95-6224

To be argued by
MARTIN J. SIEGEL

United States Court of Appeals

FOR THE SECOND CIRCUIT

Docket No. 95-6224

GOOD SAMARITAN HOSPITAL REGIONAL MEDICAL CENTER, LONG ISLAND COLLEGE HOSPITAL, and NORTHERN WESTCHESTER HOSPITAL CENTER,

Plaintiffs-Appellants,

—v.—

DONNA E. SHALALA, in her official capacity as Secretary of Health and Human Services, and EMPIRE **BLUE CROSS BLUE SHIELD,**

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

BRIEF FOR DEFENDANTS-APPELLEES

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Preliminary Statement

Plaintiffs appeal from an August 4, 1995 judgment of the United States District Court for the Southern District of New York (Honorable William C. Conner, J.), entered in accordance with an August 3, 1995 Opinion and Order. Joint Appendix ("JA") 9-42. The district court dismissed plaintiffs' complaint against defendants Donna Shalala, the Secretary of the United States Department of Health and Human Services (the "Secretary"), and Empire Blue Cross Blue Shield ("Empire").

Plaintiffs, three New York hospitals, are "providers of services" under the Medicare Act, and are therefore entitled to reimbursement for services rendered to Medicare beneficiaries. The district court held that the Provider Reimbursement Review Board ("PRRB") correctly declined to review Empire's refusal to reopen certain of plaintiffs' claims for Medicare reimbursement. The

district court also held that it lacked jurisdiction to review the merits of Empire's reopening denial.

The district court's decision was correct and should be affirmed. The PRRB's conclusion that Empire's reopening denial did not constitute an appealable decision subject to further administrative review under the Medicare statute was, at the least, a permissible construction of the statute, meriting substantial judicial deference. Likewise, the Secretary's regulations barring PRRB review are a reasonable and valid exercise of the Secretary's broad discretion to implement the Medicare statute, and are essential to preserving the integrity of the statute's appeal provisions, which are designed to bring finality to reimbursement disputes.

The district court also correctly concluded that it lacked jurisdiction to consider the merits of Empire's reopening denials, in that the court's only jurisdiction was to review the PRRB's decision finding the denials to be non-appealable. Should this Court nonetheless reach the merits of plaintiffs' underlying claims for reimbursement, it should reject them because they are based on a statutory provision that was not incorporated into subsequent Medicare amendments governing plaintiffs' claims.

Issues Presented

1. Whether the district court properly granted summary judgment upholding the PRRB's refusal to review Empire's denials of reopening motions, where that refusal was based on a reasonable construction of applicable Medicare Act provisions and regulations.

2. Whether the district court properly declined to review

the merits of Empire's reopening decisions where the PRRB's only final determination was that it lacked jurisdiction to consider those decisions.

Statement of the Case

A. Statutory And Regulatory Framework

Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 - 1395ccc, establishes Medicare, a federally funded health insurance program for the elderly and disabled. See 42 U.S.C. §§ 1395c, 1395d, 1395j, 1395k. Medicare has two parts. Part A, which is at issue here, extends Medicare coverage to beneficiaries for ninety days of hospital inpatient service in each benefit period, plus an additional sixty-day lifetime reserve. Id. §§ 1395d, 1395q; 42 C.F.R. Part 409, Subpart F. Because it is the Government -- not beneficiaries -- that pays directly for covered Medicare services, Part A also authorizes federal reimbursement of providers for various medical services, including inpatient institutional services, provided to persons covered by Medicare. 42 U.S.C. §§ 1395c - 1395i-2. Part B, which is not at issue here, governs payments for doctors', outpatient, and other related services. Id. §§ 1395j - 1395w-4.

1. Calculating Medicare Reimbursement Rates

The system by which providers are reimbursed by the Government for services rendered to Medicare patients has changed a number of times since the establishment of the program. From 1966 until 1983, Medicare reimbursed providers by paying the lesser of their customary charges and the "reasonable costs" they actually incurred in serving beneficiaries. Id. §§ 1395f(b)(1), 1395x(v).

"Under this regime, hospitals and other health care providers had little incentive to curb operating costs and render services more economically, for the federal government bore the burden of the increases." Sacred Heart Medical Center v. Sullivan, 958 F.2d 537, 540 (3d Cir. 1992). Hence, Congress enacted the Tax Equity and Fiscal Responsibility Act ("TEFRA") in 1982. See 42 U.S.C. § 1395ww(b). While TEFRA left the retrospective cost-based structure of Part A reimbursement undisturbed, it set limits on the rate of increase of Part A reimbursement for, inter alia, the operating costs of inpatient hospital services. Id. § 1395ww(b)(1); see generally, Connecticut Hospital Association v. Weicker, 46 F.3d 211, 214 (2d Cir. 1995).

TEFRA tied the rate-of-increase limit for each provider to a "target amount," defined as the provider's costs for inpatient hospital services for the "base year" of 1982 (the twelve month cost reporting period preceding TEFRA), increased by a specified percentage in each succeeding cost reporting period. 42 U.S.C. § 1395ww(b)(3)(A). A "cost reporting period" is the year-long interval, beginning and ending according to "the provider's accounting year," for which providers must submit data to the Secretary regarding their operating costs. 42 C.F.R. § 413.20(b). Under TEFRA, providers absorbed cost increases in excess of applicable target amounts and received bonuses if increases were less than those target amounts. 42 U.S.C. § 1395ww(b)(1)(A)-(B); 42 C.F.R. § 413.40. TEFRA also provided for an "exemption from, or an exception and adjustment to," the rate-of-increase limits, "where events beyond the hospital's control or extraordinary circumstances . . . create a distortion in the increase

in costs for a cost reporting period." 42 U.S.C. § 1395ww(b)(4)(A) (the "TEFRA adjustment"). The Secretary was further authorized to provide for other exemptions, exceptions or adjustments as he or she "deems appropriate." Id.; see also 42 C.F.R. § 413.40.

TEFRA did not last long. In 1983, the year after TEFRA was passed, Congress replaced TEFRA's rate-of-increase limits with an even more ambitious reform of Part A reimbursement known as the Prospective Payment System ("PPS"), by which providers are reimbursed according to prospectively determined national and regional rates rather than actual costs or charges. 42 U.S.C. § 1395ww(d). Like TEFRA, PPS provides for specific exceptions and adjustments, and directs the Secretary to provide for others by regulation as he or she "deems appropriate." Id. § 1395ww(d)(5)(A)-(I). In contrast to the TEFRA adjustment, however, PPS does not direct the Secretary to adjust reimbursement amounts where "extraordinary circumstances" distort the increase in costs for a particular cost reporting period, id., nor has the Secretary implemented such an exception by regulation. See 42 C.F.R. §§ 412.71(b)-(c), 412.72.

Seeking to "minimize disruptions that might otherwise occur because of [the] sudden change in reimbursement policy" from TEFRA to PPS, H.R. Rep. No. 25, 98th Cong., 1st Sess., 136 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 355, Congress chose to phase in the PPS system over the course of a four-year "transition period" beginning in 1984 and ending in 1988. 42 U.S.C. § 1395ww(d); H.R. Rep. No. 98-25, 98th Cong., 1st Sess. 136 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 355. During the transition period, providers were reimbursed according to a

"blended" rate composed of a hospital-specific portion ("HSP") geared to reimbursement for actual outlays, and a "federal" portion based on the PPS regime of regional and national rates. 42 U.S.C. § 1395ww(d)(1)-(2). The HSP share of the overall formula was calculated by assessing a percentage of a provider's "target amount for the cost-reporting period (as defined in subsection (b)(3)(A) of this section . . .)" ending on or before September 30, 1983. Id. § 1395ww(d)(1)(A)(i)-(ii). Providers received reasonable cost reimbursement for the costs of that year, and these costs in turn formed the "base year" for calculating the prospective PPS rate throughout the transition period. Id. During the transition period, the portion of the reimbursement amount based on the federal rate became progressively larger while the HSP portion shrank proportionately until it was phased out completely, leaving the prospective rate as the exclusive basis for PPS reimbursement. Id- § 1395ww(d)(1)(C).

2. Obtaining Reimbursement And Appealing Reimbursement Determinations

Providers are usually reimbursed through private insurance companies that, acting as agents or "fiscal intermediaries" ("intermediaries") for the Secretary, determine the amount of reimbursement due. 42 U.S.C. § 1395h; 42 C.F.R. § 421.103 (1987). These intermediaries are bound by the Secretary's regulations and by the instructions set forth in the Provider Reimbursement Manual ("PRM") issued by the Health Care Financing Administration ("HCFA"), the Department of Health and Human Services division responsible for administering Medicare. 42 C.F.R. § 421.100(h); Bowen v. Georgetown

University Hospital, 488 U.S. 204 (1988). A provider seeking reimbursement files an annual cost report with its intermediary, 42 C.F.R. § 413.20, which in turn audits the report and uses it as the basis of a final reimbursement determination. The final reimbursement determination is memorialized in a notice of program reimbursement ("NPR"). 42 C.F.R. § 405.1803. If a provider is dissatisfied with an intermediary's "final determination . . . as to the amount of total program reimbursement," the provider may request a hearing before the PRRB within 180 days of receiving its NPR. 42 U.S.C. § 1395oo(a)(1)(A)(i). If a provider then wishes to appeal a final decision made by the PRRB, it may, within sixty days, seek review by either the administrator of HCFA or a federal district court. 42 U.S.C. § 1395oo(f)(1).[1]

The Secretary's regulations additionally authorize an intermediary to permit a provider to, under limited circumstances, amend a filed cost report by requesting a "reopening" of particular aspects of the intermediary's reimbursement determination within three years of that determination's issuance. 42 C.F.R. § 405.1885. The intermediary may reopen an NPR when: (1) "new and material evidence has been submitted;" (2) "a clear and obvious error was made" and an amended cost report is needed to "correct material errors detected

[1] 42 U.S.C. § 1395oo(f)(1) also authorizes expedited 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 . . . that it is without authority to decide the question[.]" However, this section does not permit judicial review of an intermediary's decision where the PRRB lacks jurisdiction (as opposed to "authority") to review that decision. See The Edgewater Hospital Inc. v. Bowen, 857 F.2d 1123, 1130 (7th Cir. 1989); Binghamton General Hospital v. Shalala, 856 F. Supp. 786, 793 n.4 (S.D.N.Y. 1994).

subsequent to the filing of the original cost report;" or (3) the intermediary's "determination is found to be inconsistent with the law, regulations and rulings, or general instructions" and an amended cost report is necessary to "comply with the health insurance policies or regulations." PRM § 2931.2 (JA 280).

In the provision at the center of this appeal, the Secretary has provided that "jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R. § 405.1885(c). If reopening is granted and a new determination made, the provider may appeal the new determination as it could have appealed the initial one. See 42 C.F.R. § 405.1889. Because the Secretary has ruled that the decision whether to reopen "rests exclusively" with the body that made the last reimbursement determination, however, "a provider has no right to a [PRRB] hearing on a finding by an intermediary or hearing officer that a reopening or correction of a determination or decision is not warranted." PRM § 2932.1 (JA 285). As such, reopening denials may not be appealed to the PRRB.

B. Statement Of Facts

Plaintiffs are health service providers under the Medicare program. JA 47. Defendant Empire is the intermediary from which they receive reimbursement for services covered by Medicare. JA 46. From 1983 until 1985, plaintiffs participated in an experimental New York State Medicare reimbursement plan, and thus were not reimbursed according to the scheme outlined supra at 3-8. JA 48. When this experimental program ended, plaintiffs became subject to the standard

Medicare reimbursement rules in effect during the transition period.

According to their complaint, plaintiffs undertook various construction and renovation projects that were begun in the late 1970's and not completed until after 1982. JA 53-61. Because these projects were not completed until after the base year used under TEFRA to calculate the HSP portion of reimbursement during the transition period, plaintiffs were not reimbursed for the increased operating costs attributable to their construction and renovation projects. Id. Plaintiffs, however, did not appeal to the PRRB their NPRs, which failed to reflect reimbursement for increased costs. Instead, they each moved under 42 C.F.R. § 405.1885 to require Empire to reopen consideration of their cost reports for one or more of the 1986, 1987, and 1988 fiscal years. See JA 6 n.2.

In their motions to reopen, plaintiffs claimed that their projects constituted "extraordinary circumstances" under the TEFRA adjustment warranting reimbursement for the resultant increased operating costs. Id. Empire declined to reopen its determinations of plaintiffs' cost reports, concluding that the TEFRA adjustment could not form the basis for reimbursement during the transition period, and that plaintiffs' post-"base year" expenses could not be included in calculating the HSP portion of their reimbursement. JA 80-81, 83, 96, 98, 111. Plaintiffs then appealed Empire's denials of their motions to reopen to the PRRB, which determined that it lacked jurisdiction, under 42 C.F.R. § 405.1885(c), to review Empire's rulings not to reopen. JA 85-86, 91, 100-01, 106, 113-14.

C. The District Court Proceedings

Plaintiffs thereupon filed this action challenging the PRRB's decisions not to review Empire's reopening denials, and challenging Empire's decisions themselves. JA 43-69. Their complaint asked the district court to set aside the PRRB's decisions and remand the case for a hearing on the merits of the reopening requests; to invalidate the reopening regulations; and to direct Empire to reopen its determinations "in accordance with [plaintiffs'] reopening requests." JA 67-68. The parties cross-moved for summary judgment.

The court first concluded that the PRRB properly declined to review Empire's denial of plaintiffs' reopening motions. Rejecting plaintiffs' contentions that Empire's decisions not to reopen were "final determination[s] . . . as to the amount of total program reimbursement" reviewable under 42 U.S.C. § 1395oo(a)(1)(A)(i), the district court held:

> While we agree with plaintiffs that a decision not to reopen is in some sense "final," it does not, in and of itself, establish an "amount of total program reimbursement." Instead, it is a final determination that there are not grounds on which to reconsider a previous final determination as to the amount of total program reimbursement.

JA 26.

Having decided that subsection 1395oo(a)(1)(A)(i) does not mandate PRRB review of decisions not to reopen, the district court next upheld the validity of the Secretary's reopening regulation, 42 C.F.R. § 405.1885(c), which vests jurisdiction for reopening 'exclusively with that administrative body that rendered the last determination or decision" -- in this case, the intermediary. JA 31-

33. Limiting review of decisions not to reopen, the court held, both usurped no rights of plaintiffs', since the statute does not explicitly require any reopening procedures in the first place, and precluded circumvention of the statute's 180-day time limit on appealing to the PRRB the intermediaries' determinations. Id. The Court additionally held that the PRRB's construction of section 405.1885(c)'s "exclusive jurisdiction" provision was reasonable. JA 34-35.

Turning to the second question raised by plaintiffs -- the correctness of the intermediary's denials of their reopening motions -- the district court concluded that it lacked jurisdiction to review the merits of Empire's decisions. Under 42 U.S.C. § 1395oo(f)(1), which provides for judicial review of PRRB decisions, the court was limited to reviewing the PRRB's decision that it lacked jurisdiction to consider Empire's reopening denials. JA 36-37. Jurisdiction under 28 U.S.C. § 1331 was equally unavailing, the court held, because Congress "has specifically exempted cases arising under the Medicare statute from the broad reach of this 'arising under' jurisdiction." JA 37. Finally, jurisdiction under 28 U.S.C. § 1361, the Mandamus and Venue Act, was rejected because the intermediary owed plaintiffs no duty to reopen; rather, the "discretionary process" established by the Secretary's reopening regulations "is not amenable to mandamus relief." JA 41.

SUMMARY OF ARGUMENT

The district court's decision that the PRRB lacked jurisdiction to review Empire's reopening denials was correct and

merits affirmance. As the district court recognized, the PRRB's construction of the Medicare Act and the Secretary's regulations are entitled to great deference; hence, the PRRB's interpretation of the relevant statutory provisions need only be a permissible one. The PRRB's conclusion that it lacked jurisdiction to review reopening denials was correct because the statutory provision providing for PRRB review of intermediaries' final reimbursement determinations nowhere contemplates review of intermediaries* denials of reopening motions, which are wholly creatures of the Secretary's regulations. See Point I(B), infra. Moreover, the Secretary's regulations confining jurisdiction over such motions to the entity that declined to reopen -- here, the intermediary -- are more than permissible. They are, in fact, necessary to preserve the statute's appeals procedure and ensure the finality of cost reports. Thus, the vast majority of courts to have considered the plaintiffs' position have rejected it. See Point I(C)I infra.

The district court also correctly concluded that it lacked jurisdiction to consider the merits of Empire's reopening denials. Providers may seek judicial review only of final decisions of the PRRB, and in this case the sole final decision reached by the PRRB was that it lacked jurisdiction to review Empire's reopening denials. Hence that conclusion alone, and not the underlying merits of Empire's refusal to reopen plaintiffs' cost reports, is reviewable in federal court. See Point I(C), infra. If this Court concludes that the PRRB erred in declining jurisdiction over Empire's reopening denials, the matter should be remanded to the PRRB so that it may conduct the fact-

intensive inquiry as to whether Empire abused its discretion in refusing to reopen. Id. Finally, if this Court nonetheless reaches the merits of plaintiffs' underlying reimbursement claims, it should reject them because they are founded on a statutory provision that was not incorporated into subsequent Medicare amendments governing reimbursement to the plaintiffs. See Point II(B), infra.

ARGUMENT

POINT I

THE DISTRICT COURT CORRECTLYHELDTHATTHE PRRB LACKED JURISDICTION TO REVIEW EMPIRE'S REFUSAL TO REOPEN

A. The Standard Of Review

As the district court properly recognized, see JA 21, plaintiffs' attack on the PRRB's decision to decline jurisdiction over Empire's reopening decisions is reviewed according to the standards set forth in the Administrative Procedure Act, 5 U.S.C. § 701 et seq. (the "APA"), which provides that courts shall @'compel agency action unlawfully withheld or unreasonably delayed" and "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." Id. § 706(2)(A).

In this case, the PRRB's decision not to review Empire's reopening decisions was based on the Secretary's reopening regulations, which bar such review. See 42 C.F.R. § 405.1885(c). Those regulations, in turn, are based on the Secretary's construction of the Medicare Act. When, as here, "questions involving statutory construction arise, 'great deference' must be accorded 'to the interpretation given the statute by the officers or agency charged

with its administration.'" Allegheny Electric Co-On., Inc. v. FERC, 922 F.2d 73, 80 (2d Cir. 1990) (quoting Power Authority v. State of New York v. FERC, 743 F.2d 93, 103 (2d Cir. 1984)), cert. denied, 502 U.S. 810 (1991). As the district court noted, "this is particularly the case in the presence of a very complex and intricate administrative program such as Medicare." JA 21 (citing DeJesus v. Perales, 770 F.2d 316, 327 (2d Cir. 1985)).

Under this deferential standard, "unless the statutory language is clear and unambiguous, a reviewing court must defer to a reasonable administrative interpretation." Alleqhenv Electric Co-OP., Inc., 922 F.2d at 80 (citing Chevron U.S.A., Inc. v. Natural Resources Defense Counsel, Inc., 467 U.S. 837, 842-44 (1984)). As this Court has put it:

> To uphold the agency's interpretation we need not find that its construction is the only reasonable one, or even that it is the result we would have reached had the question arisen in the first instance in judicial proceedings. We need only conclude that it is a reasonable interpretation of the relevant provisions.

Weil v. Retirement Plan Administrative Committee, 933 F.2d 106, 107-08 (2d Cir. 1991) (quoting Aluminum Co. of America v. Central Lincoln Peoples' Utility District, 467 U.S. 380, 389 (1984)) (emphasis in original; citations and internal punctuation omitted).

The same level of deference must be accorded to the Secretary's constructions of her own regulations. St. Mary's Hosp. v. Blue Cross & Blue Shield Ass'n, 788 F.2d 888, 890 (2d Cir. 1986); Butler County Memorial Hosp. v. Heckler, 780 F.2d 352, 355 (3d Cir. 1985). The Supreme Court recently emphasized, with regard to the Secretary's interpretation of Medicare regulations, that

> we must give substantial deference to an agency's interpretation of its own regulations . . . . [T]his broad deference is all the more warranted when, as here, the regulation concerns "a complex and highly technical regulatory program," in which the identification and classification of relevant "criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns."

Thomas Jefferson University v. Shalala, 114 S. Ct. 2381, 2386-87 (1994) (quoting Pauley v. BethEnergy Mines, Inc., 501 U.S. 680, 697 (1991)).

B. The Medicare Statute Does Not Provide For PRRB Review Of Intermediaries' Decisions Not To Reopen

The plaintiffs first argue that the PRRB, in not reviewing reopening denials, contravened 42 U.S.C. § 1395oo(a), the statutory provision that confers jurisdiction on the PRRB to hear appeals. Plaintiffs-Appellants' Brief ("Br.") at 15-21. The PRRB's view of this subsection as not mandating PRRB jurisdiction over reopening denials, however, is more than just one of many permissible constructions; it is, in fact, "the most reasonable construction." Binghamton General Hospital v. Shalala, 856 F. Supp. 786, 795 (S.D.N.Y. 1994) (emphasis added). As such, the overwhelming majority of courts have upheld the PRRB's view of its limited jurisdiction over such denials. See Athens Community Hospital v. Schweiker, 743 F.2d 1, 4 n.4 (D.C. Cir. 1984) ("Athens II"), overruled on other grounds, Bethesda Hospital Ass'n v. Bowen, 485 U.S. 399 (1988); Binghamton General Hospital, 856 F. Supp. at 793-99; Staten Island Hospital v. Sullivan, 1992 WL 675952, at * 5 (D.D.C. 1992) (JA 399); Memorial Hospital v. Sullivan, 779 F. Supp. 1406, 1408-09 (D.D.C. 1991); University of Michigan Hospitals v. Heckler, 609 F. Supp. 756, 761-63

(E.D. Mich. 1985); John Muir Mem. Hosp. v. Califano, 457 F. Supp.848, 852-53 & n-10-11 (N.D. Cal. 1978); see also HCA Health Services v. Shalala, 27 F.3d 614, 616-622 (D.C. Cir. 1994) (even when intermediary reopens cost report, provider may not appeal to PRRB issues intermediary does not reopen); Rutland Regional Medical Center v. Sullivan, 835 F. Supp. 754, 759-762 (D. Vt. 1993) (same); Albert Einstein Medical Center v. Sullivan, 830 F. Supp. 846, 848 (E.D. Pa. 1992), aff'd, 6 F.3d 778 (3d Cir. 1993) (same); Delaware County Memorial Hospital v. Sullivan, 836 F. Supp. 238 (E.D. Pa. 1991) (same); contra State of Oregon v. Bowen, 854 F.2d 346 (9th Cir. 1988) (denials of reopening appealable to PRRB); Kootenai Hosp. Dist. v. Bowen, 650 F. Supp. 1513 (N.D. Cal. 1987) (same); Marv Imogene Bassett Hospital v. Bowen, Medicaid and Medicare Guide (CCH) ¶ 38,408 (N.D.N.Y. 1989) (JA 323) (same).

The PRRB's interpretation of subsection 1395oo(a) is compelling for a number of reasons. First, the plain language of the statute does not contemplate PRRB jurisdiction over an intermediary's denial of reopening. Subsection (a) of section 1395oo states, in pertinent part, as follows:

> 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 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 . . .
>
> (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 (l)(A)(i) . . .

42 U.S.C. § 1395oo(a)(1)-(3). The statute says nothing about reopenings, which are distinct from appeals, were conceived of by the Secretary as administrative tools, and are entirely creatures of regulation. 42 C.F.R. §§ 405.1885-1889; see Binahamton General Hospital, 856 F. Supp. at 793; Albert Einstein Medical Center, 830 F. Supp. at 851; Memorial Hospital, 779 F. Supp. at 1409. The district court, therefore, correctly noted that Congress has not explicitly spoken to the issue of PRRB jurisdiction in this context. JA 14; see also HCA Health Services, 27 F.3d at 617-619 (same).

Second, the statute's grant of PRRB jurisdiction over an intermediary's "final determination . . . as to the amount of total program reimbursement due the provider" cannot sensibly be read to include final determinations of requests to reopen. The intermediary's issuance of the NPR is its final determination as to the amount of total reimbursement due the provider. The denial of a reopening request is simply a refusal to revisit that final determination, but is not the final determination itself. See JA 20; Albert Einstein Medical Center, 830 F. Supp. at 849; Staten Island Hospital, 1992 WL 675952, at *6 n.6 (JA 404) ("a decision by the intermediary not to reopen is basically a decision not to disturb its previous determination"); John Muir Memorial Hospital, Inc., 457 F. Supp. at 853 n.lO. A reopening denial is thus "akin to a decision of a judicial panel or en banc court to deny rehearing, and 'no one supposes that that denial, as opposed to the panel opinion, is an

appealable action."' Binghamton General Hospital, 856 F. Supp. at 794 (quoting ICC Brotherhood of Locomotive Engineers, 482 U.S. 270, 280 (1987)).

Tellingly, plaintiffs repeatedly refer to section 1395oo(a) as providing PRRB jurisdiction over "all 'final determinations' of the Intermediary," Br. at 13, 20, or "all 'final determinations' of Intermediaries which affect total Medicare reimbursement," Br. at 7, 21. Both of these broad formulations ignore the limiting language of the statute, which provides for PRRB jurisdiction only where the intermediary has reached a final determination "as to the amount of . . . reimbursement due." 42 U.S.C. § 1395oo(a)(1)(A)(i). The statutory language therefore simply does not encompass all intermediary resolutions that happen to be last in time. See, e.g., Saline Comm. Hospital v. Secretary of Health and Human Services, 744 F.2d 517, 519-20 (6th Cir. 1984) (intermediary's refusal to allow untimely amendment to cost report does not constitute final determination subject to review).

Third, the Secretary's construction of this statute is in keeping with the Supreme Court's decisions, in a variety of administrative contexts, limiting jurisdiction over appeals of reopening denials. See, e.g., ICC v. Brotherhood of Locomotive Engineers, 482 U.S. 270, 278-84 (1987) (ICC's denial of reopening request based on material errors in original agency decision is not reviewable); Califano v. Sanders, 430 U.S. 99, 108 (1977) (no requirement under Social Security Act of judicial review of agency refusal to reopen benefit claims); see also Friends of Keeseville,

Inc. v. FERC, 859 F.2d 230, 237 n.16 (D.C. Cir. 1988) ("[a]lthough Locomotive Engineers involved another agency[,] the principle announced appears to be one of general applicability").

Plaintiffs argue that the Secretary's construction of subsection 1395oo(a) is incorrect because the PRM lists a number of decisions that are not specifically mentioned in subsection 1395oo(a) but are nonetheless considered by the Secretary to be appealable. See PRM § 2926.6(B) (JA 275). As such, plaintiffs conclude, a reopening denial must be appealable as well. Br. at 16. Unlike a reopening denial, however, the decisions listed in the PRM directly affect "final determination[s] . . . as to the amount of total program reimbursement due the provider." 42 U.S.C. § 1395oo(a)(1)(A)(i). Notices of payment rates or provider status, and decisions regarding requests for exceptions, see PRM § 2926.6(B)(5)-(7), are all necessary to a determination in the first instance of a provider's reimbursement. A reopening request, on the other hand, is an attempt to reexamine that original determination, and as such does not adjudge the total program reimbursement due. That is why the Secretary, later in the same cited section, provides that "a refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board." Id. § 2926.6(B)(4).

No more persuasive is plaintiffs' claim that an intermediary's reopening decision must be reviewable by the PRRB because an intermediary could simply refuse to correct a grossly wrong or patently unfair error -- the "simple hypothetical" cited involves a previously unnoticed accounting error costing a provider millions of

dollars -- and the provider would have no recourse. Br. at 18. As an initial matter, of course, Congress has given such a provider recourse, by way of direct appeal under subsection 1395oo(a)(1)(A)(i). That recourse simply has a deadline of 180 days by which providers must scrutinize their cost reports and ensure that no flagrant errors have occurred. Presumably, to use plaintiffs' example, it will not take providers 180 days to realize that they have been reimbursed $50,000 instead of $5,000,000. That the Secretary has on her own established yet another possible corrective -- the reopening procedures -- does not entitle providers to reopening relief beyond that granted by regulation. See Albert Einstein Medical Center, 830 F. Supp. at 851 ("reopening is entirely a product of the Secretary's regulations . . . the Secretary is not statutorily required to open any portion of an NPR") (emphasis in original); Memorial Hospital, 779 F. Supp. at 1409 ("plaintiff's 'rights' in the reopening process are defined by the agency's regulations and not by Congressional directive").

Furthermore, in light of Congress' decision that review of reopening denials is not required, the Secretary's limiting of the PRRB's jurisdiction over such denials simply "reflects the judgment that the providers' ability to add claims to cost reports must end at some point. The issuance of the NPR was selected as that point." University of Michigan Hospitals, 609 F. Supp. at 762. Indeed, "reopenings of administrative proceedings are disfavored" as a general matter, "due to a strong public policy in bringing litigation to an end." Binghamton General Hospital, 856 F. Supp. at 798; see generally

INS v. Abudu, 485 U.S. 94, 107-08 (1988) (motions to reopen deportation proceedings disfavored). The appealability rule's furtherance of that public policy could, as occurs with many procedural rules and deadlines, cause hardship in individual cases, although plaintiffs here -- who could have raised on an appeal of right to the PRRB the argument they raised by a reopening motion -- are ill-suited to claim such hardship. But the fact remains that the larger systemic equities are furthered by uniform application of the rule. See, e.g., McNeil v. United States, 113 S. Ct. 1980, 1984 (1993) (upholding dismissal of pro se FTCA action for failure to exhaust administrative remedies: "The interest in orderly administration of this body of litigation is best served by adherence to the straight-forward statutory command").

Just as the plaintiffs' reliance on subsection 1395oo(a) is misplaced, so too is their reliance on subsection 1395oo(g). See Br. at 19-21. That subsection forecloses PRRB review of two categories of decisions: an intermediary's decision that items listed in section 1395y are not reimbursable, and "determinations and other decisions described in section 1395ww(d)(7)." Plaintiffs argue that because Congress did not also specify that reopening denials are nonreviewable, Congress must have intended for the PRRB to review them. Congress could not, however, have expressly precluded something that did not yet exist, i.e., reopening-related appeals to the PRRB. The statutory appeal provisions do not contemplate review of reopening decisions because the reopening procedures were voluntarily created by the Secretary and only made applicable to the PRRB by regulation after

Congress created that body. By contrast, the exemptions from appeal enumerated in section 1395oo(g) provide that reimbursement decisions applying express statutorv directives for non-payment of certain costs are not subject to appeal. Whatever else may be said of subsection 1395oo(g)'s relevance, it hardly supplies the "direct" and "precise" evidence of Congressional intent that Chevron requires to render the Secretary's statutory interpretation unreasonable. See Chevron, 467 U.S. at 842-44.

The one case cited by plaintiffs construing subsection 1395oo(g) fares no better. See Board of Trustees of Knox County (Indiana) Hospital v. Sullivan, 965 F.2d 558 (7th Cir. 1992), cert. denied, 113 S. Ct. 1043 (1993) (cited in Br. at 20-21). The district court rightly found this case inapt because it did not address the jurisdiction of the Board to review the intermediary's decisions under subsection 1395oo(a), and because the determination at issue there -- the intermediary's refusal, pursuant to the Secretary's regulations, to designate a hospital as a rural referral center, see 965 F.2d at 559-60 -- was "an integral step in establishing 'the amount of payment under subsection (b) or (d) of section 1395ww.' 42 U.S.C. § 1395oo(a)(1)(A)(ii). A denial of a motion to reopen is not such a determination." JA 28 n.lO.

Finally, this Court should reject the reasoning of the small minority of decisions -- one circuit court and two district courts -- holding that the PRRB enjoys jurisdiction to review an intermediary's denial of a motion to reopen. See State of Oregon v. Bowen, 854 F.2d 346 (9th Cir. 1988); Kootenai Hosp. Dist. v. Bowen, 650 F. Supp. 1513

(N.D. Cal. 1987); Mary Imogene Bassett Hospital v. Bowen, Medicaid and Medicare Guide (CCH) ¶ 38,408 (N.D.N.Y. 1989) (JA 323). Of these, only State of Oregon actually considers the statutory PRRB appellate review provision, subsection 1395oo(a)(1), and that consideration is bare indeed. The entirety of the Ninth Circuit's statutory analysis is contained in five sentences, see 854 F.2d at 349, which include no consideration of the difference between an initial reimbursement determination and a subsequent decision about whether to reopen that determination, nor any examination of reopening in other contexts. State of Oregon is thus far less reasoned and thorough than the decision below or Judge Sand's opinion in Binahamton General Hospital, and simply does not merit following.

State of Oregon also erred in citing section 1395x(v)(1)(A)(ii), which states that the Secretary's regulations should "provide for the making of suitable retroactive corrective adjustments where . . . reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 854 F.2d at 349. Considering this to be the grant of statutory authority for reopening procedures, the Ninth Circuit noted that "nothing in the plain language of the mandate indicates unreviewability." Id. That conclusion has been overtaken by subsequent decisions of the Supreme Court:

> This argument, however, misconstrues the function of § 1395x(v)(1)(A)(ii) within the Medicare statute. As the Supreme Court has made clear since the Ninth Circuit's decisions in State of Oregon and Regents, this provision does not authorize reopening procedures; rather it authorizes a year-end book-balancing to bring interim estimated Medicare reimbursement payments into line with the actual amount of reimbursement to which a provider is

> entitled at the end of the fiscal year. See Good Samaritan Hospital v. Shalala, U.S. ___, 113 S. Ct. 2151, 2157-60, 124 L. Ed. 2d 368 (1993); Bowen v. Georgetown University Hospital, 488 U.S. 204, 209-13, 109 S. Ct. 468, 472-74, 102 L. Ed. 2d 493 (1988); Mt. Diablo Hosp. v. Shalala, 3 F.3d 1226, 1231 (9th Cir. 1992) ("to the extent that our opinion in Resents conflicts with Good Samaritan, we recognize that the decision in Regents has been overruled"). Accordingly, plaintiffs' reliance on this section of the Medicare statute is baseless.

Binghamton General Hospital, 856 F. Supp. at 795-96.

The Secretary's construction of the statutory PRRB reviewability provision as not mandating review of reopening denials best comports with the statute's plain language. It is at the least a reasonable, permissible interpretation that should be upheld, given the deference due agencies' constructions of their own statutory schemes. See Weil v. Retirement Plan Administrative Committee, 933 F.2d 106, 107-08 (2d Cir. 1991).

C. The PRRB Properly Construed Its Own Regulations To Bar Review Of Empire's Decisions Not To Reopen Plaintiffs' Cost Reports

After finding that the Medicare statute did not compel PRRB review of Empire's reopening denials, the district court examined the Secretary's reopening regulations prohibiting PRRB jurisdiction and found them valid and properly applied by the PRRB in this case. JA 31-35. This decision was correct and should be affirmed in that the relevant regulations are consistent with the Medicare statute and were correctly invoked here.

The Secretary's reopening regulations provide that an intermediary's determination may be reopened by the intermediary or on the motion of the provider, within three years of receipt of an NPR, with respect to the amount of reimbursement authorized in the NPR. 42

C.F.R. § 405,1885(a). The intermediary may reopen a determination if "new and material evidence has been submitted," a "clear and obvious error was made," or the intermediary's "determination is found to be inconsistent with the law, regulations and rulings, or general instructions." PRM § 2931.2 (JA 280). A reopening also may be instituted upon HCFA's notification that the earlier decision by the intermediary was inconsistent with "the applicable law, regulations, or general instructions issued by [HCFA]." 42 C.F.R. § 405.1885(b).

The Secretary's regulations specifically provide that "jurisdiction to reopen a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." Id. § 405.1885(c) (emphasis added). Although the regulations provide for an appeal to the PRRB of any amended NPR issued as the result of a reopening, they do not provide for appeal of a denial of a reopening request. See Id. § 405.1889. More definitive still, the PRM, interpreting these regulations, provides unequivocally that "[a] refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 CFR § 405.1885(c)." PRM § 2926.6(B)(4) (JA 275-A); see also PRM § 2932.1 (JA 285) ("A provider has no right to a hearing on a finding by an intermediary or hearing officer that a reopening or correction of a determination or decision is not warranted").

1. The Regulations Are Valid

These regulations are perfectly consistent with subsection 139500(a), given that statute's limiting of PRRB jurisdiction to final determinations regarding total program reimbursement. As the district

court put it:

> Since reopening denials are not expressly appealable under the statute, the Secretary's decision not to allow their review does not upset the Congressional scheme. Moreover, absent the Secretary's reopening provisions, plaintiffs would have no statutory recourse whatsoever for pursuing the relief they seek in this case. The Secretary's decision not to allow review of decisions not to reopen does not usurp any right granted to plaintiffs by the Medicare statute.

JA 21-22; accord Albert Einstein Medical Center, 830 F. Supp. at 851 (Secretary not statutorily required to reopen since reopening created by Secretary); Memorial Hospital, 779 F. Supp. at 1409 (same).

Perhaps more important, the Secretary's rule is also the best guarantor of subsection 1395oo(a)(3)'s deadline of 180 days by which to appeal a final determination of program reimbursement to the PRRB. Had the Secretary regulated otherwise and permitted PRRB review of reopening refusals, reopening would become effectively indistinguishable from the appellate review provided for by statute, except with a three-year statute of limitation instead of a 180-day one. As one court has aptly observed, "a provider could keep an entire cost report open indefinitely by successfully appealing one item, awaiting a revised NPR, appealing another item, and so on." Albert Einstein Medical Center, 830 F. Supp. at 851 (citation omitted). Indeed, this danger has been magnified by the Supreme Court's decision in Bethesda Hospital Association v. Bowen, 485 U.S. 399, 404-05 (1988), where the Court held that providers may raise issues on appeal before the PRRB that were not raised before the intermediary. See JA 26 n.8.

Accordingly, virtually every court to consider plaintiffs' argument that the PRRB has jurisdiction over reopening denials has

rejected it largely because it would eviscerate the appeals provision of section 139500(a)(3). Binghamton General Hospital, 856 F. Supp. at 795; Staten Island Hospital, 1992 WL 675952, at *5 & n.6; John Muir Mem. Hosp., 457 F. Supp. at 853-54 & n.10 & 11; see also HCA Health Services, 27 F.3d at 620-21 (even when intermediary reopens cost reports as to some issues, allowing appeal of items not reopened would undermine 180-day deadline). The Supreme Court has for this same reason rejected judicial review of administrative denials of petitions to reopen individual claims for social security benefits:

> [A]n interpretation that would allow a claimant judicial review simply by filing -- and being denied -- a petition to reopen his claim would frustrate the congressional purpose, plainly evidenced in § 205(g), to impose a 60-day limitation upon judicial review of the Secretary's final decision on the initial claim for benefits.

Califano, 430 U.S. at 108.

Plaintiffs offer two responses, neither persuasive, to the district court's conclusion that an alternate regulatory scheme would undermine both the 180-day deadline and cost report finality. They first argue that the Secretary can join providers in availing herself of reopening: "There is another side to the 'reopening coin.' A reopening also gives the Intermediary an additional opportunity to overturn its prior determination that the cost report is final." Br. at 25-26 & n.8. That both sides may seek and obtain reopenings from the intermediary does not, of course, speak to the appealability of the intermediary's denial of reopening.

Plaintiffs, in this connection, rely on "the broad spirit of" the Supreme Court's decision in Bethesda Hospital Association, Br. at 26, suggesting that that decision's holding that reimbursement

items not raised before the intermediary may be considered on appeal by the PRRB has relevance to the question of the PRRB's jurisdiction over reopening denials. See 485 U.S. at 403-08. That contention, when made more explicitly elsewhere, has been rejected because the Court in Bethesda Hospital Association did not address the meaning of "final determination" or examine reopenings, but rather construed the term "dissatisfied" as used in 1395oo(a)(1)(A)(i). See Binghamton General Hospital, 856 F. Supp. at 794; Albert Einstein Medical Center, 830 F. Supp. at 849-50; Memorial Hospital, 779 F. Supp. at 1408-09. Thus, the Supreme Court's decision involved "the scope of the Board's review power once it has already obtained jurisdiction over an intermediary's decision," and as such is inapt here. Binghamton, 856 F. Supp. at 794 (emphasis in original).

Plaintiffs' next response to the district court's concern over the need for finality is equally misplaced. Plaintiffs claim there is no unfairness in allowing them a "bite at the apple" at PRRB review of a reopening denial. Br. at 27. As noted supra at 21, however, the Secretary's mandate does not include the search for fairness at the expense of clear Congressional dictates. Plaintiffs' professed shortage of bites at the apple, moreover, is of their own making -- they could have appealed their cost reports within 180 days, but declined to do so. Their failure to avail themselves of their statutory remedy hardly entitles them to engraft a separate regulatory remedy onto the administrative process.

Aside from contesting the district court's holding that the Secretary's regulations best safeguard the statutory 180-day appellate

time limit, plaintiffs raise additional, but still unpersuasive, challenges to the Secretary's non-review rule. Plaintiffs argue that the district court failed to identify a statutory basis for the reopening regulations. Br. at 22-25. As the district court noted, though, plaintiff's entire attempt to recover renovation costs would be without foundation were the Secretary's reopening regulations struck down, see JA 25 n.7; perhaps more to the point, much of their suit and this appeal would be moot were they to prevail. Thus, notwithstanding plaintiffs' belief that "[they) would be better served" were the regulations struck down, see Br. at 23 n.6, this litigation simply does not provide them a vehicle for achieving that result. In any event, even were a party able to invoke this court's appellate jurisdiction for purposes of demonstrating that its appeal is actually moot, plaintiffs err in suggesting that the reopening regulations are without statutory basis. As the D.C. Circuit found, "we comfortably locate the Secretary's power to promulgate the reopening regulations in her general rulemaking authority under 42 U.S.C. §§ 1302 & 1395hh." HCA Health Services, 27 F.3d at 618; see also Califano, 430 U.S. at 108.

Plaintiffs' final challenge to the validity of the reopening regulations concerns the supposed dangers of confining reopening review to the intermediary. According to plaintiffs, this Court must find that the PRRB and thus courts can review intermediaries' reopening decisions, because the hospitals would benefit from such review:

> Medicare reimbursement to a hospital is too important, and governmental budget pressures are too great, for the

> Intermediary to be on the honor system. . . . In a time of extreme financial pressures being placed upon hospitals by proposed changes in Medicare funding, it is critically important that hospitals have the opportunity for impartial PRRB and court review. This is all the Hospitals are seeking.

Br. at 28-29.

This unabashed invitation to judicial policy-making should be declined, especially where, as here, plaintiffs had available but did not utilize an avenue of PRRB and judicial review. Congress, not this court, is charged with the duty to legislate the degree to which plaintiffs may relieve "extreme financial pressures" by taking appeals of reopening denials, and the Secretary is charged with implementing Congress's will. See, e.g., Johnson v. United States, 788 F.2d 845, 854 (2d Cir. 1986) ("policy considerations" are "properly addressed to Congress, not to this court"). Unless the Secretary's actions in this regard are arbitrary or capricious, abuse discretion, or violate law, this Court must uphold them. The degree to which plaintiffs wish the law to be otherwise is of no consequence. As the Supreme Court has said of restricted review under the Social Security Act:

> Congress' determination so to limit judicial review to the original decision denying benefits is a policy choice obviously designed to forestall repetitive or belated litigation of stale eligibility claims. Our duty, of course, is to respect that choice.

Califano, 430 U.S. at 108.

Along the same lines, plaintiffs invoke the general presumption in favor of judicial review of administrative action. Br. at 29-30. State of Oregon and Kootenai Hospital District were similarly motivated. See State of Oregon, 854 F.2d at 350; Kootenai Hospital District, 650 F. Supp. at 1520. Without judicial review,

plaintiffs and these decisions claim, intermediaries -- who are, after all, private contractors with the Secretary -- could run amok. Id. But "the fact that the denial of reopening was made by a private entity (Empire) does not mean per se that judicial or administrative review is required." Binghamton, 856 F. Supp. at 798 (citing Schweicker v. McClure, 456 U.S. 188 (1982)); see also University of Michigan Hospitals, 609 F. Supp. at 762. In this area, the presumption of judicial review of agency action is trumped by Congress's specific restriction of judicial review under the Medicare statute, and in particular its limitation that only "final determination[s] . . . as to the amount of total program reimbursements" are reviewable by the PRRB. 42 U.S.C. § 1395oo(a)(1)(A)(i). "In adopting the Medicare Act, Congress imposed strict limits on judicial review of provider medicare reimbursement claims." St. Joseph's Hospital of Kansas City v. Heckler, 786 F.2d 848, 852 (8th Cir. 1986).

2. The Regulations Were Correctly Applied

Given their faithfulness to the PRRB review statute, the Secretary's regulations are permissible and warrant deference. They were, moreover, correctly applied in this case, as the district court found. JA 23-24. The Ninth Circuit, again, erred in concluding to the contrary. In State of Oregon, the court held that the PRRB misapplies section 405.1885(c) by declining jurisdiction over intermediaries' reopening denials, in that "there is a difference between having the discretion to decide an issue, and allowing review of an administrative body's exercise of its discretion." 854 F.2d at

349. The district court properly rejected this claimed distinction. As the court below noted, "the Board's reversal of an intermediary's denial would be, essentially, an order reopening the decision -- an action the regulation jurisdictionally reserves to the intermediary." JA 34-35. Thus the Secretary's interpretation of section 405.1885(c) is perfectly reasonable. Moreover, State of Oregon takes no account of section 405.1889's provision for PRRB review of reopened cost reports and its corresponding lack of provision for PRRB review of refusals to reopen. "This oversight enervates the Ninth Circuit's conclusion that 'the Board has not been disqualified from deciding whether the fiscal intermediary abused its discretion by refusing to reopen the determination.'" Memorial Hospital, 779 F. Supp. at 1409 n.7 (quoting State of Oregon, 854 F.2d at 349).

* * * * * * * *

Ultimately, plaintiffs are unable to show that the Secretary's regulations were not followed in this case or are unworthy of the deference usually given to an agency's rulemaking. The same is true for the plaintiffs' claim that the Secretary has misconstrued the Medicare Act. As the district court concluded:

> Plaintiffs, for whatever reason, did not appeal their NPR's to the Board within 180 days of their issuance by Empire. However, the record does not indicate that plaintiffs could not have raised the instant claimed TEFRA adjustments on any such appeal. The reopening process is not a substitute for the statutory appeal process, nor is it, in the strictest sense, a review process.

JA 30. Plaintiffs should not be allowed to circumvent the statutory appeals scheme through attacks on the Secretary's construction of reopening jurisdiction. The district court's decision finding that

the Secretary properly declined jurisdiction over reopening denials should be affirmed.

POINT II

THIS COURT LACKS JURISDICTION TO REVIEW EMPIRE'S DENIALS OF PLAINTIFFS' MOTIONS TO REOPEN

A. Empire's Refusals To Reopen Plaintiffs' Reimbursement Determinations Are Not Reviewable By This Court

Devoting much attention to the substantive question of whether Empire erred in refusing to apply the TEFRA adjustment to their cost reports, plaintiffs urge this court to hold that Empire should have granted their reopening motions and reimbursed them for outlays associated with their capital improvements. See Br. at 35-50. Plaintiffs ignore, however, the threshold question of whether this Court has jurisdiction to review Empire's reopening decisions. In fact, this Court's limited jurisdiction permits review only of the PRRB's decision that it lacked jurisdiction to consider the reopening rulings. Were this Court to find that the PRRB should have reviewed the reopening decisions, it should remand this matter to the PRRB to address the substantive TEFRA issue in the first instance. Should this Court reach the merits of that issue, it should reject plaintiffs* claim that they are entitled to a TEFRA adjustment.

"Under the Medicare statute, the sole route for a provider to obtain judicial review of disputed reimbursement claims is found in § 1395oo(f)(1)." Binghamton General Hospital, 856 F. Supp. at 793; see also St. Joseph's Hospital, 786 F.2d at 850.[2] That subsection

[2] The district court also considered whether jurisdiction over the merits of Empire's reopening decisions might lie under 28 U.S.C. §§ 1331 and 1361, and properly concluded that the former was

provides:

> 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 . . . is received.

There is no jurisdiction to review decisions of the Board beyond the specific confines of section 1395oo(f)(1), for "the exercise of federal jurisdiction is circumscribed bv, and limited to, whatever jurisdiction exists under the specific Medicare provisions." Athens Community Hospital, Inc. v. Schweiker, 686 F.2d 989, 993 (D.C. Cir. 1982) (emphasis added); see also St. Joseph's Hospital, 786 F.2d at 850; Saline Community Hospital, 744 F.2d at 519 (holding that court could not review merits of intermediary's reopening decision: "our review is limited to the jurisdictional grant in § 1395oo(f) of the Medicare Act").

As this Court may review only "the final decision of the Board" that plaintiffs have appealed, 42 U.S.C. § 1395oo(f)(1), the Court is confined to reviewing the only final decision reached by the PRRB below -- that it lacked jurisdiction to consider Empire's reopening decisions. Because the PRRB did not reach the merits of plaintiffs' reopening claims, subsection 1395oo(f)(1) likewise prevents this Court from doing so. As the court held in Binghamton General Hospital, the "PRRB's decision that it lacks jurisdiction is a

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inapposite because Congress has specifically eliminated general federal question jurisdiction over Medicare claims, see JA 37-38 (and cases cited therein), while the latter was equally unavailing because the preconditions of mandamus jurisdiction -- particularly the requirement that the defendant owe a duty to the plaintiffs -- were not met, see JA 38-42 (and cases cited therein). Plaintiffs do not contest these holdings on appeal.

'final decision of the Board' which triggers the right to judicial review. This Court's jurisdiction is limited, however, to a review of whether the PRRB erred in determining that it lacked jurisdiction.@' 856 F. Supp. at 793 (citations omitted); accord Saline Community Hospital, 744 F.2d at 520; Marv Imosene Bassett Hospital v. Shalala, 86 CV 1287 (N.D.N.Y. February 17, 1995) (JA 328, 344); Albert Einstein Medical Center, 830 F. Supp. at 852; Staten Island Hospital, 1992 WL 675952, at *6 (JA 402-03); Kootenai Hospital District, 650 F. Supp. at 1517. Section 1395oo(f)(1) thus bars this Court from going beyond the scope of the PRRB's decision below and reaching the merits of plaintiffs' reopening claims.

Although plaintiffs nowhere specify the provision of law enabling this Court to reach the merits of Empire's reopening decisions, or explain why the district court erred in finding a lack of federal jurisdiction authorizing such a step, they nonetheless maintain that this Court should simply decide the question because a remand to the PRRB would be futile. Br. at 30-31. But other rationales discussed in the case law plaintiffs cite regarding exhaustion of administrative remedies counsel in favor of remand: plaintiffs' TEFRA claims are not collateral to their benefit claims but essential to them, and plaintiffs would suffer no demonstrable harm if they made their arguments first to the PRRB before proceeding to the district court or this Court. See, e.g., Abbey v. Sullivan, 978 F.2d 37, 44-45 (2d Cir. 1992) (cited in Br. at 31).

Furthermore, the PRRB has an important function to perform on remand: applying the Secretary's regulations to decide the fact-

intensive question of whether Empire abused its discretion in deciding not to reopen, because Empire overlooked new evidence or because of some error in the original NPR requiring reopening. PRM § 2931.2 (JA 280); see State of Oreaon, 854 F.2d at 349-50 (discussing scope of PRRB's abuse-of-discretion inquiry on remand). Without such PRRB review for abuse of discretion, this Court will decide the bare legal question of whether the TEFRA adjustment applies during the transition period in the absence of a record as to that provision's applicability to the plaintiffs' situations. Empire and/or the PRRB should be allowed to develop such a record, and apply agency expertise to the question, before this Court is called upon to rule. See, e.g., Guitard v. United States Secretary of the Navy, 967 F.2d 737, 740 (2d Cir. 1992) (agency should be allowed fact-finding opportunity before judicial review) (citing Schlesinger v. Councilman, 420 U.S. 738, 756-57 (1975)).

In the final analysis, though, the exhaustion doctrine upon which plaintiffs rely is simply inapt where Congress has, as in subsection 1395oo(f)(1), specifically circumscribed federal jurisdiction. That limited jurisdiction explains why -- tellingly -- none of the three courts that have held that the PRRB had jurisdiction to review the intermediary's reopening denials went on to decide the merits of the reopening question; all remanded the issue back to the PRRB. See State of Oregon, 854 F.2d at 350-51; Mary Imogene Bassett Hospital, 86 CV 1287, slip op. at 18-19 (JA 344-45); Kootenai Hospital District, 650 F. Supp. at 1520-21. In this case, as well, the Court should, if it concludes that the PRRB erred in not exercising

jurisdiction over Empire's reopening decisions, remand the case to the PRRB.

B. If Reviewable, Empire's Reopening Decisions Should Stand

Should this Court choose to reach the merits of plaintiffs' claim that they are entitled to a reopening of Empire's reimbursement determinations, it should find that Empire correctly disallowed the reopening requests. Plaintiffs' reopening claim rests on the proposition that subsection 1395ww(d)(1)(A), which fixes the amount of reimbursement during the transition period between TEFRA and PPS, incorporates subsection 1395ww(b)(4)(A), the previously-enacted TEFRA adjustment allowing reimbursement exceptions for "extraordinary circumstances." This argument centers on subsection 1395ww(d)(1)(A)'s reference to the definition of "target amount" in subsection 1395ww(b)(3)(A).

The plain statutory language confirms, however, that subsection 1395ww(d)(1)(A) does not incorporate subsection (b)(4)(A) (the TEFRA adjustment), nor does subsection (b)(3)(A) -- which is specifically incorporated in the PPS statute -- make any reference to subsection (b)(4)(A). Moreover, any statutory ambiguity is of no aid to plaintiffs since the Secretary's interpretation of the statute as barring a TEFRA adjustment is a permissible reading and thus entitled to judicial deference. As such, with a solitary exception, all circuit courts to have considered plaintiffs' argument have rejected it. See Hillsborough County Hospital Authority v. Shalala, 49 F.3d 1516, 1517 (11th Cir.), cert. denied, 116 S. Ct. 335 (1995); Episcopal Hospital v. Shalala, 994 F.2d 879, 883-84 (D.C. Cir. 1993), cert.

denied, 114 S. Ct. 876 (1994); Sacred Heart Medical Center v. Sullivan, 958 F.2d 537, 540, 545-50 (3d Cir. 1992); but see Community Hospital of Chandler, Inc. v. Sullivan, 963 F.2d 1206, 1211-14 (9th Cir. 1992).[3]

1. The Statutory Provisions

The HSP portion of provider reimbursement during the transition period is defined by subsection 1395ww(d)(1)(A)(i)(I) as:

> the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A) of this section, but determined without the application of subsection (a) of this section).

42 U.S.C. § 1395ww(d)(1)(A)(i)(I). Subsection (b)(3)(A), in turn, provides:

> Except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period --
>
> (i) in the case of the first such reporting period for which this subsection is in effect, the allowable costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period.

42 U.S.C. § 1395ww(b)(3)(A).

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[3] Although some district courts have accepted the argument plaintiffs make here, those decisions have been either vacated, reversed, or overruled by the courts of appeals controlling those districts. See, e.g., The Methodist Hospital v. Sullivan, 1991 WL 263110 (D.D.C. 1991) (JA 415), overruled by Episcopal Hospital, 994 F.2d 879; Newport Hospital and Clinic, Inc. v. Sullivan, 1990 WL 179953 (D.D.C. 1990) (JA 370), overruled by Episcopal Hospital, 994 F.2d 879; Greenville Hosp. System v. Bowen, Medicare & Medicaid Guide (CCH) ¶ 35,880 (D.S.C. 1986), vacated, CCH ¶ 36,072 (D.S.C. 1986); Redbud Hosp. Dist. v. Heckler, CCH ¶ 34,085 (N.D. Cal. 1984), vacated, 473 U.S. 1308 (1985). Accordingly, those decisions -- upon which plaintiffs rely, Br. at 39 -- are neither persuasive nor reliable authorities in support of Plaintiffs' argument.

TEFRA also provided for an "exemption from, or an exception and adjustment to," the method of calculating the target amount as described in subsection (b)(3)(A) -- the so-called "TEFRA adjustment" of subsection (b)(4)(A):

> The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such a hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured).

42 U.S.C. § 1395ww(b)(4)(A). It is this last provision, the TEFRA adjustment, that plaintiffs erroneously contend has been incorporated sub silentio into the PPS method of reimbursement.

2. The Text Of The Statute Supports Empire's Decisions

The plaintiffs correctly begin by acknowledging that, as the Supreme Court has held, "the starting point in interpreting a statute is its language, for 'if the intent of Congress is clear, that is the end of the matter." Good Samaritan Hospital v. Shalala, 113 S. Ct. 2151, 2157 (1993) (quoting Chevron, 467 U.S. at 842). See Br. at 36. As this Court has noted, "the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." Ahmetovic v. INS, 62 F.3d 48, 51 (2d Cir. 1995) (quoting Chevron, 467 U.S. at 842). In this case, there are three clear indications within the plain language of the statute that the PPS system does not incorporate the TEFRA adjustment.

First, subsection (d)(l)(A)(i)(I) expressly incorporates subsection (b)(3)(A) in its definition of the HSP reimbursement

portion, but does not likewise incorporate subsection (b)(4)(A). This omission -- as contrasted with the intentional inclusion of a separate subsection -- indicates that Congress knew how to incorporate TEFRA provisions into the new PPS statutory scheme when it so intended. "Certainly, the fact that Congress clearly incorporated subsection (b)(3)(A), while never referring to subsection (b)(4)(a), suggests that when Congress intended to incorporate a TEFRA provision into PPS, it did so expressly and that it did not intend to incorporate the provision at issue here." Episcopal Hospital, 994 F.2d at 883; accord Sacred Heart Medical Center, 958 F.2d at 545, 549 ("this omission is significant, because if Congress had intended to retain the 'extraordinary circumstances' provision, it would have so indicated").

Second, the specific TEFRA provision that is incorporated into the PPS system -- subsection (b)(3)(A) -- also makes no mention of the TEFRA adjustment. On its face, that subsection's definition of "target amounts" does not incorporate or include subsection (b)(4)(A), which established the TEFRA adjustment. Rather, by its own terms, subsection (b)(4)(A) is an "exemption from, or an exception and adjustment to," the definition of "target amount" in subsection (b)(3)(A). Moreover, subsection (b)(3)(A) does specifically incorporate other exceptions to the target amount -- in particular "subparagraphs (C), (D), and (E)" of subsection (b)(3). 42 U.S.C. § 1395ww(b)(3)(A). Again, Congress knew how to specifically incorporate exceptions to the provision calculating the target amount, and while it did incorporate certain other exceptions, it did not incorporate the TEFRA adjustment. Congress' judgment in this regard is entitled

to deference. See, e.g., NLRB v. Bildisco and Bildisco, Inc., 465 U.S. 513, 522-23 (1984) ("obviously, Congress knew how to draft an exclusion for collective-bargaining agreements when it wanted to; its failure to do so in this instance indicates" that no such exclusion exists); Securities Industry Association v. Board of Governors of the Federal Reserve Svstem, 716 F.2d 92, 96 (2d Cir. 1984) (Congress' inclusion of item in one provision and exclusion of it elsewhere in statute indicates item has been excluded).

Plaintiffs argue in this regard that the "Secretary cannot calculate the Target Amount without, where appropriate, providing for an adjustment mandated by subparagraph (b)(4)(A)," Br. at 37, but that is simply not correct. All that the intermediaries have to do, and have done, is compute HSP target amounts and forgo additional reimbursement based on claimed "exceptional circumstances." As the Sacred Heart Medical Center court commented:

> [S]ection 1395ww(b)(3)(A) does not refer to section 1395ww(b)(4)(A), although it does refer to subparagraphs (C)I (D) and (E), which constitute exceptions from the target amount set forth in (b)(3)(A). Thus by section 1395ww(b)(3)(A)'s own terms, there is no need to incorporate section 1395ww(b)(4)(A) to ensure a proper calculation of a hospital's target amount.

958 F.2d at 549.

Moreover, just as subsection (b)(3)(A) makes no mention of the TEFRA adjustment, the TEFRA adjustment makes no specific mention of subsection (b)(3)(A). See Episcopal Hospital, 994 F.2d at 883 ("nor does subsection (b)(4)(A) either define 'target amount' or modify the definition set forth in (b)(3)(A)"). As plaintiffs point out, subsection (b)(4)(A) does refer to "the method under this

subsection for determining amount of payment to a hospital." Br. at 37. But the point is not whether the TEFRA adjustment provision refers generally to other TEFRA sections, but how much the PPS amendments retained of the TEFRA system -- a question that can be answered only by reference to PPS provisions, not the TEFRA language that predated them.

Third, that the PPS statute contains its own set of permissible adjustments and exceptions, but not including an exemption for "events beyond the hospital's control or extraordinary circumstances," undercuts any contention that the drafters of the PPS statute intended to retain the TEFRA adjustment. The exceptions set out in the statute involve, inter alia, teaching hospitals, rural hospitals, and hospitals serving low-income patients. See 42 U.S.C. § 1395ww(d)(5)(A)-(H). Their existence confirms that Congress considered and enacted desirable PPS exceptions and would have explicitly included the TEFRA adjustment had it wanted to do so. Hillsboroush County Hospital Authority, 49 F.3d at 1517 (explicit PPS exemptions "eliminat[es] any need to incorporate § 1395ww(b)(4)(A)'s exception"); Episcopal Hospital, 994 F.2d at 883; Sacred Heart Medical Center, 958 F.2d at 545.

Plaintiffs' response to the list of PPS exceptions point is beside the point. They argue that because the explicit PPS exceptions are permissive while the TEFRA adjustment is mandatory, and because the TEFRA adjustment would expire at the end of the transition period while the PPS exceptions endure, the PPS exceptions and the TEFRA adjustment are not "redundant." Br. at 41. The issue, however, is

not whether the two sets of exceptions are redundant. Rather, the issue is whether Congress' specific inclusion of certain exceptions in PPS, without including the TEFRA adjustment, means that the TEFRA adjustment does not apply to PPS reimbursement. As set forth supra at 40-41, long-standing doctrines of statutory construction mandate this result.

In a strained construction of the statutory language, plaintiffs argue that "incorporation by negative inference" reveals Congress's intent that the TEFRA adjustment survive the enactment of the PPS system. Br. at 42-43. In particular, plaintiffs contend that because subsection (d)(l)(A)(i)(I) provides that the PPS target amount is to be "determined without the application of subsection (a) of this section" -- but does not also say "without the application of subsection (b)(4)(A)" -- that Congress must have meant to include subsection (b)(4)(A) within subsection (d)(l)(A)(i)(I)'s definition of "target amount." This argument is meritless because subsections (a) and (b)(4)(A) are so dissimilar. Subsection (a) must be read in conjunction with subsection (b)(3)(A) -- which is incorporated specifically in PPS -- because it defines "allowable costs," one of the relevant terms of the latter subsection; as such, Congress was required to explicitly exclude subsection (a) in order to ensure that that subsection would not be considered under PPS. By contrast, subsection (b)(4)(A) does not define a relevant term contained in subsection (b)(3)(A); thus, Congress' decision not to specify the exclusion of subsection (b)(4)(A) is of no import, for Congress had no reason to make that specification.

Plaintiffs' reliance on the single decision in their favor is no more successful than their reliance on the statutory text. The weaknesses and limitations of the Ninth Circuit's decision in Community Hosnital of Chandler, Inc., see Br. at 38-39, are legion. The court based its ruling on the general "interface between subsections § 1395ww subsections (b) and (d)," rather than the specific text of subsections (d)(l)(A)(i)(I), (b)(3)(A), and (b)(4)(A). 963 F.2d at 1214 n.4 (quotation omitted). Nor did the court consider subsections (d)(5)(A)-(I) and the effect of those PPS exceptions on the propriety of reading into PPS the TEFRA adjustment as well. Moreover, the Ninth Circuit relied upon two district court cases -- also cited by plaintiffs -- that have since been reversed by the D.C. Circuit. See supra at 37 n.3. In addition, perhaps because the issue was raised for the first time on appeal, the court mistakenly understood that the Secretary did not argue that the TEFRA provision was inapplicable to the PPS system. 963 F.2d at 1213-14 & n.4. Community Hospital of Chandler, Inc., in sum, is worth no more precedential value here than it was given by the Eleventh and D.C. Circuits, which chose instead to follow the Third Circuit's Sacred Heart Medical Center decision in holding the TEFRA adjustment inapplicable to PPS. See Hillsboroush County Hospital Authority, 49 F.3d at 1517; Episcopal Hospital, 994 F.2d at 883-84.

Finally, plaintiffs rely on legislative history to argue for the TEFRA adjustment's continuation during the transition period. Br. at 43-44. Of course, courts "do not resort to legislative history to cloud a statutory text that is clear," as is the text here, even where

that history has "contrary indications" to the statute. United States v. Johnson, 14 F.3d 766, 771 (2d Cir.) (quoting Ratzlaf v. United States, 114 S.Ct. 655 (1994)), cert. denied, 114 S.Ct. 2751 (1994). Moreover, the excerpts cited by plaintiffs hardly clarify the point. The portion of the House Report plaintiffs cite says only that subsection (a)'s exceptions are inapplicable, not that the TEFRA adjustment survives. The cited Conference report excerpt refers to narrow and particular allowable adjustments in base year costs that have since been codified in the secretary's regulations. See 42 C.F.R. § 412.71(b)-(c). It does not mention subsection (b)(4)(A), and has never been interpreted by the Secretary to cover the TEFRA adjustment. Id.

More to the point is the report of the House Ways and Means Committee, which indicates the unavailability of the TEFRA adjustment:

> The portion of a hospital's payment determined on its own cost base [during the PPS transition period] would be calculated though the hospital's target amount under the 1982 TEFRA legislation were its payment amount (that is, . . . without regard to the exceptions, exemptions and adjustments which may have been authorized under TEFRA for that year).

H. R. Rep. No. 25, 98th Cong., 1st Sess. 136, reprinted in 1983 U.S.C.C.A.N. 219, 355 (emphasis added). Equally significant is the harmony between the PPS statute's exclusion of the TEFRA adjustment and Congress' overall intent in enacting the PPS system:

> Although the legislative history is barren of commentary directly revealing Congress' intent concerning the incorporation of section 1395ww(b)(4)(A) into the PPS, the legislative history does indicate that Congress enacted the PPS to move away from the retrospective reimbursement system and replace it with prospective system with fixed national rates. This intent supports the view that an increase in a given hospital's actual operating costs should not be

considered unless the statute or the regulations expressly so provide.

Sacred Heart Medical Center, 958 F.2d at 547 (citing House and Senate reports); see also Episcopal Hospital, 994 F.2d at 883. If anything, notwithstanding plaintiffs' reliance on it, the legislative history confirms the TEFRA adjustment's demise.

3. The Secretary's Construction Of The Statute Is A Permissible One

In construing the relevant TEFRA and PPS subsections, this court does not write on a clean slate. The Secretary, charged with administering the Medicare program, has interpreted the PPS statute to have eliminated the availability of the TEFRA adjustment during the transition period and thereafter. As noted supra at 14, this interpretation is entitled to great deference from this Court, which looks only to see whether the Secretary's interpretation is a permissible construction of the statute.

PPS endowed the Secretary with the authority to "provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as (she] deem[ed] appropriate." 42 U.S.C. § 1395ww(d)(5)(I). Pursuant to this authority, the Secretary promulgated two regulations providing for several "modifications" to the PPS method of calculating of HSP base-year costs. See 42 C.F.R. §§ 412.71, 412.72. Consistent with the Secretary's view that the TEFRA adjustment did not survive the enactment of the PPS system, none of the enumerated modifications retains or revives the TEFRA adjustment, or otherwise encompasses plaintiffs' reimbursement requests. Given its firm grounding in the language in the PPS

statute, the Secretary's view "[wa]s a permissible one," Episcopal Hospital, 994 F.2d at 884, and should therefore receive substantial deference.

Plaintiffs' argument that the Secretary's interpretation of the statute should command no deference is based on a change in the Secretary's position regarding the pertinent provisions. Plaintiffs point out that the Secretary initially cited subsection {b)(4)(A), the TEFRA adjustment, in a 1984 Federal register notice discussing adjustments under PPS. Br. at 45. But the Secretary changed that position soon thereafter, stating in a 1986 Federal Register notice that "exceptions, exemptions, or adjustments granted for periods subsequent to the base year do not change the hospital-specific portion of the prospective payment rate since neither base year costs nor the target amount is altered bv such action." 51 Fed. Reg. 8208, 8210 (March 10, 1986) (emphasis added).[4]

Plaintiffs also make much of administrative correspondence that occurred in the case of Newport Hospital and Clinic, Inc. v. Sullivan, 1990 WL 179953 (D.D.C. 1990) (JA 370), see Br. at 47-48; JA 423-26, and the Secretary's decision to settle Greenville Hosp. System v. Bowen, Medicare & Medicaid Guide (CCH) ¶ 35,880 (D.S.C. 1986), after an adverse decision on the TEFRA issue by the district court,

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[4] Plaintiffs argue that the Secretary's Federal Register notice "was never promulgated as a final rule" and thus "never given the force and effect of law." Br. at 47. This is an odd contention from parties who place great reliance on statements in letters from HCFA officials. See, e.g., Br. at 45-46. Nonetheless, plaintiffs miss the point, since the notice is significant as a statement of the Secretary's statutory interpretation, not as a proposed law or regulation.

see Br. at 48-49; JA 346-64. That settlement, however, explicitly states that it has no "precedential value beyond the confines of the instant dispute" and does not constitute "a concession or admission by the [Secretary] . . . and may not be relied upon or introduced in this or any other judicial or administrative proceedings." JA 363. Furthermore, to the extent that plaintiffs seek the same treatment received by the hospitals in these two cases, see Br. at 50, "[n]o rule of administrative law requires the Secretary to extend the same erroneous treatment to [plaintiffs], thereby turning an isolated error into a uniform misapplication of the law." Sacred Heart Medical Center, 958 F.2d at 548 n.24.

In the final analysis, the Secretary simply "should not be bound by its previous interpretation of the PPS, though espoused shortly after the statute was enacted, where the agency modified its interpretation upon a more thorough examination of the statute." Sacred Heart Medical Center, 958 F.2d at 548. The Supreme Court has recently prescribed the judicial approach to a change in the Secretary's interpretation of the Medicare statute:

> The Secretary is not estopped from changing a view she believes to have been grounded upon a mistaken legal interpretation. Indeed, an administrative agency is not disqualified from changing its mind; and when it does, the courts still sit in review of the administrative decision and should not approach the statutory construction issue de novo and without regard to the administrative understanding of the statutes. . . .
>
> . . . [W]here the agency's interpretation of a statute is at least as plausible as competing ones, there is little, if any, reason not to defer to its construction.

Good Samaritan Hospital, 113 S. Ct. at 2161; see also Queen of Angels/Hollywood Presbyterian Medical Center v. Shalala, 65 F.3d 1472,

1480-81 (9th Cir. 1995) (same). The question, in other words, is not whether the Secretary has always held her current position, but whether that position is permissible. In this case, there can be little doubt that it is, and that it is entitled to deference.

CONCLUSION

The judgment of the district court should be affirmed.

Dated: New York, New York
December 18, 1995

Respectfully submitted,

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BIOGRAPHY

Martin J. Siegel was born and raised in Houston. He earned a B.A., Highest Honors, from The University of Texas at Austin in 1988, where he majored in the Plan II Liberal Arts Honors Program and graduated *Phi Beta Kappa.*

Siegel received his law degree, *Cum Laude*, from Harvard Law School in 1991. Following law school, he served as law clerk to the Honorable Irving R. Kaufman on the United States Court of Appeals for the Second Circuit in New York City.

From 1992 to 1994, Siegel was an associate in the Washington, DC office of Jenner & Block. At Jenner, he worked on appellate, commercial, intellectual property, and environmental matters. He assisted in the Supreme Court briefing for respondents in *U.S. Nat'l Bank of Oregon v. Indep. Ins. Agents of America*, 508 U.S. 439 (1993); represented MCI in patent, antitrust and other matters; and helped develop the evidence for, draft and present a petition for post-conviction relief to the Maryland state trial court on behalf of death row inmate Kevin Wiggins. Although the court denied the petition, the U.S. Supreme Court eventually granted it in a decision vacating the death sentence and setting new standards for counsel in the sentencing phase of capital cases. *See Wiggins v. Smith*, 539 U.S. 510 (2003).

From 1995 to 2000, Siegel served as an Assistant United States Attorney in the Civil Division in the Southern District of New York, where his practice focused on bringing civil rights actions, defending statutes from constitutional challenge, and defending federal agencies and officers from suits based on government action. Civil rights cases brought by Siegel include a complaint under the Voting Rights Act following fraud in a Bronx school board vote, resulting in a new election; some of the first cases in the United States brought under the Freedom of Access to Clinic Entrances Act; an action based on discriminatory zoning in violation of the Americans with Disabilities Act; and an investigation of the New York City Parks Department for employment discrimination. In a case of first impression, Siegel successfully defended provisions of the 1996 immigration and welfare reform laws (invalidating local rules against disclosing the immigration status of aliens to federal law enforcement) from constitutional attack under the 10th Amendment brought by New York City. *See City of New York and Rudolph Giuliani v. United States and Janet Reno,* 179 F.3d 29 (2d Cir. 1999).

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In all, Siegel tried eight cases in federal district court and briefed and argued twelve appeals to the Second Circuit. He received the Department of Justice's Director's Award for Superior Performance as an Assistant United States Attorney in 1999 for the successful trial defense of the former chief of the CIA's Technical Services Division in a case involving the agency's experimentation with LSD in the early 1950s.

In 2000-01, Siegel was detailed to serve as Special Counsel on the minority staff of the Senate Judiciary Committee, where his responsibilities included drafting and analyzing legislation on election reform, the McCain-Feingold campaign finance bill, criminal justice, immigration and other issues.

From 2001-06, Siegel was a partner at Watts Law Firm in Houston, where he worked on commercial, franchise, patent, trade secret, false advertising, product liability and personal injury litigation. In 2002, he successfully represented Texas beer distributors against Anheuser-Busch after it wrongfully prevented a $60 million sale of their distributorship, achieving a highly favorable confidential settlement. In 2003, he helped represent the founder of a securities trading firm forced out of the business he founded before its sale for $150 million, winning a $43 million arbitral award. In 2005, he successfully represented Stabar Enterprises, a small Austin pet products company, in multiple lawsuits arising from a licensing dispute with one of the country's largest makers of animal products, securing the dismissal of a related suit against Stabar and a favorable confidential settlement that included the sale of the company's assets.

In 2006, Siegel successfully represented the Texas Democratic Party in its suit to prevent the Republican Party of Texas from replacing Tom DeLay on the general election ballot for Congress following DeLay's withdrawal as a candidate. Siegel wrote the Democratic Party's briefs in the Fifth Circuit on an expedited schedule and co-argued the appeal, resulting in a complete victory for TDP's position under the Constitution's Qualifications Clause and state election law and an order barring the replacement.

In 2007, Siegel opened the Law Offices of Martin J. Siegel to focus on appellate advocacy. He remains of counsel to Watts Law Firm.

In 2004 and 2007, *Texas Monthly* named Siegel a "Texas Super Lawyer Rising Star," an award given to lawyers under 40 chosen by other lawyers throughout the state.

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Siegel has written frequently on legal topics. In 2007, he was named to the Board of editors of Litigation, the magazine published by the ABA's Section on Litigation. Siegel's writings include:

- *Zealous Advocacy vs. Truth*, 33 LITIGATION 31 (Fall 2006);
- *The Myth of Dem, GOP Justice*, HOUSTON CHRONICLE, September 10, 2006, at E4;
- *We Don't Have Kings in Texas*, HOUSTON CHRONICLE, May 29, 2005, at E4;
- *Congressional Power over Presidential Elections: The Constitutionality of the Help America Vote Act Under Article II, Section 1*, 28 VERMONT L. REV. 373 (Winter 2004);
- *Bryant Case Tosses a Lifeline to the Laws Against Adultery*, LOS ANGELES TIMES, August 13, 2004, at B13;
- *Why Texas Republicans Should Love the Trial Lawyers*, HOUSTON CHRONICLE, April 20, 2003, at 4C; and
- *For Better or For Worse: Adultery, Crime and the Constitution*, 30 J. FAMILY L. 45 (1991-92).

Siegel has also served as an adjunct professor at the University of Houston Law Center, as a guest lecturer there and at business and graduate school classes at Princeton and UCLA, and as a speaker at CLE seminars and workshops in Houston and elsewhere.

APPELLATE AND BRIEF WRITING EXPERIENCE

Martin Siegel has an extensive background in appellate and trial-level briefing and argument cutting across a broad range of substantive and procedural areas, including constitutional law, commercial disputes, product liability, personal injury, federal preemption, consumer protection, jurisdiction, removal and remand, governmental immunities, employment law and others.

Siegel's experience began as a federal appellate law clerk and deepened over years of representation of corporate defendants, the United States and individual plaintiffs. He has briefed and argued appeals in the United States Courts of Appeals for the Second Circuit and Fifth Circuit, the Texas Supreme Court (briefed only), and several state appellate courts, and has assisted with briefs written for the United States Supreme Court.

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Some of Siegel's more significant cases include:

- *Texas Democratic Party v. Tina Benkiser, Chairwoman of the Republican Party of Texas.* The Texas Democratic Party sued the Republican Party of Texas to prevent it from substituting a new Congressional candidate for Tom DeLay after his withdrawal from the 2006 election. TDP argued that it was too late to substitute candidates, while RPT claimed replacement was permitted because DeLay had moved to Virginia and was therefore constitutionally ineligible to serve. Siegel handled most of the briefing in the district court, wrote the briefs for TDP in the Fifth Circuit on an expedited schedule and shared oral argument with the party's full-time counsel, obtaining a complete vindication of TDP's position that it had standing to bring the case and that DeLay's replacement would violate the Constitution's Qualifications Clause and state election law. *See* 459 F.3d 582 (5th Cir. 2006).

- *City of New York and Rudolph Giuliani v. United States and Janet Reno.* New York City challenged provisions of the 1996 welfare and immigration reform laws that invalidated local rules against disclosing the immigration status of aliens to federal law enforcement. In a case of first impression, the Second Circuit held that the federal provisions do not violate the Tenth Amendment's bars on interfering with state operations or conscripting state officials to carry out federal tasks. *See* 179 F.3d 29 (2d Cir. 1999). Siegel wrote the federal government's trial and appellate briefs and successfully argued the appeal in the Second Circuit.

- *Grigsby v. ProTrader Group Management LLC, et al.* In this arbitration, Grigsby claimed that the defendants violated securities laws and committed minority shareholder oppression by squeezing him out of the company he co-founded shortly before it was sold for $150 million. As part of the team representing Grigsby, Siegel briefed and argued summary judgment motions and other issues, including ratification, duties owed under the Texas Revised Partnership Act, the statute of limitations for 10b-5 claims under Sarbanes-Oxley, standards for recovery for shareholder oppression, and others. The arbitrators accepted Grigsby's legal positions and awarded him $43 million in compensation. Case No. AAA 70 180 00648 02.

- *Barahona v. Toyota Motor Corp., et al.* The plaintiff sued Toyota when his son was rendered a quadriplegic, alleging that the defective design of the Toyota

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Echo's seatback caused the injuries. Toyota twice filed writs of mandamus in the Court of Appeals and once in the Texas Supreme Court attacking various discovery and other rulings. Siegel wrote the plaintiff's responses, obtaining denials of Toyota's petitions. *See* 191 S.W. 3d 498 (Tex. App. – Waco 2006, mandamus denied, Case No. 06-0449, TX Sup. Ct., June 5, 2006). Siegel also briefed several *Daubert,* summary judgment and other motions, resulting in rulings favorable to the plaintiff.

- *Ayala v. Ford Motor Co.* In this wrongful death case, Ford argued that it complied with applicable federal safety standards and was therefore not liable under TEX. CIV. PRAC. & REM. CODE § 82.008(a). When the plaintiffs responded that Ford's inadequate disclosures to NHTSA rebutted the presumption of nonliability under § 82.008(b)(2), Ford replied that subsection (b)(2) is impliedly preempted under the reasoning in *Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341 (2001), a position the Sixth Circuit and other courts have adopted. Siegel handled the plaintiffs' briefing, and the district court agreed with the plaintiffs that federal law does not conflict with § 82.008(b)(2) and that *Buckman* preemption applies only to fraud-on-the-agency theories of liability, not traditional state product liability claims. Case No. 2-04CV-395 (E.D. Tex. 2005).

- *Rivera v. Heyman, Secretary, Smithsonian Institution, et al.* Siegel represented the Smithsonian in this employment discrimination case raising the novel question whether the Smithsonian, a unique and independent federal trust instrumentality dating to 1836, is subject to § 501 of the Rehabilitation Act, which covers only executive branch employees. Following Siegel's briefing and argument, the district court agreed with the government that the Smithsonian is not in the executive branch and therefore not subject to § 501. As a result of the case, Congress amended the Act to include the Smithsonian. On appeal, which Siegel also briefed and argued, the Second Circuit upheld the remainder of the district court's decision holding that the plaintiff had no additional remedy under § 504 of the Act – a question on which several circuit courts had split – or state and local civil rights laws. *See* 157 F.3d 101 (2d Cir. 1998).

- *Good Samaritan Hospital Regional Medical Center, et al. v. Shalala.* Three hospitals and Medicare providers sued HHS seeking to compel review of a decision not to reopen the hospitals' claims for reimbursement of various significant expenses. Siding with the government after Siegel's briefing and argument, the Second Circuit held that jurisdiction to undertake the requested review was lacking, and that challenged HHS regulations were permissible in

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light of the Medicare Act. The Second Circuit reached this conclusion despite Ninth Circuit precedent to the contrary. *See* 85 F.3d 1057 (1996).

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