]iven the administrative realities," the Court explained that 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.

The court of appeals' ruling now allows those "tens of thousands of sophisticated Medicare-provider recipients" to evade the carefully circumscribed and clear limits of the reopening regulation, as well as the "good cause" regulation. The court's decision thus transforms a provider's ability to seek reopening (and "good cause" extensions) from a time-limited right existing solely by grace of the Secretary into an indefinite tolling regime defined by the courts under general principles of equity. The same "administrative realities" that caused this Court in *Your Home* to envision a Medicare payment scheme without *any* opportunity for reopening render the court of appeals' equitable tolling rule contrary to the statutory and regulatory scheme, as well as disruptive and highly burdensome. Cf. *Heckler* v. *Ringer*, 466 U.S. 602, 627 (1984) ("Congress must have felt that cases of individual hardship resulting from delays in the administrative process had to be balanced against the

potential for overly casual or premature judicial intervention in an administrative system that processes literally millions of claims every year.").

3. The court of appeals' decision, if allowed to stand, will have substantial adverse effects on the orderly review of Medicare claims for payment.

For nearly 40 years, providers and the Medicare program have been operating under a statutory and regulatory scheme that required an appeal to the PRRB to be filed within 180 days of issuance of an NPR—or within three years if good cause is shown. The D.C. Circuit's decision now upends that regime and supplements it with an open-ended, judicially imposed equitable tolling exception that allows sophisticated providers to raise stale claims that could conceivably date back to the very inception of the Medicare program.

Respondents' claims alone cover cost years as far back as 1987. See p. 6, *supra*. And this is just the first of more than a dozen post-*Baystate* lawsuits in the District Court for the District of Columbia filed on behalf of hundreds of hospitals—all relying on equitable tolling and seeking recalculation of payment determinations made many years (and, oftentimes, a decade or more) ago. See App., *infra*, 11a-12a; *Forsyth Med. Ctr.* v. *Sebelius*, No. 10-1038 (D.D.C. filed June 17, 2010); *Bon Secours Health Sys., Inc.* v. *Sebelius*, No. 10-1406 (D.D.C. filed Aug. 20, 2010). Most of the other cases have been stayed pending the outcome of this case. See, *e.g.*, 5/21/10 Minute Order, *Aurora Sinai Med. Cntr. Inc* v. *Sebelius*, No. 09-0823 (D.D.C.). In addition, HHS has informed this Office that still more providers are now seeking equitable tolling before the PRRB on the *Baystate* issue with respect to Medicare cost reporting years long closed, and that since the court of appeals'

decision issued, providers have filed numerous new and untimely appeals with the PRRB relating to other payment issues and relying on equitable tolling.[14] This is not surprising because health care consulting firms and providers have every incentive to scour old cost reports looking for asserted reimbursement errors that, in the aggregate, could lead to claims for billions of dollars. The statute and regulations permit health care consulting firms to bring group appeals on behalf of large numbers of providers, see 42 U.S.C. 1395*oo*(b); 42 C.F.R. 405.1837, 405.1881 (2011), making the expenditure of resources a cost-effective private enterprise.

Even if provider appeals to equity ultimately fall short in particular cases, substantial resources would have to be devoted to adjudicating (at the Board level) and litigating (at the court level) untimely claims. See *Credit Suisse Sec.* v. *Simmonds*, No. 10-1261 (Mar. 26, 2012), slip op. 5, 7 (explaining that equitable tolling involves "fact-intensive disputes" about whether a litigant has diligently pursued his rights and whether "some extraordinary circumstance stood in his way").[15] As the

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[14] Other untimely appeals relying on equitable tolling were filed before the D.C. Circuit's decision and remain pending. See, *e.g.*, 3/5/12 Order, *Russel-Murray Hospice, Inc.* v. *Sebelius*, No. 10-5326 (D.C. Cir.) (case held in abeyance pending conclusion of settlement proceedings or filing of a petition for a writ of certiorari in this case).

[15] For similar reasons, the fact that the court of appeals' decision is interlocutory does not counsel against further review at this time. Regardless of whether it might ultimately be determined on remand that equitable tolling is inappropriate in this particular case, the decision below would remain binding precedent, and the agency would be required "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." See *Brockamp*, 519 U.S. at 352.

Secretary explained in revising and refining the "good cause" regulation, "[w]hen the Board finds good cause to extend the 180-day period for requesting a hearing, another case is added to the backlog" and "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); see 73 Fed. Reg. at 30,192 (backlog of approximately 6800 cases). The D.C. Circuit's decision, which extends well beyond the "lengthy 3-year period" and is considerably broader in scope than the "good cause" exception, would only further exacerbate the Board's backlog. An equitable tolling regime would thus 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.

By the same token, if the Board (or a court) were to determine that equitable tolling *is* appropriate in a particular case by virtue of the court of appeals' decision, intermediaries and the Board would then have to devote substantial additional resources to recalculating payment determinations for cost reporting periods that have long been closed. There are approximately 30,000 institutional providers participating in the Medicare program, including more than 6100 hospitals, see *2011 Stats*, Tbl. II.3, and each of those providers must file an annual cost report, see 42 C.F.R. 413.20(b), 413.24(f) (2011). A hospital cost report is complex, consisting of a variety of statistical schedules, numerous different worksheets, and detailed assembly instructions. See CMS, *The Provider Reimbursement Manual,* Pt. 2, ch. 36, 2011, http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html (last visited Apr. 13, 2012). Any

errors in calculations under the statutorily prescribed formula to determine the prospective rates could impact other providers subject to those rates. Payment calculations (and DSH payments in particular) are exceedingly complex, and intermediaries should not have to divert their limited and valuable auditing resources to reviewing and recalculating stale claims relating to NPRs from which the providers never bothered to appeal—or even sought to have reopened within the time allowed by the Secretary's regulations.

In addition, a requirement that equitable tolling be allowed would expose the Medicare program to claims of enormous amounts in the aggregate and make it more difficult for the Secretary and Congress to accurately gauge the financial status of the Medicare system when faced with open-ended claims from many years earlier. Allowing claims that can be a decade or more old would also reduce accuracy and increase uncertainty when determining providers' DSH allocations and ultimately inpatient PPS payments going forward. See, *e.g.*, *Methodist Hosp.*, 38 F.3d at 1229 (upholding as reasonable Secretary's longstanding policy of treating prospective-payment rate determinations as final and not generally subject to retroactive correction); *Palisades Gen. Hosp., Inc.* v. *Leavitt*, 426 F.3d 400, 404 (D.C. Cir. 2005) (upholding as reasonable Secretary's determination that retroactive corrections would result in an unsupportable administrative burden on the agency and disrupt the Secretary's already complex administration of the Medicare program).

* * * * *

This Court's review is warranted to correct the court of appeals' erroneous imposition of equitable tolling on the complex payment and administrative review scheme

established by Congress and the Secretary for the Medicare program, to resolve the conflict in the circuits concerning extensions of the 180-day period for filing administrative appeals, to bring judicial rulings governing the Medicare appeals process into conformity with this Court's decisions in *Your Home* and *Vermont Yankee*, and to prevent the imposition of substantial programmatic and financial burdens on the Medicare program.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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APRIL 2012

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 10-5115

AUBURN REGIONAL MEDICAL CENTER, ET AL., APPELLANTS

v.

KATHLEEN SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, APPELLEE

Argued: Dec. 7, 2010
Decided: June 24, 2011

Appeal from the United States District Court
for the District of Columbia
(No. 1:07-cv-02075)

OPINION

Before: HENDERSON and GRIFFITH, *Circuit Judges*, and WILLIAMS, *Senior Circuit Judge*.

Opinion for the Court filed by *Circuit Judge* GRIFFITH.

GRIFFITH, *Circuit Judge*: Since 1983, Medicare has used a prospective payment system to reimburse hospitals for their inpatient operating costs. These payments are based on predetermined, nationally applicable rates and are subject to various adjustments. One such adjustment is the disproportionate share hospital (DSH) payment, which provides an additional reimbursement to hospitals that serve large numbers of low-income patients. A hospital's DSH payment depends on its "DSH percentage," a figure that the Center for Medicare & Medicaid Services (CMS) must calculate. The DSH percentage varies based on the number of Medicare beneficiaries entitled to Supplementary Security Income, a federal low-income supplement established by the Social Security Act.

This case stems from the discovery in an unrelated case that CMS had paid hospitals less than they were due because it had miscalculated the DSH percentage for fiscal years 1993-1996. *See Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The appellants in this case, a group of hospitals that receive DSH payments, filed claims with the Provider Reimbursement Review Board (PRRB) in 2006 seeking full payments for the fiscal years 1987-1994. Appellants acknowledged that they filed their claim more than a decade after the deadline for challenging payments, but argued that the limitations period should be equitably tolled because CMS knowingly and unlawfully failed to disclose that the DSH payments had been understated.

The PRRB held that it was without authority to toll the limitations period, making appellants' claim untimely and beyond the jurisdiction of the PRRB. Appellants then filed suit in the district court, which held that

it also lacked jurisdiction in this matter because the PRRB's determination was not a "final decision." The district court further held that the statute does not allow for equitable tolling. We take jurisdiction pursuant to 28 U.S.C. § 1291 and reverse and remand.

I

We consider first whether the PRRB's dismissal of appellants' claims for lack of jurisdiction was a "final decision." The Medicare statute grants "[p]roviders . . . the right to obtain judicial review of any final decision of the [PRRB] . . . by a civil action commenced within 60 days of the date on which notice of any final decision by the [PRRB] . . . is received." 42 U.S.C. § 1395oo(f). There is no question that this appeal was brought within sixty days. The only question is whether the PRRB's decision was final.

To understand the Secretary's argument, a word of explanation is needed about how providers receive Medicare reimbursements and how they can challenge those they think are wrong. Each year, Medicare providers submit cost reports to fiscal intermediaries, who then determine the amount of Medicare reimbursement due, which is announced in a Notice of Provider Reimbursement (NPR). If a provider is dissatisfied, it may appeal that determination to the PRRB but must do so within 180 days of the NPR. 42 U.S.C. § 1395oo(a). According to the Secretary and the district court, the Board's dismissal of an untimely claim is not a final decision. We fail to see how this could be the case. The district court thought this was our holding in *Athens Community Hospital, Inc. v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982), but it was not. In *Athens*, we held that "*if the threshold requirements of 42 U.S.C. § 1395oo(f)(1) are*

met, a court has jurisdiction to review a decision by the PRRB that it lacks jurisdiction to review a determination of the fiscal intermediary." 686 F.2d at 994 (emphasis added). But § 1395oo(f)(1) only requires that "a civil action [be] commenced within 60 days" of the PRRB's "final decision." It says nothing about the 180-day limitations period.

The Secretary's confusion seems to stem from our reference to *John Muir Memorial Hospital, Inc. v. Califano*, 457 F. Supp. 848 (N.D. Cal. 1978)), in *Athens*. We stated there that "jurisdiction was not available to the court in *John Muir* because the provider failed to timely file its appeal. Under [§ 1395oo(f)(1)], a decision by the PRRB not to hear a case on this basis is, by definition, not a 'final decision.'" 686 F.2d at 994 n.4. The Secretary reads this statement to suggest that a PRRB conclusion that it lacks jurisdiction over an untimely claim is not a final decision subject to judicial review. But that was not our point. In *John Muir*, the provider, without having appealed the fiscal intermediary's final determination to the PRRB within 180 days, went straight to the district court. It did not go there arguing the PRRB was wrong to deny jurisdiction. Rather, it argued the court could review the intermediary's decision on the merits pursuant to the grant of general federal question jurisdiction under 28 U.S.C. § 1331, even if a timely claim was never pressed before the PRRB. *See John Muir*, 457 F. Supp. at 852-53. The court disagreed, holding that it could only review cases on the merits that were filed within sixty days of a final decision by the PRRB. *See id*. The *John Muir* court did not hold that a dismissal for want of jurisdiction is not a final decision on that issue. And with good reason. Such a dismissal is final in any sense of the word. It is not

pending, interlocutory, tentative, conditional, doubtful, unsettled, or otherwise indeterminate. It is done.

Indeed, we took jurisdiction in *Athens* after explaining that courts have "jurisdiction to review a decision by the PRRB declining to hear a case on the basis of lack of PRRB jurisdiction." 686 F.2d at 993. If it were otherwise, "the PRRB could effectively preclude any judicial review of its decisions simply by denying jurisdiction of those claims that it deems to be non-meritorious." *Id.* (quoting *Cleveland Mem'l Hosp., Inc. v. Califano*, 444 F. Supp. 125, 128 (E.D.N.C. 1978), *aff'd*, 594 F.2d 993 (4th Cir. 1979)) (internal quotation marks omitted). Accordingly, courts of appeals in comparable situations have consistently understood dismissals for lack of jurisdiction as "final decisions." *See id.* (analogizing to 28 U.S.C. § 1291, where courts have consistently understood dismissals for lack of jurisdiction as final decisions). This approach accords not only with common sense but also with the relevant regulations. *Cf.* 42 C.F.R. § 405.1836(e)(2) ("A Board dismissal decision under paragraph (e)(1) [which concerns dismissals for 'lack of Board jurisdiction'] of this section is final and binding on the parties. . . . "). We reaffirm, then, that a decision of the PRRB denying jurisdiction is a final decision subject to judicial review.

II

The hospitals' claims, brought over a decade after the statute of limitations had expired, may only be heard by the PRRB if the limitations period can be equitably tolled. As we recently reiterated, "It is hornbook law that limitations periods are customarily subject to equitable tolling unless tolling would be inconsistent with the text of the relevant statute." *Menominee Indian Tribe*

of Wis. v. United States, 614 F.3d 519, 529 (D.C. Cir. 2010) (internal quotation marks omitted). In general, "the same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States," *Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 95-96 (1990), and the presumption of equitable tolling is not disturbed by the fact that Medicare is a government benefits program, *see, e.g.*, *Scarborough v. Principi*, 541 U.S. 401, 422 (2004).[1]

The district court rejected equitable tolling on the ground that "plaintiffs have proffered nothing suggesting that . . . Congress intended to authorize equitable tolling for provider claims." *Auburn Reg'l Med. Ctr. v. Sebelius*, 686 F. Supp. 2d 55, 70 (D.D.C. 2010). Subsequently, *Menominee* made clear that the appropriate inquiry is just the opposite: whether there was good reason to think Congress did *not* want equitable tolling.

This presumption in favor of equitable tolling holds here. The statute specifies that "[a]ny provider of services which has filed a required cost report within the

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[1] We have also required that the injury be "of a type familiar to private litigation." *Menominee*, 614 F.3d at 529 (quoting *Chung v. DOJ*, 333 F.3d 273, 277 (D.C. Cir. 2003)). Following the Supreme Court's recent decision in *Holland v. Florida*, 130 S. Ct. 2549 (2010), it is not entirely clear how similar the claim must be to "private litigation" for equitable tolling to apply. The Court in *Holland* applied the presumption of equitable tolling to a limitations period in the Antiterrorism and Effective Death Penalty Act without first identifying a private-litigation equivalent, stating simply that "a nonjurisdictional federal statute of limitations is normally subject to a 'rebuttable presumption' in favor 'of equitable tolling.'" *Id.* at 2560. In any event, the contours of that requirement need not be determined now, as this case is "of a type familiar to private litigation" because it is analogous to a contract claim.

time specified in regulations may obtain a hearing with respect to such cost report . . . if . . . such provider files a request for hearing within 180 days after notice of the intermediary's final determination." 42 U.S.C. § 1395oo(a). This language is similar to other statutes that have been held to permit equitable tolling. *See Menominee*, 614 F.3d at 529-31 (finding equitable tolling permissible where statute required all claims to "be submitted within 6 years after the accrual of the claim"); *see also Irwin*, 498 U.S. at 94-96 (finding equitable tolling permissible where statute stated that "[w]ithin thirty days of receipt of notice of final action . . . an employee . . . may file a civil action"); *Kirkendall v. Dep't of Army*, 479 F.3d 830, 837-42 (Fed. Cir. 2007) (en banc) (finding equitable tolling permissible where statute provided that "within 60 days after the date on which [the complaint] is filed, the complainant may elect to appeal . . . except that in no event may any such appeal be brought . . . before the 61st day after the date on which the complaint is filed").

The Secretary argues that the presumption is rebutted here, relying upon *United States v. Brockamp*, 519 U.S. 347 (1997). In *Brockamp*, the Supreme Court found that the statute of limitations for filing tax refund claims, IRC § 6511, cannot be equitably tolled. But the Court in *Brockamp* did so by pointing to a number of factors not present here. First, the Court observed that ordinarily, "limitations statutes use fairly simple language," citing as an example 42 U.S.C. § 2000e-16(c), which provides that a suit must be filed "[w]ithin 90 days of receipt of notice of final [EEOC] action." 519 U.S. at 350. By contrast, the Court reasoned, the language in IRC § 6511 is "not simple," but instead "sets forth its limitations in a highly detailed technical manner," *id.*,

and "reiterates its limitations several times in several different ways," *id.* at 351.[2] Also unlike the statute at issue here, IRC § 6511 "sets forth explicit exceptions to its basic time limits," *id.*, including special time-limit rules for "refunds related to operating losses, credit carrybacks, foreign taxes, self-employment taxes, worthless securities, and bad debts." *Id.* at 351-52. In the detailed landscape of exceptions before the Court in *Brockamp*, there was no reference to equitable tolling —a fact the Court found particularly conspicuous given that "[t]ax law . . . is not normally characterized by case-specific exceptions reflecting individualized equities." *Id.* at 352. These reasons, "taken together, indicate[d] . . . that Congress did not intend courts to

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[2] IRC § 6511 begins by stating that a "[c]laim for . . . refund . . . of any tax . . . shall be filed by the taxpayer within 3 years from the time the return was filed or 2 years from the time the tax was paid, whichever of such periods expires the later, or if no return was filed . . . within 2 years from the time the tax was paid." IRC § 6511(a). It reiterates that "[n]o credit or refund shall be allowed or made after the expiration of the period of limitation prescribed . . . unless a claim for . . . refund is filed . . . within such period." *Id.* § 6511(b)(1). It again states that "[i]f the claim was filed by the taxpayer during the 3-year period . . . the amount of the credit or refund shall not exceed the portion of the tax paid within the period, immediately preceding the filing of the claim, equal to 3 years plus the period of any extension of time for filing the return . . . ." *Id.* § 6511(b)(2)(A). Later, § 6511 provides that "[i]f the claim was not filed within such 3-year period, the amount of the credit or refund shall not exceed the portion of the tax paid during the 2 years immediately preceding the filing of the claim." *Id.* § 6511(b)(2)(B). As the *Brockamp* Court noted, the tax code also "reemphasizes the point when it says that refunds that do not comply with these limitations 'shall be considered erroneous,' and specifies procedures for the Government's recovery of any such 'erroneous' refund payment." 519 U.S. at 351 (citations omitted).

read other, unmentioned, open-ended 'equitable' exceptions into the statute that it wrote." *Id.*

The statute in this case is different enough from the one in *Brockamp* for us to conclude that the presumption of equitable tolling has not been rebutted. First, the language in § 1395oo resembles the "fairly simple language" in § 2000e-16(c) that the *Brockamp* Court said clearly allowed equitable tolling. *Compare* 42 U.S.C. § 1395oo(a) (allowing "any provider of services which has filed a required cost report within the time specified in regulations [to] obtain a hearing . . . if . . . such provider files a request for hearing within 180 days after notice of the intermediary's final determination") *with id.* § 2000e-16(c) (stating that a suit must be filed "[w]ithin 90 days of receipt of notice of final [agency] action"). Second, although the statute of limitations here has a "good cause" exception that lasts no longer than three years, that exception is in the regulations, not the statute, *see* 42 C.F.R 405.1841(b) (2007), and does not bear on whether Congress rebutted the presumption of equitable tolling by enacting a complex set of exceptions to the statute of limitations. In any event, that one exception is unlike the numerous "highly technical" exceptions in the Internal Revenue Code, and is not "reiterate[d] . . . several times in several different ways." *Brockamp*, 519 U.S. at 350-51. Furthermore, contrary to the Secretary's suggestions, the Court's focus in *Brockamp* was not the complexity of tax law per se, but rather the complexity of the provisions governing whether and when a claim could be filed. *Menominee*, 614 F.3d at 530 ("[F]ocus on the regulatory scheme as a whole is misplaced. The *Brockamp* Court did not concern itself with the complexity of the Tax Code as a whole, but the complexity of the time limitations found

in § 6511.”). It is true that as a general matter, the Medicare statute, like the Internal Revenue Code, is quite complex. But unlike the tax code, the Medicare statute does not create a detailed Jenga tower of deadlines and exceptions that equitable tolling might topple. Rather, its timing scheme is straightforward and readily amenable to tolling.

Given that the factors emphasized in *Brockamp* do not apply to the facts presented here, and without any other reasons for rebutting the presumption of equitable tolling, we find that equitable tolling is available under § 1395oo(a). Whether tolling is appropriate in this particular case, however, is a different question that cannot be answered without further factual development. That question is for the district court on remand.

Appellants also raise alternative arguments about the availability of mandamus and general federal question jurisdiction in the event that equitable tolling is not available. Given our disposition, we need not reach those arguments today.

III

For the foregoing reasons, we reverse and remand for further proceedings consistent with this opinion.

So ordered.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 07-2075 (JDB)

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
PLAINTIFFS

v.

KATHLEEN SEBELIUS, SECRETARY,
UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES, DEFENDANT

Filed: Mar. 11, 2010

AMENDED MEMORANDUM OPINION

The Secretary of the Department of Health and Human Services, through the Centers for Medicare and Medicaid Services ("CMS"), is responsible for providing payments known as "disproportionate share hospital" ("DSH") adjustments to hospitals that serve a significantly disproportionate share of low income patients, as set forth under the Medicare statute, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. Hundreds of Medicare providers have, collectively, filed twelve lawsuits in this district to obtain recalculation of their DSH payments as a result of findings made by the Provider Reimbursement Review Board on March 17, 2006,

concerning systemic flaws in the data used by CMS and in the process used to assess the data. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, Case Nos. 96-1822; 97-1579; 98-1827; 99-2061, Decision No. 2006-D20 (Mar. 17, 2006) (Pl.'s Mem., Ex. A) ("*Baystate* Board Decision"). Those findings were reviewed by this Court, and sustained in part, as set forth in an opinion issued on March 31, 2008. *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *amended in part*, 587 F. Supp. 2d 37 (D.D.C. 2008).

In this first of the post-*Baystate* lawsuits, seventeen Medicare providers seek judicial relief from allegedly erroneous DSH payment determinations for fiscal years 1987-1994. Plaintiffs filed administrative appeals of those DSH determinations with the Board on September 12, 2006. *See* Compl. ¶ 52. They requested "equitable tolling" of the 180-day limitations period for filing such appeals, recognizing that, absent such tolling, their appeals would be barred by the 180-day deadline set forth in 42 U.S.C. § 1395oo(a). The Board dismissed their appeals as untimely, holding, *inter alia*, that it lacked authority to grant a request for equitable tolling. *See In re Crowell & Moring 87-93 DSH Equitable Tolling Group*, Case No. 06-2357G (Sept. 18, 2007) (Compl., Ex. B) ("*In re Equitable Tolling Group*, Board Decision"). Plaintiffs contend that the Board's decision was contrary to law and ask this Court to hold their administrative appeals timely. Compl. ¶¶ 59-60. In the alternative, they seek an order from this Court directing the Secretary to order the Medicare fiscal intermediaries "to make new DSH determinations for the FYs at issue . . . using correct . . . percentages" through a grant of mandamus or similar order under the Mandamus Act, 28 U.S.C. § 1361, the All Writs Act, 28 U.S.C. § 1651, or

the federal question statute, 28 U.S.C. § 1331. *Id.* ¶¶ 61-64.

In response, defendants have moved to dismiss the complaint on the ground that plaintiffs' administrative appeals were untimely and hence, judicial review is not available under § 1395oo(f). Defendants further contend that plaintiffs are not entitled to mandamus relief under § 1361 or any other statute because they have failed to identify a nondiscretionary duty owed to plaintiffs or otherwise satisfied the extraordinary requirements for mandamus relief. A hearing on defendant's motion was held on January 21, 2010. For the reasons explained below, the Court will grant defendant's motion to dismiss.[1]

BACKGROUND

I. Statutory and Regulatory Background

Through a complex statutory and regulatory regime, the Medicare program reimburses qualifying hospitals for the services they provide to eligible elderly and disabled patients. *See generally County of Los Angeles v. Shalala*, 192 F.3d 1005, 1008 (D.C. Cir. 1999). The "operating costs of inpatient hospital services" are reimbursed under a prospective payment system ("PPS")—that is, based on prospectively determined standardized rates—but subject to hospital-specific adjustments. 42 U.S.C. § 1395ww(d); *see generally In re Medicare Reimbursement Litig.*, 309 F. Supp. 2d 89, 92 (D.D.C. 2004), *aff'd*, 414 F.3d 7, 8-9 (D.C. Cir. 2005). One such

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[1] For ease of reference, the memorandum in support of defendant's motion to dismiss and reply brief will be cited as "Def.s' Mem.," and "Def.s' Reply," respectively. Plaintiffs' opposition brief will be cited as "Pls.' Mem."

adjustment is the "disproportionate share hospital" ("DSH") adjustment which requires the Secretary to provide an additional payment to each hospital that "serves a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and the amount of the adjustment it receives, depends on the "disproportionate patient percentage" determined by the Secretary under a statutory formula. 42 U.S.C. § 1395ww(d)(5)(F)(v)-(vii). This percentage is a "proxy measure for low income." *See* H.R. Rep. No. 99-241, at 16-17 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 594-95.

The disproportionate patient percentage is the sum of two fractions, commonly referred to as the Medicaid fraction (often called the Medicaid Low Income Proxy) and the Medicare fraction (the Medicare Low Income Proxy). 42 U.S.C. § 1395ww(d)(5)(F)(vi); *Jewish Hospital, Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270, 272 (6th Cir. 1994). The Medicare fraction—the focus of this litigation—reflects the number of hospital inpatient days attributable to Medicare Part A patients who are also entitled to Supplemental Security Income ("SSI") benefits at the time of their hospital stays, and, hence, is often referred to as the SSI fraction or SSI percentage. *See Baystate,* 545 F. Supp. 2d at 22-23. A detailed description of the data underlying the SSI fraction and the methodology used by CMS is set forth in this Court's *Baystate* decision.[2] *See* 545 F. Supp. 2d at 23-24. It is sufficient to state here that cal-

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[2] CMS was known as the Health Care Financing Administration during the fiscal years at issue. Hence, the references to CMS throughout this opinion encompass HCFA as well.

culation of the numerator of the SSI fraction requires use of voluminous SSI data from the Social Security Administration, and that CMS has taken on sole responsibility for computation of the SSI fraction. *Id.* (citing 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986) (DSH final rule)).

Medicare payments are initially determined by a "fiscal intermediary"—typically an insurance company that acts as the Secretary's agent for purposes of reimbursing health care providers. *See* 42 C.F.R. §§ 421.1, 421.3, 421.100-.128.[3] A fiscal intermediary is required by regulation to apply the SSI fraction computed by CMS. *See id.* § 412.106(b)(2) and (b)(5). The intermediary sets forth the total payment—including any DSH payment—due to a provider for a particular fiscal year in a Notice of Program Reimbursement ("NPR"). *Id.* § 405.1803.

A provider dissatisfied with the amount of the award may request a hearing before the Provider Reimbursement Review Board ("PRRB" or "Board"), an administrative body composed of five members appointed by the Secretary. 42 U.S.C. § 1395oo(a), (h). Section 1395oo(a)(3) provides that such appeals must be filed "within 180 days after notice of the intermediary's final determination." The PRRB has the authority to affirm, modify, or reverse the final determination of the intermediary, and the Secretary may then reverse, affirm, or modify the Board's decision within 60 days thereafter.

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[3] The citations to the Code of Federal Regulations are to the 2007 version in effect at the time the Board issued the decision under review. Defendant notes that the Secretary has amended the regulations since then, but the applicability of the amendments is limited to "'appeals pending as of, or filed on or after, August 21, 2008,'" with exceptions not applicable here. *See* Def.'s Mem. at 6 n.3 (quoting 73 Fed. Reg. 30,190 (May 23, 2008)). Plaintiffs agree that the 2007 version applies. Pls.' Mem. at 21.

Id. § 1395oo(d) and (f). Providers may obtain judicial review of "any final decision of the Board" or the Secretary's reversal, affirmance, or modification thereof, by commencing a civil action within 60 days of receipt of any final decision. *Id.* § 1395oo(f).

The Secretary has, by regulation, authorized the Board to grant an extension of the 180-day administrative appeal period "for good cause shown," if a request for extension is filed not "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). The regulation prohibits the Board from extending the 180-day deadline for administrative appeals if the request is submitted after that three-year period. *Id.*

Apart from the administrative appeal process, a provider also may obtain administrative relief from an intermediary's determination by requesting a "reopening." In most instances, a request for reopening must be submitted within three years of the date of the intermediary determination or Board decision at issue, but in cases of "fraud or similar fault of any party to the determination," the three-year deadline does not apply. *See* 42 C.F.R. § 405.1885(a), (d); *see generally Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 809 (D.C. Cir. 2001). The regulations provide that reopening is discretionary in some circumstances and mandatory in others. 42 C.F.R. § 405.1885(a)-(b), (d). Hospitals may not seek judicial review of an intermediary's denial of a motion to reopen because a refusal to reopen is not a "final determination . . . as to the amount" reviewable by the Board under § 1395oo(a)(1), but rather is a refusal to make a new determination. *Your Home Visiting Nurse*

Servs., Inc. v. *Shalala*, 525 U.S. 449, 453 (1999); *accord*, *Monmouth*, 257 F.3d at 811.

II. Factual Background

Plaintiffs are various hospitals who participated in the Medicare program at various times between fiscal years 1987 through 1994. Compl. ¶¶ 4-11. Each hospital received a Notice of Program Reimbursement setting forth its DSH payment determination, which typically occurs within two to three years of the end of a fiscal year. *Id.* ¶¶ 50-51, 53; *see Baystate Med. Ctr.*, 545 F. Supp. 2d at 42.[4] None of the plaintiffs filed an administrative appeal within 180 days of receipt of the NPRs. Compl. ¶ 53.

On March 17, 2006, over ten years after the fiscal years at issue, the PRRB addressed whether there were systemic flaws in the data underlying the DSH payment determinations in the context of resolving the claims of Baystate Medical Center—a nonparty to this case—which had lodged a timely appeal of its DSH payments for fiscal years 1993 through 1996. 545 F. Supp. 2d at 26-30. Baystate had alleged that certain categories of SSI eligibility records were omitted from the data tapes used by CMS to calculate the SSI fraction of the DSH percentage and that the patient identifiers used by CMS resulted in undercalculation of the SSI fraction. *Id.* The Board found, *inter alia*, that several categories of SSI eligibility data had been omitted from the CMS calcula-

[4] The complaint is silent on the exact date the NPRs were issued. Defendant represents that the NPRs were issued during the 1989-1996 time frame, consistent with the two-to-three year cost settlement process described in *Baystate*, and plaintiffs have not disputed this. *See* Def.'s Mem. at 7. The exact dates are not, in any event, material to the resolution of defendant's motion.

tions, that the "match process" used by CMS to determine the number of SSI eligible Medicare beneficiaries was flawed, and that these omissions and flaws tended to deflate the overall DSH payment. *Id.* The Board thus remanded the case to the intermediary for recalculation of Baystate's DSH payment. *Id.* at 30. The Board's findings subsequently underwent additional administrative and judicial review, resulting in this Court's decision in the *Baystate* litigation, which left the Board's findings concerning the omissions in data and flaws in the match process largely intact. *See* 545 F. Supp. 2d at 40-55.[5]

On September 12, 2006, about three months after the Board's *Baystate* decision, plaintiffs appealed their DSH payment determinations to the Board on the ground that the determinations were made using an understated SSI fraction. Compl. ¶ 52. They acknowledged that each of their appeals was filed more than three years after the NPRs had been issued. *Id.* ¶ 53. However, plaintiffs asked the Board to find the appeals timely under the principle of equitable tolling. *Id.* ¶ 54. They contended that equitable tolling applied 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 hos-

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[5] The CMS Administrator, acting for the Secretary, reversed the Board's decision granting relief to Baystate, reasoning that CMS had relied on the "best available data" and that the omissions were not significant. *Baystate*, 545 F. Supp. 2d at 31-34. Baystate then sought judicial review in this Court. On cross-motions for summary judgment, the Court held, in relevant part, that the Administrator acted arbitrarily and capriciously in finding that CMS had relied on the "best available data" to calculate the SSI fraction because several categories of SSI eligibility data available to CMS had been excluded from the calculations. *Id.* at 40-50.

pitals that their SSI percentages were incorrectly understated for the fiscal years at issue, citing the Board's *Baystate* decision. *Id.* ¶ 55. In their view, then, the appeals were timely because they were filed within 180 days of the Board's *Baystate* decision. *Id.* ¶¶ 54-56.

On September 18, 2007, the Board held that it lacked jurisdiction over the hospitals' appeals because they were not timely filed. *See In re Equitable Tolling Group*, Board Decision at 3. The Board reasoned that it had only the powers granted to it by statute and regulation, which limited its authority to hear an administrative appeal to requests filed within 180 days of the date of the final determination (42 U.S.C. § 1395oo(a)) or requests demonstrating "good cause" for a late appeal within three years after the intermediary's determination was mailed to the provider (42 C.F.R. § 405.1841(b)). *Id.* The Board determined that "[g]ood cause for late filing cannot be considered in these cases because the cases [were] filed more than three years after the issuance of the NPRs . . . ." *Id.* at 2. The Board further concluded that it did not have "general equitable powers," but instead was limited to the equitable powers granted by § 405.1841(b), as well as the reopening regulation, § 405.1885. *Id.* Therefore, the Board held the appeals untimely. *Id.* at 3. The Secretary declined to review the Board's decision. *See* Compl., Ex. B. Plaintiffs then brought this action seeking judicial review pursuant to § 1395oo(f) or, in the alternative, a judicial order directing the Secretary to order the Medicare fiscal intermediaries "to make new DSH determinations for the FYs at issue . . . using correct SSI percentages" through a grant of mandamus. Plaintiffs also contend that their challenges may be re-

viewed directly under the federal question statute if judicial review is not available elsewhere.

STANDARD OF REVIEW

"[I]n passing on a motion to dismiss, whether on the ground of lack of jurisdiction over the subject matter or for failure to state a cause of action, the allegations of the complaint should be construed favorably to the pleader." *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974); *see Leatherman v. Tarrant Cty. Narcotics and Coordination Unit*, 507 U.S. 163, 164 (1993); *Phillips v. Bureau of Prisons*, 591 F.2d 966, 968 (D.C. Cir. 1979). Therefore, the factual allegations must be presumed true, and plaintiff must be given every favorable inference that may be drawn from the allegations of fact. *Scheuer*, 416 U.S. at 236; *Sparrow v. United Air Lines, Inc.*, 216 F.3d 1111, 1113 (D.C. Cir. 2000). However, the Court need not accept as true "a legal conclusion couched as a factual allegation," nor inferences that are unsupported by the facts set out in the complaint. *Trudeau v. Federal Trade Comm'n*, 456 F.3d 178, 193 (D.C. Cir. 2006) (quoting *Papasan v. Allain*, 478 U.S. 265, 286 (1986)).

Under Rule 12(b)(1), the party seeking to invoke the jurisdiction of a federal court—plaintiffs here—bears the burden of establishing that the court has jurisdiction. *See US Ecology, Inc. v. U.S. Dep't of Interior*, 231 F.3d 20, 24 (D.C. Cir. 2000); *see also Grand Lodge of Fraternal Order of Police v. Ashcroft*, 185 F. Supp. 2d 9, 13 (D.D.C. 2001) (a court has an "affirmative obligation to ensure that it is acting within the scope of its jurisdictional authority."); *Pitney Bowes, Inc. v. United States Postal Serv.*, 27 F. Supp. 2d 15, 19 (D.D.C. 1998). "'[P]laintiff's factual allegations in the complaint . . .

will bear closer scrutiny in resolving a 12(b)(1) motion' than in resolving a 12(b)(6) motion for failure to state a claim." *Grand Lodge*, 185 F. Supp. 2d at 13-14 (quoting 5A Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 1350 (2d ed. 1987)). Additionally, a court may consider material other than the allegations of the complaint in determining whether it has jurisdiction to hear the case, as long as it still accepts the factual allegations in the complaint as true. *See Jerome Stevens Pharm., Inc. v. FDA*, 402 F.3d 1249, 1253-54 (D.C. Cir. 2005); *EEOC v. St. Francis Xavier Parochial Sch.*, 117 F.3d 621, 624-25 n.3 (D.C. Cir. 1997); *Herbert v. Nat'l Acad. of Scis.*, 974 F.2d 192, 197 (D.C. Cir. 1992).

In reviewing a motion to dismiss pursuant to Rule 12(b)(6), the Court is mindful that all that the Federal Rules of Civil Procedure require of a complaint is that it contain "'a short and plain statement of the claim showing that the pleader is entitled to relief,' in order to 'give the defendant fair notice of what the . . . claim is and the grounds upon which it rests.'" *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (quoting *Conley v. Gibson*, 355 U.S. 41, 47 (1957)); *accord Erickson v. Pardus*, 551 U.S. 89, 93 (2007) (per curiam). Although "detailed factual allegations" are not necessary to withstand a Rule 12(b)(6) motion to dismiss, to provide the "grounds" of "entitle[ment] to relief," a plaintiff must furnish "more than labels and conclusions" or "a formulaic recitation of the elements of a cause of action." *Twombly*, 550 U.S. at 555-56; *see also Papasan v. Allain*, 478 U.S. 265, 286 (1986). "To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. ___,

129 S. Ct. 1937, 1949 (2009) (quoting *Twombly*, 550 U.S. at 570); *Atherton v. District of Columbia Office of the Mayor*, 567 F.3d 672, 681 (D.C. Cir. 2009). A complaint is plausible on its face "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 129 S. Ct. at 1949.

In resolving a motion to dismiss an action for relief in the nature of mandamus, courts have characterized the issue as involving both a jurisdictional and a merits inquiry because, in determining whether the court has jurisdiction to compel an agency or official to act, the court must consider the merits question of whether a legal duty is owed to the plaintiff under the relevant statute. *See In re Cheney*, 406 F.3d 723, 729 (D.C. Cir. 2005) (en banc) (noting that to the extent a court considers whether a statute creates a duty, "mandamus jurisdiction under [28 U.S.C.] § 1361 merges with the merits"). Whether a motion to dismiss a mandamus action should be considered pursuant to Rule 12(b)(1) or Rule 12(b)(6) is a matter on which there are "conflicting signals,"[6] but *In re Cheney* indicates that the better course is to consider the matter a merits issue, both in the court's characterization of the jurisdictional and merits inquiries as "merged" and in the purposeful manner in which it limited its review of the record to the sufficiency of the complaint and the documents attached thereto. *Id.* at 729-30. Therefore, with respect to the mandamus claim, defendant's motion to dismiss will be considered pursuant to Rule 12(b)(6).

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[6] *See Ahmed v. Dep't of Homeland Security*, 328 F.3d 383, 386-87 (7th Cir. 2003); *Swan v. Clinton*, 100 F.3d 973, 976-77 n.1 (D.C. Cir. 1996).

DISCUSSION

I. Availability of Judicial Review Under 42 U.S.C. § 1395oo(f)

Defendant raises the threshold issue of whether the Court has jurisdiction under the Medicare Act, 42 U.S.C. § 1395oo(f), to review the Board's decision. Defendant contends that § 1395oo(f) limits judicial review to a "final decision of the Board," and that under *Athens Comm. Hosp. v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982),[7] a Board decision dismissing an appeal based on expiration of the 180-day statutory deadline is not a "final decision" within the meaning of the statute. *See* Def.'s Mem. at 9-11; Def.'s Reply at 3-7. Plaintiffs respond that the 180-day limitations period is not a jurisdictional hurdle subject to Rule 12(b)(1) scrutiny, but is instead properly construed as a statute of limitations that, like other limitations periods, is subject to equitable tolling. Pls.' Mem. at 13-16. Plaintiffs further counter that *Athens* confirms that judicial review of the Board's dismissal decision is available under § 1395oo(f), and posit that defendant has misconstrued *Athens*. *Id.* at 16-19. Resolution of defendant's motion requires a close examination of the language of both § 1395oo and *Athens*.

[7] *Athens Comm. Hosp.* was modified on rehearing with respect to an issue unrelated to this "final decision" question. *See* 743 F.2d 1 (D.C. Cir. 1984). The modified opinion was later overruled by the Supreme Court in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988). The parties presume that the original *Athens* opinion remains the governing law of this circuit on what constitutes a "final decision" subject to judicial review, and the Court agrees. A careful review of those subsequent decisions shows that the "final decision" analysis set forth in the original *Athens* opinion was not subsequently called into question.

The relevant statutory language is as follows:

> (a) 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 [PRRB] . . . and any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww . . . may obtain a hearing with respect to such payment by the Board, if—
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> > (3) such provider files a request for hearing *within 180 days after notice of the intermediary's final determination* . . .
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> (f) . . . Providers shall have the right to obtain judicial review of *any final decision of the Board* . . . by a civil action commenced within 60 days of the date on which notice of *any final decision by the Board* . . . is received. . . . .

42 U.S.C. § 1395oo (emphasis added). At the outset, it is important to note that the 180-day limitations period cannot plausibly be characterized as jurisdictional. First and foremost, there is no language in § 1395oo(a) or (f) indicating that the limitations period is jurisdictional. The Supreme Court has cautioned that, "when Congress does not rank a statutory limitation . . . as jurisdictional, courts should treat the restriction as nonjurisdictional in character." *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 515-16 (2006); *see also Union Pacific R. Co. v. Bhd. of Locomotive Eng'rs and Trainmen Gen. Comm. of Adjustment*, 130 S. Ct. 584, 596 (2009) ("Recognizing that the word 'jurisdiction' has been used by courts, including this Court, to convey 'many, too

many, meanings,' we have cautioned, in recent decisions, against profligate use of the term. Not all mandatory 'prescriptions, however emphatic, are . . . properly typed jurisdictional.'") (quoting *Arbaugh*, 546 U.S. at 510); *Oryszak v. Sullivan*, 576 F.3d 522, 525 & n.2 (D.C. Cir. 2009) (describing *Arbaugh* as holding that a "limitation on [a] cause of action that 'does not speak in jurisdictional terms or refer in any way to the jurisdiction of the district courts' is not jurisdictional"). Second, the agency has promulgated regulations authorizing extension of the 180-day period for good cause, if such a request is filed within three years of issuance of the NPR. *See* 42 C.F.R. § 405.1841(b). If the statutory 180-day period were jurisdictional, the Board could not enlarge it by rule.

Ultimately, however, defendant's argument against judicial review under § 1395oo(f) does not depend on whether the 180-day limitations period is characterized as "jurisdictional" or as a nonjurisdictional prerequisite to obtaining relief. Even in the latter case, the Court still must consider whether a Board decision dismissing an appeal based on expiration of the 180-day limitations period is a "final decision" subject to judicial review. Resolution of what constitutes a "final decision" subject to judicial review requires close examination of *Athens*.

In *Athens*, the provider had filed a timely administrative appeal challenging several cost adjustments in its Notice of Program Reimbursement, and later sought to amend its appeal to include additional categories of costs that it had not originally sought from the intermediary. 686 F.2d at 992-93. The Board held that it lacked jurisdiction to consider the new claims. *Id.* The court considered in that context "whether a decision by the

PRRB not to exercise jurisdiction is a 'final decision' sufficient to establish [the court's] jurisdiction" under § 1395oo(f). *Id.* at 993. The court held "*if the threshold requirements of 42 U.S.C. § 1395oo(f)(1) are met*, a court has jurisdiction to review a decision by the PRRB that it lacks jurisdiction to review a determination of the fiscal intermediary." *Id.* at 994 (emphasis added). Hence, the court held that it had jurisdiction to review the PRRB decision before it, because an appeal had been filed with the Board within the 180-day limitations period and the other threshold statutory requirements had been satisfied.

Athens left no doubt that it considered one of the essential "threshold requirements" giving rise to a "final decision" to be the filing of an administrative appeal within the 180-day limitations period. This is made clear from the court's approval of the district court's dismissal of an untimely challenge to a PRRB decision in *John Muir Mem. Hosp. v. Califano*, 457 F. Supp. 848 (N.D. Cal. 1978). The court in *Athens* explained that "in *John Muir* . . . the question was whether the Board had jurisdiction to hear an appeal from an intermediary's decision" where an appeal had *not* been filed with the Board within the 180-day limitations period. 686 F.2d at 993. It found *John Muir* was "easily distinguished" from the outcome in *Athens* because "42 U.S.C. § 1395oo(f)(1) jurisdiction was not available to the court." *Id.* at 993-94 (discussing *John Muir*, 457 F. Supp. at 853). The court elaborated in a footnote that "[§ 1395oo(f)] jurisdiction was not available to the court in *John Muir because the provider failed to timely file its appeal*. Under the statute, a decision by the PRRB not to hear a case on this basis is, by definition, not a 'final decision.'" *Id.* at 994 n.4 (emphasis added).

In light of *Athens'* express reference to satisfaction of "the threshold requirements of 42 U.S.C. § 1395oo(f)(1)," and its statement in footnote 4 that, with respect to a "provider [who] failed to timely file its appeal . . . a decision by the PRRB not to hear a case on this basis is, by definition, not a 'final decision,'" *Athens* is properly understood as holding that a plaintiff may obtain judicial review of a PRRB refusal to exercise jurisdiction only if an administrative appeal has been filed within the 180-day limitations period.

Admittedly, this reading does not lead to the most intuitive result. The PRRB decision at issue has the hallmarks of decisions that are commonly considered "final" in other areas of the law. For example, it marks the consummation of the agency's decisionmaking process and is an action that results in rights having been determined. *See Bennett v. Spear*, 520 U.S. 154, 177-78 (1997) (discussing requirements of "final agency action" within the meaning of the Administrative Procedure Act). Indeed, both the Board and the Secretary presumed that the Board decision would be subject to judicial review. *See In re Equitable Tolling Group*, Board Decision at 3 ("Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1)"); Letter from CMS to Robert Roth, dated Nov. 1, 2007 (referring to availability of judicial review within 60 days of Board decision) (Compl., Ex. B). Moreover, as *Athens* observed, "[judicial] dismissals for lack of jurisdiction consistently have been understood as 'final decisions,'" and by analogy, Board dismissals also may be considered final decisions. 686 F.2d at 993 (discussing *Cleveland Mem. Hosp. v. Califano*, 444 F. Supp. 125 (E.D.N.C. 1978), *aff'd*, 594 F.2d 993 (4th Cir. 1979)).

Indeed, *Athens* approved of the determination in *Cleveland* that a PRRB dismissal order based on failure to satisfy the § 1395oo(a) amount-in-controversy provision—another threshold statutory requirement—was a "final decision" within the meaning of that statute. Hence, there is some tension in the conclusion that the PRRB decision in *Cleveland* was a "final decision," but the PRRB decision in *John Muir* was not. One can reconcile that tension in perhaps two ways: first, as defendant suggested at the motions hearing here, the 180-day limitations period stands in a different stead than the amount-in-controversy requirement because of the government's recognized interest in imposing finality on the Medicare reimbursement process;[8] and second, where there is a "real dispute" over whether a threshold requirement of § 1395oo(f) is satisfied, such as with the amount-in-controversy in *Cleveland* (in contrast to the parties' agreement in *Muir* that 180 calendar days from the final NPR had run), then the Board's resolution of that issue will constitute a judicially reviewable "final decision." *See St. Joseph's Hosp. of Kansas City v. Heckler*, 786 F.2d 848, 852 (8th Cir. 1986). Neither explanation is entirely satisfactory, but the Court need not choose between those explanations, nor identify another, in light of the clear decision in *Athens*.

This Court must follow *Athens'* instruction that, with respect to a "provider [who] failed to timely file its appeal . . . a decision by the PRRB not to hear a case on this basis is, by definition, not a 'final decision.'" *Athens*, 686 F.2d at 994 & n.4. Plaintiffs concede that they

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[8] As defendant noted at the motions hearing, this interest was recognized in *Califano v. Sanders*, 430 U.S. 99, 108 (1977), and *Your Home Visiting Nurse Servs.*, 525 U.S. at 453.

filed their appeals to the Board "more than three years after the Medicare NPRs had been issued for each of the FYs at issue." Compl. ¶ 53. Hence, under *Athens*, the Board decision dismissing their appeals as untimely is not a "final decision" within the meaning of § 1395oo(f), and is accordingly not subject to judicial review.[9]

[9] This understanding of *Athens* is in accord with the decisions of other courts that have considered the consequences of a provider's failure to comply with the 180-day limitations period, notwithstanding a provider's proffer of equitable reasons in support of an extension or reopening. *See St. Joseph's Hosp. of Kansas City*, 786 F.2d at 852 (observing that, in *Athens*, "the District of Columbia Circuit, while not specifically faced with the issue of whether the Board's refusal to hear an untimely appeal is a final decision, . . . endorsed the decision in *John Muir*," and agreeing that "section 1395oo(a) defines the limits of the Board's jurisdiction to render a final decision"); *Miami Gen. Hosp. v. Bowen*, 652 F. Supp. 812, 814 (S.D. Fla. 1986) ("42 U.S.C. § 1395oo provides for judicial review of [fiscal intermediary] determinations only where all of its procedural requisites have been met, among which is the requirement that a provider . . . file a request for hearing before the . . . [PRRB] within 180 days after . . . [the NPR] has been received"); *Arcadia Valley Hosp. v. Bowen*, 641 F. Supp. 190, 192 (E.D. Mo. 1986) ("Without meeting the 180 day time period of the statute, the Board . . . cannot issue a judicially reviewable final decision"); *Univ. of Chicago Hosp. & Clinics v. Heckler*, 605 F. Supp. 585, 586 (N.D. Ill. 1985). *But cf. Ozark Mountain Regional Rehabilitation Ctr. v. HHS*, 798 F. Supp. 16, 20 n.2 (D.D.C. 1992) (construing *Athens* as authorizing judicial review over appeals brought within the three-year period set forth at 42 C.F.R. § 405.1841(b)).

Plaintiffs contend that these cases are not applicable because they involve requests for a "good cause" extension of the 180-day limitations period in accordance with 42 C.F.R. § 405.1841, whereas plaintiffs never asked the Board for a "good cause" extension of the appeal period, instead requesting equitable tolling. *See* Pls.' Mem. at 19 n.8. But plaintiffs fail to recognize that, to the extent those cases discuss the law governing what is a "final decision" within the meaning of § 1395oo(f)—one of the main issues here—and do so in a manner that sheds light on the correct interpretation of *Athens*, they are, of course, relevant.

II. Equitable Tolling

Even if the PRRB decision is a "final decision" subject to judicial review under § 1395oo(f), plaintiffs may not obtain relief thereunder unless the statute authorizes "equitable tolling." Defendant contends that the explicit language of the statute shows that Congress intended to achieve finality by imposing a firm limitation on the time period within which payment determinations may be challenged. *See* Def.'s Mem. at 19-20. Defendant urges that equitable tolling therefore must be rejected here, just as it was rejected by the Supreme Court in the tax collection context in *United States v. Brockamp*, 519 U.S. 347 (1997). Defendant acknowledges that the Secretary has created an exception to the statutory time limit—the three year "good cause" extension authorized by 42 C.F.R. § 405.1841(b)—but contends that this exception is within the broad grant of rulemaking authority at 42 U.S.C. §§ 1302 and 1395hh and does not undercut defendant's position that no equitable tolling is otherwise allowed since it still imposes an outer limit of three years for administrative appeals, consistent with Congress's intent to achieve finality for payment calculations. *Id.* at 20. In defendant's view, plaintiffs' equitable tolling theory would effectively "extinguish" the time limitations on the handling of administrative claims. *Id.*

In response, plaintiffs contend that, under Supreme Court precedent, there is a presumption in favor of equitable tolling, relying primarily on *Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 95-96 (1990), *Bowen v. City of New York*, 476 U.S. 468 (1986), and *Bradford Hosp. v. Shalala*, 108 F. Supp. 2d 473 (W.D. Pa. 2000). Plaintiffs view *Brockamp* as an outlier that was based on specific

statutory language and the uniqueness of the IRS taxpayer refund context at issue.

The starting point in determining whether equitable tolling is available under § 1395oo(f) is Congressional intent, rather than the applicability of one presumption or another. This is clear from the cases cited by both plaintiffs and defendant. *See Brockamp*, 519 U.S. at 350 (resolving the equitable tolling issue based on the standard: "Is there good reason to believe that Congress did *not* want the equitable tolling doctrine to apply?"); *City of New York*, 476 U.S. at 480 (examining whether application of equitable tolling to 60-day judicial review period is "consistent with the overall Congressional purpose" and is "nowhere eschewed by Congress"); *Irwin*, 498 U.S. at 95 (emphasizing importance of "greater fidelity to the intent of Congress" and application of a principle that is "a realistic assessment of legislative intent").

Irwin, however, offers little instruction on whether Congress intended equitable tolling to apply under a regime such as the Medicare program. *Irwin* was a Title VII case that considered whether the limitations period for filing a Title VII suit against the federal government was subject to equitable tolling, as it was for "private" employers. *See* 498 U.S. at 95. The Supreme Court held "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. Since then, *Irwin* has been interpreted as "announcing a 'general rule' establishing a presumption in favor of equitable tolling," but only where there is a "sufficiently similar" private suit that warrants application of such a presumption. *See Chung*

v. Dep't of Justice, 333 F.3d 273, 277 (D.C. Cir. 2003) (citing *Brockamp*, 519 U.S. at 350). Although the "similarity" inquiry is to be conducted "at a fairly high level of generality," *id.*, without the existence of equitable tolling in a "similar" suit against a private defendant—and none has been identified here, where the programmatic reimbursement at issue is not familiar to private litigation—there would be no presumption of equitable tolling.[10]

Nor does *City of New York* advance the analysis in any significant measure. There, the Supreme Court considered whether equitable tolling applied to the 60-day judicial review period for agency determinations as to Social Security "disability" status, and held that equitable tolling was available. But the language of the relevant statute, 42 U.S.C. § 405(g), was materially different. *See* 476 U.S. at 471-75. Section 405(g) provided for judicial review of an agency decision "within sixty days after the mailing to him of notice of such decision *or within such further time as the Secretary may allow*." 476 U.S. at 472 n.3 (emphasis added). That open-ended discretionary language—"within such further time as the Secretary may allow"—is altogether absent

[10] For this reason, plaintiffs' reliance on *Bradford Hospital v. Shalala*, 108 F. Supp. 2d. 473 (W.D. Pa. 2000), does little to advance their argument. In finding equitable tolling available, the district court deemed the Medicare regulation at issue (42 C.F.R. § 412.328(f)) "more analogous to the Title VII limitation provision in 42 U.S.C. § 2000e-16," and hence applied *Irwin*'s presumption of equitable tolling, finding *Brockamp* inapposite. 108 F. Supp. 2d at 485. But that characterization is incorrect, for as discussed above, *Irwin* has little applicability to limitations periods in the Medicare context. In any event, the district court's assessment of 42 C.F.R. § 412.328(f) sheds no light on this Court's assessment of a separate statutory provision.

from the 180-day limitations period set forth in § 1395oo(a)(3).

Brockamp offers the most insightful guidance on discerning Congressional intent with respect to equitable tolling, indicating that in a complex regulatory regime, courts should focus on the language of the statute and the "nature of the underlying subject matter." 519 U.S. at 350-53. In *Brockamp*, the Supreme Court considered whether the limitations period for filing tax refund claims, 26 U.S.C. § 6511, was subject to equitable tolling, and held that "Congress did not intend the 'equitable tolling' doctrine to apply." *Id.* at 348, 354. The Court found significant that the statute expressed its time limitations in "unusually emphatic form," and "in a highly detailed technical manner, that, linguistically speaking, cannot easily be read as containing implicit exceptions."[11] *Id.* at 350-51. The Court also emphasized that the statute set forth "explicit exceptions to its basic time limits, and those very specific exceptions do not include 'equitable tolling.'" *Id.* at 351. The Court considered secondarily whether the "nature of the underlying subject matter"—tax collection—supported its conclusion that Congress did not intend for equitable tolling to apply. *Id.* at 352-53 ("The nature of the underlying subject matter . . . underscores the linguistic point."). Considering the sheer number of tax returns and tax refunds processed each year—200 million tax returns, and 90 million refunds—the Court found it reasonable to

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[11] Section 6511 states that a "[c]laim for . . . refund . . . of any tax . . . shall be filed by the taxpayer within 3 years from the time the return was filed or 2 years from the time the tax was paid, whichever of such periods expires the later, or if no return was filed . . . within 2 years from the time the tax was paid." 26 U.S.C. § 6511(a)

infer that Congress did not intend equitable tolling to apply. *Id.* ("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 tax enforcement system.")

Applying these considerations here, the Court's assessment is that § 1395oo sets forth in "emphatic" language that the 180-day limitations period shall apply, albeit to a slightly lesser degree than does 26 U.S.C. § 6511. Section 1395oo(a)(3) states that a provider may obtain a Board hearing in enumerated scenarios "if"—

> (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.

Section 1395oo also contains a provision concerning accumulation of interest that is tied to the 180-day limitations period:

> (f)(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. . . .

42 U.S.C. § 1395oo(f)(2). As in the tax refund setting, moreover, the limitations provisions appear "in a highly detailed technical manner."

To be sure, the statutory language addressing the limitations period here is not as complex as that reviewed in *Brockamp*. Nonetheless, the language on its face bears no indicia that equitable tolling is intended, and the D.C. Circuit, in *HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 620 (D.C. Cir. 1994), described the statutory language as demonstrating that, "[i]f a provider permits that deadline to lapse, the Statute envisions no further appeal of the intermediary's decision." That court further observed that allowing a provider to bypass the 180-day limitations period (in that case, by obtaining reopening more broadly than authorized by the reopening regulations) "'would frustrate the congressional purpose, *plainly evidenced in [the statute], to impose a [time] limitation upon . . . review*.'" *Id.* at 620 (quoting *Califano v. Sanders*, 430 U.S. 99, 108 (1977)) (alterations in original, emphasis added). Hence, under *HCA*, and this Court's own reading of § 1395oo(a)(3), the plain language of the statute indicates that Congress did not intend to authorize equitable tolling.

And there is more. As noted earlier, the Secretary has longstanding and comprehensive regulations governing extension of the administrative appeal period and also reopening of payment determinations by an intermediary or, in an appropriate case, the Board or Secretary. 42 C.F.R. §§ 405.1841(b), 405.1885. *Brockamp* did not have occasion to consider whether an agency's promulgation of rules that effectively extend or toll the time for seeking administrative relief would have affected its

analysis. But because those regulations were promulgated pursuant to the Secretary's statutory authority, and have been validated by the D.C. Circuit and the Supreme Court, they must weigh in this calculus.

The regulations governing extension of the administrative appeal period and reopening of old decisions are very detailed—comparable to the detailed timing provisions at issue in *Brockamp*. They generally establish three years as the outer limit for reopening where one of the showings enumerated in the regulation has been made, and like the provision reviewed in *Brockamp*, the time limitations are set forth in "unusually emphatic form," and "in a highly detailed technical manner, that, linguistically speaking, cannot easily be read as containing implicit exceptions." *See* 519 U.S. at 35-51. In particular, they provide, *inter alia*, that: "Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision. . . . No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section." 42 C.F.R. § 405.1885(a). The regulations also delineate the standard for determining when reopening will be mandatory, providing that a determination "must be reopened and revised by the intermediary if, within the three year period specified in paragraph (a) of this section, CMS . . . provides notice to the intermediary that the intermediary determination . . . is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect. . . ." *Id.* § 405.1885(b). One circumstance where the three-year period shall not apply is identified—where "it is established that such determination or decision was procured by fraud or similar fault

of any party to the determination or decision." *Id.* § 405.1885(d) (emphasis added).

HCA Health Servs. held that the Secretary's reopening regulations fell "comfortably" within her rulemaking authority under 42 U.S.C. §§ 1302 and 1395hh. 27 F.3d at 618. More significantly, in rejecting a provider's argument that the reopening provisions should be read broadly, the court observed that "[p]erhaps the most convincing argument in favor of choosing the Secretary's reading over that urged by [the provider] is the preservation of the Medicare Statute's 180-day limitation on reviewing an intermediary's determination of total program reimbursement" as set forth in § 1395oo(a)(3). *Id.* at 620. Hence, the court rejected the provider's argument that all matters covered by an NPR can be reopened whenever any single issue in the NPR is reopened by the intermediary. *Id.* Here, the "preservation of the Medicare Statute's 180-day limitation period" would be entirely undercut by plaintiffs' broad proposition that equitable tolling is authorized by § 1395oo(a)(3). Indeed, the reopening regulations would be rendered virtually superfluous.

In *Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449, 453 (1999), the Supreme Court indicated that the plain language of the 180-day limitations period in § 1395oo(a)(3) demonstrated that judicial review of stale determinations was not allowed—there, under the mantel of an attempt to obtain judicial review of a reopening decision. The Court in *Your Home* considered whether the PRRB had jurisdiction to review a fiscal intermediary's refusal to reopen a reimbursement determination, and ultimately concluded that the Board—and hence the district court—did *not* have jurisdiction to

review a refusal to reopen. *Id.* at 453-55. In reaching this conclusion, the Court effectively upheld the reopening regulations in language strongly suggesting that the 180-day limitations period cannot be circumvented based on general fairness considerations:

> The right of a provider to seek reopening exists only by grace of the Secretary, and the statutory purpose of imposing a 180-day limit on the right to seek Board review of NPRs, see 42 U.S.C. § 1395oo(a)(3), would be frustrated by permitting requests to reopen to be reviewed indefinitely.
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> Title 42 CFR § 405.1885 (1997) generously gives them [providers] a second chance to get the decision changed—this time at the hands of the intermediary itself, but without the benefit of administrative review. That is a "suitable" procedure, especially in light of the traditional rule of administrative law that an agency's refusal to reopen a closed case is generally "'committed to agency discretion by law'" and therefore exempt from judicial review. . . . As for the alleged "double standard," given the administrative realities we would not be shocked by a system in which underpayments could *never* be the basis for reopening. . . . [E]ach 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. § 1395oo(a)(3).

525 U.S. at 454-56 (emphasis in original, citations omitted). The Supreme Court's assessment of § 405.1885 strongly indicates that the 180-day limitations period is not subject to equitable tolling. Based on the statutory

language, the regulations granting only limited exceptions to the 180-day limitations period, and the Supreme Court's determination in *Your Home* that the 180-day limit may not be circumvented by expanding Board (and hence, district court) jurisdiction to review requests to reopen, the Court concludes that equitable tolling of the 180-day limitations period is not available under 42 U.S.C. § 1395oo.

Brockamp suggests that the Court may consider, albeit secondarily, whether "the nature of the underlying subject matter" supports the Court's assessment of the statutory language. *See* 519 U.S. at 352 ("The nature of the underlying subject matter—tax collection—underscores the linguistic point."). Hence, defendant submits an array of statistics to demonstrate that the complexity of the Medicare program and the administrative burden of allowing equitable tolling under § 1395oo(a) confirm the unreasonableness of construing the statute to authorize equitable tolling.[12] *See* Def.'s Mem. at 21-22. The Court declines to rely specifically on that extra-pleading information here because the viability of most of plaintiffs' claims is being challenged on a motion to dismiss under Rule 12(b)(6), rather than on summary judgment. However, the Court notes the Supreme Court's observation in *Your Home* that "tens of

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[12] For example, defendant asserts that "[t]he Medicare program involves nearly $212 billion in annual payments to over 38,000 providers" as well as other entities, that it processes "more than a billion claims per year," and that 25 contractors process $202 billion in claims for about 6,000 hospitals, 15,000 skilled nursing facilities, and other providers of institutional care under Medicare Part A." *See* Def.'s Mem. at 21-22 (citing http://www.cms.hhs.gov/CapMarketUpdates/Downloads/2007CMSstat.pdf). Although plaintiffs do not dispute these figures, they are technically beyond the scope of a Rule 12(b)(6) motion.

thousands of sophisticated Medicare-providers" are recipients of NPRs, and its corresponding assessment that, hence, "administrative realities" may result in underpayments that are never reopened. 525 U.S. at 456. The volume and complexity of the provider reimbursement program at issue here is, quite plainly, comparable to the tax refund program in *Brockamp*, as to which the Supreme Court observed that the "magnitude of the administrative problem" cut against the availability of equitable tolling. To this extent, then, the complexity and nature of the Medicare Part A program supports the Court's conclusion that Congress did not intend to authorize equitable tolling in § 1395oo(a). In any event, plaintiffs have proffered nothing suggesting that the nature of the Medicare program implies that Congress intended to authorize equitable tolling for provider claims, notwithstanding the express language of § 1395oo(a) and the longstanding regulations granting only limited relief from the 180-day limitations period. Hence, although not central to this Court's analysis, the Court's determination that equitable tolling is not authorized by §1395oo(a) is buttressed by the scope and complexity of the Medicare program.

III. Mandamus

Plaintiffs contend that, in the event they are precluded from obtaining relief under § 1395oo(f), they are entitled to a writ of mandamus requiring new DSH determinations under 28 U.S.C. § 1361 because defendant has a "non-discretionary duty to use correct SSI percentages" when determining DSH payments. *See* Pls.' Mem. at 20-22. Plaintiffs further assert that defendant has a nondiscretionary duty to reopen intermediary determinations "if it is established that such determination

. . . was procured by fraud or similar fault of any party to the determination or decision"—a point they consider established by the *Baystate* decisions issued by the Board and this Court. Pls.' Mem. at 12, 21 (quoting 42 C.F.R. § 405.1885(d)). Defendant counters that the Court lacks mandamus jurisdiction because plaintiffs fail to satisfy the prerequisites for mandamus relief. *See* Def.'s Mem. at 12-18; Def.'s Reply at 8-9. The relevant duty for the mandamus inquiry, in defendant's view, is whether the Secretary had a nondiscretionary duty to extend the 180-day limitations period or to reopen the NPR. Under the regulations, both of those matters are plainly discretionary, which would preclude mandamus relief. Defendant further contends that plaintiffs' failure to exhaust administrative remedies precludes them from obtaining mandamus relief.

Mandamus is a drastic remedy to be invoked only in extraordinary situations and to be granted only when essential to the interests of justice. *See Oglala Sioux Tribe of Pine Ridge Indian Reservation v. U.S. Army Corps of Eng'rs*, 570 F.3d 327, 333 (D.C. Cir. 2009). Under 28 U.S.C. § 1361,[13] a court has jurisdiction to grant mandamus relief only if "(1) the plaintiff has a clear right to relief; (2) the defendant has a clear duty to act; and (3) there is no other adequate remedy available to plaintiff." *In re Medicare Reimbursement Litig.*, 414 F.3d at 10 (quoting *Power v. Barnhart*, 292 F.3d 781, 784 (D.C. Cir. 2002)); *Fornaro v. James*, 416 F.3d 63, 69 (D.C. Cir. 2005). To maintain a mandamus action

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[13] The mandamus statute provides that "[t]he district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." 28 U.S.C. § 1361.

in the Medicare context, a plaintiff also must exhaust his administrative remedies unless exhaustion would be futile. *Heckler v. Ringer*, 466 U.S. 602, 616-18 (1984); *Monmouth Med. Ctr.*, 257 F.3d at 813. "[I]f there is no clear and compelling duty under the statute as interpreted, the district court must dismiss the action." *In re Cheney*, 406 F.3d at 729. The party seeking mandamus has the "burden of showing that [his] right to issuance of the writ is clear and indisputable." *Gulfstream Aerospace Corp v. Mayacamas Corp.*, 485 U.S. 271, 289 (1988) (internal quotation marks and citation omitted).

The parties focus primarily on whether defendant owes plaintiffs a nondiscretionary duty, but identification of the relevant duty has shifted as the litigation has developed. Plaintiffs' complaint alleges that the nondiscretionary duty owed to providers is a "nondiscretionary duty to use correct SSI percentages" when determining DSH payments. Compl. ¶¶ 62, 64; *see* Pls.' Mem. at 20. In their merits brief and at the motions hearing, however, plaintiffs rely almost exclusively on defendant's duty to reopen and revise a determination whenever "fraud or similar fault of any party" is established. *See* Pl.'s Mem. at 21-22 (quoting 42 C.F.R. § 405.1885(d)).

Plaintiffs fail to establish a nondiscretionary duty to act in either formulation. With respect to the so-called "duty to use correct SSI percentages" in determining DSH payments, plaintiffs misconstrue the case law. This Court has previously held that the "best available data" standard, long-recognized in the case law as governing other Medicare reimbursement determinations, governs the validity of SSI percentages, not some abstract standard of "correctness" or perfection. *See*

Baystate, 545 F. Supp. 2d at 49 ("The case law amply supports the proposition that the best available data standard leaves room for error, so long as more reliable data did not exist at the time of the agency decision.") (citing *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1228-30 (D.C. Cir. 1994), and *Mt. Diablo Hosp. v. Shalala*, 3 F.3d 1226, 1233 (9th Cir. 1993)).

Even recasting plaintiff's "duty" argument as a duty to determine the SSI percentages based on the "best available data," plaintiffs would not succeed. The failure to use the "best available data"—or to use "correct" SSI percentages for that matter—is, in essence, an allegation that the intermediary's determination was "inconsistent with the applicable law." The regulations require reopening of an NPR in this circumstance only where "CMS . . . [p]rovides notice to the intermediary that the intermediary determination . . . is inconsistent with the applicable law, regulations, CMS rulings, 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." 42 C.F.R. § 405.1885(b)(1)(i). As defendant points out, "CMS has never explicitly (or implicitly) notified plaintiffs' intermediaries that their determinations were inconsistent with applicable law," and, indeed, defendant's position is that those determinations involve, at worst, a "flawed data" problem, not any inconsistency with the law.[14] *See* Def.'s Mem. at 14-15. In the absence of CMS

[14] Even if this Court's *Baystate* decision operated as a *de facto* notice of inconsistency with applicable law, § 405.1885(b)(1)(i) would not impose a duty on CMS or the intermediaries to reopen the NPRs at issue. This is because, with respect to inconsistency with applicable law, the regulation imposes a duty to reopen only if the notice of inconsistency occurs "within the three-year period" after the date of the

issuing a notice to the intermediary stating that the determination is inconsistent with applicable law, there is no mandatory duty to reopen a payment determination.

Plaintiffs' main contention, in any event, is that they are entitled to mandamus relief based on defendant's duty to reopen payment determinations procured by fraud. *See* Pl.'s Mem. at 21- 22 (discussing 42 C.F.R. § 405.1885(d)). In their view, the *Baystate* decisions issued by the Board in 2006 and this Court in 2008 establish that the data flaws underlying their NPRs were "deliberately concealed" by CMS, which requires reopening under the fraud provision "at any time." *Id.* at 22. There are two problems with this argument. First, nothing in either of the *Baystate* decisions reflects a finding that CMS "deliberately concealed" the data flaws at issue or otherwise engaged in fraud. Rather, the Board simply found that "'that CMS knew or should have known at least by 1993 that there was a problem with the SSI data received from SSA,'" and thus rejected the contention that CMS had used the "best available data." *Baystate*, 545 F. Supp. 2d at 27 (quoting *Baystate* Board Decision at 34-35). The Board made no finding regarding fraud or deliberate concealment. This Court, reviewing the Board's decision, similarly concluded that CMS had not used the "best available data," but likewise made no finding regarding fraud or deliberate concealment. *Id.*

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intermediary's determination (i.e., NPR issuance), effectively excluding NPRs older than three years from the mandatory reopening. *See Baptist Mem. Hosp. v. Johnson*, 603 F. Supp. 2d 40, 43-44 (D.D.C. 2009). Here, plaintiffs' NPRs were issued far outside of that three-year window, with the most recent having been issued in or around 1996.

Second, and equally significant, plaintiffs have failed to exhaust their administrative remedies. As noted earlier, exhaustion of administrative remedies is a prerequisite to the extraordinary remedy of mandamus, unless exhaustion would be futile. *See Monmouth*, 257 F.3d at 810 ("we must first examine all other possible avenues of relief to ensure that the hospitals have fully exhausted those which were available"); *In re Medicare Reimbursement Litig.*, 414 F.3d at 11 (finding that futility was demonstrated where, *inter alia*, the reopening period had expired and CMS had issued a ruling "barr[ing] intermediaries from reopening closed NPRs to recalculate DSH entitlement"). Indeed, where providers seek mandamus based on the reopening provisions, they must show that "they have done all they can to vindicate their right to reopening." *Monmouth*, 257 F.3d at 815.

There is no allegation in the complaint that plaintiffs ever sought to reopen their NPRs based on fraud, and they admitted as much at the motions hearing. Their only excuse is that they anticipate difficulties in obtaining information from the agency to support their claim of fraud. But by plaintiffs' own account, they believe evidence in the Board's *Baystate* administrative record supports their allegations of fraud, and that record was long-ago filed with this Court in the *Baystate* civil action. *See Baystate Med. Ctr. v. Leavitt*, Civil Action No. 06-1263, Notice of Filing of Administrative Record (D.D.C. filed Nov. 22, 2006). Moreover, plaintiffs have other means for obtaining information in support of their claim, such as the Freedom of Information Act. Plaintiffs suggested at the motions hearing that, even if they obtain evidence demonstrating fraud, a request for reopening is likely to be unsuccessful, and defendant's

litigation counsel suggested the same.[15] But as was observed recently in *Bradley Mem. Hosp. v. Leavitt*, 599 F. Supp. 2d 6, 17 (D.D.C. 2009), "[t]he point of pursuing administrative relief is to exhaust avenues by which [p]laintiffs might have convinced the agency to change its position without resorting to the type of extraordinary relief that [p]laintiffs now request." In short, there is no basis here for excusing plaintiffs from the requirement to exhaust administrative remedies as a prerequisite to mandamus relief.

Should plaintiffs exhaust their administrative remedies, and then return to court with evidence that establishes fraud or concealment with respect to the calculation of the SSI percentages, a court may consider their request for mandamus relief anew. But at this time, plaintiffs have fallen far short of alleging facts that would establish their entitlement to the extraordinary remedy of mandamus.[16]

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[15] At the motions hearing, a Department of Justice attorney suggested for the first time during rebuttal argument that the fraud reopening provision is not applicable if the person allegedly acting fraudulently is the Secretary because the Secretary is not a "party" to the intermediary's determination within the meaning of the regulation. This contradicts defendant's earlier statement in its brief that plaintiffs should be required to exhaust their administrative remedies with respect to the allegation of fraud under § 405.1885(d). *See* Def.'s Reply at 9 n.5. Because the attorney presenting rebuttal offered only a post hoc interpretation of the regulation that is inconsistent with the brief approved by the agency, the Court gives the statement no weight.

[16] In Count Three of the complaint, plaintiffs seek substantially the same mandamus relief under the All Writs Act, 28 U.S.C. § 1651(a). *See* Compl. ¶¶ 63-64. It is well-settled, however, that "the Act itself is not a grant of jurisdiction." *In re Tennant*, 359 F.3d 523, 527 (D.C. Cir. 2004). The All Writs Act provides that the federal courts "may issue all writs necessary or appropriate *in aid of* their respective

IV. Availability of Relief under 28 U.S.C. § 1331

As a last resort, plaintiffs invoke the federal question statute, 28 U.S.C. § 1331, as a basis for bringing their claims for relief. Plaintiffs contend that if judicial review of their challenges is not available under § 1395oo(f) or the mandamus statute, they are entitled to bring their claims for relief directly under § 1331. Defendant responds that Congress has disallowed judicial review of Medicare claims under § 1331, as set forth in 42 U.S.C. § 405(h) and § 1395ii, instead choosing to channel judicial review under § 1395oo. The Court agrees.

As the D.C. Circuit explained in *Monmouth*, § 1395oo sets forth "detailed instructions on the means for seeking review of payment determinations," and in tandem with that provision, "[§] 1395ii generally forecloses other avenues of review by incorporating the review-limiting provisions of the Social Security Act, 42 U.S.C. § 405(h)." 257 F.3d at 809. Section 405(h), with the substitutions required by § 1395ii, provides that:

> The findings and decision of [the Secretary of HHS] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of [the Secretary of HHS] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against

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jurisdictions and agreeable to the usages and principles of law." 28 U.S.C. § 1651(a) (emphasis added). This statutory language makes clear that the authority to issue writs is confined to the issuance of process "in aid of" jurisdiction that is created by some other source and not otherwise enlarged by the Act. *In re Tennant*, 359 F.3d at 527. Because the All Writs Act does not provide a separate basis for relief, Count Three will be dismissed.

> the United States, the [Secretary of HHS], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

Monmouth, 257 F.3d at 809 (quoting 42 U.S.C. § 405(h), alterations in original).[17] Hence, § 1331 "review [of Medicare payment determinations] could not be more plainly off limits under 42 U.S.C. § 405(h), which explicitly withholds § 1331 jurisdiction for 'any claim arising under this title.' " *Id.* at 812. A provider's claim "arise[s] under" the Medicare Act within the meaning of § 405(h) when " 'both the standing and the substantive basis for the presentation of the claim are the Medicare Act.' " *Your Home*, 525 U.S. at 456 (quoting *Ringer*, 466 U.S. at 615). Here, plaintiffs' claims clearly arise under the Medicare Act—and hence are covered by § 405(h)—because they arise from the calculation of payments under the Medicare DSH provision and have as their ultimate goal the recovery of additional sums under the Medicare Act. *See Monmouth*, 257 F.3d at 812.

To be sure, the Supreme Court has recognized a narrow exception to § 405(h) where its application "would not simply channel review through the agency, but would mean no review at all." *See Shalala v. Illinois Council on Long Term Care*, 529 U.S. 1, 19 (2000). Plaintiffs contend that they fall within this exception

[17] Section 1395ii provides that "[t]he provisions . . . 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 [Medicare], any reference therein to the Commissioner of the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively."

because, without judicial review of their DSH payments under § 1331, the Secretary's actions would be immunized from judicial scrutiny. *See* Pls.' Mem. at 22. The flaw in plaintiffs' position, however, is that judicial review of plaintiffs' DSH payments was, in fact, available under § 1395oo(f), but plaintiffs missed their opportunity to obtain judicial review by failing to seek Board review within 180 days of receiving the intermediary's final determination. Hence, it is only by virtue of plaintiffs' untimeliness that judicial review on their current claims may be foreclosed. The Secretary's actions in implementing the DSH program have *not* generally been immunized from judicial review, then, as demonstrated by cases before this Court in which providers did, in fact, file timely administrative appeals raising the same issues as plaintiffs, as well as cases under § 1395oo. *See, e.g.*, *Baystate*, 545 F. Supp. 2d 20; *Northeast Hosp. Corp. v. Sebelius*, Civil Action No. 09-0180 (D.D.C. filed Jan. 30, 2009).[18] Moreover, to the extent that plaintiffs can identify a nondiscretionary duty owed to them under the Medicare Act, they may obtain judicial review and relief under the mandamus statute—an avenue left open by this Court's resolution of the mandamus claim. As with any claim for relief, the failure of plaintiff to seek judicial review in a timely manner, or to prevail on a claim, does not mean that there is, under *Illinois Council*, "no review at all." Accordingly, pursuant to § 1395ii and § 405(h), the Court concludes that it

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[18] In *Northeast Hosp.*, the Secretary has conceded that a provider who filed a timely appeal contesting its DSH payment based on the defects described in *Baystate* (and raised by plaintiffs in this case) was entitled to a remand for recalculation of its DSH payment. *See Northeast Hosp.*, Def.'s Mem. in Supp. of Mot. for Summ. J. at 5-6 (filed Oct. 2, 2009).

lacks jurisdiction to review plaintiffs' claims for relief directly under § 1331.

CONCLUSION

For the foregoing reasons, the Court will grant defendant's motion to dismiss. Plaintiffs' claims for relief under 42 U.S.C. § 1395oo and in the nature of mandamus will be dismissed for failure to state a claim upon which relief can be granted. Plaintiffs' claims for relief directly under 28 U.S.C. § 1331 will be dismissed for lack of subject matter jurisdiction. A separate order has been issued on this date.

/s/ JOHN D. BATES
JOHN D. BATES
United States District Judge

Dated: Mar. 11, 2010

APPENDIX C

[SEAL OMITTED]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Phone: 410-786-2671 **FAX: 410-786-5298**

Internet: www.cms.hhs.gov/PRRBReview

Suzanne Cochran, Esq., Chairperson
Elaine Crews Powell, CPA
Anjali Mulchandani-West
Yvette C. Hayes
Michael D. Richards

Refer to: 06-2359G [Received: Sept. 18, 2007]

CERTIFIED MAIL

Robert L. Roth, Esq.
Crowell & Moring, LLP
1001 Pennsylvania Ave., NW
Washington, D.C. 20004-2595

Linda Uzzle
Blue Cross Blue Shield Association
7004 Security Blvd.
Baltimore, MD 21244-2534

RE: UHS 87-94 DSH/SSI Equitable Tolling Grp
Provider Nos. Varopis
FYE 1987-1994
PRRB Case No. 06-2359G

Dear Mr. Roth and Ms. Uzzle:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional briefs of the parties in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Procedural History

The Providers filed this appeal on September 12, 2006 for the fiscal years (FYs) 1987-1993. There is no dispute regarding the fact that the Notices of Program Reimbursement (NPRs) for the fiscal years under dispute were all issued more than three years before the current request for hearing was filed. The Providers have requested that the Board consider whether the appeal is timely filed under the doctrine of equitable tolling over the issue under dispute: whether the Intermediary used an understated Supplemental Security Income (SSI) percentage when calculating the disproportionate share (DSH) adjustment.

Positions of the Parties

The Providers observe that the Centers for Medicare & Medicaid Services (CMS) calculates the SSI percentage but does not and believes its cannot share the data with providers. Further, the Claims Processing Manual (CMS Pub. 100-04) requires that intermediaries calculate the DSH adjustment using the SSI percentage fur-

nished to them by CMS. The Providers point to the decision in *Loma Linda Hospital v. Shalala*[1] to support its position that CMS will not release SSI data. The Board's decision in *Baystate Medical Center v. Mutual of Omaha*[2] (*Baystate*) is cited for the proposition that the SSI percentage is understated.

The Providers explained in their hearing request that their failure to file a timely appeal was the result of CMS' alleged knowing and unlawful refusal to inform hospitals that the SSI percentage was incorrectly stated for the fiscal years under appeal. Under 42 C.F.R. § 405.1841(b), the Board has the authority to extend the time for filing an appeal for up to three years from the issuance of the NPR based on "good cause." Good cause for late filing cannot be considered in these cases because the cases are being filed more than three years after the issuance of the NPRs for the FYEs in question. Consequently, the Providers are requesting that the Board apply the principle of equitable tolling and find that the appeal is timely.

The decision in *Bradford Hospital v. Shalala*[3] is cited for the proposition that equitable tolling is proper "when the principles of equity would make the rigid application of a limitation period unfair." In addition, *Irwin v. Veterans Administration*[4] (*Irwin*) is cited for the proposition that equitable tolling applies "where the complain-

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[1] 907 F. Supp. 1399 (C.D. Calif. 1995)

[2] PRRB Dec. 2006-D20 (March 17, 2006) (Medicare & Medicaid Guide (CCH)), ¶ 81,468; modified CMS Administrator's Dec. May 11, 2006 (Medicare & Medicaid Guide (CCH)) ¶ 81,506.

[3] 108 F. Supp. 2d 473 (W.D. Pa. 2000)

[4] 498 U.S. 89, 96 (1990)

ant has been induced or tricked by his adversary's misconduct into allowing the filing deadline to pass." The Providers assert that its failure to file on time was the direct result of CMS' failure to inform providers that the SSI percentages were understated for the FYEs under appeal. The Providers' believe that the Board's decision in *Baystate* establishes the fact that the SSI percentage is understated.

The Intermediary asserts that the Board lacks jurisdiction over the appeal because the NPRs were issued more than three years before the appeal was filed; therefore, the Board cannot consider good cause for late filing. Further, the Providers cannot establish that there was misconduct on the part of the other party which would make *Irwin* applicable. In addition, the Providers cannot prove that they were "induced or tricked" into missing appeal deadlines. There was no evidence in the *Baystate* decision that CMS knew 20 years ago that there was any defect in the SSI data. The Intermediary believes that the doctrine of equitable tolling is not appropriate here because the Providers are simply trying to take advantage of the favorable decision in *Baystate*.

The Intermediary points out that in *Anaheim Memorial Hospital v. Blue Cross of California*[5] (*Anaheim*) the Board found that it lacks the general equitable powers necessary to consider equitable tolling. The decision in *Bradford* can be distinguished from the current case because it dealt with the filing for a redetermination of the provider's hospital specific rate which is different from the timely filing of appeals. Finally, the Interme-

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[5] PRRB Dec. 2000-D72 (Medicare and Medicaid Guide (CCH)) ¶ 80,257.

diary points out that the statute of limitations for considering good cause is a statute of repose because it sets the final period of time for an appeal to be filed. The purpose is "to relieve potential defendants from anxiety and liability over acts committed long ago."

Decision of the Board

The Board finds that it lacks jurisdiction over the Providers' appeal of the fiscal years 1987-1993 because the appeal was not timely filed.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 and 405.1841, a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $50,000 or more for a group appeal and the request for hearing is filed within 180 days of the date of the final determination. Pursuant to 42 C.F.R. § 405.1841(b) the Board may consider a request for good cause for late filing if such a request was made within three years after the date the notice of intermediary determination is mailed to the provider. In this case, there is no dispute that the request for hearing was not made within three years of the issuance of the NPRs and good cause cannot be considered.

Further, consistent with the decision in *Anaheim*, the Board concludes that it does not have general equitable powers and cannot grant equitable relief such as equitable tolling. The Board is an administrative forum and, unlike the courts, does not have general equitable powers but rather only the powers granted to it by statute and regulation. The equitable powers granted to the

Board are found in 42 C.F.R. §§ 405.1841(b) (good cause) and 405.1885 (reopenings).

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

Suzanne Cochran, Esq.
Elaine Crews Powell, CPA
Anjali Mulchandani-West, CPA
Yvette C. Hayes

FOR THE BOARD:

/s/ SUZANNE COCHRAN
SUZANNE COCHRAN, Esq.
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: George Porette, National Government Services (NY)
Wilson Leong, BCBSA

APPENDIX D

[LOGO OMITTED]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-01-20
Baltimore, Maryland 21244-1850
Telephone 410-786-3176 Facsimile 410-786-0043

[Received: Nov. 1, 2007]

Office of the Attorney Advisor

VIA FACSIMILE AND
FIRST CLASS MAIL

Robert L. Roth, Esquire
Crowell & Moring LLP
1001 Pennsylvania Avenue, NW
Washington, DC 2004-2595

Re: Hackensack University Medical Center, PRRB Case No. 06-2296; Crowell & Moring 87-93 DSH/SSI Equitable Tolling Group, PRRB Case No. 06-2357G; UHS 87-94 DSH/SSI Equitable Tolling Group, PRRB Case No. 06-2359G; Franklin Hospital Medical Center, PRRB Case No. 06-2355; Long Island Jewish Medical Center, PRRB Case No. 06-2352; North Shore University Hospital, PRRB Case No. 06-2354; Southside Hospital, PRRB Case No. 06-2356

Dear Mr. Roth:

This is to advise that the Administrator of the Centers for Medicare & Medicaid Services (CMS) has declined to review the decision entered by the Provider Reimbursement Review Board in the captioned case.

If the Provider wishes to obtain judicial review of the matter, civil action must be initiated within 60 days of the date the Board's decision was received in accordance with 42 CFR 405.1877.

Sincerely yours,

JACQUELINE R. VAUGHN
JACQUELINE R. VAUGHN
Attorney Advisor

Enclosure

cc: Ms. Linda Uzzle, Intermediary's Representative

[LOGO OMITTED]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-01-20
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Phone 410-786-3176 Facsimile 410-786-0043

Office of the Attorney Advisor

Re: Hackensack University Medical Center, PRRB Case No. 06-2296; Crowell & Moring 87-93 DSH/SSI Equitable Tolling Group, PRRB Case No. 06-2357G; UHS 87-94 DSH/SSI Equitable Tolling Group, PRRB Case No. 06-2359G; Franklin Hospital Medical Center, PRRB Case No. 06-2355; Long Island Jewish Medical Center, PRRB Case No. 06-2352; North Shore University Hospital, PRRB Case No. 06-2354; Southside Hospital, PRRB Case No. 06-2356

Pursuant to 42 CFR 405.1875(d)(2), I recommend that the Administrator, Centers for Medicare & Medicaid Services, decline to review the decisions entered by the Provider Reimbursement Review Board in these cases.

/s/ JACQUELINE R. VAUGHN
JACQUELINE R. VAUGHN
Attorney Advisor

APPROVED:

Date: [10/26/07] /s/ HERB B. KUHN
HERB B. KUHN
Deputy Administrator
Centers for Medicare &
Medicaid Services

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 10-5115
September Term 2011
1:07-cv-02075-JDB

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
APPELLANTS

v.

KATHLEEN SEBELIUS, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
APPELLEE

Filed: Dec. 20, 2011

ORDER

Before: HENDERSON and GRIFFITH*, Circuit Judges, and WILLIAMS*, Senior Circuit Judge

Upon consideration of appellee's petition for panel rehearing filed August 8, 2011, it is

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* Circuit Judge Griffith and Senior Circuit Judge Williams vote to deny the petition for the reasons set forth in their statement concurring in the denial of appellee's petition for rehearing en banc filed December 20, 2011.

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/ MICHAEL C. McGRAIL
MICHAEL C. MCGRAIL
Deputy Clerk

APPENDIX F

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 10-5115
September Term 2011
1:07-cv-02075-JDB

AUBURN REGIONAL MEDICAL CENTER, ET AL.,
APPELLANTS

v.

KATHLEEN SEBELIUS, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
APPELLEE

Filed: Dec. 20, 2011

ORDER

Before: SENTELLE, Chief Judge, and HENDERSON, ROGERS, TATEL, GARLAND, BROWN, GRIFFITH*, and KAVANAUGH, Circuit Judges, and WILLIAMS*, Senior Circuit Judge

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* A statement by Circuit Judge Griffith, joined by Senior Circuit Judge Williams, concurring in the denial of rehearing en banc is attached.

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

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: /s/ MICHAEL C. McGRAIL
MICHAEL C. MCGRAIL
Deputy Clerk

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 10-5115
September Term 2011

Griffith, Circuit Judge, joined by Williams, Senior Circuit Judge, concurring in the denial of rehearing en banc: The Secretary urges the reconsideration of our conclusion that Congress did not preclude equitable tolling of the limitations period for filing Medicare reimbursement claims on the ground that we overlooked the administrative burdens that tolling brings. But we were simply following the analytical framework set forth in *United States v. Brockamp*, 519 U.S. 347 (1997). Panel Op. 7-10. The Supreme Court undertook the inquiry in two stages. Looking first at the limitations provisions of the statute, the Court concluded that the statute's "detail, its technical language, the iteration of the limitations in both procedural and substantive forms, and the explicit listing of exceptions," taken together, showed that Congress did not intend other equitable exceptions to be read into the statute. *Brockamp*, 519 U.S. at 352. The burdens caused by equitable tolling, the second stage in the Court's analysis, simply underscored what an analysis of the text had already revealed. As we read *Brockamp*, we need not look at any burdens that might flow from equitable tolling when the textual factors fail to rebut the presumption. We can imagine their relevance when the text of the statute is not otherwise clear, but in this case the statute itself is without any clues that suggest Congress barred equitable tolling.

It is unclear whether *Holland v. Florida*, 130 S. Ct. 2549 (2010), transformed *Brockamp*'s two-step approach

into a balancing test that puts administrative burdens on an equal footing with the textual factors. In *Holland*, the Supreme Court included the administrative burdens that might result from equitable tolling alongside the textual factors the Court used in *Brockamp* to conclude that the limitations period in the Antiterrorism and Effective Death Penalty Act of 1996 may be equitably tolled. *See id.* at 2561. We need not decide whether this marks a change in the Court's analysis because even if the burdens created by equitable tolling are now an indispensable part of the inquiry, they do not change the outcome in this case. None of the textual factors in the Medicare reimbursement statute weigh in favor of equitable tolling. Unlike the emphatic, detailed, and repeated limitations provisions in *Brockamp*, the limitations provision here is simple and includes no exceptions that suggest Congress intended to preclude equitable tolling. *See* Panel Op. 7-8. While allowing equitable tolling may increase the amount of interest recoverable, that effect is straightforward relative to the potential effect of tolling in *Brockamp*, where the calculation of the refund itself changed depending on when claims were filed. *See Brockamp*, 519 U.S. at 351. Although it is no doubt true that the complex Medicare reimbursement scheme will be more difficult to administer with equitable tolling available to claimants, that factor alone is not enough to persuade us that Congress rejected the presumption of equitable tolling with the type of clarity the precedents require.

Accordingly, we concur in the denial of rehearing en banc.

APPENDIX G

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. 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.

3. 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.

4. 42 U.S.C. 1395ww(d)(5) provides in pertinent part:

(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.

* * * * *

5. 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 re-

ceives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in 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 de-

termining 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.

6. 42 C.F.R. 405.1836 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, modfied, 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 Administrator, 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.

7. 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 provider 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.

8. 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 pe-

riod 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).