

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

MAINEGENERAL)	
MEDICAL CENTER,)	
)	
Plaintiff)	
)	
v.)	Civil No. 98-34-B-H
)	
DONNA SHALALA,)	
Secretary of the U.S.)	
Department of Health and)	
Human Services,)	
)	
Defendant)	

Recommended Decision

Before the Court are Plaintiff’s and Defendant’s cross-motions for summary judgment pursuant to Fed. R. Civ. Proc. 56.¹ Plaintiff challenges Defendant’s refusal, acting through the Provider Reimbursement Review Board (“PRRB” or “Board”), to hear bad-debt claims filed by Plaintiff’s predecessor, Mid-Maine Medical Center (MMMC).² The issue presented to the Court is whether Defendant’s decision was arbitrary, capricious, an abuse of discretion, or otherwise not in

¹ Defendant filed a motion for dismissal, or in the alternative, a motion for summary judgment. The Court will analyze Defendant’s motion as one for summary judgment.

² Originally, Plaintiff filed three suits based on the PRRB’s refusal to hear the bad debts claims from MMMC’s 1994 cost report, and KVMC’s 1993 and 1994 cost report. The matters were consolidated pursuant to Fed. R. Civ. P. 42 (a).

accordance with the law. After carefully reviewing the record, I recommend that Defendant's motion be GRANTED and Plaintiff's motion be DENIED.

Background

This dispute centers around the Medicare Program³ and the method providers obtain reimbursement for costs associated with the program. Medicare is a program that supplements the cost of health services for the elderly and other indigent persons. Under the program, a provider, often a hospital, provides services to patients covered by Medicare. At the end of the year, the provider files a cost report seeking reimbursement for Medicare expenses to an intermediary. The intermediary reviews the cost report, determines what amounts claimed are reimbursable, and issues a Notice of Program Reimbursement ("NPR") to the provider and the Department of Health and Human Services. If the Provider disputes the intermediary's determination in the NPR, the Provider can appeal to the PRRB.

Plaintiff MaineGeneral, successor to Kennebec Valley Medical Center ("KVMC") and MMMC, brings this action challenging the PRRB's decision involving MMMC's 1994 cost report. In its cost report MMMC did not claim

³Title XVIII of the Social Security Act, 42 U.S.C. §§1395 to 1395fff, creates the Medicare Program for the elderly and indigent persons.

reimbursement for Medicare “bad debts”.⁴ On appeal Plaintiff asked the Board to consider the bad debts issue and the Board refused because MMMC failed to claim reimbursement for bad debts in its cost report. Specifically, the Board determined that when a Provider can claim costs under the regulations but fails to include those costs in the cost report for the intermediary to review, those costs cannot be raised before the Board. Plaintiff now asks the Court to grant its motion for summary judgment and order the Board to consider the appeal of the bad debts issue.

A. Summary Judgment

Summary judgment is appropriate only if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). "A material fact is one which has the 'potential to affect the outcome of the suit under applicable law.'" *FDIC v. Anchor Properties*, 13 F.3d 27, 30 (1st Cir. 1994) (quoting *Nereida-Gonzalez v. Tirado-Delgado*, 990 F.2d 701, 703 (1st Cir. 1993)). The Court views the record

⁴ Charges under Medicare originally involved reimbursing providers based on the reasonable cost of the services. In 1983 Congress modified reimbursement procedures and created a Prospective Payment System (“PPS”). Under the PPS hospital costs are reimbursed based on fixed rates, depending on what “diagnostic related group” (“DRG”) is assigned to the discharged patient. Certain costs, that fall outside the PPS, are still reimbursed based on the reasonable cost of the provider’s services. One of the costs that falls outside the PPS are “bad debts”. Among the cost regarded as bad debts are unpaid deductibles and unpaid coinsurance statements.

on summary judgment in the light most favorable to the nonmovant. *Levy v. FDIC*, 7 F.3d 1054, 1056 (1st Cir. 1993).

Judicial Review

The starting point for judicial review of an agency's decision is the statute itself. *Chevron U.S.A. Inc., v. Natural Resources Defense Council*, 467 U.S. 837, 842 (1986). If Congress speaks directly to the question before the Court, the Court must give effect to the express intent of Congress. *Id.* However, when the statute at issue is silent or ambiguous with respect to the issue before the Court, the Court must review the agency's construction of the statute to determine whether the agency's interpretation of the statute is reasonable. *Id.*

Section 1395oo(f)(1) sets forth the applicable standard of review by incorporating the standards specified in 706 of the Administrative Procedure Act (APA). 5 U.S.C. §706. Under section 706, a court may set aside the Secretary's decision if the decision was, "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. §706 (2)(A). This standard is highly deferential to the agency and demands the court to give "considerable weight" to the agency's interpretation of the statute. *Chevron*, 467 U.S. at 844. Court's have routinely deferred to the agency's interpretation when analyzing the statutes that enable the Medicare/Medicaid program. *Cheshire Hosp. v. New Hampshire-Vermont*

Hosp. Serv., 689 F.2d 1112, 1117 (1st Cir. 1982); *DeJesus v. Perales*, 770 F.2d 316, 327 (2nd Cir. 1985) (“courts must exhibit particular deference to the Secretary’s position with respect to legislation as intricate as [Medicaid]”); *Butler County Mem. Hosp. v. Heckler*, 780 F.2d 352, 356 (3rd Cir. 1985). When reviewing the agency’s interpretation, the Court is not examining whether the agency’s interpretation is correct, the Court is only determining whether the agency’s interpretation is reasonable. *Little Co. of Mary Hosp. & Health Care Ctrs. v. Shalala*, 994 F. Supp. 950, 953 (N.D.Ill. 1998).

Plaintiff challenges the PRRB’s decision that it lacked jurisdiction to hear the bad debts claim. The Board’s jurisdictional parameters are delineated by section 1395oo(a). Under that section, a provider may obtain a hearing before the Board if the provider:

(1) (A)(i) is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payments may be made under this title for the period covered by such cost report.

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

(3) such provider files a request for a hearing within 180 days after the notice of the intermediary’s final determination under paragraph (1)(A)(i),

Defendant does not dispute that Plaintiff fulfills the latter two jurisdictional requirements above. Rather, Defendant maintains that by listing the amount of \$0

next to “bad debts” Plaintiff cannot now claim to the PRRB that it was “dissatisfied”, pursuant to 139500(a), paragraph 1(A)(i), with the intermediary’s decision.

The parties agree that *Bethesda Hosp. Ass’n v. Bowen*, 485 U.S. 399, (1988), in part, controls the question and direction of the Court’s reasoning. In *Bethesda*, a provider purposefully omitted a claim from its cost report because it knew that under the existing regulation it could not claim the costs. The Court permitted the provider to raise the “self-disallowed” costs before the PRRB because an attempt to raise the regulatory challenge before the intermediary would be “futile” and “quite unnecessary,” because the intermediary did not have the authority to disregard or revise the regulations. *Bethesda*, 485 U.S. at 404, 407. Finding that the submission of the cost report was in full compliance with the Secretary’s rules and regulations, the Court permitted the provider to raise the “self-disallowed” costs before the PRRB.

Most significant for the parties in this matter are the following two sentences in *Bethesda*:

Thus, petitioners stand on different grounds than do providers who bypass a clearly prescribed exhaustion requirement or who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules. While such details might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.

Bethesda, 485 U.S. at 404-405. Referring to the language above, one court found that, “[t]his language strongly suggests that a hospital that does not ask its intermediary to reimburse it for all of the costs for which it is entitled to be reimbursed cannot, on appeal to the Board, first ask for new costs.” *Little Co. of Mary Hosp. & Health Care Ctrs. v. Shalala*, 24 F.3d 984, 993 (7th Cir. 1994).

In this matter, the applicable Medicare regulations clearly permitted MMMC to claim reimbursement for bad debts on its cost report. See 42 C.F.R. § 413.80(d) and (e). Plaintiff wants the Court to overlook the omission, and basically, extend the *Bethesda* model to instances when a provider fails to list allowable costs in the cost report. This the Court refuses to do. Instead, the Court heeds the strong suggestion in *Bethesda* and finds that MMMC’s failure to claim bad debts on its cost report precludes Plaintiff from arguing before the PRRB that it is “dissatisfied” with the intermediary’s fiscal determination of the bad debts issue.⁵

⁵ The only First Circuit case that addresses the jurisdictional issue is *St. Luke’s Hosp. v. Secretary of Health and Human Serv.*, 810 F.2d 325 (1st Cir. 1987), a case decided before *Bethesda*. In *St. Luke’s* the Court permitted the provider to raise a claim for self-disallowed costs before the PRRB. In its 1978 cost report the provider did list certain sick leave costs in its report but the intermediary refused to award the cost. In light of the intermediary’s refusal to award the sick leave costs in the 1978 cost report, the provider “self-disallowed” a claim for the sick leave costs in its 1979 cost report. On appeal, the PRRB reimbursed the provider for the 1978 costs but refused to reimburse the provider for the 1979 costs, citing the provider’s failure to list the costs in the report. The Court reversed the PRRB’s refusal to hear the 1979 costs, reasoning that at the time the provider failed to list the costs it had already appealed the 1978 cost report thereby giving notice to the Secretary that it was challenging the intermediary’s decision on reimbursement for sick leave costs. Further, the Court stated that once the intermediary refused reimbursement for sick leave costs in the 1978 cost report, an attempt to claim those costs again may open the provider to fraud charges. In

Plaintiff next maintains that even if the Court determines that the PRRB properly decided that it did not have jurisdiction over the claim pursuant to section 1395oo(a), section 1395oo(d) imposes an obligation on the Secretary to hear the bad debts claim. Section 1395oo(d) reads, in part:

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 . . . even though such matters were not considered by the intermediary in making such determination.

Plaintiff agrees with Defendant that section 1395oo(d) does not, independently of subsection(a), confer Board jurisdiction. As the Supreme Court wrote in *Bethesda*, “This [section 1395oo(d)] language allows the Board, *once* it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary.” *Bethesda*, 485 U.S. at 406 (italics added). Rather, Plaintiff argues that when the PRRB agreed to review the medical records and IME-adjustment claims from the 1994 cost report, it was required, pursuant to subsection (d), to review the entire report including those matters not considered by the intermediary.

Even if the Court agrees with Plaintiff that, in spite of Plaintiff’s failure to claim the bad debts in the cost report, the PRRB had the opportunity to review the

essence, like *Bethesda*, the provider in *St. Luke’s* omitted the costs on the cost report not through mere neglect, but because it intended to challenge an administrative decision.

bad debts claim once it agreed to review the other matters in the cost report, the PRRB's decision to review the claim is clearly discretionary. Section 139500(d) merely gives the PRRB the power to review the claim, it does not order the PRRB to hear the claim. The Court in *Bethesda* recognized the distinction by noting that once jurisdiction is invoked under subsection (a), subsection (d) *allows* the PRRB to hear the claim. *Bethesda*, 485 U.S. at 405. *Also see, St. Luke's*, 810 F.2d at 326, 327 (PRRB's discretion whether to "consider matters not specifically raised before the intermediary, like many similar powers of courts and agencies, should be exercised only sparingly."); *Delaware County Mem'l Hosp. v. Sullivan*, 836 F. Supp. 238, 245 (E.D. Pa. 1991) (PRRB decision whether to hear items not claimed in the cost report is discretionary.) In light of the analysis above, I recommend that even if the PRRB could assert jurisdiction over the bad debts claim once it agreed to review other items in the report, it was well within its authority to refuse to hear the bad debts claim.

Conclusion

Accordingly, having found that the Secretary conducted a reasonable interpretation of the statutory language when she denied to hear the Plaintiff's bad debts claim, I recommend that the Court GRANT Defendant's Motion for Summary Judgment and DENY Plaintiff's Motion for Summary Judgment.

NOTICE

A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. § 636(b)(1)(B) (1988) for which *de novo* review by the district court is sought, together with a supporting memorandum, within ten (10) days of being served with a copy thereof. A responsive memorandum shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to *de novo* review by the district court and to appeal the district court's order.

Eugene W. Beaulieu
United States Magistrate Judge

Dated on October 15, 1998.