SUPREME COURT OF THE UNITED STATES

In the Matter of:

BETHESDA HOSPITAL ASSOCIATION, ET AL.,

Petitioner

v.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES.

No. 86-1764

Pages: 1 through 45

Place: Washington, D.C.

Date: February 29, 1988

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Washington, D.C.

Monday, February 29, 1988

The above-entitled matter came on for oral argument before the Supreme Court of the United States at 11:52 a.m.

APPEARANCES:

LEONARD C. HOMER, ESQ., Baltimore, Maryland;
on behalf of the Petitioners.

ANDREW J. PINCUS, ESQ., Assistant to the Solicitor General, Department of Justice, Washington, D.C.;
on behalf of the Respondent.

C O N T E N T S

P R O C E E D I N G S

(11:52 a.m.)

CHIEF JUSTICE REHNQUIST: We'll hear argument next in number 86-1764, Bethesda Hospital Association versus Otis Bowen, Secretary of Health and Human Services.

Mr. Homer, you may proceed whenever you're ready.

ORAL ARGUMENT OF LEONARD C. HOMER, ESQ.

ON BEHALF OF PETITIONERS

MR. HOMER: Thank you, Mr. Chief Justice, and may it please the Court.

The issue before this Court is whether the Secretary of Health and Human Services can deny Medicare providers a hearing with respect to the amount of malpractice premium cost they are reimbursed under his regulations on the grounds that they followed those regulations when completing their cost reports.

Petitioners Bethesda and Deaconess provided service to Medicare beneficiaries and should not be denied the right to challenge how those services are reimbursed simply because they followed the Secretary's regulations in completing their cost reports.

After listing their malpractice premium costs in the cost report, Bethesda and Deaconess had three options available to them when the apportioned those costs between Medicare and non-Medicare patients.

First option. They could do as they did and complete the cost report in accordance with the malpractice regulation and submit it to the intermediary. The Secretary that says compliance with his Regulation is not an acceptable option if one is to challenge that regulation before the Provider Reimbursement Review Board.

Second option. They could decline to follow the Secretary's regulation and apportion the cost contrary to regulation and submit it to the intermediary. The Secretary says through an informal policy that has been adopted that this is what they should have done if they wanted to challenge the regulation.

Third option. They could apportion their malpractice premium costs in accordance with the regulation, submit the cost report to the intermediary with a cover letter indicating they wanted to challenge the malpractice regulation. While this is not the process that the Secretary claims to be necessary for the Provider Reimbursement Review Board, which I'll refer to as the PRRB, to entertain such a challenge, he concedes that it is an available option.

Now, the only difference between the first option, which is what we did, completing in accordance with the regulation and submitting it to the intermediary, and the third option, completing in accordance with the regulation and submitting with the cover letter indicating a general

dissatisfaction or desire to challenge the regulation.

I'd like to comment first on this second option, apportioning costs contrary to regulation. The Secretary contends such a requirement should be read into subparagraph (a)(1)(A) of subsection 139500.

Now, there is a practical consideration here that has not been mentioned in the briefs, and that is by filing costs contrary to regulations, providers run a risk of the intermediary not accepting the cost report. Subparagraphs (a)(1)(B) and (a)(1)(C) provide that the intermediary cannot be required to render a final determination or forced to proceed with a final determination of the cost of the reimbursement due unless the cost reports comply with the Secretary's regulations.

And also with regard to the second option, no purpose is served by filing out of compliance with the regulations. The intermediary cannot give relief. The intermediary's bound by contract to audit the cost report and bring it into compliance with regulations.

When the question is the substance of the regulation, the dispute is with the Secretary, not the intermediary. Filing out of compliance does nothing more than create additional work for the intermediary who must now issue an audited adjustment and conform the cost report so that it complies with the regulations, redoing the calculations.

QUESTION: I would assume though that the intermediary could reallocate the claimed costs under some other category that was permissible. If you claimed $15,000 for malpractice, it might find a way to give you $8,000 or $9,000 of those costs under some other category.

MR. HOMER: No, that's not correct, Your Honor.

If we have something that's by definition a malpractice cost, then it must be allocated in accordance with the malpractice regulation.

QUESTION: But aren't there cases where it's difficult to characterize costs, or there's some question as to their proper characterization?

MR. HOMER: Oh, there are cases in those instances but that's not what we're talking about today.

QUESTION: Well, insofar as the rule is concerned, might not there be instances where how to characterize a cost is open to question and so it serves a purpose to submit the issue to the fiscal intermediary for its determination as to allocation?

MR. HOMER: The fiscal intermediary is required and they spend about 300 hours on a medium to large hospital doing the audit of the cost report, and they are required to look at each and every cost and determine how it is to be allocated under the regulations. There may be, as you indicate, an instance where that would be the case.

Let me given an example of a different kind of instance. Let's said that we made an error in the filing of the cost report and we made the error in the Government's favor. It would be the intermediary's job in that instance when they do the audit to issue an audit adjustment in the provider's favor, bringing that allocation into conformity with the regulations. But it's not something where they take advantage of the mistakes in the Government's favor and then go forward with the regulations.

Let's go further and say the intermediary missed that and there's no intermediary action or audit adjustment. Should the provider have a right to a hearing? And certainly they should. Because the first time the provider gets to the Government agency with a complaint that they didn't get paid what they should have for their services is when they go to the Provider Reimbursement Review Board.

The cost report stops with the intermediary. It does not go on to the Agency unless it is appealed to the Provider Reimbursement Review Board.

And I had mentioned, there is no purpose served by filing out of compliance. And if, in this instance, the Secretary felt that there was a purpose, they wanted some early warning of an intent to challenge the regulation, in this particular case, these providers had already challenged that regulation in the Hadley litigation in the Tenth Circuit and

had been told they had to go to the PRRB, only to be tripped up by this informal policy with regard to how the cost report is to be completed.

With regard to the third option, that is, filing the cost report in accordance with regulation but attaching a cover letter saying you want to challenge the regulation. This option serves no purpose at either the audit process level or at the Provider Reimbursement Review Board. The cover letter is not a part of the cost report. It does not generate any intermediary action and it generates no intermediary comment.

When the intermediary renders its final determination of total program reimbursement due, there is no substantive difference between what we did, filing in compliance with the regulation, and the third option that the Secretary has conceded will be a basis for jurisdiction, that is, filing in compliance and attaching a cover note saying, I would like to challenge the regulation.

QUESTION: Were you aware that that was an option?

MR. HOMER: It's not clear at the time these cost reports were filed whether these particular hospitals, I believe they may have been aware of that option, but they may not have determined that they wanted to continue with this litigation at that point. And they're not required to under the Statute.

Subsection A of 139500 says you don't have to give

the Secretary notice that you want to litigate until you get your final determination of reimbursement due. And there's good reason for that. If I'm happy with the amount I get, I may not choose to proceed with litigation over some regulation to get a few dollars more. That's a very wise choice by Congress.

QUESTION: Yes, but you know you're not going to get more than you ask for.

MR. HOMER: That's correct. That's correct, Your Honor.

Now, as I mentioned, subsection A is the basis on which providers are entitled to proceed for a hearing.

CHIEF JUSTICE REHNQUIST: We'll resume at 1:00 o'clock, Mr. Homer.

MR. HOMER: Thank you, Mr. Chief Justice.

(Whereupon, at 12:00 o'clock noon, the Court recessed, to reconvene at 1:00 o'clock p.m. this same day.)

AFTERNOON SESSION

(1:00 p.m.)

CHIEF JUSTICE REHNQUIST: Mr. Homer, you may continue.

MR. HOMER: Thank you, Mr. Chief Justice.

I would like to continue by clarifying a point that was made by Justice O'Connor and that is the fact that indeed we did ask for reimbursement of malpractice premium costs. We entered those in the cost report and then apportioned them in accordance with the regulation requiring them to be apportioned in the manner we did, and then proceeded before the Provider Reimbursement Review Board to ask for a hearing once we got our notice of program reimbursement.

Now, the Secretary claims that filing the cost report or entering costs in non-compliance with the regulation or out of conformity with the regulation is something required by subparagraph (a)(1)(A) of the Statute. He says that Bethesda and Deaconess forfeited their right to a hearing by following his regulations when they completed their cost report.

Now, subparagraph (a)(1)(A) of 139500 sets forth when providers have a right to proceed to a hearing before the Provider Reimbursement Review Board. It says that the provider may proceed to a hearing if, and I will quote, "if the provider is dissatisfied with a final determination of its fiscal intermediary as to the amount of total program reimbursement

do."

The Secretary asks this Court to rewrite subparagraph (a)(1)(A) so that it reads, "the provider may obtain a hearing only if dissatisfied with the intermediary's disallowance of costs entered in the cost report and then submitted to the intermediary."

The foundation or core of the Secretary's argument that one must file contrary to regulation to generate the intermediary adjustment is his characterization of the cost reporting and audit process as an adjudicative process in which the intermediary is both adversary and tribunal. However, if you'll keep in mind, the Secretary has conceded that a cover letter attached to a cost report that is filed in compliance with the regulation will suffice for jurisdiction.

And as I mentioned, the cover note is not part of the cost report. It generates no intermediary action or comment when the final determination is made. Indeed, it does not serve a single purpose advanced by the Secretary for this purported need for an adjudicative process during the audit.

QUESTION: I suppose if the Statute were clear, it really wouldn't make any difference whether it served any purpose or not. If Congress says you have to file this report to have it considered and you have to make this claim to have it considered, that's that, isn't it?

MR. HOMER: That's correct, Mr. Chief Justice.

The Statute is clear, however. The Statute says under Section 139500(a), you have to file the cost report and that you have to file a claim within 180 days after you've received your notice of program reimbursement if you're dissatisfied with the total amount of reimbursement received. It doesn't say, if you're dissatisfied with an intermediary adjustment. It says, total amount of reimbursement received, and that's the bottom line, how much we got for our services.

QUESTION: If you win, I suppose you -- you say the regulation is invalid?

MR. HOMER: The regulation has been declared invalid.

QUESTION: Well, if the regulation is invalid, what will you do with your next cost report?

MR. HOMER: The next cost report would be filed under the prevailing regulation at the time and that's invalid.

QUESTION: And you would include this item?

MR. HOMER: We would follow the regulation that's in existence telling how we include it. The item is included. It's just a matter of how you apportion it between Medicare and non-Medicare patients. So that we would follow the prevailing regulation at the time.

The prevailing regulation according to three circuits is the pre-1979 regulation, which is based on utilization. Three of the circuits have said that the Secretary cannot retroactively apply his 1986 rule.

QUESTION: So the government position is that if you claim the regulation is invalid, which you did, you should file your cost report as though it weren't in effect.

MR. HOMER: That's correct, Justice White.

QUESTION: What's wrong with that? If you really believe what you say, well, file your cost report that way.

MR. HOMER: Well, it gets down to a matter of being a trap for the unwary. The tendency, when you're filing a document, --

QUESTION: Is to live up to a regulation even though you claim it's invalid.

MR. HOMER: That's correct, Your Honor. The tendency is to follow directions. You're talking about a cost report that's 150 pages long with very complex calculations and you tend to follow the directions when you complete that. And the regulation says, do it this way, so that's the way you do it.

QUESTION: Even though you're about to claim that it's invalid?

MR. HOMER: That's correct, Your Honor.

There is no effective notice given by the Secretary as to how to proceed if you want to claim a regulation is invalid. If they wanted to give effective notice, what they would have to do --

QUESTION: Well, you know what to do now that it's been declared invalid.

MR. HOMER: As a matter of fact, --

QUESTION: I said you did.

MR. HOMER: That's right, Your Honor.

As a matter of fact, a number of the hospitals in this very group appeal filed it as the Secretary suggested out of conformity with regulations three years in a row and then slipped up the fourth year because they followed directions. It's a trap for the unwary.

And the point is, I believe, that the Secretary has no authority to impose that condition precedent at the cost reporting level. The only express power given to the Secretary under subsection (a) of 139500 is to set the time within which cost reports may be filed. That is the only express authority given the Secretary to deal with that front end part of it.

Absent the express authority to impose a condition precedent that would narrow the waiver of sovereign immunity that's involved in this case, it should not be implied.

QUESTION: Mr. Homer, is there any analogy that would favor your side in the income tax field? One can file an income tax return and make mistakes in it, or he can file it in accordance with prevailing regulations later declared invalid and still come back with a claim for a refund, may he not?

MR. HOMER: The Secretary's position is that the latter course will not work. It's the Secretary's position that you have to proceed --

QUESTION: I know what the Secretary's position is here. What I'm asking is there an analogy in the income tax field?

MR. HOMER: There is no analogy in the income tax field in this instance, because the Secretary's position is that --

QUESTION: I'm trying to give you one and you don't grasp the bait.

MR. HOMER: Yes, I think there is an analogy.

QUESTION: I think so, too.

MR. HOMER: What I should say with regard to the Secretary's position on his concession as to the sufficiency of a cover letter being a basis for PRRB jurisdiction is that when he conceded that, he conceded away his entire case.

The simple fact is that those cost reports are filed in compliance with the regulation. The intermediary does not touch that cover letter.

QUESTION: I wondered why he conceded that. And you know why I think he conceded it, Mr. Homer, is that if he didn't, he thought he would be met with the argument that there is a great loss for the hospital if it challenges the regulation and does not follow the regulation in the report.

That is, if you read 139500(a)(1)(B) and (C). If it's not following the regulations, it cannot appeal when the provider simply sits on the submission.

MR. HOMER: That's correct, Your Honor.

QUESTION: And takes no action at all.

MR. HOMER: That's correct, Your Honor. And that's why I had pointed that out.

QUESTION: That's a big loss.

MR. HOMER: He concedes this cover note point in footnote 8 on page 11.

QUESTION: In order to give you a way of avoiding 1(B) and (C).

MR. HOMER: That would appear to be the basis because that would avoid 1(B) and (C). However, if you'll notice, that is a concession in the footnote and that is the only point you'll see in the Secretary's brief. Because the Secretary's entire argument is based upon the need for the adjudicative process in the cost reporting and audit process.

QUESTION: Right. I understand.

MR. HOMER: And that is why he has conceded the whole thing away with this concession. The Secretary has never promulgated a regulation saying, thou shalt attach a cover note to the cost report if you want to proceed with a challenge to the regulation.

And my point is that the Secretary doesn't have the power in any event to attach such a condition precedent at that point under either subsection (a) which specifically says when we are entitled to proceed with a hearing before the Provider

Reimbursement Review Board.

Also, even if you look at filing out of conformity with the regulation, it serves no purpose whatsoever because the dispute is with the substance of the regulation, not with the intermediary. The intermediary cannot give relief if you are taking contrary to a regulation. They are bound to apply the regulation.

A point that should be made is that the Secretary argues that he should be given deference in his proposed reading of subsection (a). Now, Congress has addressed the issue of when a provider is entitled to review. And the language used is clear and without ambiguity. What could be clearer than being entitled to a hearing when one is dissatisfied with the total amount of program reimbursement determined to be due.

Interestingly, although the Secretary asks for deference, not once in his brief has he asserted any ambiguity in the language of Section 139500. Even if you take his assertions, ignoring the ambiguity issue which I think once when the statute addresses something and there's no ambiguity, there's no room to talk about deference, but looking at what he proposes, he says that his reading is a permissible reading of the statute.

QUESTION: Give him credit, at least. He does assert ambiguity. Now, you may not agree with it. He says the word,

dissatisfied, is the peg.

MR. HOMER: He attempts to urge ambiguity through the argumentation. He does not at any point directly assert that the language of subsection (a) is ambiguous. And he uses the word, dissatisfied, in isolation.

QUESTION: He is arguing it is clear in his direction, which is even better than ambiguous, right? You're not going to criticize him for that?

MR. HOMER: Well, you're correct that he is arguing it's clear in his direction. But that is not something that entitles him to deference. He can argue the language of the statute, but what he's arguing for is an intermediary adjustment and us being required to file contrary to regulation, and there's nothing like that in the statutory language.

And his argument that we have to file contrary to the malpractice regulation, as I mentioned, runs specifically afoul of subparagraphs (a)(1)(B) and (a)(1)(C) where he's saying on the one hand, we have to violate the regulation to get a right to challenge it. On the other hand, the Congress is saying, if we don't follow the regulation, they can sit on the cost report.

And if anything creates an inconsistency within the statutory language itself, it's that reading and that was not a permissible reading. And also as I mentioned, not a single

reason urged by the Secretary in support of deference survives his concession as to the cover note jurisdiction.

Because if you look at every reason advanced, it all flows through the notion of an adversary proceeding at the audit level. And if the cover note is not looked at by the intermediary and not commented on, there is no adversary proceeding at the audit level. And this is a situation where none of the reasons urged for deference hold up or survive his argument.

MR. HOMER: If the Court has no further questions, I would like to reserve my remaining time for rebuttal.

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Homer.

We'll hear now from you, Mr. Pincus.

ORAL ARGUMENT OF ANDREW J. PINCUS, ESQ.

ON BEHALF OF RESPONDENT

MR. PINCUS: Thank you, Mr. Chief Justice, and may it please the Court.

Despite petitioners' attempts to depict this case as one that turns on the procedural peculiarities of the Medicare reimbursement system, we think that the issue of statutory interpretation that's presented here is neither novel nor complex. It's an issue that arises with some frequency in administrative law, which is whether claimant must exhaust its administrative remedies in order to preserve its claim for further review.

Now, this Court and the lower Federal courts have held in a variety of contexts that where Congress has established a multi-tiered administrative process, a party must exhaust its administrative remedies in order to obtain further review of its claim.

QUESTION: Mr. Pincus, most administrative remedies can give you relief. I mean, the very term, exhaust administrative remedies, it means there's some administrator who can provide you relief.

But here the intermediary cannot provide you relief, so how can you possibly call that an administrative remedy. The administrator has to follow the regulation.

MR. PINCUS: Well, Your Honor, we think that there are two questions presented in this case, and we rely by analogy the way the Court has interpreted other exhaustion requirements under other parts of the Social Security laws in cases like Southland and Ringer.

In those cases, the Court has really applied a two step process. The Court has first looked to see whether there is a general exhaustion requirement in a run of the mill case, a case in which the administrator can grant relief. And then it's looked to see whether the facts of the case before it in which the claimant is typically urging that exhaustion is not necessary merit an exception from that general principle.

And we think that's the proper way to analyze this

case.

Petitioners focus on the fact that this case involves a reimbursement claim that rests on a challenge to a regulation. But it's still a reimbursement claim, and there are a lot of cases raising this same issue in which there wasn't a challenge to a regulation. Some of those cases are now pending before the Court on certiorari.

QUESTION: But Mr. Pincus, what is your answer to Justice Scalia's point that there was no administrative remedy? Is that not correct in the facts of this case?

MR. PINCUS: Well, on the --

QUESTION: That's a yes or no, I think.

MR. PINCUS: Yes. I think it is certainly true that the intermediary could not award the relief that they sought. But in Ringer the Court specifically said that exhaustion may be required in a case where it appears to be futile. For example, it may be that a provider frames its claim for reimbursement, the provider thinks that it depends on the invalidation of the regulation. Upon examination of the claim, it may turn out that reimbursement can be rewarded because the provider is under a misapprehension about the scope of the regulation, or because the reimbursement can be awarded under some other theory, or it may turn out that the claim is barred for some reason that the provider didn't recognize and so the challenge to the regulation is moot.

And the Court recognized in Ringer that it is appropriate to have an administrative entity that can't rule on the precise claim look at those issues to apply its expertise to make sure that what is in fact presented is a challenge to the statute that the administrative entity can't resolve. And I think those rationales are equally applicable here.

QUESTION: Mr. Pincus, why can we treat these regulation cases differently from the other ones that you say are lurking there in the wings to pounce upon us if we come out this way on regulation?

I mean, certainly the statute treats regulations differently. In (a)(1)(B) and (C), it does make a special provision. That is, you can't appeal unless you can appeal when you don't receive a final determination from the intermediary, except that you can't appeal if you haven't filed your report in accordance with the rules and regulations of the Secretary.

Now, the statute treats that kind of an issue quite differently from other issues.

MR. PINCUS: Well, Your Honor, we don't think that language has anything to do with a substantive claim. We think the rules and regulations that those provisions are talking about are the rules and regulations dealing with the form and procedural requirements in preparing a cost report. We don't think it's a coincidence that this point is not discussed in

the briefs or any of the appellate decisions raising the issue because we think it is simply a non -- it doesn't have anything to do with the substantive disagreement about the cost rules. It has to do with the procedural rules.

And if a provider files a cost report applying a substantive cost rule or not following a substantive cost rule, we don't think that that provision applies and to our knowledge it hasn't ever been applied to throw out a cost report.

And let me just go back to your question about why there should not be a difference for claims based on challenges to regulations. In addition to the reasons that I've already given, which is that in many cases what a provider thinks to be a challenge to a regulation may not be, we don't think there's any basis in the Statute for making that distinction. And especially we look to subsection (F)(1) which is where Congress created an expedited judicial review remedy to deal specifically with cases resting on challenges to regulations.

And what Congress did --

QUESTION: Where will we find that?

MR. PINCUS: That is on page 3 -- the relevant language is on page 3(a) of our brief.

Prior to the amendment in 1980 that added the language to which I'm about to refer, all claims had to be brought to the PRRB and had to go through a formal hearing before the PRRB, even challenges to regulations which the PRRB

cannot award relief on. Like the intermediary, the PRRB is bound by the Secretary's regulation.

Nonetheless, prior to the addition of this language, a provider that was challenging a regulation had to bring that reimbursement claim before the PRRB, had to have it heard by the PRRB --

QUESTION: When you said, this language, Mr. Pincus, it's just a solid page. Is there any particular part of it you're referring to?

MR. PINCUS: Well, let me -- the language on which we rely is excerpted maybe a little more clearly on the top of page 15 of our brief. What Congress did was add a provision that allowed a provider to bypass a Board hearing in these cases. It said, providers shall 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.

And we think what Congress did here very specifically was to say, there has to be an action of the fiscal intermediary. That's the peg for getting expedited judicial review. If you've got that, if you've raised this claim before the intermediary and it's been rejected, then you can go before the Board. And if the Board decides that in fact your claim does rest on a challenge to regulations, then the Board can in

effect certify your question for immediate judicial review.

QUESTION: Is your interest in this case just to make sure you follow the letter of the law, or do you, does the Secretary really have some substantial reason for wanting this to happen?

MR. PINCUS: Well, Your Honor, the Secretary has very substantial reasons for wanting this to happen. The Court has recognized in a variety of cases that the exhaustion doctrine rests upon a number of important policies, primarily the policy of administrative efficiency. And this is a very large administrative system. There are 15,000 --

QUESTION: What is efficient about filing a useless claim?

MR. PINCUS: Well, Your Honor, as I said, there are two categories of claims. There are claims that are not useless because they are claims for which relief can be granted by the intermediary, and then there are claims which the provider might think can only be granted by a Court.

But as to the first class of claims, we think it's self-evident that there is great efficiency in having claims that the intermediary may grant raised before the intermediary.

QUESTION: What about the claim that's involved in this case?

MR. PINCUS: The type of claim that's involved in this case we think there are also the important reasons that

the Court has recognized in Ringer, which are while the provider might think that the only way it can get relief is if the regulation is overturned, it might be that the provider is wrong about what the regulation means, and that if the claim had been raised before the intermediary, the intermediary would have interpreted the regulation to award relief.

Now, this regulation --

QUESTION: Yes, but isn't it true that in Ringer there was an express requirement the Statute spelled out what had to be exhausted before you could get judicial review. You don't have that here. It's a rather different statute.

MR. PINCUS: Well, Your Honor, we think that in the dissatisfaction language of subsection (A)(1) and in the language that I've just referred to in the expedited judicial review provision, Congress has made clear that there is a similar exhaustion requirement here.

QUESTION: Or at least you think it's clear enough to justify your regulation??

MR. PINCUS: We think it's clear, but if the Court thinks it's ambiguous, we think that the Secretary's interpretation is certainly reasonable and that the Court should adopt it.

QUESTION: Has the Secretary been consistent in the past?

MR. PINCUS: Yes, Your Honor, in our view, the

Secretary has consistently --

QUESTION: The Amicus says he hasn't been.

MR. PINCUS: Yes, and we explain in our brief in some detail the argument on pages 35 and 36 of our brief, we respond to the argument that there has been some inconsistency. The Secretary has always required that in order to invoke the Board's jurisdiction, the provider is only entitled to invoke the Board's jurisdiction on a claim that it raised before the intermediary.

QUESTION: Well, does it do the Secretary any good to make them file this claim? You think it may be that he might get relief on some other basis?

MR. PINCUS: We think that the claim might go away, either because he's entitled to relief on some other basis or for some other --

QUESTION: I thought it was also because -- would the intermediary ever look at the claim if it were filed?

MR. PINCUS: Yes. We think that the intermediaries are obligated to look at the claims and they do.

QUESTION: And I suppose, would the intermediary say, well, this looks like a straightforward claim that is barred by the regulation except we think it's too big, I mean, it's just erroneous. If there's a claim like this, it's only half this.

MR. PINCUS: Well, Your Honor, the intermediary certainly could say that even under the theory advanced by the

provider that the claim is wrong.

QUESTION: Well, Mr. Pincus, do you think if all that was done here was to attach a cover letter, that the cost report filing was just as it was, but a little cover letter were attached, that the intermediary would then go into the merits of that and try to figure out some way to adjust the amounts allowable to take account of it?

MR. PINCUS: Yes.

QUESTION: I mean it sounds like the cover letter the intermediary isn't concerned with looking at it at all.

MR. PINCUS: Well, the Secretary believes that part of the intermediary's obligations are to look at things in cover letters and to do the kind of evaluation to which I've just referred. We don't think that --

QUESTION: Was there --

MR. PINCUS: We think the cover letter option is really for the convenience of the provider more than anything else. It's --

QUESTION: Was there ever an express regulation explaining that providers could file such a cover letter and it would suffice?

MR. PINCUS: This rule has evolved through cost reimbursement decisions of the Board which are reviewed by the Administrator of the Health Care Financing Administration. And those decisions are reported in a widely distributed Reporter

that is certainly something with which members of the industry are well informed.

We think it's important to realize in this case that this is not similar to for example the disability area where the claimants are individuals that might be poor and not well counseled.

The providers in this case are large health care institutions that have staffs devoted to complying with Medicare regulations, have trade organizations that publicize recent decisions and make sure their members are aware of what the rules are and to which the members can go if they want assistance in finding out what the regulations are.

We think when the Secretary issued decisions embodying this regulation and let me add that the rule was subsequently codified in a manual that is distributed to all providers, we think that's enough to inform this class of claimants about --

QUESTION: What about the first claim filed before all this development took place, I mean, just relying on the statute as it was written and the regulations which say fill out the form in accordance with regulations. How could a lawyer know what was going to hit them, what it's going to be hit with until you get these later --

MR. PINCUS: Well, Your Honor, those -- it might be --

QUESTION: Somebody's got to go first, you know.

MR. PINCUS: -- it might be a different case. We think that if you look at the statute and the regulations --

QUESTION: You rely on the word, dissatisfied, that they really were not dissatisfied because they didn't tell you in advance?

MR. PINCUS: We rely on the word, dissatisfied. We rely on the language of the judicial review provision.

QUESTION: The (F)(1) which gives him an additional remedy but doesn't say anything about what happens at the administrative review.

MR. PINCUS: Well, Your Honor, we think that, that --

QUESTION: But apart from (F)(1), all you've got is the word, dissatisfied, isn't it?

MR. PINCUS: We also have the fact that this was called the Provider Reimbursement Review Board and it was designed to review something, not to make decisions.

QUESTION: Designed to review a lot of audits and facts and figures but not the validity of the regulations.

MR. PINCUS: Well, Your Honor, it does not review the regulations but what it does review is review intermediary determinations. We think --

QUESTION: Determinations that intermediaries have authority to make, not review determinations they don't have authority to make. And they didn't have the authority to make

the determination at issue here.

MR. PINCUS: Well, Your Honor, again, I think it's a mistake to concentrate on the particular narrow question involved here. Again, the Board itself --

QUESTION: I don't agree with you at all. We should decide the case in front of us. Maybe there are a lot of other tough cases out there but this one doesn't look very hard.

MR. PINCUS: Well, Your Honor, we think that the principles that the Court has applied in the other social security contexts indicate that even where the Court has held that even where the particular decisionmaker does not have the authority to decide the claim, exhaustion may be appropriate.

QUESTION: If the Statute says you must exhaust. But the Statute doesn't say that.

MR. PINCUS: But those statutes, Your Honor, those statutes, the statute there referred to a final decision. It did not expressly lay out a detailed exhaustion plan, and the Court found that what final decision meant was a particular exhaustion requirement.

And we think here what dissatisfied means as interpreted in the context of the statute is a similar exhaustion requirement. Let me add that these terms are illuminated we think very significantly by the legislative history. When the Medicare program was first adopted, the only entity that looked at a cost report was the intermediary.

There was no Board. There was no further review.

The provider filed its cost report, the intermediary made the determinations, and that was the end of it unless the Secretary chose to review the determination which did not happen very frequently.

In turn, the providers were very dissatisfied with the state of affairs because they had no way to challenge the decisions of intermediaries which they were unhappy with. And They --

QUESTION: Mr. Pincus, if you prevail here, will you do so on a regulation that has been declared illegal?

MR. PINCUS: Well, nothing about the exhaustion requirement has been declared illegal, Your Honor. And some Courts have concluded that the substantive rule here, the Medicare Malpractice Insurance Reimbursement Rule, has been declared unlawful. But we don't think the substantive claim should influence the Court's determination of this important procedural question.

QUESTION: So far as the case being so open and shut, certainly the panel below didn't think it was, did it?

MR. PINCUS: Well, Your Honor, the panel indicated that perhaps it might come out --

QUESTION: The other way.

MR. PINCUS: -- the other way.

QUESTION: The other way, if it hadn't been bound by

a prior Sixth Circuit case.

MR. PINCUS: But the prior panel came out our way and a number of other courts of appeals have come out our way, and we think that this is a very appropriate case if this Court or other courts have felt that the statutory language is ambiguous, this is a textbook case for deference to the agency. This is the administrative scheme that the Secretary oversees and we think that the Secretary has expertise in deciding what Congress intended in order to have a properly functioning process.

And so we think even if the statutory language is less than clear, it is an appropriate case for deference, and we think that the Secretary's interpretation is imminently reasonable.

QUESTION: There's nothing unclear about being dissatisfied. I've gotten a decision and I'm dissatisfied with it. It doesn't seem unclear to me.

MR. PINCUS: Well, Your Honor, the language is dissatisfied with a final determination of the -- and I'll skip a few words -- fiscal intermediary -- and I'll skip a few more words -- as to the amount of total program reimbursement due the provider.

And we think as three courts of appeals have concluded that what that language means is that a provider can be dissatisfied when the intermediary doesn't award something

that the provider wanted. That's when you're dissatisfied with the intermediary's determination.

Otherwise, you're dissatisfied with yourself because you didn't ask for enough. You got everything you wanted. You should have asked for more. You're not dissatisfied with what the decisionmaker did; you're dissatisfied with your own request.

QUESTION: I would look on it as you're dissatisfied with the fact that the provider gave you all the provider could possibly have given you. Why should you be dissatisfied with yourself. It would have been no use asking him for more anyway, because he couldn't give you more. He had to follow the regulation. You're dissatisfied with the fact that he had to follow the regulation.

MR. PINCUS: That's looking at the statutory language. Again, I know Justice Stevens will disagree, but the only context in which this issue can arise is not the regulation context. And I think it is certainly clear that in the run of the mill case where the intermediary could grant relief, there is ample reason to be dissatisfied. And we think that the general meeting that the language should not be interpreted simply by focusing on this provision but should be looked at generally and generally if you don't ask for it, you shouldn't be dissatisfied if you didn't get it.

QUESTION: Mr. Pincus, what about this to solve that

problem you're worried about where somebody doesn't ask for relief which the provider could have given, and he's still dissatisfied. I agree it would cover that situation.

But all that would show is that there is jurisdiction to take the appeal and to go to the Review Board. It doesn't show that the Review Board has to entertain the claim.

Couldn't the review board do what courts of appeals do when they refuse to hear an issue that was not raised below where it could have been acted upon below. They don't say they have no jurisdiction. They just say, this point wasn't raised below. We're not going to listen to it.

Why wouldn't that meet all of the Secretary's desires about these other cases lurking in the wings?

MR. PINCUS: Well, Your Honor, we make that argument in our brief as an alternative argument and we certainly think --

QUESTION: For a different purpose.

MR. PINCUS: -- that's a possibility if the Court disagrees with our principal submission.

But we think that there's no reason why the Board's authority to decide to do that would be limited to the non-regulation cases. The Board could well determine we think that the policies that I've been discussing that also apply in a situation where the intermediary might not have authority to decide the claim on the ground that the provider is asserting,

also warrant an across the board rule.

And we think that the Board or the Secretary should have the authority to decide the case on that basis.

QUESTION: Am I correct that you would substitute for the word, dissatisfied, you say what the Statute really means is every time the provider receives less than the amount claimed in the cost report filed in accordance with the regulations.

But you know, even if you change the statute that way, he wouldn't recover if he had to file a supplemental letter. I don't know how you substitute --

MR. PINCUS: We think the supplemental level is the functional equivalent of claiming the amount in the cost report. We think it's sort of six of one and half a dozen of another. The supplemental letter states a claim for additional reimbursement and it is attached to the cost report. So we think that this argument that the cover letter somehow blows our case out of the water is just a red herring. It is the same thing, and it's just designed to make things a little easier for the provider.

But we think it is important because it serves the exact same function of alerting the intermediary --

QUESTION: When did the Secretary first make it known publicly that a side cover letter of that kind must be made in order to preserve the rights such as at stake in this case?

MR. PINCUS: The first reported case that we were able to find we discuss in a footnote on page 34 our brief. We list a number of the Board and administrative decisions embodying this requirement and the first one that we list was in 1977.

And that decision I'm not sure whether that decision expressly gave -- that decision I think referred to claiming the cost, and I'm not sure whether it expressly defined the options. In subsequent decisions, the rule has been clarified.

QUESTION: But the rule was just developed on a case by case basis. There was no regulation that spelled it out in advance?

MR. PINCUS: It was developed on -- it is now spelled out in a provision in the manual that the Secretary issues to guide providers in filling out cost reports.

QUESTION: And when was that issued?

MR. PINCUS: That was issued in July, 1981.

QUESTION: 1981.

MR. PINCUS: The current version which makes everything clear.

Let me turn back to the legislative history for a moment because I think that the legislative history really illuminates what Congress was trying to do when it created the PRRB.

As I was saying, the Board was created in response to

complaints of providers who were dissatisfied with their intermediaries determinations, and more particularly dissatisfied with the fact that they had no where to contest the determinations that intermediaries made.

And the legislative history is quite explicit that filled with those complaints and Congress made clear when it created the Board that it was doing so in response in order to create a forum for resolution of those disputed issues.

And we think the fact that Congress was focusing on that illuminates the dissatisfaction requirement and makes clear that what Congress was doing was creating a body designed to review disputed intermediary determinations. And in order for the determination to be disputed, it's got to be raised before the intermediary.

And let me just return one more time to the question of why exhaustion makes sense in this situation. The cost reimbursement, I think the regulatory challenge in this case may be somewhat deceptive in terms of the way the Secretary's cost reimbursement regulations are written.

In this case, the question is just what percentage of medical malpractice insurance costs are going to be allocated to the Medicare program and just reimbursable. In other cases, the Regulations may contain more flexible definitions of whether a cost is reimbursable, what the standard is for reimbursement.

For example, the Secretary treats differently transactions between related entities, and the definition of whether an entity is related is of course there are standards set out in the regulations but those standards are somewhat flexible in application. And so it may, a providers claim is really always just a claim for reimbursement. And the fact that the provider places a particular label on the basis for its legal challenge to the claim may not be determinative of how the claim is resolved.

So we think it is deceptive to say, this is a regulation challenge so we can put it in this box. What this is really, is just a claim for more money, and the provider presumably will be happy to get the money on any basis that it can. And frequently, the regulations that govern that question will have some flexibility in them. And we think that the intermediary should be allowed to determine in the first instance, or given the opportunity to determine in the first instance, whether the regulation covers the particular situation.

And that way, the question as it goes to the Board will be illuminated, and perhaps the claim will be resolved without any need to resolve the challenge to the regulation.

Similarly, the intermediary may find that the particular regulation that the provider wants to challenge is inapplicable for some completely unrelated reason that the

provider didn't realize or didn't want to bring to anyone's attention at the time.

And we think because of the complexity of the situation, it's just not possible to pigeon-hole a claim as a regulation challenge claim and automatically give that some exemption from the exhaustion requirement. These cost reimbursement issues are complex and we think that the better course is to allow exhaustion in all circumstances so that the intermediary which has expertise in dealing with the claim has the opportunity to winnow out those cases that actually don't involve challenges to regulations. And save the Board's time and the Court's time for challenges that actually do.

Unless the Court has any further questions.

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Pincus.

Mr. Homer, you have seven minutes remaining.

ORAL ARGUMENT OF LEONARD C. HOMER, ESQ.

ON BEHALF OF PETITIONERS - REBUTTAL

MR. HOMER: Let me first focus on the issue of dissatisfaction. And what it seems to boil down to is when we are supposed to be dissatisfied.

The statute says we are to be dissatisfied when we learn what our total reimbursement is at the time the intermediary makes its final determination.

The Secretary says, no, we're to be dissatisfied and express that dissatisfaction when we file the cost report.

Now, what's to stop the Secretary from moving that back further and saying, no, when you signed up as a provider, you knew what the regulations were and you should have attached an addendum to your provider agreement saying your dissatisfied with these regulations. Otherwise, we're not going to hear a challenge to the regulation.

The difficult area that is being presented to you is the fact that the cost report and audit process is being presented to you by the Secretary as an adversary process. The Secretary relies on notions of exhaustion.

It is not a remedy when I hand you a bill of costs for the services I've rendered and say, pay me under your contract. The remedy aspect of it doesn't start until you short change me. And that is what has happened under this regulation.

The Secretary has short changed us and we --

QUESTION: Are you saying there's no decisional process going on within the Board before they short change you, as you put it?

MR. HOMER: At the Board, that's right, Your Honor.

The process as I mentioned earlier, the cost reports don't even go to the Board. The cost reports stop with the intermediary unless there 's a challenge taken to the Board, they send them to storage out in St. Louis somewhere. They don't go to the Government. The Government doesn't see them

unless the audit the intermediary to see if the intermediary's doing their job so that the first time that we stand at the threshold of the Agency, is when we ask for a hearing before the PRRB.

QUESTION: Well, how about a decisional process of the intermediary?

MR. HOMER: At the audit level, there is a process by which the intermediary takes the costs that have been entered in the cost report and reviews them to assure that the costs were indeed incurred, and that they have been treated by the provider in accordance with the regulations.

QUESTION: But there's some judgment exercised there, surely. It isn't just --

MR. HOMER: That's right, Your Honor. That's an accounting type judgment.

QUESTION: Well, but how different is an accounting type judgment than the sort of judgments many other legal review boards make?

MR. HOMER: It's no different than any other government contract on a cost basis. All we did was provide services on what is in effect is a cost contract and ask to be paid. The decisional part, other than just as Government auditors come into G.E. and do an audit on the Government contract, that's not a remedy. That is their attempt to get paid for their services.

The remedy phase of it starts once they have been denied what they feel, in this instance, what their total reimbursement is that they are dissatisfied with that amount.

And on that basis, that's where Ringer and Southland and the other cases of that type are not applicable in this instance. We did what was required. We filed the cost report as the regulations require and presented it to the intermediary, and then when we got our notice of program reimbursement back, then we filed our appeal with the Provider Reimbursement Review Board.

We didn't skip any administrative steps.

And with that, unless the Court has additional questions, that is my argument.

QUESTION: I do. I do just have one additional question.

On the alternative basis that the Government urges, why isn't it the case that the Government can acknowledge that there was jurisdiction to appear before the Board, but simply say, we accepted jurisdiction and as a matter of sound practice we are simply not going to allow a claim that you didn't raise at the first step.

What's the matter with that? That doesn't get you into the language of the Statute at all.

MR. HOMER: That's correct, Your Honor. Actually, that is one of the arguments made under subsection (D) which

the Secretary has conceded does not control access to the PRRB or entitlement to a hearing. There is nothing discretionary in the language of subsection (a). And let's face it, the Provider Reimbursement Review Board is our first contact with the Agency.

If we've slipped up somewhere in the cost report, and that's not the case in this case with the regulation, but say something where there could have been discretion, why shouldn't we be able to stand before the Agency and say, well, we think we're entitled to more.

And that's what Congress has said.

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Homer.

The case is submitted.

(Whereupon, at 1:45 p.m., the case in the above-entitled matter was submitted.)

REPORTERS' CERTIFICATE

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I hereby certify that the proceedings and evidence are contained fully and accurately on the tapes and notes reported by me at the hearing in the above case before the

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Margaret Daly
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HERITAGE REPORTING CORPORATION
1220 L Street, N.W.
Washington, D. C. 20005