ADMINISTRATIVE LAW—JURISDICTIONAL AUTHORITY OF THE PROVIDER REIMBURSEMENT REVIEW BOARD

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Introduction

The Medicare Act was enacted in 1965 to provide a health insurance program to assure health care to Social Security recipients over sixty-five years of age and to those permanently disabled. One major section of the Medicare Act, Part A, governs payment for inpatient hospitalization and medical care for the elderly and disabled. Under the statute, the federal government reimburses providers of medical services for the care rendered to patients, subject to certain guide-


In 1984, the Medicare program provided hospital and medical insurance protection for 30.5 million persons. The benefits paid through the program have increased from $4.5 billion in 1967 to $63 billion in 1984. Public Rel. Div. Health Ins. Ass'n of Am., Source Book of Health Ins. 1986 Update 16 (1986).

2. H. McCormick, supra note 1, at viii. This part of the Medicare Act is financed through payroll deductions.


3. 42 U.S.C. § 1395x(u) (1982) states: "The term 'provider of services' means a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility or home health agency, [or] hospice program. . . ." In the reported cases discussed in this comment, the providers were hospitals. See U.S. Dep't of Health and Human Servs., The Pro-
lines and limitations. The Medicare Act sets forth general costs allowed for reimbursement and authorizes the Secretary of the Department of Health and Human Services to promulgate regulations and policies that further define and interpret those costs.5

The Secretary employs fiscal intermediaries as agents to assist in the administration of the program.6 Intermediaries are responsible for assisting providers in recording and reporting program costs and, subject to regulations and policies promulgated by the Secretary, determining what costs are allowable and then distributing funds to the providers to cover those costs.

In 1972, Congress created a Provider Reimbursement Review Board (Board) to settle cost disputes between fiscal intermediaries and providers of services.7 Although Congress gave the Board broad reviewing authority,8 the Board has declined to hear a certain class of appeals. If providers have not initially presented their claims for reimbursement of particular costs to fiscal intermediaries, the Board states that it lacks statutory power to exercise jurisdiction over the appeals and dismisses them.9 This denial of jurisdiction is critical; it not only affects the providers' access to judicial review of the particular intermediary decision, but, more importantly, it forecloses judicial review of the Secretary's regulations governing an entire class of costs. If the Board lacks jurisdiction over the appeals, then the federal courts also lack jurisdiction.10

Providers have challenged the Board's dismissals of their appeals, and the United States Courts of Appeals have developed five different
approaches to evaluate the propriety of the Board’s decisions.\textsuperscript{11} The United States Supreme Court in \textit{Bethesda Hospital Association v. Secretary of Health and Human Services}\textsuperscript{12} attempted to resolve the controversy among the federal circuit courts of appeals by constructing the proper interpretation of the Board’s reviewing authority.\textsuperscript{13} However, the Court developed an approach which unduly expands the Board’s reviewing authority and raises several policy concerns.

This comment analyzes the Supreme Court’s decision in \textit{Bethesda} and explores the five competing interpretations of the Board’s reviewing authority which the federal courts of appeals developed prior to \textit{Bethesda}. Part I of this comment discusses the reimbursement and appeal procedures of Part A of the Medicare program. Part II discusses the case law construing the Board’s jurisdiction. It discusses separately the cases that affirm the Board’s lack of jurisdiction, those that hold that the Board has discretion to determine whether and when it has jurisdiction, and those that hold that the Board has and must assert jurisdiction.\textsuperscript{14} Part III reviews the United States Supreme Court’s interpretation in \textit{Bethesda} of the Board’s governing statute. Part IV offers a critique of the Supreme Court’s approach in \textit{Bethesda} and argues that the Court should have endorsed the Ninth Circuit Court of Appeals’ interpretation in \textit{Adams House Health Care v. Bowen}. In \textit{Adams House},\textsuperscript{15} the Ninth Circuit Court of Appeals held that the Board has jurisdiction over claims where the providers challenge a regulation or policy provision, and affirmed the Board’s lack of jurisdiction in situations where the provider has simply failed to submit the required cost information to the intermediary.\textsuperscript{16} This preferred approach is consistent with the language of the statute, its legislative history, and the strong policy favoring judicial review of administrative action.

\begin{enumerate}
\item These approaches are discussed in further detail later in this comment. \textit{See infra} notes 42-129 and accompanying text.
\item 108 S. Ct. 1255 (1988).
\item \textit{See infra} notes 41-129 and accompanying text.
\item 817 F.2d 587 (9th Cir. 1987), \textit{vacated and remanded}, 108 S. Ct. 1569 (1988).
\item \textit{See infra} text accompanying notes 120-22.
\end{enumerate}
I. THE STATUTORY BACKGROUND OF THE REIMBURSEMENT AND APPEAL PROCEDURES

The Medicare Act provides a comprehensive system of reimbursement and an administrative appeals process for dissatisfied providers of services. Under the Act, the federal government reimburses providers on a reasonable cost basis for inpatient hospital expenses. A provider submits an annual cost report to a financial intermediary three months after the close of the provider's fiscal year. The cost report includes costs incurred for services rendered to beneficiaries within the reporting period.

In a cost report, providers separately record reimbursable costs (as defined by statutory, regulatory and/or policy provisions) and nonreimbursable costs, with nonreimbursable costs listed in a section

17. 42 U.S.C. § 1395x(v)(1)(A) (1982) provides: "The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used. . . ." Id.

Prior to 1972, Medicare providers were reimbursed for the reasonable costs incurred in caring for Medicare beneficiaries. However, as the reasonable costs incurred began to exceed the amount normally charged to non-program beneficiaries, Congress feared that the Medicare program was bearing part of the costs of treating non-program patients.

Thus, in 1972 Congress amended the Medicare statute to require that the program reimburse providers the lesser of "the reasonable cost of services . . . or the customary charges with respect to such services." In other words, if a provider incurs costs with respect to a service which are greater than the amount the provider would normally charge non-Medicare patients for the service, Medicare will only reimburse the provider the amount of the customary charge. The remainder of the costs are disallowed, no matter how reasonable. Likewise, if a provider's cost with respect to a service are [sic] less than the amount normally charged for the service Medicare will reimburse the provider only for its reasonable costs.


The 1983 Amendments to the Medicare Act, Pub. L. No. 98-2, 97 Stat. 65, created a prospective payment system to be effective on October 1, 1983. Under this system, hospitals are paid a predetermined amount according to a standard national rate calculated for 470 treatment categories or "Diagnosis Related Groups." However, payment for other costs related to inpatient services are still made on a reasonable cost basis. See 42 C.F.R. §§ 412.1-.2 (1987). Reasonable cost reimbursement is used for capital related costs, direct medical education costs, anesthesia services, and kidney acquisition costs. 42 C.F.R. § 412.113 (1987). See also 42 U.S.C. § 1395ww(d) (1982).

18. 42 C.F.R. § 409.10 (1987) states: "[I]npatient hospital operating costs include those costs (including malpractice insurance costs) for general routine service, ancillary service, and intensive care-type unit services with respect to inpatient hospital services. . . ." See also U.S. DEP'T OF HEALTH AND HUMAN SERV., supra note 3, at 2801.


entitled Work Sheet A-8. This practice of including nonreimbursable costs in the cost report but listing them on a separate work sheet is known as "self-disallowance." For example, a statutory provision excludes personal comfort items from reimbursement, such as a personal telephone which is defined by the regulations as a personal comfort item. A provider will self-disallow costs incurred in providing personal telephones to beneficiaries by listing the costs on Work Sheet A-8 of its medical cost report.

The intermediary audits a provider's cost report for reimbursable costs. If a provider reports a cost for reimbursement which a statute, regulation, or policy provision prohibits from reimbursement, the intermediary disallows the cost. The intermediary then sends a Notice of Amount of Program Reimbursement (NPR) to the provider which sets forth adjustments and modifications of total costs permitted for reimbursement.

A provider that wishes to challenge the intermediary with respect

21. On Work Sheet A-8, a provider will list items prohibited from reimbursement under Medicare principles. Also on this work sheet, a provider will offset costs by the amount of revenue received to reflect actual expenses.


25. 42 U.S.C. § 1395h(a) (1982); 42 C.F.R. § 413.24(c) (1987). An intermediary initially conducts a desk review of the provider's cost report, followed by an extensive field audit at the provider's principle place of business. In order for an intermediary to audit the reimbursable costs accurately under the Medicare system, it must review the total operating costs, amount of revenue received, the apportionment of costs and revenues, the computation of Medicare costs from total costs, and the computation of reimbursable costs from total Medicare costs. Thus, the auditor examines each cost listed on every page of a cost report, including Work Sheet A-8. See supra note 21. See also infra note 101. A field audit is a very comprehensive task and may take up to four weeks to complete. Interview with John Roemer, Vice President of Finance at Franklin Medical Center, in Greenfield, Massachusetts (Nov. 7, 1987).

From the reported decisions, it appears that the courts are unaware of the nature and extent of the intermediary's auditing process. The courts focus only on the intermediary's auditing of reimbursable costs under the Medicare system and seem unaware that the intermediary must audit all costs, including those on Work Sheet A-8, in order to arrive at a reimbursement figure. Several courts have stated incorrectly that an intermediary does not audit self-disallowed claims, and have used the finding that self-disallowed claims are not reviewed initially by the intermediary as a basis for concluding that the Board does not have jurisdiction. See infra notes 42-82 and accompanying text.

26. 42 C.F.R. § 405.1803(a) (1987). Intermediaries are required to send providers a final determination within a reasonable time (12 months) after filing a cost report. 42 C.F.R. 405.1835(e) (1987). If a provider has not received a final determination within a reasonable time, it can appeal to the Provider Reimbursement Review Board. 42 U.S.C. § 1395oo(d) (1982). The cases discussed in this comment use the term "final determination" when referring to the NPR.
to the findings in the NPR may exercise its rights to an appeal. When the amount in controversy exceeds $10,000.00, a provider can appeal to the Board if it is dissatisfied with the intermediary's final determination or if the provider has not received a NPR within a reasonable time.

The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such determination.

The decision of the Board is binding on the parties unless the Secretary revises, affirms, or modifies the Board's decision within sixty days.
of the provider’s receipt of the final determination.31

Either upon a provider’s request or sua sponte, an intermediary hearing officer, the Board, or the Secretary may reopen a final decision to re-examine the correctness of its decision.32 However, the administrative body has full discretion in deciding this request. According to the Secretary’s regulations, the decision on whether to reopen is not subject to review by the Board or the courts.33

A provider has the right to judicial review of a final decision made by the Board or the Secretary.34 In addition, by virtue of the 1980 amendments, a provider has a right to obtain judicial review of the Board’s determination that it is without the authority to decide the issue.35 The Board does not have statutory authority to decide whether a regulation or policy provision contravenes a statute or whether a policy provision violates a regulation. The Board is bound by the Secretary’s regulations and policies.36 Thus, for example, if a provider challenges before the Board the legality of the Secretary’s regulation that defines personal telephones as personal comfort items, the Board is without the authority to decide the issue. Although the Board has limited authority concerning these issues, Board review is a necessary precondition to judicial review.37

33. 42 C.F.R. § 405.1885(c) (1987); U.S. DEP’T OF HEALTH AND HUMAN SERVS., supra note 3, at 2931.1.
34. 42 U.S.C. § 1395oo(f)(1) (1982); 42 C.F.R. § 405.1877 (1987). The provider has to file a civil action within 60 days of receipt of a final determination in the district court for the judicial district where the provider is located or in the District Court for the District of Columbia. 42 U.S.C. § 1395oo(T) (1982).
35. 42 U.S.C. § 1395oo(f) (1982). The Board must determine that it is without authority to decide the issue within 30 days. If the Board fails to render a decision, the Board is presumed to have no authority to decide the issue, and the provider may commence a civil action within 60 days. Id.
37. In Aristocrat South, Inc. v. Mathews, 420 F. Supp. 23 (D.D.C. 1976), the provider challenged a Medicare accounting regulation as being inconsistent with statutory reimbursement procedures. The court held:

Even if initial application to the PRRB . . . seems formalistic and futile . . . it is a statutory prerequisite to judicial review which must be followed. . . . [T]his Court is not convinced that the futility of resort to the PRRB is a foregone conclusion. . . . This Court thus finds that . . . 42 U.S.C. § 1395oo provides an administrative review process . . . which must be resorted to as a prerequisite to obtaining judicial review.

Id. at 26. See also Hadley Memorial Hosp., Inc. v. Schweiker, 689 F.2d 905 (10th Cir. 1982). In Hadley, providers challenged the validity of the 1979 Malpractice Rule and argued, inter alia, the futility of presenting a challenge to the Board in order to obtain judicial review. The Tenth Circuit Court of Appeals rejected the providers’ futility argument be-
Prior to the 1980 amendments, providers were required to conduct a full review of such challenges before the Board in order to obtain judicial review. This time-consuming and inconsequential administrative review procedure delayed the resolution of disputed matters for extended periods of time. The amendment gives providers a vehicle to obtain immediate judicial review in instances where the Board determines that it lacks the authority to grant the relief sought.

II. THE CONFLICTING CASE LAW ON BOARD JURISDICTION

This section presents the conflicting case law interpreting the Board's governing statute prior to the Supreme Court's decision in Bethesda. The District of Columbia Circuit Court of Appeals, in Athens Community Hospital, Inc. v. Schweiker (Athens II), presented a restrictive interpretation to the Board's governing statute. In that case, the court held that the Board lacks jurisdiction to hear any claims not listed for reimbursement in the provider's cost report. This restrictive interpretation subsequently was endorsed by the Sixth Circuit Court of Appeals in two factually distinct cases. This discussion notes that because Board review is a prerequisite to judicial review, the effect of this restrictive interpretation is to deny providers their statutory cause a "final decision" by the Secretary is a necessary prerequisite to obtain federal court jurisdiction. Id. at 910.

The futility of presenting a regulatory challenge to the Board when the Board has no authority to grant the relief sought was an issue prior to the enactment of the 1980 amendments to subsection (f) of the Board's governing statute. Although courts recognized the futility of presenting such a claim, it was clear from the statute that Congress intended providers to exhaust their administrative remedies prior to obtaining judicial review. The original grant of jurisdiction of subsection (f) requires a final decision by the Board as a prerequisite to judicial review. See infra text accompanying notes 105-15.

In the absence of statutory authority, section 704 of the Administrative Procedure Act limits judicial review of an administrative action to "final agency action." The requirement of final agency action as a prerequisite to judicial review serves many purposes. It avoids premature judicial involvement in the agency decision-making process; it makes judicial deference to administrative action possible; and it provides a detailed statement of the agency's actions and evidence. R. PIERCE, S. SHAPIRO & P. VERKUIL, ADMINISTRATIVE LAW AND PROCESS 182 (1985).

The 1980 amendment provides a somewhat quicker and easier process for providers to exhaust their administrative remedies and to obtain judicial review by requiring only a determination by the Board that it has no authority to decide the issue presented by the provider. See infra text accompanying notes 105-15.

39. Id.
40. See infra notes 105-15 and accompanying text.
41. 686 F.2d 989 (D.C. Cir. 1982).
tory right to judicial review of the Secretary's regulations and policy provisions.

The contrary approaches taken by the First, Eleventh, Ninth, and Seventh Circuit Courts of Appeals assure providers their right to judicial review of regulations and policy provisions. Each of these courts either allows or requires the Board to exercise jurisdiction to hear self-disallowed claims. However, the courts differ markedly in the rationale of their decisions.

A. The Athens II Approach: The Board Lacks Jurisdiction

Although the Board was established in 1972, the scope of the Board's jurisdiction was not reviewed judicially until 1982 by the District of Columbia Circuit Court of Appeals in Athens Community Hospital, Inc., v. Schweiker (Athens I). In that case, the United States Court of Appeals for the District of Columbia Circuit held that the Board did not have authority to review claims that were not included in the provider's cost report.

In Athens I, Hospital Corporation of America (HCA) filed timely cost reports for fiscal years 1973 and 1974. When HCA received its notice of reimbursement for 1973, it filed an appeal with the Board contesting six adjustments. Prior to the Board's decision, HCA requested permission from the intermediary to amend its 1973 and 1974 cost reports to include claims for reimbursement for stock option costs and federal income tax payments which it had omitted from its original filings inadvertently. The intermediary denied the request for amendments, and HCA asked the Board to consider these claims for

42. The Board was created in 1972, but it did not review its first case until 1975. However, it was not until seven years later that providers challenged the Board's decisions that it lacked jurisdiction to hear provider's self-disallowed claims. While Arthur Owens was chairman of the Board from 1975 to 1980, the Board did not recognize a providers' right to appeal a claim not initially requested for reimbursement. However, in 1980, William Tierney replaced Arthur Owens as chairman. From approximately 1980 to 1982, the Board allowed providers the right to appeal to the Board those claims which they initially failed to present to the intermediary for reimbursement. The Board soon became so overwhelmed with these types of claims that Mr. Tierney sent a letter to providers informing them that the Board no longer would exercise jurisdiction over self-disallowed claims. Telephone Interview with Arthur Owens, Member of the Provider Reimbursement Review Board (Sept. 24, 1987).


44. Id. at 991.

45. Id. There was no dispute that the Board had jurisdiction to hear arguments concerning the intermediary's six adjustments to HCA's 1973 cost report.

46. Id. at 991-92.

47. The intermediary denied HCA's request to reopen not because the claims were
reimbursement. The Board refused to review these claims because they were not filed within the time required by the regulation.\textsuperscript{48} 

In affirming the Board’s decision that it did not have jurisdiction over that portion of HCA’s appeal that concerned the late-filed claims, Judge Bork, writing for the court, focused on the statute governing the Board’s authority, quoting part of, and emphasizing section 13950o(d): “The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report...”\textsuperscript{49} The court interpreted this provision as limiting the Board’s authority to matters included in the cost report and excluding from the Board’s authority all claims not reported in the cost report.\textsuperscript{50} Therefore, because HCA inadvertently omitted claims for stock option costs and federal income taxes when it submitted its cost report to the fiscal intermediary, the Board had no jurisdiction to hear the appeal of these claims.

Following a decision of the Seventh Circuit Court of Appeals in a related but factually distinct case,\textsuperscript{51} HCA successfully petitioned for rehearing, after which the court, in a decision known as \textit{Athens II},\textsuperscript{52} revised the reasoning but affirmed the result of \textit{Athens I}.\textsuperscript{53} The new issue in \textit{Athens II} was the provider’s contention that the second part of section 13950o(d), the statute which governs the Board’s authority and which the court relied on in \textit{Athens I}, allowed the Board to consider costs not specifically claimed or shown in the cost report.\textsuperscript{54}

\textsuperscript{untimely, but because the claims were not reimbursable under the Medicare regulations. \textit{Id.} at 992.}

\textsuperscript{48.\textit{Id.} HCA appealed the Board’s decision to the United States District Court for the District of Columbia. The court addressed the issue of whether an intermediary’s decision not to reopen to consider new claims was reviewable. The court held that because these claims were not presented to the intermediary initially, its decision not to reopen was an initial decision (on the claims), in contrast to a final decision, and thus was reviewable. \textit{Athens}, 514 F. Supp. 1336, 1339-40 (D.D.C. 1981). The Secretary of the Department of Health & Human Services then appealed the district court’s decision to the District of Columbia Circuit Court of Appeals.}

\textsuperscript{49. \textit{Athens I}, 686 F.2d at 995 (quoting 42 U.S.C. § 1395oo(d)(1982)) (emphasis in \textit{Athens I}).}

\textsuperscript{50. \textit{Id.} at 995.}

\textsuperscript{51. Following \textit{Athens I}, the Seventh Circuit Court of Appeals ruled that the statute defining the Board’s authority vests broad power in the Board to decide claims totally excluded from the cost report. Saint Mary of Nazareth Hosp. Center v. Department of Health & Human Serv., 698 F.2d 1337, 1346 (7th Cir. 1983). \textit{See infra} notes 124-29 and accompanying text.}

\textsuperscript{52. \textit{Athens Community Hosp., Inc. v. Schweiker}, 743 F.2d 1 (D.C. Cir. 1984) (\textit{Athens II}).}

\textsuperscript{53. \textit{Id.} at 4-8.}

\textsuperscript{54. \textit{Id.} at 2.
The *Athens II* analysis of subsection (d) limited the Board's authority to costs included in the final determination and costs claimed for reimbursement.55 The first jurisdictional grant limits the Board's jurisdiction to a "final determination,\"56 the second grant limits the Board's jurisdiction to "matters covered by such cost report.\"57 According to Judge Bork, these two phrases are analogous. He reasoned that an intermediary does not make a final determination on a specific cost unless that cost was claimed for reimbursement. Thus, the Board has jurisdiction to consider "matters covered by . . . [the] cost report" only if the cost was listed in the cost report and "added into the final figure of reimbursement requested.\"58 Therefore, if a cost is not disclosed to the intermediary initially, which to the *Athens II* court meant claimed for reimbursement, it is not "covered by such cost report" and the statute precludes the Board from exercising jurisdiction over the provider's claim.59

The court pointed out that this analysis "must be read in light of the Board's functions" in subsection (a).60 That subsection requires that a provider be dissatisfied with an intermediary's final determination in order to appeal to the Board.61 According to the court, if a

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55. *Id.* at 4. The *Athens II* court stated that § 1395oo(d) contains two separate jurisdictional grants.

First, the PRRB has "the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report." 42 U.S.C. § 1395oo(d) (1982). Second, the PRRB has the power "to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination."

*Id.* While the court failed to mention, let alone discuss, this second part in *Athens I*, the court of appeals in *Athens II* devoted considerable attention to a review and analysis of subsection (a) and both parts of subsection (d).

56. *Athens II*, 743 F.2d at 4-5.

57. *Id*.

58. *Id.* at 4.

59. *Id.* With regard to this issue, *Athens II* goes beyond *Athens I*, where the court in dicta seemed to endorse self-disallowance. The court stated in *Athens I* that a self-disallowed cost is different from a totally omitted cost because those costs [are] timely disclosed to the intermediary. By making such disclosure, the provider gives the intermediary an opportunity at that point to decide that reimbursement is proper. The provider also puts the Medicare system on notice that the costs exist and may be claimed at some stage if it later becomes likely that such costs should be considered reimbursable. The providers' "self disallowances" are thus analogous to a disallowance by the intermediary of costs claimed in the initial cost report.

*Athens I*, 686 F.2d at 997.

60. *Athens II*, 743 F.2d at 6.

"cost report" was construed to include costs not claimed for reimbursement, a provider could allege dissatisfaction with the final determination whenever the intermediary did not allow reimbursement for an undisclosed cost. As the court stated:

It simply is not plausible to contend that Congress has created a scheme where the provider can claim dissatisfaction and have recourse to an appeal procedure because the intermediary failed to read the provider's mind and anticipate all those things the provider would like to be reimbursed for, even though it did not request them.

As the final part of the court's statutory analysis, the court further reviewed the second jurisdictional grant of subsection (d), which permits the Board to "make . . . revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination." In order to give effect and consistency to both clauses in subsection (d), the court construed this provision as giving the Board the authority to revise claims not considered by the intermediary only as a means to accommodate claims contested by the provider.

The Athens II court also predicted that significant adverse consequences would result if the providers' interpretation was upheld and the Board was required to review costs not presented to the intermediary initially. According to Judge Bork, such a broadened interpretation would eliminate a necessary tier of review, render meaningless the time limits for filing cost reports, undermine the effectiveness of the reopening regulations, and cause frivolous padding of claims in cost reports. In his view, then, practical policy considerations reinforced his reading of the jurisdictional statutes.

The Sixth Circuit Court of Appeals has applied the District of Columbia Circuit's restrictive approach to two factual settings that are

63. Id. (citation omitted).
64. 42 U.S.C. § 1395oo(d) (1982). While the Seventh Circuit Court of Appeals had used this language to find Board jurisdiction, see infra notes 124-29 and accompanying text, Judge Bork gave it a narrower reading.
65. Athens II, 743 F.2d at 9. For example, a provider may self-disallow certain medical malpractice expenses. When the intermediary audits the provider's cost report, it might disallow other costs associated with medical malpractice expenses that the provider claimed for reimbursement. The provider may contest these disallowed costs before the Board, and if the intermediary prevails, these claims will be added to those which the provider already disallowed.
66. Id. at 6.
67. Id.
distinct from the Sixth Circuit’s first analysis of the Board’s jurisdictional scope. One case involved a claim that was mistakenly self-disallowed by a provider, and the other case involved a claim properly self-disallowed because a regulation prohibited reimbursement. In the cases involving the latter type of claim, the Sixth Circuit Court of Appeals followed Athens II, but did so reluctantly.

In University of Cincinnati v. Secretary of Health & Human Services, the court held that the Board did not have jurisdiction over self-disallowed claims because these claims were not included in an intermediary’s final determination. University Hospital self-disallowed claims for education costs of interns and residents and related overhead expenses in connection with the hospital’s family practice and psychiatric clinics for fiscal years 1979 through 1981, mistakenly believing them to be nonreimbursable costs. When the provider received its Notice of Program Reimbursement (NPR), it requested a hearing before the Board. The Board denied jurisdiction over the provider’s claims because they were not requested for reimbursement in the cost reports for the years in question.

The court held that presenting the disputed cost to the intermediary is a prerequisite to an appeal to the Board. Because subsection (a) gives the Board jurisdiction only over an intermediary’s final determination, a cost must be reported in the final determination in order for the Board to have jurisdiction. Because a self-disallowed claim is not subject to revisions or modifications and is not included in a final determination, the court concluded that the Board has no jurisdiction.

68. The Sixth Circuit Court of Appeals also has decided a case factually similar to Athens II. In Saline Community Hosp. v. Secretary of Health & Human Servs., 744 F.2d 517 (6th Cir. 1984), the court held that the Board lacks jurisdiction over claims not reported initially in a cost report.

Three nonprofit hospitals did not include a claim for reimbursement for a return on net-invested equity capital in their 1979 cost reports. Id. at 518. Prior to the intermediary’s final determination, they requested to amend their cost reports to include these claims. The intermediary denied their request to amend because it was untimely. The providers appealed the intermediary’s decision to the Board. However, the Board denied jurisdiction over the claims because they were not included in the intermediary’s final determination. Id.

The court, following Athens II, affirmed the Board’s decision that it lacked jurisdiction to review self-disallowed claims. However, rather than extensively analyzing subsections (a) and (d), the court focused its analysis on whether the court had jurisdiction to decide the correctness of the Board’s determination. Id. at 518-19.

70. Id. at 308.
71. Id.
72. Id. at 312.
73. See supra note 29.
over the claim.\textsuperscript{74} While the court’s ruling deprived the provider of a second chance to request reimbursement for a claim it mistakenly self-disallowed, it was the correct decision in light of the facts of the case. Congress intended the Board to settle cost disputes between fiscal intermediaries and providers.\textsuperscript{75} In \textit{University of Cincinnati}, however, there was no cost dispute. The provider did not dispute the correctness or validity of a cost but instead requested reimbursement of a cost it self-disallowed because of its own error.

While willing to apply \textit{Athens II} to the factual setting presented

\textsuperscript{74} \textit{University of Cincinnati}, 809 F.2d at 312. Although the court adopted the \textit{Athens II} interpretation of subsection (a), it rejected the \textit{Athens II} interpretation of the second part of the Board’s jurisdictional authority in subsection (d). Subsection (d) allows the Board to affirm, modify, or reverse matters covered by a cost report “even though such matters were not considered by the intermediary in making such final determination.” 42 U.S.C. § 1395oo(d) (1982) (emphasis added). \textit{See supra} text accompanying note 30. The Sixth Circuit Court of Appeals used the conventional definition of the term “consider” and construed it as it is applied in subsection (d) to mean “attentively inspected or examined.” \textit{University of Cincinnati}, 809 F.2d at 314 (quoting \textit{WEBSTER'S NEW INTERNATIONAL DICTIONARY} 568 (2d ed. 1942)). Applying this definition to the second part of the Board’s authority, the court concluded that a claim is a “‘matter . . . in the cost report’ ” only if it is subject to the intermediary’s inspection or examination. Therefore, the court interpreted this clause as giving the Board the authority to revise only reimbursable costs that the intermediary overlooked. \textit{Id.} at 314.

The Eleventh Circuit Court of Appeals in \textit{North Broward Hosp. Dist. v. Bowen}, 808 F.2d 1405 (11th Cir. 1987), \textit{vacated and remanded}, 108 S. Ct. 1569 (1988), presents a case factually similar to \textit{University of Cincinnati}. In \textit{North Broward}, the hospital incurred large tax expenses in its fiscal year 1977. It initially included these costs for reimbursement in its cost report but later mistakenly self-disallowed them. \textit{Id.} at 1407. \textit{North Broward} appealed the intermediary’s final determination to the Board to claim reimbursement for these expenses. The Board denied jurisdiction because they were not presented initially as reimbursable costs in the provider’s cost report. \textit{Id.}

The Eleventh Circuit Court of Appeals adopted the \textit{Athens II} approach and affirmed the Board’s lack of jurisdiction. The court stated that “[i]the only plausible construction of § 1395oo(d) requires that an expense be overtly disclosed and contested before the fiscal intermediary in order to be a ‘matter covered by such cost report’ and appealable before the [Board]. . . .” \textit{Id.} at 1409. Further, the Court agreed with \textit{Athens II} that if the Board has jurisdiction over nonreimbursable claims there will be significant adverse practical consequences. \textit{Id.} \textit{See supra} text accompanying notes 66-67.

\textsuperscript{75} \textit{H.R. REP. NO.} 92d Cong., 2d Sess., \textit{reprinted in} 1972 \textit{U.S. CODE CONG. \& ADMIN. NEWS} 4898, 5094. The legislative history states:

Under present law there is no specific provision for an appeal by a provider of services of a fiscal intermediary’s final reasonable cost determination. Although the HEW has developed administrative procedures to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items, your committee believes that it is desirable to prescribe in law a specific procedure for settling disputed final determinations applying to the amount of program reimbursement. \textit{Id.}
in University of Cincinnati, the Sixth Circuit Court of Appeals was reluctant to do so in the different context presented by Baptist Hospital East v. Secretary of Health & Human Services. In Baptist, five hospitals sought judicial review of the Secretary's regulation denying reimbursement for bad debts, charity and courtesy allowances. Four of the hospitals did not comply with the regulation and claimed reimbursement for a portion of the expenses in the regular part of their cost report. However, William Booth Memorial Hospital complied with the regulation and self-disallowed costs for free services by reporting them on Work Sheet A-8 in its cost report for fiscal year 1981. The Board granted jurisdiction to the four noncomplying hospitals but denied jurisdiction to William Booth because it failed to present costs for free services to the intermediary initially.

Although it quoted significant sections of Athens II and affirmed the Board's decision, the court recognized that in cases involving challenges to a regulation, unlike the situation presented in Athens II and Saline Community Hosp. v. Secretary of Health & Human Services, it is futile to require the providers to present these claims initially to the intermediary. The intermediary is bound by the Secretary's regulations, has no authority to alter them, and must deny a claim for costs disallowed by a regulation. Therefore, the Sixth Circuit Court of

76. 802 F.2d 860 (6th Cir. 1986).
77. Id. at 862. Specifically, the providers contended that 42 C.F.R. § 413.80 (originally 405.420) (1987) was in conflict with the reasonable cost provision of the Medicare Act. 42 U.S.C. § 1395(v)(1)(a) (1982). Bad debts, charity, and courtesy allowances are defined as follows:

1. **Bad Debts.** Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. “Accounts receivable” and “notes receivable” are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

2. **Charity allowances.** Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

3. **Courtesy allowances.** Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personal health programs, are not considered to be courtesy allowances.

42 C.F.R. § 413.80(b)(1)(2) and (3) (1987).
78. Baptist, 802 F.2d at 862. In an unreported decision, the district court held that a provider's self-disallowance is not a matter covered by a cost report and does not preserve the jurisdiction of the Board. The provider appealed this decision. Id. at 862-63.
80. Baptist, 802 F.2d at 864.
81. Id. at 865.
Appeals reasoned that requiring the provider to exhaust its administrative remedies by presenting its distinctly legal challenge to the intermediary served no purpose. 82

The court properly applied the *Athens II* analysis to the factual setting presented in *University of Cincinnati* because the provider in that case was not challenging the Secretary's regulations or policy provisions, but was requesting reimbursement of a claim that it had mistakenly self-disallowed. As stated in *Athens II*, the administrative appeals process was not designed to assist providers in requesting reimbursement for a claim they mistakenly did not present to an intermediary. However, as the Court of Appeals for the Sixth Circuit in *Baptist* recognized, this analysis should not apply to legitimate, self-disallowed claims. The application of this restrictive interpretation to such claims denies providers their statutory right to judicial review of the Secretary's regulations. In recognition of this fact, other courts have developed alternative interpretations of the Board's jurisdictional statutes.

B. Decisions Finding Discretionary and Mandatory Jurisdiction

Four United States Courts of Appeals have interpreted subsections (a), (d), and (f) of section 1395oo to permit the Board to exercise jurisdiction over self-disallowed claims. 83 Although their rationales differ, the result is that providers in those circuits have the opportunity to seek judicial review of the Secretary's regulations and policies. This section first discusses a decision of the First Circuit Court of Appeals holding that the Board has discretion to decide whether to review a provider's claim, but must exercise that discretion in a reasoned, law-

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82. *Id.* For a factually similar case, see *Community Hosp. of Roanoke Valley v. Health & Human Servs.*, 770 F.2d 1257 (4th Cir. 1985). The providers wished to challenge the Secretary's policy provision of including patients in the labor/delivery room in the overall patient count at the midnight census hour. *Id.* at 1258. The complying hospitals self-disallowed the costs that were prohibited from reimbursement while the noncomplying hospitals included prohibited costs in their cost reports for reimbursement. *Id.* The Board denied jurisdiction to the complying hospitals. *Id.*

The court held "that a provider must affirmatively place an issue in controversy at the time it files its cost report in order to preserve its ability to appeal the matter to . . . the [Board]." *Id.* at 1262-63. Because the complying hospitals, by self-disallowing these costs, did not notify the intermediary of its intent to challenge the policy, the Board lacked jurisdiction over these claims. *Id.* at 1263.

ful, manner. This section then presents the approaches of the Eleventh, Ninth, and Seventh Circuit Courts of Appeals which have interpreted the governing statutes to require the Board to exercise jurisdiction over self-disallowed claims.

1. *Saint Luke's Hospital v. Secretary of Health and Human Services* 84

In *Saint Luke's*, the First Circuit Court of Appeals interpreted subsection (d) as granting the Board discretion to decide whether to hear providers' claims not presented to the intermediary. In that case, the provider included in its 1978 cost report sick leave expenses paid to its employees for their unused sick days. 85 The intermediary disallowed the expenses and Saint Luke's appealed to the Board. 86 While its 1978 appeal was pending, it filed its 1979 cost report, self-disallowing sick leave expenses for that year. 87 After receiving its 1979 final determination, Saint Luke's appealed several aspects of it to the Board, including the disallowance of its sick leave expenses. 88 After consolidating the 1978 and 1979 appeals, the Board awarded the 1978 sick leave expenses. 89 However, the Board ruled that it lacked jurisdiction to hear the 1979 claims because they were not presented to the intermediary in the 1979 cost report. 90

The court of appeals held that the Board has discretion to hear a

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84. 810 F.2d 325 (1st Cir. 1987).
85. *Id.* at 326-27. Under Saint Luke's sick pay/sick leave plan, full time employees earn one day of sick leave per month, and are allowed to accumulate sick days from year to year up to a maximum of 60 days. . . . Employees who do not use their accumulated days of sick leave prior to terminating their employment can acquire a vested right to a cash payment for their unused sick days upon termination.
86. *Saint Luke's*, 810 F.2d at 327. The intermediary disallowed these costs because the provider reimbursement manual requires that a provider report these costs when they are paid, and Saint Luke's reported the costs when they became vested. See U.S. DEPT OF HEALTH AND HUMAN SERVS., *supra* note 3, at 2144.8. Saint Luke's argued that the manual was inconsistent with departmental regulations which provide that expenses are to be recorded whenever they are incurred, regardless of when they are paid. 42 C.F.R. § 413.24(a) (formerly 405.453(b)(2) (1987)).
88. *Id.*
89. *Id.* However, the Secretary reversed the 1978 award for sick leave expenses, and Saint Luke's appealed to the district court. *Id.*
90. *Saint Luke's*, 632 F. Supp. at 1390. The district court held that "where a provider is denied reimbursement for a claimed cost, and in a subsequent year, self-disallows that same type of cost while its appeal of the initial denial is still pending, the Board has jurisdiction to hear an appeal concerning the self-disallowed cost." *Id.* at 1394.
provider's claim. The court based its reasoning on section 1395oo(d) which begins: "The Board shall have the power. . . ." The court stated that "[t]he statute does not say that the Board must consider matters not considered by the intermediary. But, it does says [sic] the Board may. . . ."

In contrast to Athens II, the court viewed the second part of subsection (d) as granting the Board the authority to consider claims not mentioned explicitly in an intermediary's final determination. Judge Breyer, writing for the court, reasoned that Congress had established the Board as "a kind of 'hybrid,' exhibiting some features of initial fact finding . . . and some features of review." As a hybrid, the Board could receive new information and data which may result in revisions and modifications that the intermediary and provider did not anticipate. Comparing the Board's reviewing features with those of appellate courts, the court observed that "appellate courts, in reviewing the judgments of district courts, will normally not consider issues not raised below . . . but will nonetheless in 'exceptional cases or particular circumstances . . . review questions of law neither pressed nor decided below.'"

The court remanded the case to the Board with instructions to use its discretionary authority to decide whether to hear the provider's claim and to articulate the reasons for its exercise of discretion. Since the court invalidated the Board's statutory argument that it lacked the power to hear a provider's self-disallowed claim, the Board

91. Saint Luke's, 810 F.2d at 327.
93. Saint Luke's, 810 F.2d at 327. The Saint Luke's court did not limit the Board's jurisdiction to self-disallowed claims. In the court's view, the Board has to exercise discretion to decide whether to hear all types of claims, including totally omitted claims.
94. Id. at 328.
95. Id.
96. Id. However, the court did not analyze the jurisdictional requirements set forth in subsection (a).
97. Id. (citations omitted) "The basic legal principle in respect to review of matters not raised below . . . is not 'never,' it is 'hardly ever'; the legal power exists; a reviewing body exercises it sparingly." Id. at 329. But see North Broward Hosp. Dist. v. Bowen, 808 F.2d 1405, 1409 n.6 (11th Cir. 1987), vacated and remanded, 108 S. Ct. 1569 (1988). There the court stated that

[i]tthe reimbursement review procedure is modeled after the civil litigation procedure, and the [Board's] review of the fiscal intermediary's decision is limited in the same manner as an appellate court's review of a trial decision: the claim had to be brought at the initial hearing to be recognized on appeal.

Id.
98. Saint Luke's, 810 F.2d at 333.
must decide on remand as a matter of Board policy whether it will review the claim. 99 Therefore, the Board is not precluded from denying review to a provider with a self-disallowed claim, but its reasoning must be based on policy rather than the absence of statutory power.

2. Tallahassee Memorial Regional Medical Center v. Bowen 100

In Tallahassee, the Eleventh Circuit Court of Appeals formulated a unique approach for determining when the Board has jurisdiction over self-disallowed claims. Factually similar to Bethesda, Tallahassee involved providers who complied with the 1979 Malpractice Rule 101 and self-disallowed malpractice insurance costs not permitted under the rule. 102 The hospitals requested that the Board grant review of their appeal so they could challenge the validity of the regulation in

99. The court's holding that the Board has the discretion to review a self-disallowed claim is consistent with the United States Supreme Court's holding in SEC v. Chenery Corp., 318 U.S. 80 (1943). In Chenery, the Court held that the judiciary can review an agency's actions only on the grounds stated by the agency. Id. "If those grounds are inadequate or improper . . . the court must reverse the agency action even if the action could be affirmed on a basis not stated by the agency." R. PIERCE, S. SHAPIRO & P. VERKUIL, supra note 37, at 356 (discussing Chenery).


101. The case involved two consolidated appeals of 35 hospitals. Thirty hospitals claimed reimbursement for malpractice insurance costs using the pre-1979 malpractice rule. However, five hospitals complied with the 1979 malpractice rule and self-disallowed costs prohibited from reimbursement. Tallahassee, 815 F.2d at 1441.

Under the pre-1979 rule, medical malpractice insurance was reimbursed according to the percentage of Medicare patient utilization of the medical facility. Id., at 1445 n.13. For example, if a hospital had a Medicare utilization rate of 43%, the hospital would be reimbursed 43% of its malpractice insurance costs. Id. at 1440.

The 1979 Malpractice Rule reduced the total amount of reimbursement due a provider under the pre-1979 rule. Under the 1979 Malpractice Rule, if a provider had paid any malpractice claims to Medicare patients over the preceding five years, it would be reimbursed for insurance premiums by the percentage of those claims paid to Medicare patients. Id. at 1440. However, if no malpractice claims were paid in the preceding five years, the hospital would be reimbursed for insurance premiums based on an average national figure set at 5.1%. U.S. DEP'T OF HEALTH AND HUMAN SERVS., supra note 3, at 2163.3(c). For a full explanation of the method, see 42 C.F.R. § 413.56 (1987); U.S. DEP'T OF HEALTH AND HUMAN SERVS., supra note 3, at 2163.

Because a majority of Medicare patients are elderly, there are very few malpractice payments made to Medicare patients. Therefore, a majority of hospitals are reimbursed on the national rate of 5.1%. Interview with John Roemer, Vice-President of Finance at Franklin Medical Center, in Greenfield, Massachusetts (Nov. 7, 1987).

An example of the amount of money at stake in these challenges is illustrated in Lloyd Noland Hosp. & Clinic v. Heckler, 762 F.2d 1561 (11th Cir. 1985). In that case, two hospitals had a 32% and 42% Medicare patient utilization rate, respectively. Because the hospitals did not pay any malpractice claims to Medicare patients, they were limited to reimbursement based on the national rate of 5.1%. The amounts at issue were $13,191.00 and $10,626.00, respectively. Id. at 1564.

102. Tallahassee, 815 F.2d at 1457.
court.\textsuperscript{103} However, the Board ruled that it lacked jurisdiction because the providers did not request reimbursement for the claims and thus the final determination did not include any adjustments related to these claims.\textsuperscript{104}

Unlike the previous courts, which focused their analyses on subsections (a) and (d) of section 1395oo, the court of appeals in Tallahassee centered its analysis on subsection (f),\textsuperscript{105} which grants to providers the right to judicial review in two instances.\textsuperscript{106} Under the 1972 grant,\textsuperscript{107} providers have a right to obtain judicial review of any final decision by the Board or Secretary. Additionally, under the 1980 grant, providers may obtain judicial review whenever the Board determines that it is without the authority to decide a question of law or regulation.\textsuperscript{108} The Tallahassee court attached special significance to the fact that the 1972 grant uses the word "decision" and the 1980 grant uses "determine."\textsuperscript{109} In the court's view, the 1972 grant requires a decision or a hearing by the Board, whereas the 1980 grant requires only a determination. There is no question that Congress enacted the

\textsuperscript{103} Id. at 1458.
\textsuperscript{104} Id. at 1442.
\textsuperscript{105} Id. at 1458.
\textsuperscript{106} Id. at 1461.
\textsuperscript{107} 42 U.S.C. § 1395oo(f)(1) (Supp. II 1984) states:

Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary. . . . Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines . . . that it is without authority to decide the question. . . .

A version of the first sentence was part of the original enactment in 1972. The Tallahassee court labeled this general right of review as the "1972 grant." The second sentence is the "1980 grant." Tallahassee, 815 F.2d at 1461.


The second sentence was added by the 1980 amendments. It clarified, and perhaps expanded, the right to obtain judicial review when the Board makes a "determination," as opposed to a final decision, that it does not have the authority to decide the issue. See supra notes 34-40 and accompanying text.

The dissent in Tallahassee disagreed that the self-disallowed providers are entitled to judicial review. Judge Edmonson interpreted the 1980 grant of subsection (f) as allowing providers the right to judicial review of "any action of the fiscal intermediary." Tallahassee, 815 F.2d at 1466 (Edmonson, J., dissenting). Therefore, because the self-disallowed providers did not present their claims initially to the intermediary, they are not entitled to judicial review. Justice Edmonson stated that the legislative history supports his holding. "The history shows that Congress expedited the review process by cutting back on the second (PRRB) stage not by minimizing the first (fiscal intermediary) stage." Id. at 1466 n.1 (Edmonson, J., dissenting).

\textsuperscript{109} Tallahassee, 815 F.2d at 1461.
1980 grant to authorize and to encourage the Board to make determinations more quickly than it had been making decisions. However, the Tallahassee court sought to carry the distinction between decisions and determinations further and related the "determination" language of the 1980 grant to other statutory sections. The court reasoned that because subsection (d), which sets forth the Board's decision-making authority, mentions only decisions by the Board, it does not apply to the 1980 grant. However, subsection (f) explicitly states that if a provider can obtain a hearing under subsection (a), such provider may request the Board to make a determination that it is without the authority to decide the question of law or regulation. Thus, for a provider to obtain judicial review of agency regulations, it need only satisfy the jurisdictional requirements under subsection (a) of the Board's governing statute.

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110. The legislative history is explicit. It provides:
Under present law, a provider's dissatisfaction with a particular determination made by its fiscal intermediary on the basis of a regulation issued by a Secretary must first be brought to the Board, even though the Board may not have the authority to reverse or overrule the regulation. (The Board has no authority, for example, to rule on the legality of the Secretary's regulations but it must, nonetheless, conduct a full review of the challenge.) The effect of this process has been to delay the resolution of controversies for extended periods of time and to require providers to pursue a time-consuming and irrelevant administrative review merely to have the right to bring suit in a U.S. District Court. Title VIII [Omnibus Reconciliation Act] addresses this problem by giving medicare providers the right to obtain immediate judicial review in instances where the Board determines that it lacks jurisdiction to grant the relief sought. This section is effective on enactment.


111. See supra text accompanying note 30 for the text of subsection (d).

112. Tallahassee, 815 F.2d at 1461.


114. Id. In support of the Court's holding that the Board has jurisdiction over self-disallowed claims, it cited Bowen v. Michigan Academy of Family Physicians, 106 S. Ct. 2133 (1986). Although Bowen involved judicial review of regulations promulgated under Part B of the Medicare Act, the Supreme Court held that Congress clearly precluded judicial review of the determinations of amounts of benefits due an individual under Part B, not individual review of the method of calculation. Id. Thus, the Tallahassee court stated, "Congress intended to restrict litigation over benefits where the underlying regulatory scheme is clear, but did not foreclose judicial review of the regulations themselves." Tallahassee, 815 F.2d at 1463 n.54.

For further support of the court's holding, it cited Memorial Hosp. v. Heckler, 706 F.2d 1130 (11th Cir. 1983), cert. denied, 465 U.S. 1023 (1984). Although Memorial is not directly relevant to the issue in Tallahassee, it deals with an exception to subsection (f). Section 1395oo(g) exempts from judicial review health care costs defined in 42 U.S.C. § 1395y (1982). The court held that subsection (g) only precludes judicial review of individual determinations by the intermediaries, not review of the regulations.

To expand the non-reviewability of intermediary decisions to include policy deci-
In Tallahassee, the court of appeals assumed that the five self-disallowing hospitals had met the jurisdictional requirements contained in subsection (a). The court did not engage in an independent analysis of that subsection to determine whether providers with self-disallowed claims satisfy the jurisdictional requirements. As a result, the Tallahassee approach provides no guidance as to when self-disallowing providers are able to invoke the 1980 grant of judicial review contained in subsection (f).

3. Adams House Health Care v. Heckler

In Adams House, the Ninth Circuit Court of Appeals addressed the two relevant subsections, (a) and (d), of the Board's governing statute. In that case, the providers complied with a policy provision and in its 1981 cost report self-disallowed costs of equity capital invested for more than six months. Adams House appealed to the Board to challenge the policy provision as being inconsistent with the regulation that permits reimbursement of a reasonable return on equity capital. However, the Board denied jurisdiction over the claims because the provider had not requested reimbursement of the investments of the Secretary would not merely insulate from judicial scrutiny the finding of an intermediary. It would give the Secretary virtually unbridled discretion to prevent reimbursement through regulations. Such a result would run contrary to the presumption favoring judicial review.

Memorial, 706 F.2d at 1133. See also Saint Mary of Nazareth Hosp. Center v. Department of Health & Human Servs., 698 F.2d 1337, 1346 (7th Cir. 1983). See infra notes 124-29 and accompanying text.

115. Tallahassee, 815 F.2d at 1465.
117. Id. at 589.
118. The provision in the manual provides that “[i]nvested funds are funds diverted to income producing activities which are not related to patient care. Any portion of the provider’s general funds or operating funds invested in such activities for more than 6 consecutive months is not includable in the provider’s equity capital.” U.S. DEP’T OF HEALTH AND HUMAN SERVS., supra note 3, at 1218.2.

The regulations require that income produced from the vested funds is to be used to offset allowable interest expenses. See 42 C.F.R. § 405.311-.376 (1987). Thus, if providers exclude costs from a return on net equity capital, they are in effect excluding such costs twice. The net effect is that reimbursement for a “reasonable return on equity capital” is reduced significantly by the exclusion required in the manual.

The Adams House case consolidated appeals from Adams House Health Care and the Board of Trustees of Stanford University. In 1981, Stanford Hospital complied with the policy that costs for services rendered be calculated using “average cost per diem.” Later, Stanford appealed to the Board claiming that the policy improperly required inclusion of labor and delivery room patient days in the per diem calculation. The Board denied jurisdiction over the claims because Stanford did not expressly disclose them to the intermediary on the cost report. Adams House, 817 F.2d at 590.
disputed cost in the cost report.\textsuperscript{119}

The court held that the Board had jurisdiction over the self-disallowed claims.\textsuperscript{120} Like \textit{Athens II}, the court focused its analysis on section 1395oo(a) and (d). While conceding that subsection (d) limits the Board's authority to matters 'covered by a cost report, the court concluded "that a cost is 'covered by a cost report' if it was incurred within the period which is the subject of the report and is reflected in that report, even if it is not expressly claimed."\textsuperscript{121}

The court applied this interpretation to the jurisdictional requirement in subsection (a) that a provider be dissatisfied with a final determination of the intermediary. The court of appeals stated the provider need only be "dissatisfied with the total [dollar] amount of reimbursement offered by an intermediary, not with the intermediary's reasoning process with respect to any specific cost."\textsuperscript{122} The court's interpretation of the Board's jurisdictional scope limits the Board's reviewing authority to self-disallowed claims challenging the Secretary's regulations. In this way, the Ninth Circuit Court of Appeals provides an interpretation of the Board's governing statute which is consistent with the statutory language and which also serves the important policy of judicial review of agency regulations and policies.


The Seventh Circuit Court of Appeals has pronounced the broadest interpretation of the Board's jurisdictional scope, holding in \textit{Saint Mary} that the Board must hear both self-disallowed claims and claims totally omitted from the cost report.\textsuperscript{124} In compliance with a regulation which specifically prohibits reimbursement of expenses for personal telephones, Saint James Hospital self-disallowed the cost of bedside telephones in its 1977 cost report. On appeal to the Board, Saint James challenged this regulation as being inconsistent with the

\textsuperscript{119} Adams House Health Care v. Heckler, 604 F. Supp. 110, 113 (N.D. Cal. 1984). Adams House appealed the Board's decision to the district court which held that the Board had jurisdiction to hear self-disallowed claims. The Secretary then appealed. \textit{Id.} at 117.

\textsuperscript{120} \textit{Adams House}, 817 F.2d at 590-91.

\textsuperscript{121} \textit{Id.} at 591. The court's analysis of subsection (a) and (d) limited the Board's jurisdiction to self-disallowed claims, unlike the analysis in \textit{Saint Luke's}, where the court held that the Board had discretion to decide to review totally omitted as well as self-disallowed claims. \textit{See supra} text accompanying notes 90-92.

\textsuperscript{122} \textit{Adams House}, 817 F.2d at 592.

\textsuperscript{123} 698 F.2d 1337 (7th Cir. 1983).

\textsuperscript{124} \textit{Id.} at 1346.
governing statute, 42 U.S.C. section 1395y. The Board held that it lacked jurisdiction to rule on the issue.

In deciding the jurisdictional issue, the court focused on the language in section 1395oo(d) noting that the statute provides that “[t]he Board shall have the power to . . . make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination.” Saint Mary’s construed this provision as vesting broad authority with the Board to review matters not considered by the intermediary and granting the Board jurisdiction to hear any and all claims including self-disallowed as well as totally omitted claims. While this broad interpretation of Board jurisdiction allows a provider the right to obtain judicial review of a Secretary’s regulation and policy provision, it arguably gives providers a second chance to request reimbursement for claims omitted from a cost report as a result of a provider’s negligence or inadvertence. This result is inconsistent with the purpose of the Board. Congress intended the Board to settle cost disputes between intermediaries and providers. Congress did not intend the Board to act as a supplemental agency for providers to seek reimbursement for claims not initially presented to the intermediary due to the provider’s inadvertence or negligence.

III. BETHESDA HOSPITAL ASSOCIATION V. SECRETARY OF HEALTH & HUMAN SERVICES

The United States Supreme Court, in Bethesda Hospital Association v. Secretary of Health & Human Services, was presented with an opportunity to resolve the controversy concerning the appropriate limits of the Board’s reviewing authority. Pursuant to an analysis of the


126. Saint Mary, 698 F.2d at 1341. Saint James appealed this decision to the district court pursuant to § 1395oo(f). Without providing a statutory analysis of the Board’s jurisdictional authority, the district court reached the merits of the case and ruled that a bedside telephone furnished by a hospital was not a “personal comfort item[.]” Saint James Hosp. v. Harris, 535 F. Supp. 751, 765 (N.D. Ill. 1981). The Secretary appealed this decision.

The Court of Appeals for the Seventh Circuit first reviewed the jurisdictional issue concerning the Board.

127. Saint Mary, 698 F.2d at 1346 (quoting 42 U.S.C. § 1395oo(d) (1982) (emphasis added)).

128. Id.


plain-meaning of the statute, the Court properly held that the Board has jurisdiction to review self-disallowed claims challenging the Secretary's regulations. However, the Court's approach was deficient in two respects. Instead of restricting the interpretation of the Board's reviewing power to self-disallowed claims and claims listed in a provider's cost report, the Court seemed to endorse an approach which also would have required the Board to hear mistakenly self-disallowed and totally omitted claims. Second, by limiting its holding to the facts of Bethesda, the Court missed an opportunity to declare the limits of the Board's reviewing power.

In Bethesda, two hospitals comlied with the 1979 Malpractice Rule and self-disallowed costs that were prohibited from reimbursement under the Malpractice Rule by listing them on Work Sheet D-8. The providers appealed the validity of the 1979 Malpractice Rule to the Board, and the Board denied jurisdiction. The Sixth

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131. In Bethesda, Justice Kennedy, writing for the Court, cited Chevron U.S.A. Inc., v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), for support of the Court's plain-meaning approach to the Board's governing statute. Bethesda, 108 S. Ct. at 1258. However, Chevron did not endorse a plain-meaning approach to evaluate the proper interpretation of an ambiguous statute—a plain-meaning to an ambiguous statute. Rather, Chevron presented a specific guideline for courts reviewing an ambiguous statute. When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute. Chevron, 467 U.S. at 842-43 (footnotes omitted). See supra note 188 for the application of Chevron to Athens II.


133. Bethesda, 108 S. Ct. at 1257. For a detailed explanation of the 1979 Malpractice Rule, see supra note 101.

Work Sheet D-8 is entitled “Apportionment of Malpractice Insurance Costs.” This work sheet is used to compute reimbursable malpractice insurance premiums. See Form HCFA-2552 and Related Schedules; Instructions, Medicare and Medicaid Guide (CCH) ¶ 9339 (1987).

134. Bethesda and Deaconess Hospitals appealed the Board's decision to the United States District Court for the District of Ohio. The court held that the Board had jurisdiction over self-disallowed claims and based its reasoning on the plain-meaning of subsection (d). The court stated that the Board had jurisdiction over "those items disclosed in the cost
Circuit Court of Appeals reversed the district court’s holding that the Board had jurisdiction over self-disallowed claims. Following *Athens II*, the court reasoned that the Board lacked jurisdiction to consider self-disallowed claims because the providers did not initially present the claims to the intermediary. However, the court explicitly stated its reluctance to follow *Athens II*.

Were we considering this issue as a matter of first impression, we may well have reached a different conclusion as to the advisability of requiring submission of statutory and/or constitutional challenges to a private insurance company as a condition precedent to further administrative as well as judicial review of the Secretary’s regulations.\(^{135}\)

The Sixth Circuit Court of Appeals’ reluctance was justified. The United States Supreme Court recognized that the *Athens II* analysis is inconsistent with the statutory scheme. The Court recognized that the intermediary has no authority to rule on the validity of a regulatory challenge. Therefore, pursuant to the plain-meaning of the Board’s governing statute, the Court held that the Board has jurisdiction over providers with self-disallowed claims challenging the Secretary’s regulations.\(^{136}\)

The Supreme Court reviewed the three relevant subsections of the statute, subsections (a), (d), and (f). Subsection (a), which sets forth the jurisdictional requirements which a provider must satisfy to obtain Board review, requires a provider to be “dissatisfied with a final determination of . . . its fiscal intermediary . . .”\(^{137}\) Justice Kennedy, writing for the Court, construed this provision as requiring the provider to be dissatisfied with the total amount of reimbursement.\(^{138}\) The Court, therefore, rejected the Secretary’s interpretation that the Board’s jurisdiction extends only to claims presented to the intermediary because

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\(^{135}\) Bethesda v. Secretary of Health & Human Services, 810 F.2d 558, 562 (6th Cir. 1987). The court in Athens Community Hosp. v. Schweiker (Athens I), 686 F.2d 989 (D.C. Cir. 1982), concluded that it was necessary for the provider to present the claim initially to the intermediary in its cost report because failing to do so “would deprive [the Board] of the intermediary’s analysis and conclusions and make the PRRB the tribunal of original jurisdiction, eliminating a tier of review, and possibly substantially slowing the reimbursement process for other providers.” *Id.* at 997.

\(^{136}\) *Bethesda*, 108 S. Ct. at 1259.

\(^{137}\) 42 U.S.C. § 1395oo(a) (1982). See *supra* note 29 for the full text of this provision.

\(^{138}\) *Bethesda*, 108 S. Ct. at 1258.
the provider cannot be "dissatisfied" with the final determination if the claim is not in the provider's cost report. 139 The Court stated that this "strained interpretation" is inconsistent with the express language of subsection (a). 140 According to the Court, the plain meaning of the statute does not prohibit a self-disallowing provider from being "dissatisfied" with the total amount of reimbursement when the Secretary's regulations preclude the provider from requesting the claim for reimbursement in the cost report. The Court stated that "the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations." 141

The Court further reasoned that requiring a provider to submit a regulatory challenge to the intermediary is not in the contemplation of the statutory scheme. The Court emphasized that the intermediary's job is limited statutorily to the application of the Secretary's regulations and the intermediary has no authority to decide the validity of a regulation. Therefore, the Court concluded that a provider is not required to submit a regulatory challenge to the intermediary as a prerequisite to Board review. 142

The Court supported its interpretation of subsection (a) with an analysis of the plain meaning of subsection (d). Subsection (d) provides the Board with the authority to "make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary . . . ." 143 The Court construed this provision as giving the Board broad authority to review matters not contested before the intermediary as long as such matters were covered by the cost report. 144 The Court stated that a matter is "covered by such cost report" if it was "a cost or expense . . . incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed." 145 In interpreting "matters

139. Id. at 1259.
140. Id. at 1258.
141. Id.
142. Id. at 1259-60.
145. Id. The Supreme Court's interpretation of subsection (d) is very similar to the interpretation presented by the Ninth Circuit Court of Appeals in Adams House, 817 F.2d at 591. In that case, the court stated that "a cost is 'covered by a cost report' if it was incurred within the period which is the subject of the report and is reflected in that report, even if it is not expressly claimed." Id. (emphasis added). The Supreme Court either deliberately or carelessly omitted the Adams House terminology: "is reflected in that report." Id.
covered by such cost report," the Court offers a very expansive inter­
pretation of the type of claims that the Board can review. Because the 
Court did not limit the Board's jurisdiction to costs "reflected in" the 
cost report, the Board conceivably has jurisdiction over totally omitted 
claims.146

The Court interpreted subsection (f) as granting to providers the 
right to obtain judicial review of the Board's determination that it 
lacks the authority to rule on the issue presented. The Court rejected 
the Secretary's contention that the statute requires a final determina­
tion by the intermediary concerning the challenged claim as a precon­
dition to judicial review.147 The Secretary argued that such a 
requirement is a statutory prerequisite to judicial review.148 The 
Court, however, stated that the right to judicial review is not triggered 
by the intermediary's final determination, but is triggered by the 
Board's determination that it lacks the authority to decide the matter 
because the claim involves a question of law or regulation.149 The 
Court explained that the Board and the intermediary are two different 
entities with two separate roles in the Medicare reimbursement 
process. It is the Board's role "in shaping the controversy that is sub­
ject to judicial review; the intermediary does not" shape the 
controversy.150

IV. ANALYSIS OF THE CONFLICTING INTERPRETATIONS OF THE 
BOARD'S GOVERNING STATUTE

The United States Supreme Court in Bethesda correctly held that 
the Board has jurisdiction over providers with self-disallowed claims. 
However, the Court's plain meaning approach to the statutory inter­
pretation is an inappropriate method to resolve the controversy over 
the limits of the Board's reviewing authority. The Court should have 
considered the policy concerns implicated in the reimbursement pro­
cess. This section begins by analyzing the Supreme Court's interpreta­
tion of the Board's governing statute and predicts how the Courts of 
Appeals will decide University of Cincinnati v. Secretary of Health &

(emphasis added). The omission of this language is critical to the interpretation presented 
by the Supreme Court because the omission allows the Board to review totally omitted 
claims.

146. The Seventh Circuit Court of Appeals in Saint Mary endorses a similar inter­
pretation of subsection (d). See supra notes 124-29 and accompanying text.
148. Id.
149. Id.
150. Id.
Human Services\textsuperscript{151} and North Broward Hospital District\textit{ v. Bowen}\textsuperscript{152} if it adheres to its interpretation in those cases. This section next reviews the policy considerations that the District of Columbia Circuit Court of Appeals raised in Athens\textit{ II} concerning the "adverse practical consequences" that would occur if the Board is deemed to have jurisdiction over claims not presented to the intermediary. This discussion concludes that there would be adverse consequences under the Bethesda approach but there would not be if the Board's jurisdiction is limited to self-disallowed claims challenging the Secretary's regulations and policies.

Finally, this section reasons that the Supreme Court should not have followed the plain meaning rule but instead should have applied an analytical approach that best effectuates policy concerns and congressional intent. The Court should have endorsed the Adams House approach as the most reasonable and practical interpretation. The Adams House approach best harmonizes the different statutory provisions and best serves the dual congressional goals of effectively utilizing an administrative process to control Medicare costs and allowing providers judicial review of agency regulations governing the cost control process.

A. Analysis of the Bethesda Interpretation

The United States Supreme Court, in Bethesda, broadly interpreted subsections (a) and (d) of the Board's governing statute based on a plain-meaning approach\textsuperscript{153} The Court attempted to present an


\textsuperscript{152} 808 F.2d 1405 (11th Cir. 1987), aff'g North Broward Hosp. Dist. v. Heckler, vacated and remanded, 108 S. Ct. 1569 (1988). See supra note 74 for a discussion of this case.

\textsuperscript{153} The Supreme Court applied the plain meaning rule to the interpretation of § 1395oo. According to the plain-meaning rule, "courts are bound to give effect to the literal meaning without consulting other indicia of intent or meaning when the meaning of the statutory text itself is 'plain' or 'clear and unambiguous.'" N. Singer, Sutherland Statutory Construction § 46.04 (1984). See also American Tobacco Co. v. Patterson, 456 U.S. 63 (1982). Clearly, the statutory language in § 1395oo is not "clear and unambiguous." The fact that the United States Courts of Appeals have presented conflicting interpretations of several phrases of the Board's jurisdictional statute is evidence of the ambiguity of the statute. "The fact that a statute has been interpreted differently by different courts has been cited as evidence that the statute is ambiguous and unclear." N. Singer, supra, at § 46.04. Therefore, because § 1395oo is ambiguous, the Supreme Court should have considered "other indicia of intent" to determine its meaning.

The Supreme Court should have analyzed the five different interpretations presented by the circuit courts of appeals as well as congressional intent and policy considerations rather than applying a plain-meaning approach to the Board's governing statute.
interpretation that would resolve the conflict among the courts of appeals over the proper interpretation of the statute. However, the Court's narrow holding and limited analysis of the statute fails to resolve the conflict and instead presents an ambiguous interpretation that raises several policy concerns.

The Court construed subsection (a) as requiring the provider to be dissatisfied with the total amount of reimbursement as a precondition to obtaining Board review. This was the interpretation which the Ninth Circuit Court of Appeals adopted in Adams House. In Adams House, the court of appeals stated that the provider need only be "dissatisfied with the total [dollar] amount of reimbursement offered by an intermediary." In Bethesda, the Supreme Court emphasized that the "express language of subsection (a) requires . . . [this] result."

However, further examination of the Court's analysis of subsection (a) presents an inconsistency with this interpretation. The Court distinguished providers with self-disallowed claims from those that failed to request reimbursement in their cost reports for costs which are reimbursable under the regulations. The Court suggested that a provider with a totally omitted or mistakenly self-disallowed claim will not satisfy the jurisdictional requirements of subsection (a). It stated that "such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary. . . ." The Court’s use of the words “amounts requested” limits a provider’s dissatisfaction to claims requested for reimbursement in the provider’s cost report. This is the Athens II interpretation of subsection (a). The District of Columbia Circuit Court of Appeals in Athens II stated that a provider must be dissatisfied with the final determination of the intermediary. If the Court’s statement was intended to imply that providers with mistakenly self-disallowed or totally omitted claims should be denied Board jurisdiction, it is inconsistent with the Court's initial interpretation of subsection (a) because dissatisfaction with the "amounts requested" is more restrictive than dissatisfaction with the total amount of reimbursement. Additionally, this interpretation which limits jurisdiction to providers

155. Adams House, 817 F.2d at 592.
157. Id.
158. Id.
159. Id. (emphasis added).
who are dissatisfied with "amounts requested" is inconsistent with the Court's view of subsection (d).

Subsection (d) permits the Board to exercise jurisdiction over "matters covered by such cost report."161 The Court in its plain-meaning analysis interpreted this phrase to include "a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed."162 Therefore, under the Bethesda approach, "matters covered by such cost report" arguably include self-disallowed as well as totally omitted and mistakenly self-disallowed claims. This expansive reading of subsection (d) is exemplified in the Court's analysis of subsection (a). The Court observed that the provider "could claim dissatisfaction, within the meaning of the statute, without incorporating their challenge in the cost reports filed with their fiscal intermediary."163 Thus, this expansive interpretation of the Board's jurisdiction is inconsistent with the Court's intimation that the provider be dissatisfied with the "amounts requested" and awarded by the intermediary before Board jurisdiction attaches.

Subsection (d) explicitly limits the Board's jurisdictional authority to "matters covered by such cost report." An interpretation of subsection (d) that is logically consistent with the Court's initial reading of subsection (a) is to limit the Board's authority to matters covered within the cost report. However, the Court in Bethesda disregarded this logical consistency and construed subsection (d) as permitting the Board to exercise broad authority over all claims. The Seventh Circuit Court of Appeals, in Saint Mary, endorsed a similar interpretation to subsection (d).164 In that case, the court construed subsection (d) as vesting broad authority in the Board to consider all claims regardless of whether they were reported in the cost report.

The Court adhered to this broad interpretation of the Board's governing statute and vacated and remanded two appellate decisions factually distinct from Bethesda. In University of Cincinnati v. Secretary of Health & Human Services165 and North Broward Hospital District v. Bowen,166 the providers mistakenly and inadvertently self-

163. Id.
164. See supra notes 125-29 and accompanying text.
166. 808 F.2d 1405 (11th Cir. 1987), aff'd North Broward Hosp. Dist. v. Heckler,
disallowed costs that were reimbursable under the Secretary's regulations. The Sixth and Eleventh Circuit Courts of Appeals, respectively, denied Board jurisdiction over these claims. Although the courts' reasoning was based on the restrictive interpretation of subsection (d) endorsed by the District of Columbia Circuit Court of Appeals in *Athens II*, the Sixth and Eleventh Circuit Court of Appeals were correct in applying this restrictive interpretation to mistakenly self-disallowed claims. The United States Supreme Court's interpretation of subsection (d) will allow providers with these types of claims to bypass a clearly prescribed tier of review. The Medicare Act and the Secretary's regulations require the provider to submit a cost report to the intermediary for a cost analysis of all reimbursable costs prior to Board review. Although the Supreme Court recognized that the Board and intermediary are two separate entities with distinct roles, the Court's interpretation of subsection (d) in *Bethesda* seemingly requires the Board to act as the initial tier of review of reimbursable claims, a role statutorily designed only for the intermediary.

The Court's interpretation of subsection (d) disregards congressional intent, policy considerations, and the practical aspects of the Medicare reimbursement process. By permitting the Board to consider totally omitted and mistakenly self-disallowed claims, the Court disregarded the "adverse practical consequences" that the District of Columbia Circuit Court of Appeals in *Athens II* predicted would occur if the Board was allowed to consider claims not requested for reimbursement in the provider's cost report. The discussion now addresses the Court's oversight.

B. *Athens II* and *Bethesda*: Application and Limitation

The United States Supreme Court, in *Bethesda*, endorsed an unduly broad interpretation of the Board's governing statute, thus invalidating the restrictive interpretation which the District of Columbia Circuit Court of Appeals presented in *Athens II*. These two interpretations, therefore, represent the two extreme poles in the array of possible interpretations of the Board's governing statute. This discussion suggests that the restrictive interpretation furnished by the District of Columbia Circuit Court of Appeals in *Athens II* is correct as applied to totally omitted claims but incorrect as applied to self-disallowed claims. Further, this discussion shows that the *Bethesda* approach will

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167. See supra text accompanying note 63.
produce the "adverse practical consequences" which the District of Columbia Circuit Court of Appeals in Athens II predicted would occur if the Board is allowed to review costs that the provider has not initially presented to the intermediary. This section concludes that the proper interpretation of the Board's governing statute should achieve the result the Supreme Court reached in Bethesda, namely, that the Board should be allowed to review self-disallowed claims challenging the Secretary's regulations. However, the proper approach to the statutory interpretation should be an analysis that satisfies congressional intent, policy considerations, and best effectuates the practical aspects of the Medicare reimbursement process. Therefore, the Supreme Court in Bethesda should have endorsed the Adams House interpretation of the Board's governing statute.

A restrictive interpretation of the Board's governing statute correctly applies to the factual setting presented in Athens II. If a provider with a totally omitted claim appeals to the Board to request reimbursement of a cost, the provider has not presented its cost information on the claim to the intermediary. The Board was created as an administrative appellate body to settle cost disputes between providers and intermediaries. It was not created as a supplemental agency to investigate claims for reimbursement. 168

The determination that needs to be made to resolve totally omitted claims or mistakenly self-disallowed claims is purely factual. Did Athens Community Hospital spend X dollars on stock option costs and federal income tax payments in 1973 and 1974? Did the University of Cincinnati spend X dollars on educational costs for interns and residents and related overhead expenses? Under the administrative scheme established by Congress, such determinations are to be made by the intermediaries and not the Board. 169 Thus, according to the District of Columbia Circuit Court of Appeals in Athens II, the Board has jurisdiction only over claims requested for reimbursement and presented to the intermediary in the provider's cost report. Following this line of reasoning, Judge Bork assumed that if the Board was to consider all costs included in the cost report, there would be "significant adverse practical consequences." 170 However, Judge Bork's assumption, while correct when the Board has jurisdiction over totally omitted and mistakenly self-disallowed claims, is erroneous when the

168. See supra notes 6-10 and accompanying text.
170. See supra text accompanying note 66.
Board is permitted to review self-disallowed claims challenging the Secretary's regulations and policies.

In Athens I, the court stated that "[p]ermitting de novo claims before the PRRB would deprive that body of the intermediary's analysis and conclusions and make the PRRB the tribunal of original jurisdiction, eliminating a tier of review, and possibly substantially slowing the reimbursement process for other providers." Such a tier of review is removed if the Board is permitted to review totally omitted or mistakenly self-disallowed claims. In that circumstance, the Board would be forced to make factual findings of cost reimbursement which is a statutorily designed role of the intermediary.

However, even if permitting the Board to review claims not recorded initially in the cost report eliminates a tier of review, it does not follow that the absence of intermediary review over self-disallowed claims is of concern. Such cases necessarily involve challenges to the Secretary's regulations and policy provisions. Intermediaries serve a very limited but necessary function in the Medicare reimbursement process. The intermediary is to serve as an administrator of the Secretary's regulations, and to act as an information conduit and auditor. According to the Supreme Court in Bethesda, when auditing a cost report, the intermediary's role is limited "to the mere application of the Secretary's regulations ... [and the intermediary] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the intermediary to do otherwise would be futile." Therefore, because the intermediary is without the authority to rule on the validity of a regulation or policy provision, the intermediary serves no purpose in an administrative appeals procedure.

Indeed at several points in its analysis in Bethesda, the Supreme Court emphatically stressed the different roles of the intermediary and the Board. The Court referred to the intermediary and the Board as separate entities each serving a distinct function in the statutory scheme. The Court emphasized that the intermediary has no authority to deviate from the regulations and thus presenting a challenge to the regulations before the intermediary serves no administrative purpose. Therefore, the statutory scheme established by Congress does not require such challenges to be presented initially to the intermedi-

171. The United States Court of Appeals for the District of Columbia reaffirmed Athens I, 686 F.2d 989 (D.C. Cir. 1982), in Athens II, 743 F.2d 1, 6-7 (D.C. Cir. 1984).
172. Athens I, 686 F.2d at 997.
ary, but such challenges must be brought before the Board so that it can use its powers in subsection (f) to facilitate judicial review.

A second "adverse practical consequence" which the Athens II court predicted would occur if it adopted the providers' interpretation is that it would nullify the reopening regulations. The court feared that allowing a provider to present claims for reimbursement after the intermediary denied its request for reopening would "eviscerate" the finality provision. According to the Secretary's regulation, an intermediary's decision to deny reopening is not reviewable by the Board or the courts.

Under the broad interpretation presented by the Supreme Court in Bethesda, the Board will be forced to reopen the cost report to consider whether a provider should be reimbursed for a particular cost. If the Board declines to make that factual determination, it could, arguably, require the intermediary to reopen the cost report thereby eviscerating the finality provision. However, a provider that self-disallows a claim because a regulation or policy prohibits reimbursement would not request a reopening hearing before the intermediary. If a regulation or policy prohibits reimbursement, the intermediary has no authority to determine whether a regulation or policy provision is valid. Therefore, the reopening regulations would not be affected if the Board's jurisdiction was limited to review of self-disallowed claims.

Lastly, Athens II suggests that if the Board was allowed to have jurisdiction to review a claim not requested for reimbursement in the provider's cost report, it would encourage frivolous reporting of nonreimbursable claims.

[A] provider could list every conceivable cost on its cost report, without claiming reimbursement, and hope that the intermediary will reimburse it for the reported but unclaimed costs, secure that it nevertheless will have until 180 days following the NPR to concoct

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176. Athens II, 743 F.2d at 7-8. The providers urged the court to interpret the Board's jurisdictional authority to allow review of all costs whether or not claimed in the cost report. Id.

177. Id. at 7. The finality provision 42 C.F.R. § 405.1885(c)(1987) states that the "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." Id.

178. 42 C.F.R. § 405.1885(c) (1987).

179. Even if a provider is allowed to appeal to the Board for reimbursement of a self-disallowed claim after the intermediary has denied reopening, it does not "eviscerate" the finality provision. An "appeal to the Board does not force an intermediary to reopen its deliberations against its will." Adams House, 817 F.2d at 593. The Board would review only those claims that the provider wished to bring before the intermediary in a reopening hearing.

some reasons to urge upon the [Board] for reimbursement of the unclaimed costs.\textsuperscript{181}

However, providers only are allowed reimbursement for those claims that Congress has authorized expressly. The Secretary has promulgated regulations and policies to be used as guidelines for calculating and interpreting costs permitted for reimbursement. If a provider claims costs in its report in violation of these policies and regulations, it is subject to criminal and administrative penalties. The Medicare Act provides an anti-fraud provision to deter these types of abuses.\textsuperscript{182} Thus, if a provider "knowingly and willfully" makes a false statement or representation on a cost report, it is subject to penalties under this provision.\textsuperscript{183}

Therefore, this adverse practical consequence will not occur if the Board is permitted to review self-disallowed claims as well as mistakenly self-disallowed and totally omitted claims. Under the Bethesda approach, the Board seems to have authority to review claims not reported in the provider's cost report so there is no incentive to include frivolous claims in the report.

Although the Court of Appeals in Athens II feared providers would report frivolous, nonreimbursable claims, the Athens II approach ironically encourages providers to include impermissible, nonreimbursable claims with its reimbursable claims. The Secretary instituted a scheme to assist providers in obtaining Board review to challenge regulations and policy provisions that are inconsistent with the anti-fraud provision. Under this scheme, a provider "knowingly and willfully" claims a cost that is nonreimbursable, but "preserve[s] [its] appeal rights by . . . disclosing the existence of such costs to the Medicare intermediary."\textsuperscript{184} The purpose of this scheme is to notify

\begin{enumerate}
\item\textsuperscript{181} Id.
\item\textsuperscript{182} This provision states:
Whoever-(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this subchapter, (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment . . . shall . . . be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 . . . .
\item\textsuperscript{183} Id.
\item\textsuperscript{184} Athens II, 743 F.2d at 10.
\end{enumerate}

There will be no referral to the U.S. Attorney if the allowability of a cost report item or items have [sic] been or are [sic] being disputed, and the provider clearly indicates on the subsequent cost report that the items are included, and the reason for inclusion (i.e., such as to preserve the provider's right to appeal, or other legal rights.)
the intermediary of the provider's intent to appeal. However, the United States Supreme Court in *Bethesda* properly rejected this scheme.

The Secretary cannot maintain, on the one hand, that it is of vital importance to present challenges to the Secretary's regulations in the first instance to the fiscal intermediary and, on the other, acknowledge that a mere cover letter would . . . [satisfy the Secretary's requirement of presenting challenges to the intermediary] because the fiscal intermediary lacks authority to rule on the challenge.\(^{185}\)

Further, this scheme is inconsistent with section 1395oo(a), which sets forth the jurisdictional requirements to obtain Board review.\(^{186}\) Neither the Board's jurisdictional statute nor its jurisdictional regulation require a provider to disregard the Secretary's cost reimbursement regulations as a prerequisite to obtaining review nor does it require intermediary notice of the provider's intent to appeal.\(^{187}\) Although this scheme is inconsistent with section 1395oo(a) and the anti-fraud provision, courts, prior to *Bethesda*, had been encouraging providers to use it to obtain Board review.\(^{188}\)

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\(^{185}\) *Bethesda*, 108 S. Ct. at 1260.

\(^{186}\) See supra note 29.

\(^{187}\) Id.

\(^{188}\) See Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d 1435, 1466, (11th Cir. 1987), cert. denied, 108 S. Ct. 1573 (1988) (Edmondson, J., concurring in part and dissenting in part); North Broward Hosp. Dist. v. Bowen, 808 F.2d 1405, 1410 n.7 (11th Cir. 1987); Baptist Hosp. East v. Secretary of Health & Human Servs., 802 F.2d 860, 865-66 (6th Cir. 1986); *Athens II*, 743 F.2d at 10.

At the conclusion of the *Athens II* analysis of the predicted adverse consequences, the court stated: "[W]here the statute is unclear . . . we should not construe the statute in a way that would invalidate a series of regulations promulgated by the agency charged with administering that statute." *Athens II*, 743 F.2d at 8. As a general proposition, this statement is correct. Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984). However, the court misapplied this proposition in this context.

The Supreme Court in *Chevron* stated:

If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute.

*Id.* at 843-44 (footnote omitted). The Secretary did not promulgate a regulation that clearly defined the Board's jurisdictional authority but instead used the same broad and ambiguous language that is set forth in the statute. The District of Columbia Circuit Court
Therefore, permitting the Board to have jurisdiction over providers' totally omitted or mistakenly self-disallowed claims probably would result in the elimination of a tier of review and would eviscerate the finality provision concerning the reopening regulations suggested by the District of Columbia Circuit Court of Appeals in *Athens II*. However, these "adverse practical consequences" will not result if the Board's jurisdiction is limited to self-disallowed claims.

As a matter of statutory construction, practical effect, and policy, the proper interpretation of the Board's governing statute should recognize that the scope of the Board's jurisdiction turns on the nature of the claim presented for review. The proper interpretation of the Board's jurisdictional scope should adhere to the *Bethesda* Court's concern over the futility of presenting a regulatory challenge to the intermediary as well as the "adverse practical consequences" predicted in *Athens II*.

of Appeals used various interrelated regulations and policies as a means to define the Board's jurisdictional authority.

In *Chevron*, the Environmental Protection Agency (EPA) promulgated an interpretative regulation defining the statutory term "stationary source." The respondents contended that the regulation defining "source" was contrary to the legislative history, language, and purposes of the Clean Air Act. The controversy over the proper definition of "source" focused on two competing policy concerns: the allowance of economic growth and the desire to curtail air pollution. The Supreme Court stated that "[t]he responsibilities for assessing the wisdom of such policy choices and resolving the struggle between competing views . . . [is] not [a] judicial one[.]" *Id.* at 866. Thus, the Court held that the agency's "interpretation represents a reasonable accommodation of manifestly competing interests and is entitled to deference." *Id.* at 865.

Similarly, there are two specific competing policy considerations governing the proper statutory interpretation of the Board's governing authority. The policy concern of the agency is that if self-disallowed providers are allowed Board jurisdiction, then providers will be able to appeal all claims not initially presented to the intermediary, thus avoiding a level of review. The competing policy concern is the providers' right to judicial review of agency regulations and policies. However, in contrast to the interpretive regulation promulgated by the EPA in *Chevron*, the Secretary did not promulgate a regulation that articulated its policy choice to which a court could defer.

Unlike *Chevron*, where the Court found the legislative history unilluminating, the legislative history of subsection (f) clearly shows Congress' intent to allow providers with self-disallowed claims a right to judicial review. *See supra* note 107. Therefore, Congress did not explicitly give the Secretary a choice between the competing policy considerations. "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 842-43. Thus, even if the agency created a regulation which articulated its policy choice, the courts should not defer to it. Regardless of the clarity of the Secretary's regulation defining the Board's jurisdictional scope, deference to the Secretary's policy choice would be inappropriate in this circumstance because the choice is "manifestly contrary to the statute." *Id.* at 844.
C. Adams House: Defining the Proper Limits of the Board's Jurisdictional Authority

The Court's analysis and interpretation of the Board's governing statute based on the plain-meaning rule in Bethesda is inadequate to resolve the controversy over the proper interpretation of the Board's jurisdictional scope. The Supreme Court should have endorsed the Adams House interpretation which best effectuates the policy concerns expressed in Bethesda and Athens II. Similar to the holding in Bethesda, the Ninth Circuit Court of Appeals, in Adams House, held that the Board has jurisdiction over providers' self-disallowed claims that challenge the Secretary's regulations. In its reasoning, the court rejected the District of Columbia Circuit Court of Appeals' restrictive interpretation of the Board's governing statute developed in Athens II.

The Ninth Circuit Court of Appeals in Adams House correctly analyzed the two relevant subsections of the Board's governing statute and presented the most reasonable interpretation of the Board's jurisdictional authority. In construing the subsection (a) requirement that a provider can appeal to the Board only if it is "dissatisfied with a final determination," the court in Adams House, like the Supreme Court in Bethesda, stated that a provider need only be dissatisfied with the total amount of program reimbursement to appeal to the Board.189

The relevant language of subsection (d) of section 139500 concerns the Board's authority over intermediary decisions on "matters covered by such cost report."190 Adams House gives this provision a broad but practical interpretation. The court interpreted "matters covered by such cost report" to include all costs presented in a cost report, even those not claimed for reimbursement.191 This interpretation of subsection (d) recognizes an intermediary's detailed auditing process of a cost report. An annual cost report consists of hundreds of pages of cost information.192 The report is divided into schedules and work sheets including reimbursable and self-disallowed claims. An intermediary's auditing process entails reviewing the computation of reimbursable costs, which at times necessitates identification of nonreimbursable items.193 Nonreimbursable items are included in

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189. Adams House, 817 F.2d at 592; Bethesda, 108 S. Ct. at 1258. See supra text accompanying note 122.
190. See supra text accompanying note 30.
191. Adams House, 817 F.2d at 591. See supra note 121 and accompanying text.
193. For example, in Saint Luke's, the provider initially recorded sick leave costs under the broader category of general and administrative costs, for which reimbursement was claimed. Several pages later, it made an adjustment on Work Sheet A-8 which re-
larger categories of costs such as general and administrative costs. However, in order to tally reimbursable costs, the nonreimbursable costs are deducted and recorded on separate work sheets. Adams House correctly interprets “matters covered by such cost report” because the court recognizes that a complete cost report includes reimbursable as well as self-disallowed claims which the intermediary must review.

Both the District of Columbia Circuit Court of Appeals in Athens II and the Supreme Court in Bethesda disregarded the intermediary’s detailed auditing process. In Athens II, the court interpreted “matters covered by such cost report” to mean only costs claimed for reimbursement. By applying a restrictive interpretation to this provision, the court denied the Board jurisdiction to review providers’ self-disallowed claims. The Supreme Court in Bethesda broadly interpreted subsection (d) to include costs incurred within the period for which the report was filed whether or not the claim was reported in the cost report. This interpretation, in essence, endorses the Seventh Circuit Court of Appeals’ interpretation in Saint Mary, which permitted the Board to exercise original jurisdiction over mistakenly self-disallowed as well as totally omitted claims.194 As the court in Athens II noted, this exercise of jurisdiction would eliminate the intermediary’s factual findings concerning whether such claims are reimbursable and thereby eliminates a necessary tier of review. Although broad, the Adams House interpretation of subsection (d) still requires that self-disallowed claims be recorded in the provider’s cost report and be presented to the intermediary as a necessary requirement for Board review, thus retaining the tier of review.

Adams House correctly rejected the First Circuit Court of Appeals’ statutory interpretation, in Saint Luke’s, of subsection (a) and (d) of the Board’s jurisdictional statute. In Saint Luke’s, the court held that the Board’s exercise of jurisdiction over self-disallowed claims is discretionary. Adams House construed the operative language in the statute to mean that the Board must exercise jurisdiction over self-disallowed claims. Adams House construed the word “shall,” in subsection (d), as referring to the Board’s options once an appeal is filed, and not to the Board’s decision-making authority to hear appeals.195 Furthermore, subsection (a) states that “[a]ny provider of

moved the sick leave costs from the general and administrative category, thereby self-disallowing the cost. Id. at 327.

194. See supra text accompanying note 128.
services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report. . . .” The court construed “may” in this provision to “con-note[] not contingency but entitlement.” Likewise, the Supreme Court’s plain meaning approach in Bethesda implicitly rejected the First Circuit Court of Appeals discretionary approach.

The Ninth Circuit Court of Appeals’ interpretation is consistent with sound policy and congressional intent because it allows providers to judicially challenge the validity of the Secretary’s regulations and policies that prohibit reimbursement. The Adams House court’s interpretation of the Board’s governing statute allows providers to challenge these regulations before an independent tribunal. Although the Supreme Court’s analysis in Bethesda allows providers with self-disallowed claims the right to judicial review, it failed to discuss the importance of judicial review of agency regulations.

Judicial review of an agency’s actions is a crucial component in the administrative process because it ensures “that unelected agency decision-makers follow statutory standards and implement delegated


197. Adams House, 817 F.2d at 594.

198. However, in 1983, when the provider reimbursement procedure changed from a reasonable cost basis to a prospective payment system, see supra note 17, providers were denied reimbursement for attorneys’ fees. This denial of reimbursement reduces providers’ incentive to challenge the Secretary’s regulations because, in many cases, the costs of attorney fees outweigh the costs at stake. Interview with John Roemer, Vice President of Finance at Franklin Medical Center, in Greenfield, Massachusetts (Nov. 7, 1987).

199. “Our desire to have courts review administrative actions arises from the historic principle of the ‘supremacy of law’ or ‘rule of law’ as it is called. We want an independent assessment by the court to see that the agency has stayed within the bounds authorized by the legislature.” Coffman, Judicial Review of Administrative Interpretations of Statutes 6 W. NEW ENG. L. REV. 1, 9 (1983). As one noted scholar states:

From the point of view of an agency, the question of the legitimacy of its action is secondary to that of the positive solution of a problem. It is for this reason that we, in common with nearly all the Western countries, have concluded that the maintenance of legitimacy requires a judicial body independent of the active administration.

L. JAFFE, JUDICIAL CONTROL OF ADMINISTRATIVE ACTION 323 (1965). In a colorful analogy, Professor Jaffe states:

An agency is not an island entire of itself. It is one of the many rooms in the magnificent mansion of the law. The very subordination of the agency to judicial jurisdiction is intended to proclaim the premise that each agency is to be brought into harmony with the totality of the law; the law as it is found in the statute at hand, the statute book at large, the principles and conceptions of the “common law,” and the ultimate guarantees associated with the Constitution.

Id. at 327.
authority in a rational manner." The Athens II approach, however, insulates the Secretary's rulemaking authority from judicial scrutiny and gives providers no recourse to challenge the agency's regulations and policy provisions. As Tallahassee demonstrated, Congress in-


The scope of judicial review of the agency's regulations is defined in subsection (f). This section provides that an action filed in a district court "shall be tried pursuant to the applicable provisions under chapter 7 of title 5..." 42 U.S.C. § 1395o(f)(1) (1982). The applicable provision of the Administrative Procedure Act (APA) which governs the scope of a court's review of an agency's regulation is § 706. This section provides that a reviewing court can reverse or sustain an agency's regulation under an "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" standard of review. 5 U.S.C. § 706(2)(A) (1982).

[T]he court reviews the agency's justification of its decision to determine whether the decision is rational and not contrary to the available evidence and takes into account what should be considered. If, given what the agency should consider, the explanation demonstrates a reasonable connection between the evidence and the choice made, the action is sustained.

S. CHILDRESS & M. DAVIS, FEDERAL CRIMINAL CASES & ADMINISTRATIVE APPEALS § 15.7, at 290 (1986). It is necessary for the court to know the basis of the agency's decision before it can reverse or sustain an agency's action. "[T]he action must be judged by the standards which the [agency] itself invoked." SEC v. Chenery Corp., 318 U.S. 80, 89 (1943). An agency's regulation will be held to be arbitrary and capricious

if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Motor Vehicle Mfrs. Ass'n of the United States, Inc., v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983). Courts also inquiry into whether the Secretary has acted within the scope of his or her authority and whether the Secretary has followed the necessary procedures set out in the APA. Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971). In Lloyd Noland Hosp. and Clinic v. Heckler, 762 F.2d 1561 (11th Cir. 1985), the court held that the 1979 Medical Malpractice regulation was arbitrary and capricious because it failed to show a proper basis for its decision and that the Secretary violated the requirement of proper notice (5 U.S.C. § 553(b) (1982)) and failed to incorporate in the regulation a general statement of its basis and purpose (5 U.S.C. § 553(c) (1982)).

However, when reviewing the validity of a regulation, courts will sometimes defer to the Secretary. In Schweiker v. Gray Panthers, 453 U.S. 34 (1981), the Court reviewed a Medicaid regulation which permits states to determine eligibility by including a spouse's income as income "available" to the applicant. The Court stated that "the Secretary's definition of the term 'available' is entitled to more than mere deference or weight..." Rather, the Secretary's definition is entitled to 'legislative effect' because, '[i]n a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term.'" Id. at 44 (citations omitted). But see Saint James Hosp. v. Heckler, 760 F.2d 1460, 1470 (7th Cir. 1985) ("[A] lesser degree of deference is required when reviewing the Secretary's actions under the Medicare Act's reimbursement provisions.")

201. See supra note 110 and accompanying text.
tended that providers have the right to judicial review.\textsuperscript{202} Similarly, the \textit{Bethesda} approach is incorrect because it disregards congressional intent to limit Board review to self-disallowed claims challenging the Secretary's regulations, and it disregards policy considerations and the practical aspects of the reimbursement process.

**CONCLUSION**

The United States Supreme Court in \textit{Bethesda} presented an expansive interpretation to the Board's governing statute. The Court rejected the \textit{Athens II} restrictive approach by permitting the Board to review claims not initially presented to the intermediary. Similarly, the Court rejected the First Circuit Court of Appeals' approach which gives the Board discretion to review claims presented on appeal. However, \textit{Bethesda} essentially has endorsed the Seventh Circuit Court of Appeals' interpretation that requires the Board to review all claims presented. The four United States Courts of Appeals that have explored the array of possible interpretations all have rejected this expansive view because it disregards the restrictive language of the statute, congressional intent, and policy considerations. As Judge Bork stated in his analysis of the "practical adverse consequences" in \textit{Athens II}, this expansive interpretation of the Board's jurisdictional scope will eliminate a tier of review and "eviscerate" the finality provision concerning reopening regulations. This broad interpretation overreaches the Board's jurisdictional limitations which Congress explicitly defined in the statute.

The Ninth Circuit Court of Appeals offers the most reasonable and practical approach to the Board's governing statute. \textit{Adams House} presents an interpretation that best effectuates the Medicare reimbursement process and Congress' intent to provide judicial review of agency regulations. An analysis of the intricacies of the reimbursement process, statutory construction, legislative history, case law, and policy shows why the proper interpretation to the Board's governing statute is the Ninth Circuit Court of Appeals' approach in \textit{Adams House}.

\textit{Kathleen A. Carrigan}

\textsuperscript{202.} Although the Court of Appeals for the Eleventh Circuit in \textit{Tallahassee} emphasized the right to judicial review, it does not provide the necessary statutory interpretation to the Board's governing statute to give effect to that right. The court failed to explain whether a provider with a self-disallowed claim satisfies the jurisdictional requirements in subsection (a). Subsection (a) and (d) should be interpreted to allow providers to exercise the general grant of judicial review stated in subsection (f).