Empowering the Provider: A Better Way to Resolve Medicare Hospital Payment Disputes

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ARTICLES

EMPOWERING THE PROVIDER:
A BETTER WAY TO RESOLVE MEDICARE
HOSPITAL PAYMENT DISPUTES

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INTRODUCTION

Many thought that 1994 would mark the beginning of major, national reform of the systems for financing and providing health care services to the American public. For the first time since 1965, when the Kerr-Mills bill created the Medicare program, Congress was slated to consider a mammoth piece of legislation designed to expand health insurance availability for tens of millions of people. Indeed, under the legislation that President Clinton proposed in October 1993, coverage for health services was supposed to become "universal," leaving no American citizen without health insurance in some form and greatly increasing access to primary, preventive health services. By September 1994, the expectations for large-scale health reform were declared officially dead by Senate Majority Leader George Mitchell. Those taking aim at the ever-moving target of health care reform began reconsidering the benefits of incremental change—i.e., wrestling with the huge, slippery problem amendment by amendment. However, piecemeal reform surely will take a number of years to implement. Meanwhile, the current system sputters along, plagued by complaints of inefficiency and injustice.

This article addresses one aspect of the health care reform picture: payments to institutional health care providers, such as hospitals, from the fund established by Part A of the Medicare program. These payments form one of the largest and most costly items in the federal budget. Yet the mechanism established to handle administrative review of provider payment disputes is one of the smaller and perhaps more anachronistic entities in federal government. This adjudicatory body is known as the Provider Reimburse-

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4. The Medicare program consists of two payment funds. The first, "Part A—Hospital Insurance Benefits for the Aged and Disabled," pays for inpatient hospital services, post-hospital extended care services, home health services, hospice care, inpatient psychiatric care, and end-stage renal disease services. 42 U.S.C. §§ 1395d, 1395rr. The second, "Part B—Supplementary Medical Benefits for Aged and Disabled," pays for outpatient, sub-acute care, including physicians’ services, as well as for therapeutic drugs and medical supplies. Id. §§ 1395j-1395w-4.

ment Review Board (PRRB or “the Board”). The PRRB adjudicates disputes over Medicare reimbursement amounts between institutional health care providers and the Health Care Financing Administration (HCFA), another agency within the Department of Health and Human Services (HHS) that administers the fund for Part A Medicare payments and establishes reimbursement regulations and policy.

The Board consists of five members who are knowledgeable about health care financing. At least one must be a certified public accountant. Usually but not necessarily, another is an attorney. All are charged with untangling the knots created when various financing and management stratagems collide with federal law, regulation, and policy concerning Medicare payments. Hundreds of hospitals, nursing homes, and home health agencies annually seek the PRRB as a forum to obtain a review of the overhead expenses that they believe should be reimbursed under Medicare Part A. Their unreimbursed claims, however, must amount to at least $10,000 before the PRRB can hear the case. As in any administrative adjudication, the objective is to obtain an accurate, swift evaluation of the propriety of agency actions taken by utilizing a panel experienced in the technical jargon and industry practice.

Some providers argue that changes in Medicare payment formulas—namely, the introduction of prospective payments—have eliminated the need for the PRRB, whose adjudicatory process was developed under retrospective, cost-based reimbursement formulas. If so, then the PRRB, as

6. 42 U.S.C. § 1395oo. A “provider” of services is a term of art under the Medicare statute. Although colloquially—and often professionally—the word “provider” has come to encompass medical, nursing, and social practitioners providing therapeutic services, this is not its legal meaning under the statute. A “provider,” as used in Medicare statutes and in this article, refers solely to those entities defined under 42 U.S.C. § 1395x(u): a “hospital, rural primary care hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice.”

7. Diagrams of the current and previous relationships between these agencies may be found infra Parts III.B and C.

10. Id. § 1395oo(a)(2).
11. Id. § 1395ww(d).
12. The PRRB was originally established in order to clarify what “reasonable costs” were owed to an institutional provider of Medicare services for overhead expenses incurred during the fiscal year. 42 C.F.R. §§ 413-414. Roughly put, providers accrued direct and indirect costs over the year and allocated those costs to the Medicare program according to the percentage of utilization by Medicare beneficiaries. This was, by definition, a retrospective analysis of payments due. The prospective payment system, in contrast, pays a flat rate per Medicare case treated, that rate being based upon national averages for the cost of treating that diagnosis group. 42 U.S.C. § 1395ww(d). This flat rate per diagnosis (or, more specifically, diagnosis related group, or DRG) represents a nearly complete
Currently constituted, has largely outlived its usefulness. However, until recently, even under Medicare’s prospective payment system (PPS), significant, high-dollar issues remained for adjudication, such as capital-related costs. In fact, because the PRRB caseload has skyrocketed since the institution of the PPS, although it was expected to decrease, some argue that the PRRB should be enlarged rather than eliminated.  

Whether to assure that the adjudicatory process matches the legal task or to assure that the appeals process matches the changes in workload, now is the time to examine the administrative appeals process for Medicare provider disputes. The provider community and Congress have recognized payment for both direct and indirect costs of care. However, Congress has severely limited the ability of providers to seek clarification of prospective, DRG-based payments, both at the administrative level and in judicial review. 42 U.S.C. § 1395ww(d)(7) (1995 Supp.).


14. Since the introduction of the prospective payment system (PPS), hospitals have filed aggressively at the PRRB, apparently needing every Medicare dollar now more than ever. One of the continuing challenges in analyzing PRRB operations is understanding the nature of the cases in inventory. Until 1987, the PRRB’s operations were completely manual. Even with belated computerization and the use of outside contractors, the inventory has overwhelmed in-house efforts to identify and categorize the cases. In 1990, the General Accounting Office found that, “of the approximately 1,600 cases in the manual system, 1,572 had no activity since November 1987 or earlier.” General Accounting Office, Rep. No. GAO/HRD-90-23-BR, Slowness of Appeals Process for Medicare Part A Reimbursements 1990, printed in [1989-1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,492 (Feb. 9, 1990) [hereinafter GAO Report].

15. In 1986, ACUS issued a report on the PRRB that offered one of the first in-depth examinations of the Part A adjudicatory process, its history, and its development up to the time when the PRRB moved from hearing only cost reimbursement appeals to also hearing appeals about rates set under the PPS. See generally Eleanor D. Kinney, The Medicare Appeals System for Coverage and Payment Disputes, 1986 ACUS 339. Professor Kinney’s report to ACUS covered a range of Medicare appeals issues, including both Parts A and B of the program, for beneficiaries and providers, and for coverage and payment.

At that time, ACUS put forward the following recommendations and suggestions for further study concerning the administrative appeals process for Medicare Part A:

A. The Health Care Financing Administration (HCFA) should keep up to date and provide reasonable access to all standards, guidelines and procedures used in making coverage and payment determinations under Part A and Part B of the Medicare program.

C. When resolving hospital rate appeals under the prospective payment system, the Provider Reimbursement Review Board should be authorized, by regulations (or, if necessary, by legislation) to assume jurisdiction of an individual hospital’s appeal in a manner that affords timely relief to successful appellants.
that the Provider Reimbursement Review Board faces a turning point.\textsuperscript{16} HCFA and the Board have indicated that they recognize that the next few years will require a serious reexamination of this tribunal's ability to meet the twin goals of administrative justice: fairness and efficiency.\textsuperscript{17}

Key among the shorter-range concerns is how to work expeditiously through the 9,100 pending cases.\textsuperscript{18} As of this writing, the typical waiting period between the filing of a PRRB appeal and the date of its hearing was four years.\textsuperscript{19} Not surprisingly, many providers—especially smaller, non-

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\textsuperscript{16} GAO REPORT, supra note 14, at 22,786.

\textsuperscript{17} The opinions and judgments reported in this article are the product of the author’s numerous confidential interviews with representatives of providers, intermediaries, and past and current government officials conducted from 1994 through 1995.

\textsuperscript{18} Letter from Streimer, supra note 15, at 1.

\textsuperscript{19} The four-year delay in obtaining a hearing raises one of the PRRB’s most difficult and unexplained problems. For several years, discussions have occurred both informally and on the record about the nature of the backlog and why so many cases, once filed, remain inactive or proceed with great slowness. See e.g., transcript of meeting with the PRRB and Robert Klein, Esq., Weissburg and Aronson, Inc.; Albert Baker, Federation of American Health Systems; Larry McFarland, AMI, Anita Reed, HCA (May 6, 1987) (on file with author). While this article explores this issue in as much detail as the documents currently available permit, other undocumented factors must also be considered. For example, the fact that large numbers of PRRB cases languish in backlog, largely unpursued, may imply that the provider community itself has only a minimal interest in the Part A appeals process. In addition, a critical element in the delay could well be the severe lack of legal staff for Blue Cross and Blue Shield of America, the primary fiscal intermediary
hospital providers highly dependent on Medicare revenue—perceive the long delay for justice as justice virtually denied.\textsuperscript{20}

Even if the immediate problems are resolved, the long-term, fundamental question, which is the focus of this article, looms large: Has the PRRB, as presently constituted, outlived its usefulness? The federal courts have largely resolved the major jurisdictional issues regarding the PPS and have left few, if any, major dollar issues for general acute-care hospitals to be resolved. After the backlog of pending cases has been resolved, what role will the PRRB serve? It seems reasonably clear that during the next five to ten years, the Medicare program will move increasingly toward a managed care model in which cost accounting has little relevance to the payor.\textsuperscript{21} Already, retrospective, cost-based reimbursement for non-hospital providers is being restructured into models of prospective, per-case payment. Thus, even the non-hospital providers that now protest cost-based matters before the Board will, in the near future, have virtually no legal issues concerning Medicare payments that are eligible for administrative or judicial review.

Could the administrative appeals functions currently provided by the Board be better managed in a different format or before a different tribunal entirely? Although Vice President Gore’s National Performance Review largely focused on regulatory reform and rulemaking, the same principle of “creating a government that works better and costs less”\textsuperscript{22} would argue strongly in favor of reconfiguring or eliminating entirely those adjudicatory structures that have outlived their usefulness. Moreover, President Clinton’s Executive Order 12,988 of February 5, 1996, would seem to compel a major reworking of PRRB functions.\textsuperscript{23} The preamble to the Executive Order

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bringing cases before the PRRB on behalf of HCFA. See supra note 17 (concerning interviews).
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\end{quote}

\textsuperscript{20} See supra note 17 (concerning interviews).

\textsuperscript{21} In a managed care system—especially a health maintenance organization—the provider of services typically negotiates a per capita rate for rendering a set of services to covered beneficiaries. The provider, naturally, is concerned that its costs are covered; however, it does not bill the third-party payor on a cost basis. Rather, the institutional provider’s costs of services are part of the calculations the provider considers as it negotiates its best rate. Costs incurred that exceed that rate must be absorbed by the provider (usually through reinsurance). 42 U.S.C. § 1395ww(a) (1994). Costs that are below that rate represent a profit, which is an incentive to the provider health maintenance organization to exercise cost control internally. The negotiated managed care rate is not subject to administrative or judicial review in the way that cost-based reimbursement under Medicare Part A has been in the past. Id. § 1395ww(d)(7).


\textsuperscript{23} Exec. Order No. 12,988, 61 Fed. Reg. 4729 (1996). As the order states, Whenever feasible, claims should be resolved through informal discussions, negotiations and settlements rather than through utilization of any formal court proceed-
makes it clear that the directive to attempt to resolve disputes through negotiations and settlements applies not only to federal court litigation but also to administrative adjudicatory tribunals, such as the PRRB. 24

This article presents suggestions for reconfiguring the current structure of the PRRB in ways that are sensitive to present and future concerns about administrative justice. 25 One of the suggested models might assist in developing appropriate review mechanisms under whatever health care reform amendments are finally enacted. At a minimum, this focus on the legal issues involved should help policymakers think more carefully about what appeals mechanisms might be adopted for a reformed system of health care financing.

Part I of this article first focuses on the operational structure of the PRRB and describes the current appeals process for Medicare provider payment disputes. Section B then attempts to place the current PRRB structure in perspective and spotlights the PRRB's relationship with HCFA as the agency has implemented its statutory mandate to staff the PRRB 26. The staffing and distribution of duties and responsibilities between the Board and HCFA have been issues of great controversy over the years.

Part II of this article explains the PRRB in its context within the federal

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24.  Id.
25.  Id. § 1(c)(1).
26.  Id.

There are those who would criticize the broad solicitation of consumer input as preferring "mere anecdote" to statistics. It is sometimes quite difficult to acknowledge that government bears a responsibility to be responsive to widespread concerns expressed by the public citizens who utilize its services. Moreover, it may be quite a challenge for anyone deeply immersed in the adversarial administrative process to yield to true alternative means of dispute resolution, including a wholly different agency structure for achieving those new resolutions. The results of this study surprised the author, who as an attorney "grew up" litigating PRRB issues and who came to maturity as a litigator and Board member considering issues—such as the nature of PRRB adjudications vis-à-vis the APA and whether the PRRB is necessary to protect the due process interests of institutional Medicare providers—totally and properly closed. The recommendations in Part III are not made lightly and represent a painful truth-telling.

Under negotiated settlement, the bulk of power would rest in the hands of the private parties and private agents for the government—not in the bureaucratic structure. This may represent the most significant challenge for implementing President Clinton's Executive Order 12,988. Perhaps the efforts to implement the Executive Order and the continuing efforts of organizations such as the CPR Health Disputes Project will in time create new structures for resolving government payment disputes that better match fuss to forum. See generally Edward A. Dauer et al., Strategies and Tools for Cost-Effective Dispute Management, 11 ALTERNATIVES TO HIGH COST LITIG. 154 (1993).

administrative judiciary. It examines the degree to which the PRRB resembles other federal tribunals and conforms to the Administrative Procedure Act (APA).  

Although the PRRB’s unique structure might have been a benefit in its early days, it may be time to consider whether its idiosyncratic nature has become a liability. The answers to these questions could become potent weapons between the emerging factions within the PRRB and HCFA. Other questions also arise: Can the PRRB claim independence from HCFA in terms of its decisionmaking process? Can it control its own staff to ensure that independence?  

With this contextual focus, Section B of Part II analyzes the issues adjudicated by the Board in relation to the agency structures established to resolve those issues. This section thus examines whether particular types of Medicare payment issues might be best handled through the existing structure or whether alternative models might address the legal and policy issues more efficiently.

To this end, Part III presents five models for reconfiguring the adjudicatory functions currently served by the PRRB and appraises them according to the legal and policy concerns raised in Part II. The first model would maintain the PRRB as it is currently structured, subsequent to its recent reorganization. The second model would undo the reorganization and reduce

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28. According to ACUS’s 1992 analysis of the federal administrative judiciary, that independence can only be accorded if PRRB hearings are in fact formal adjudications under the APA. See Paul Verkuil et al., The Federal Judiciary, 1992 ACUS 771. Then the PRRB would be unquestionably entitled to the doctrinal protections of separation of functions and statutory protection against ex parte contacts, even within the agency.

The language of the PRRB’s implementing statute is not unequivocal when analyzed within the framework of ACUS’s 1992 report. Board hearings that, under traditional analysis, would surely be formal adjudications would, instead, be categorized as what ACUS called “formal-informal,” “functionally formal,” or “functionally equivalent” processes. See id. Federal courts have not been uniform in their treatment of PRRB decisions upon review. Reaching a clear-cut determination about the APA status of PRRB hearings is further hampered by the PRRB’s singular nature in the federal administrative judiciary. The author knows of no tribunal whose administration and adjudications are comparable to those of the PRRB, but she would welcome news of one. See discussion infra Part II.A.

Ultimately, although this issue has consumed a great deal of energy and ire for those currently enmeshed in the PRRB turf wars, it may bear little relevance to the fundamental point of this article. ACUS commissioned the underlying study not as a means of providing intellectual ordnance to one side or another. Rather, the study sought to examine the critical question left unanswered by Professor Kinney’s earlier study of the PRRB: After the full implementation of the PPS, is there still a purpose for the PRRB as traditionally structured? See Kinney, supra note 15. Since Medicare clearly is moving toward PPS for all services for all providers and is eventually moving even further to managed care contracts, what purpose will the PRRB serve in five or ten years?
HCFA control over PRRB operations. The third model would maintain the current PRRB structure, including the reorganization, but eliminate the HCFA Administrator's sua sponte review. The fourth model would significantly change the PRRB structure to incorporate alternative dispute resolution (ADR) and the current administrative law judges (ALJs) who adjudicate Medicare claims for the Social Security Administration. The fifth model eliminates the PRRB entirely and transfers its functions to the Departmental Appeals Board of HHS.

I. THE PROVIDER ADMINISTRATIVE APPEALS PROCESS

A. The Path of a Payment Dispute

1. From Cost Incurred to Cost Disputed

Under the traditional retrospective payment system, HCFA reimburses providers of health care services for the reasonable costs of the services provided to Medicare recipients.29 These providers aggregate their costs of doing business throughout the year and array them, according to Medicare accounting principles, in a bulky document called the Medicare cost report.30 HCFA sends each provider periodic interim payments representing an estimate of the amount of "allowable costs" the program will reimburse.31 At the end of the cost-reporting year (which is usually the provider's fiscal year as well), an "intermediary"32 reviews the provider's cost report in toto. The intermediary is an insurance company that serves under contract as the agent for HCFA in administering payments for the Medicare program.33

The intermediary might perform only a "desk audit," in which the accountant assigned to the provider literally reviews the cost report at his or her own desk, checking for mathematical accuracy, consistency with prior years, and facial compliance with Medicare payment guidelines.34 These guidelines are set forth primarily in interpretive rules in the Provider Reimbursement Manual, known as "HIM-15."35 Instead of a desk audit, the in-

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30. Id. § 413.20.
31. Id. §§ 413.60-413.64.
32. Id. § 413.60.
33. Id. §§ 421.3-421.100.
35. Id. ¶ 4600.
termediary might perform a “field audit,” in which the intermediary’s accountant goes on-site to the provider’s facility to conduct an in-depth check of the cost report against documentation at the facility.36

Following either the desk or field audit, the intermediary issues an audit adjustment report setting forth in summary fashion various points where the intermediary’s accountant disagrees with the provider’s accountant about the appropriate treatment of particular cost issues.37 This results in various adjustments to the monies due the provider from the Medicare Part A program. An adjustment in the provider’s favor results in increased reimbursement from HCFA; an adjustment against the provider’s interpretation of the guidelines results in a loss. The audit adjustment report is supposed to reference a provision of the vast array of Medicare regulations or manuals that supports or explains the adjustment. Typically, however, the regulatory or manual support is quite cursory, especially in light of the usually complex facts and sometimes complex law surrounding the adjustments.

The intermediary then holds an exit conference with the provider.38 In the exit conference, the provider’s fiscal staff meets with the auditor to obtain fuller explanations of—and sometimes to debate—the various adjustments. The provider’s staff seeks to reverse or modify whatever downward adjustments they can. They also seek an understanding of what the implications might be for future years, since the intermediary’s challenge to the accounting method for one fiscal year may well carry forward for several years.

At least with regard to the largest intermediary, Blue Cross and Blue Shield of America, the provider’s only recourse at this point is to request another conference with the same auditor who determined the original adjustments. There is no other in-house review, such as a conference with the auditor’s supervisor or an auditor not associated with that particular provider’s audit. If the amount in dispute exceeds $10,000, the provider technically has the right to obtain a review of the intermediary’s actions by the PRRB.39 As a practical matter, however, hospital managers must consider the cost and other burdens of pursuing an appeal, and they often decide not to file. As a former Chairman of the PRRB said, “The trouble and expense of an appeal is a self-selective process.”40 The legal and accounting costs of preparing and presenting an appeal can easily amount to between $25,000

36. Id. ¶ 7984.24.
37. Id. ¶ 7993. The audit adjustment report is formalized by issuance of a document entitled “Notice of Program Reimbursement” (NPR). Id. ¶ 7666. See infra note 45 (discussing NPRs).
38. PRRB MANUAL, supra note 34, ¶ 7667.
and $100,000.\textsuperscript{41} Thus, if a hospital has less than $50,000 in dispute, an appeal is unlikely. The benefit of pursuing even a $100,000 dispute is marginal, according to some intimately involved in the process.\textsuperscript{42}

Nevertheless, a provider might well appeal so-called marginal amounts because of the accounting principles involved. For example, for a small home health agency, the amount at issue in the one fiscal year currently under review might total only $75,000. But if the $75,000 represented the owner’s salary and benefits, the matter would be of great concern to the agency’s owner. Additionally, the reimbursability of his or her compensation in future years might well determine whether he or she could continue operating the agency.

Of course, one of the critical factors in deciding whether to file an appeal is the provider’s calculation of the likelihood of success. There are no reliable statistics on the frequency with which PRRB decisions have favored providers or intermediaries. In 1989, Hospitals magazine (the American Hospital Association’s trade publication) concluded that “health care providers have about a 40 percent chance of receiving a favorable decision from the board.”\textsuperscript{43} “Favorable,” for these purposes, also included modifications of intermediary determinations. Such favorable modifications, however, might allow reimbursement for the provider’s cost of borrowing $2 million, even though the provider had sought and been denied reimbursement for the cost of a $5 million loan.\textsuperscript{44}

2. From Adjudication to Judgment

\textit{a. The PRRB Process}

If the provider decides to pursue a PRRB appeal, it must wait until the intermediary has issued its final determination in a Notice of Program Reimbursement (NPR).\textsuperscript{45} There are also situations where the provider has re-

\begin{itemize}
\item \textsuperscript{41} Id.
\item \textsuperscript{42} Id. (quoting Dennis M. Barry, Esq., then partner in law firm of Wood, Luckinger & Epstein, Washington, D.C.).
\item \textsuperscript{43} Id. at 40.
\item \textsuperscript{44} Id.
\item \textsuperscript{45} 42 C.F.R. § 413.40(e)(4)(ii) (1996); PRRB Manual, supra note 34, ¶ 7768. In the late 1980s, providers became concerned that intermediaries were perhaps purposefully not issuing NPRs to prevent providers from bringing appeals to the Board. In all fairness, this was a period of great turmoil in Medicare law, as providers, intermediaries, the Board, HCFA, and the courts wrestled to understand the impact of the prospective payment system on Medicare appeals processes. In January 1989, however, HCFA acquiesced in a ruling by the Court of Appeals for the District of Columbia Circuit, (and the likely position
quested an exception, exemption, or adjustment under various Medicare payment regulations. As an illustration, an isolated, rural hospital might request treatment as a “sole community hospital” so that it would be entitled to more generous Medicare reimbursement.\(^\text{46}\) If the request is denied, the provider can appeal that denial to the PRRB.\(^\text{47}\) In that case, the denial of the request becomes the trigger for filing.\(^\text{48}\)

Upon issuance of the NPR or a denial of the request, the provider has 180 days to file a written request for a PRRB hearing.\(^\text{49}\) After the intermediary responds, the case is docketed on the PRRB’s computerized hearing schedule,\(^\text{50}\) known as the monthly calendar, and a Notice of Hearing is issued.\(^\text{51}\) The PRRB may schedule an oral hearing or decide the case after reviewing the written record.\(^\text{52}\) For an appeal filed in fall 1994, the hearing date was

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\item[46] HeinOnline -- 49 Admin. L. Rev. 281 1997
\item[47] of the Supreme Court). Georgetown Univ. Hosp. v. Bowen, 862 F.2d 323 (D.C. Cir. 1988). If the intermediary refuses to issue or unreasonably delays the issuance of the NPR, the provider may still proceed without it, even as to the cost-based portion of prospective payments. HCFA Rul. 89-1, [1989 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 37,614 (Jan. 26, 1989). After the issuance of HCFA Ruling 89-1, intermediaries began again issuing NPRs, and appeals before the PRRB doubled in one year. PRRB WORKLOAD STATISTICS, supra note 13. For a fuller discussion, see Phyllis E. Bernard, Social Security and Medicare Adjudications at HHS: Two Approaches to Administrative Justice in an Ever-Expanding Bureaucracy, 3 HEALTH MATRIX 339, 402-10 (1993) (discussing Medicare appeals system). This article returns to this issue infra Part II.B.4, which addresses the future of the PRRB under the PPS.
\item[48] 42 C.F.R. §§ 412.92(a)(3), 412.348.
\item[50] PRRB MANUAL, supra note 34, ¶ 7668. A hospital that has protested its classification as rural instead of urban, for purposes of calculating the appropriate wage index for labor costs, also can bring an appeal. Until 1991, such appeals were taken before the PRRB. Since passage of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), tit. 4, Pub. L. No. 101-508, 104 Stat. 1388, 1388-30, however, such appeals are brought before the Medicare Geographic Classification Review Board, which is housed in PRRB offices yet conducts almost all business through telephonic conferences. 42 U.S.C. § 1395ww (d)(10).
\item[51] 42 C.F.R. § 405.1841(a); PRRB MANUAL, supra note 34, ¶ 7700. The provider then has 15 to 60 days to submit its List of Issues and a stipulation of jurisdiction, and the intermediary has 15 to 60 days to respond. Id. ¶¶ 7703-7704A.
\item[52] 42 C.F.R. § 405.1849; PRRB MANUAL, supra note 34, ¶ 7704A(A).
\item[53] 42 C.F.R. § 405.1849; PRRB MANUAL, supra note 34, ¶ 7712.
\item[54] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1859, 405.1861; PRRB MANUAL, supra note 34, ¶ 7717G. Oral hearings last from one to three full days (or more in rare cases). The entire panel of Board members, sitting en banc, hears the case. This remains the standard practice despite statutory and logistical provisions for Board members to hear cases simultaneously in two panels, in adjoining hearing rooms. Id. ¶ 7704C. However, because one panel would have less than a full quorum—only two of the five members, instead of three—both parties subject to the decision of the two-member panel must consent to the change and waive their right to a quorum. Another obstacle to the dual panel option
\end{footnotes}
commonly set four years later, in 1998. Procedures exist for providers to request an expedited hearing, but few have taken advantage of this route.

PRRB hearing procedures are adversarial in form, yet flexible. Indeed, from the earliest implementing regulations, the Board has enjoyed the authority to adjust procedures to fit needs. The regulatory mandate of the Board is to “inquire fully into all of the matters at issue and . . . receive into evidence the testimony of witnesses and any documents which are relevant and material to such matters.” Parties may engage in pre-hearing discovery, including inspection of documents and examination of witnesses. The purpose of discovery is (or ought to be) to facilitate a pre-hearing resolution of the issues, rather than to expand the litigation. However, in a practice that has come under some criticism, the Board allows parties to raise new issues up to the date of the hearing, so long as they relate to the cost-reporting period under review.

The Board may issue a Request for Position Papers, which requires the provider to submit a brief and the intermediary to submit a response. If the Board finds it “reasonably necessary for the full presentation of a case,” it may issue subpoenas “for the attendance and testimony of witnesses and for

is that, when the Board does not have a full complement of members, both panels lack a statutory quorum. This invites deadlock. Dual panels have been used only in very recent years.

53. 42 C.F.R. § 405.1842; PRRB Manual, supra note 34, ¶ 7719.
55. 42 C.F.R. § 405.1851.
56. Id. § 405.1859; PRRB Manual, supra note 34, ¶¶ 7711, 7717.
57. In fact, the procedural regulations promulgated by HHS for the conduct of PRRB hearings instruct the intermediary “expeditiously [to] attempt to join with the provider in written stipulations setting forth the issues.” 42 C.F.R. § 405.1853. The regulations indicate that even before the position paper has been filed, the intermediary and provider are to attempt to negotiate agreements. As the PRRB manual states,

The Board encourages the parties to enter into negotiations early in the appeals process either directly or with the assistance of a mediator. Generally, the Board does not become involved in this process. The parties notify the Board promptly of

a settlement which results in withdrawal of an issue or an appeal.

PRRB Manual, supra note 34, ¶ 7716. The relative lack of consistency by the Board in promoting negotiated settlements is quite striking compared with the growth of ADR in health care disputes more generally. See generally National Health Lawyers Ass’n, Alternative Dispute Resolution Service: Code of Ethics and Rules of Procedure (1991); Michael Carbine, Adapting Dispute Resolution Techniques to the Health Care Field, Forum, Summer/Fall 1991, at 17.

58. 42 C.F.R. § 405.1842.
59. PRRB Manual, supra note 34, ¶ 7704B & C. The provider must send its brief to the intermediary within 90 days of its receipt of the Board’s request. The intermediary is to respond within 60 days. The provider then must serve its response on the intermediary within 30 days. Id. ¶ 7704A.
the production of books, records, correspondence, papers, or other documents which are relevant and material to any matter in issue at the hearing.\textsuperscript{60} For better or worse, the Board has rarely found need to exercise its subpoena power. Perhaps, like many tribunals dealing with closely regulated industries, the mere fact that most providers and intermediaries will eventually have to deal with the PRRB again helps them to comply with informal requests for information, obviating formal subpoenas.

The Board has authority to develop flexible hearing procedures suitable to each situation.\textsuperscript{61} The style and format of the live hearings, however, closely follow the formal trial-type adjudication prescribed by the APA.\textsuperscript{62} Witnesses testify under oath, and party representatives (usually, but not necessarily, attorneys) make opening and closing statements; examine and cross-examine witnesses; and present and challenge documentary evidence.\textsuperscript{63} Board members also may examine witnesses; they are expected, however, to do so as independent neutrals.\textsuperscript{64} The Board may receive evidence “even though inadmissible under the rules of evidence applicable to court procedure”\textsuperscript{65} and exclude evidence that is “irrelevant, immaterial, or unduly repetitious.”\textsuperscript{66} The entire hearing is recorded by a court reporter and transcribed.\textsuperscript{67} All these procedures, taken together with the language of the statute, give strong support to those who would characterize the PRRB hearing process as a formal APA adjudication, despite the fact that the hearing officers are not ALJs.\textsuperscript{68}

After the hearing, parties again submit briefs, which typically include re-

\textsuperscript{60} 42 C.F.R. § 405.1857. HCFA assumes the cost of the issuance, fees, and mileage of any witness so subpoenaed. \textit{Id.}
\textsuperscript{61} \textit{Id.} § 405.1851.
\textsuperscript{63} 42 C.F.R. §§ 405.1859, 405.1861; PRRB Manual, \textit{supra} note 34, ¶ 7717.
\textsuperscript{64} As explained in the Board's hearing manual (which has recently been redesignated as part of the HCFA manual, ostensibly for reasons of fiscal economy alone): “The intent of the Congress in establishing the PRRB was to afford providers dissatisfied with the amount of program payment an independent forum where disputes could be fairly and justly settled. The PRRB provides administrative due process and objective review in cases which come before it.” PRRB Manual, \textit{supra} note 34, ¶ 7709.
\textsuperscript{65} 42 U.S.C. § 1395oo(c)(1994); 42 C.F.R. § 405.1855.
\textsuperscript{66} 42 C.F.R. § 405.1855.
\textsuperscript{67} \textit{Id.} § 405.1865.
\textsuperscript{68} The following statutory language also supports this view:
A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole.

42 U.S.C. § 1395oo(d).
sponses to issues raised by the Board during the course of witness examination and responses to requests for further documentation.\textsuperscript{69} Under new procedures instituted since 1992, parties also submit proposed findings of fact and conclusions of law to assist the Board in developing its opinion.\textsuperscript{70}

The Board weighs the position papers, transcripts, documentary evidence, and post-hearing submissions in a joint decision conference.\textsuperscript{71} This conference constitutes perhaps the most sensitive part of the decisionmaking process at the PRRB. Members air their evaluations of the evidence and law, attempting to develop a preferably unanimous decision. Unanimity is not always possible, of course, and dissenting members may prepare a separate opinion, which they hope may influence the reviewing court. Some concern has arisen about whether board members have been constrained not to issue dissents on some matters, particularly jurisdictional issues.\textsuperscript{72}

A critical task for the Board in its deliberations involves balancing the mission of providing fair and just settlement of payment issues with the need to comply with all provisions of the Medicare statutes, the implementing regulations, and HCFA rulings,\textsuperscript{73} which the Board has no authority to countermand. However, relatively few clear-cut regulatory or statutory issues come before the tribunal because straightforward legal problems are usually resolved in prior discussions with the intermediary. Providers that seek to challenge only the statute or regulation can bypass the PRRB and move directly to federal court for expedited judicial review.\textsuperscript{74} Most PRRB cases arise in the gray areas defined not by substantive rules duly promulgated and published but, instead, by interpretive rules set forth in the reimbursement manual.\textsuperscript{75} Often the Board's most challenging responsibility is determining when, where, and how to "afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by HCFA."\textsuperscript{76} This is especially true when the facts of a particular case suggest that applying the guidelines would result in gross inequity.

\textsuperscript{69} PRRB MANUAL, supra note 34, ¶¶ 7704B & C, 7717A; see 42 C.F.R. § 405.186.

\textsuperscript{70} PRRB MANUAL, supra note 34, ¶ 7704C.

\textsuperscript{71} Id. ¶ 7717E.

\textsuperscript{72} See supra note 17 (concerning interviews); see also Plaintiff's Motion for Summary Judgment with Respect to PRRB Non-Disclosure Policy, Methodist Hosps. of Memphis v. Sullivan, 799 F. Supp. 1210 (D.D.C. 1992) (C.A. No. 92-0009 JHP) (regarding Board's new policy of prohibiting publication of dissenting opinions with respect to expedited judicial review) (on file with author).

\textsuperscript{73} 42 C.F.R. § 405.1867; PRRB MANUAL, supra note 34, ¶ 7717F.

\textsuperscript{74} 42 U.S.C. § 1395oo(f)(1); PRRB MANUAL, supra note 34, ¶ 7719.

\textsuperscript{75} See generally PRRB MANUAL, supra note 34.

\textsuperscript{76} 42 C.F.R. § 405.1867.
The Board members inevitably broker agreements among themselves on the issue raised, including the rationale. The Board advisor, the paralegal specialist who is assigned to the case and sits in on the deliberations, uses the parties' proposed findings of fact and conclusions of law to assist in drafting an opinion that reflects the members' agreed positions. The draft opinion circulates to the Board for revision and editing. Because the decision is not final until issued, Board members may continue deliberations, informally negotiating or renegotiating the decision throughout the revision and editing period. Thus, because the period between the close of the hearing and the issuance of the final decision can be protracted, there is some concern about possible contamination of the sensitive deliberations through ex parte contacts. The Board's rules of procedure state that "all matters pertaining to the deliberative process taken by Board members and staff on an individual case, from the beginning of the process until the decision is issued, are confidential and must be treated as such." The mandate

77. One of the most controversial and sensitive issues in the decisionmaking process is the role of the Executive Director of the PRRB. Until the reorganization of April 1994, the Executive Director played no direct role in formulating Board decisions. See HCFA, Statement of Organization, Functions, and Delegations of Authority, 59 Fed. Reg. 14,628 (1994); Letter from Darrel J. Grinstead, Chief Counsel, Health Care Financing Division, HHS, to Michael Richards, Acting Chairman, PRRB (Aug. 10, 1994) (on file with author). After the reorganization, disputes arose about whether the Executive Director in fact had authority to sit in the conference room and participate in the Board's confidential deliberations. Id. at 1. Further disputes arose as to whether the Executive Director was appropriately supervising the paralegal assistants: Was the Executive Director's role to assure that the paralegal specialists' advice concerning Board cases and drafts of Board decisions conformed with HCFA policy—even if the Board did not concur in that policy?

Some of the strain inherent in the division of personnel between HCFA and the Board surfaced in the creation of the new Office of Hearings. This new arrangement fully places the PRRB staff under the direction of the Executive Director, rather than the Board members. Id. The response, as it has affected the handling of cases, is noteworthy. For a period of time, two Board members refused on principle to participate in hearings utilizing such staff. Furthermore, parties litigating before the PRRB have been asked to submit briefs "on the issue of who should control staff assigned to an independent fact finding tribunal." Request for Post-Hearing Submissions by Provider Reimbursement Review Board, Treasure Coast Rehabilitation Hospital, PRRB Case No. 91-1882 (on file with author). They have been asked further to research sub-issues of

1) agency interference with judicial independence in administrative proceedings;
2) agency control of staff assigned to administrative proceedings;
3) rules regarding confidentiality of decision prior to issuance; and
4) rules regarding confidentiality for staff assigned to decisionmakers.

Id. The outcome at the present time remains unclear. What does appear certain is that both justice and efficiency are under fire within this embattled tribunal.

78. PRRB Manual, supra note 34, ¶ 7709; see id. ¶ 7705D (prohibiting ex parte communications).
for confidentiality extends to "anyone, including, but not limited to, HCFA, intermediaries, providers or their representatives." Procedures exist for officially notifying HCFA when an administrative policy is at issue in a case. It is unclear, though, whether unofficial, informal contacts with HCFA concerning policy constitute ex parte contacts.

b. The Administrator's Review

The Board's decision is final as issued unless, within sixty days, the Secretary of HHS, acting through the Administrator of HCFA, elects to review it. The Administrator, acting through the Office of the Attorney Advisor, examines the Board's decision in conjunction with requests from either party or HCFA. The Administrator's power to review a decision on his or her own motion has come under fire by providers because of the broad, deeply discretionary bases for its exercise. The power of sua sponte review has also come under attack for undermining the PRRB process. As some attorneys have characterized it, "the fact that HCFA reviews all board decisions, and reverses many of them, diminishes the importance of the board and often makes arguing before it an exercise in futility." As calculated by Hospi-

79. Id. ¶ 7709.
80. 42 C.F.R. § 405.1863 ("Where a party to the Board hearing puts into issue an administrative policy which is interpretative of the law or regulations, the Board will promptly notify the Health Care Financing Administration."). The Board's manual provides that
[the Board is authorized to call as a witness any employee or officer of the Department having personal knowledge of the facts, and/or a designee of the Secretary as a consultant in a Board hearing (whether on its own motion, or at the request of a party) upon the Board's finding that the witness testimony will materially aid the resolution of the case. When a member of HCFA is requested to offer testimony, the Board advises HCFA of the request and the purpose of the testimony.
PRRB MANUAL, supra note 34, ¶ 7717C.
81. 42 C.F.R. § 405.1871(b). If the Administrator elects to exercise sua sponte review, a notice is sent to both parties and to the Board. PRRB MANUAL, supra note 34, ¶ 7724(C)(2). Within 15 days of receipt of that notice, a party or HCFA may submit to the Administrator proposed findings and conclusions, "supporting views or exceptions to the Board decision," and rebuttals. 42 C.F.R. § 405.1875(e), PRRB MANUAL, supra note 34, ¶ 7724(C)(3). The Administrator, through the attorney advisor, will consider the submissions in determining whether to affirm, reverse, modify, or remand the case. 42 C.F.R. § 405.1875(a)(2) & (g); PRRB MANUAL, supra note 34, ¶ 7724(C)(6). The Administrator's decision is due 60 days after the provider is notified of the Board's decision. 42 U.S.C. § 1395oo(f)(1) (1994); 42 C.F.R. § 405.1875(g)(2); PRRB MANUAL, supra note 34, ¶ 7724(C)(6).
82. 42 C.F.R. § 405.1875(a)(2); PRRB MANUAL, supra note 34, ¶ 7724(B).
83. Holthaus, supra note 40, at 40. The passage continues: "The reversals illustrate rather strongly the kangaroo court aspect of administrative review." Id. (quoting Ronald
tals magazine, about half of the PRRB decisions issued between 1975 and 1989 that favored the provider were reversed by the Administrator of HCFA. Many of those decisions involved the weighing of HCFA interpretive guidelines, where the Board decided against the intermediary. Yet, the Board’s decisions were usually upheld by the federal courts, which often used the PRRB decision as a virtual road map for their rulings. In time, HCFA chose to acquiesce on these issues, but the long history of reversals has left an undeniable residue of hard skepticism in the provider community.

Clearly, something more than a mere struggle for turf may be at stake. Fundamental questions about the proper allocation of policymaking authority are involved. Just as fundamental are concerns about the appropriate level of autonomy that any ostensibly independent review body within an agency can exercise.

HCFA can assert authority over the Board’s decision on any of several bases. If HCFA believes the Board made “an erroneous interpretation of law, regulation, or HCFA Ruling,” the attorney advisor will correct the PRRB interpretation to match HCFA’s. Similarly, the Administrator may review decisions where the “Board has incorrectly assumed or denied jurisdiction or extended its authority to a degree not provided for by statute, regulation or HCFA Ruling.” On a case-by-case basis, the Administrator can thereby maintain control of precedent. If the case “presents a significant policy issue having a basis in law and regulations,” HCFA may move more broadly and review the case with an eye to issuing a “HCFA Ruling or other directive” in order “to clarify a statutory or regulatory provision.”

The Administrator arguably can exert more subtle control over policy when he or she asserts review jurisdiction for reasons relating to the quality of the writing in the decision. The Administrator can assert jurisdiction because the Board’s decision requires “clarification, amplification, or an alternative legal basis for the decision.”

Sutter, Esq., a partner with law firm of Powers, Pyles & Sutter, Washington, D.C.).

84. Id.
85. For a more in-depth discussion of these issues, see infra Part II.
86. 42 C.F.R. § 405.1875(c)(1).
87. Id. § 405.1875(c)(4).
88. Id. § 405.1875(c)(3).
89. Id. § 405.1875(c)(5). The question of quality and clarity in Board decisions poses one of the most sensitive and elusive matters for consideration. Past and present critics of the Board in the federal courts, in the provider community, and within HCFA have raised concerns—sometimes oblique and sometimes pointed—about whether the Board has met the basic, objective standards of good legal writing. Of course, perceptive observers could validly dispute the very use of the word “objective.” If the Board seeks to challenge the underlying legal standard, breaking with HCFA over the applicability and meaning of par-
because the decision fails to identify facts in the record that meet the substantial evidence standard. The Administrator also reserves the right to review "for other reasons" when he or she "deems it fitting and proper." The Administrator's decision becomes the final agency determination.

c. Article III Court Review

A provider dissatisfied with the final agency decision, whether that of the PRRB or of the Administrator, can seek review in a federal district court. The provider must file an appeal within sixty days of receiving notice of the final agency decision. Significant questions can be raised about the propriety of bringing PRRB appeals in a district court rather than in a court of appeals. This additional and largely unnecessary layer of review adds to the cost and impracticality of the appeals process.

On appeal, the provider bears the burden of proof and of challenging the intermediary's action, as affirmed or modified by the PRRB or HCFA. Typically, the decision itself, as the product of a full, trial-type adjudication, is judged under the "substantial evidence" test of section 706(2)(E) of the APA. However, if the provider also has challenged the underlying HCFA

ticular regulatory interpretations, would HCFA not see the Board's decision as deficient? Who is to determine which of the Administrator's modifications of a Board decision were for purposes of clarity and which were for purposes of policy control?

As it stands now, the Executive Director of the PRRB, who answers directly to the Administrator of HCFA (not to the Chairman of the PRRB nor to the other members), is the enforcer of quality standards for Board decisions before such decisions leave the tribunal. Memorandum from Bruce V. Vladeck, Administrator, HCFA, to Executive Director, PRRB, and Appeals Staff, Subject: Delegation of Administrative Authority (Apr. 11, 1994) [hereinafter HCFA Administrator's Memorandum] (on file with author). Because the decisionmaking process is protected and confidential, it is not possible for outsiders to evaluate the manner in which this function is carried out. PRRB MANUAL, supra note 34, ¶ 7709. On the other hand, a close examination of the Administrator's reversals of PRRB decisions before and after the April 1994 reorganization might suggest whether quality control based on "objective" standards has indeed improved the Board's output and decreased reversals.

90. 42 U.S.C. §§ 1395oo(d) & (f) (1994); see discussion of standard infra note 95.
91. PRRB MANUAL, supra note 34, ¶ 7724(B)(6).
92. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1877.
93. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1877(a).
95. 5 U.S.C. § 706(2)(E) (1994). The enabling legislation at 42 U.S.C. § 1395oo(f) provides that the federal courts are to review PRRB actions under the Administrative Pro-
payment policy, the regulation or manual provision would be reviewed under the "arbitrary and capricious" test of section 706(2)(A). 96

B. PRRB Operations and HCFA

The relationship between the PRRB and HCFA has been strained almost since its inception in 1974. Although Congress established the PRRB as an ostensibly independent administrative tribunal, that independence has limits. The PRRB does not have authority to exercise absolute discretion in an adjudication before it; rather, it acts as the delegate of the Secretary of HHS when it performs a review. 97 In theory, the perceived tension between the PRRB and HCFA has no basis for existing, since both serve as delegates of the Secretary and both seek the goal of fair and efficient administration of the Medicare program. However, a very real sense of skepticism and inter-

cedure Act. Although subsection (d) requires that the Board decision be supported by "substantial evidence when the record is viewed as a whole," id. § 1395oo(d), Congress did not specify in subsection (f) on judicial review nor in committee reports precisely which subsection of 5 U.S.C. § 706(2) would apply. Absolute certainty about the standard of review is difficult to attain; some variation exists in how courts have applied the standard of review. Some have limited this APA provision to subsection A, which requires that the decision be reviewed to determine whether it was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Do courts that take this approach base their choice on the fact that the PRRB hearing is not presided over by an ALJ? Is this the necessary step to trigger the more rigorous standard of review set forth in § 706(2)(E)—that the decision must be supported by "substantial evidence"? Or, do they base their standard of review upon the need to interpret regulations? Or, do they base their choice more upon the Secretary's adoption of the PRRB's decision than on the PRRB's decision itself? See University of Cincinnati v. Bowen, 875 F.2d 1207 (6th Cir. 1989) (discussing whether Secretary's and PRRB's actions were arbitrary and capricious in denying cost of stipends and related overhead for medical residents working at hospital's outpatient clinics).

Unfortunately, the author's review of decades of federal court decisions reviewing PRRB decisions discovered no courts that have precisely explained the choice of standard. Other courts interpret the enabling legislation's injunction somewhat more broadly and employ not only APA § 706(2)(A) (the "arbitrary and capricious" standard) but also the standards in subsections B ("contrary to constitutional right") and E ("unsupported by substantial evidence"). See National Med. Enters., Inc. v. Shalala, 826 F. Supp. 558 (D.D.C. 1993) (questioning sufficiency of evidence to support reclassification of intravenous therapy administered to Medicare beneficiaries on per diem basis).

96. 5 U.S.C. § 706(2)(A). Courts reviewing regulatory policy will also stress that much deference is due the Secretary's interpretation, generally as expressed through the HCFA Administrator. See Sacred Heart Med. Ctr. v. Sullivan, 958 F.2d 537 (3d Cir. 1992) (reviewing HCFA's interpretation that certain provisions of prior reimbursement law, which would have been favorable to provider, had implicitly been superseded by PPS).

97. 42 U.S.C. § 1395oo(f) & (h).
agency rivalry has developed between the PRRB and HCFA. What is the
source of this underlying conflict? On the one hand, the Secretary appoints
the Board members and swears them to an oath of fairness and independent
judgment according to the laws, regulations, and rulings of the Medicare
program.98 On the other hand, the staff and all administrative support for
the Board are supplied by HCFA, which is the real party in interest in all
PRRB cases because HCFA is charged with administering the fund for
Medicare Part A provider reimbursements. Thus, the Board members and
staff may pull in opposite directions. Despite efforts to mollify critics and
dispel notions that strains between HCFA and the PRRB have impaired the
adjudicatory process, the tension remains.

The strain between the PRRB and HCFA has surfaced in two significant
documents: a report by the General Accounting Office (GAO)99 and
HCFA’s reorganization plan for the PRRB.100 The report by the GAO
culminated in an investigation of whether HCFA exercised real political and
bureaucratic control over the PRRB by purposefully limiting staff and
budgetary support, thus resulting in a severe decline in case output in the
late 1980s. Subsequent to that report, the Chairman of the PRRB, with the
assistance of the Executive Director, streamlined the appeals process and
built up the legal staff to handle the increasingly complex cases that were
being appealed to the Board. Some people argue that the issues raised in the
GAO report have largely been superseded by these internal changes.101 Oth-
ers, however, argue that the problems presented in that report are not moot
and that its recommendations should at least be considered for implementa-
tion.102

The second document, the April 1994 reorganization plan for the
PRRB,103 was initiated by the HCFA Administrator. This reorganization
substantially realigned the flow of power and authority within the PRRB,
giving practical and political control over the Board—both staff and Board
members—to a civil service employee designated by HCFA.104 The reor-
ganization regenerated debates concerning the appropriate division of res-
sponsibilities and loyalties between the PRRB and HCFA. In particular,

98.  Id. § 1395oo(h).
99.  GAO REPORT, supra note 14, ¶ 38,492.
100.  Health Care Financing Admin., Statement of Organizations, Functions, and Dele-
gations of Authority's Substructure Reorganization of the Health Care Financing Admin-
101.  See supra note 17 (concerning interviews).
102.  Id.
103.  Reorganization Statement, supra note 100.
104.  HCFA Administrator’s Memorandum, supra note 89, at 1.
this change has raised a great deal of concern in the provider community.105

1. The GAO’s Findings Regarding the HCFA/PRRB Relationship and Efficiency

In 1990, the GAO completed an investigation of the PRRB and HCFA and issued a report that focused specifically on staffing, organization, and the impact of these two factors on the efficiency of appeals processing.106

105. See supra note 17 (concerning interviews). Recent changes within HHS have highlighted the timeliness of reconsidering the existence and configuration of the PRRB. PRRB facilities have now moved to the main HCFA campus, breaking a tradition of physical separation that had existed from the Board’s inception. To many, that physical separation served as more than a mere matter of logistics; it indicated the intellectual and operational independence of the Board. Other alterations are seemingly small but, to some, are outward evidence of a profound inner change. Some of the PRRB’s letterhead has changed to show HCFA at the top, in large type, superior to that of the PRRB itself. In addition, the PRRB’s hearing procedures manual has been eliminated as a separate publication and now is contained as simply another part of the Provider Reimbursement Manual prepared by HCFA. See generally PRRB Manual, supra note 34. Although this change was effected ostensibly as a money-saving effort, the change also removes from the PRRB control over amendments to its own procedures. Taken alone, any one of these changes might not have raised much notice. However, taken in conjunction with the April 1994 reorganization, they generate a picture of greatly increased HCFA control over an operation that had touted its independence.

These changes come at a time when all of HHS is undergoing a reconsideration of functions. The largest change, of course, is the reengineering of the Social Security Administration. See generally Social Security Admin., HHS, Disability Process Redesign: The Proposal from the SSA Disability Process Reengineering Team (1994); Judicial Conference, Disability Process Redesign: Defining a New Role for the Appeals Council (1995); Social Security Admin., HHS, Transfer of Review Responsibility for Medicare Cases: From the Associate Commissioner’s Desk 4 (1995). This redesign should have a great impact on the future of PRRB appeals because the Social Security Administration’s Medicare ALJs have now been consolidated within the Departmental Appeals Board (DAB) of HHS. Rationalizing all Medicare appeals within the DAB—for both providers and beneficiaries under Parts A and B—would further contribute to efficient use of resources. Review of Medicare appeals would be centered in the tribunal that has carried the primary responsibility for promoting mediation and negotiated settlement within the department. The DAB’s long history of quality decisionmaking, even about complex scientific and financial matters, and its customer-oriented mode of providing resolution services contrast sharply with the concerns voiced over the years about the PRRB. See, e.g., Richard B. Cappell, Model for Case Management: The Grant Appeals Board (1986); Recommendation 86-7: Case Management as a Tool for Improving Agency Adjudication, 1986 ACUS 30. Much of that difference in perceived effectiveness is due to the lack of clarity about the PRRB’s fundamental role and function within HHS.

106. See generally GAO Report, supra note 14. The GAO reviewed the legal and organizational relationship between HCFA and the PRRB. It analyzed the authorized and
The GAO report responded to a June 1988 directive by the House Committee on Appropriations to study the roles of the PRRB and HCFA in providing staff and technical support to the Board for the “potential appearance of a conflict of interest.” Because the term “conflict of interest” does not appropriately apply to agencies (as opposed to individuals), the GAO redefined its task as seeking “to determine whether HCFA impaired PRRB’s effectiveness in processing cases by limiting its staff allocations.”

The GAO first studied the statutory basis for the allocation of duties and responsibilities between the PRRB and HCFA. The PRRB’s enabling legislation provides that “the Secretary of HHS make available the technical, secretarial, and other support the Board may require” to fulfill its responsibility of serving as an administrative appeals forum for providers. While the Secretary retains authority to appoint Board members, the Secretary has delegated responsibilities for supporting the Board to the HCFA Administrator. Moreover, “[t]he annual HHS budget appropriation request does not identify PRRB’s staff and monetary needs separately but incorporates them with the HCFA’s.”

At the time of the GAO study, the organizational composition of the Board, as diagrammed by the GAO, clearly showed the Executive Director overseeing the two branches of PRRB staff operations: jurisdiction and case management on the one hand and hearings and decisions on the other. The Executive Director reported directly to the Chairman, and the Board was on a parallel with the Chairman, although not directly supervising the Executive Director.

The GAO found that the PRRB and HCFA were functioning “in a manner consistent with their legislatively prescribed roles.” The investigators found no evidence that the Secretary had relinquished his responsibility for “insuring that HCFA performs its delegated responsibilities in accordance with applicable law and regulations.” Although the GAO acknowledged that it would be possible for HCFA to impair the PRRB’s operations by

actual staffing levels and processing of cases as of February 1989. GAO investigators interviewed PRRB staff and Board members and discussed with HCFA officials “the rationale for PRRB’s current staff levels.” Id. at 22,786.

107. Id. at 22,786.
108. Id.
110. GAO REPORT, supra note 14, at 22,789.
111. Id.
112. Id.
113. Id. at 22,799.
114. Id.
115. Id. at 22,791.
116. GAO REPORT, supra note 14, at 22,791.
limiting staff, the investigation found "no evidence that HCFA had acted
deliberately" to do so.\textsuperscript{117}

The GAO anticipated that the provider community and some Board mem-
bers might criticize its findings. The wary, oftentimes antagonistic tenor of
the relationship between HCFA and the PRRB may have revealed itself
during the GAO's interviews with staff, Board members, and HCFA offi-
cials. Attempting to cut through the miasma of distrust, the GAO investiga-
tors unequivocally stated: "HCFA has no direct monetary stake in the out-
come of the Board's cases. If the PRRB rules that a provider is due
additional reimbursement, the money comes from the Federal Hospital
Insurance Fund—not HCFA-appropriated funds."\textsuperscript{118}

The report further underscored the principle that has both guided and
dogged academicians and officials in analyzing the appropriate nature of a
so-called independent adjudicatory forum: "While PRRB reaches its deci-
sions independently, it functions as part of the administrative process within
HHS, as does HCFA, for resolving provider disputes."\textsuperscript{119} Thus, the investi-
gators found little rational basis for the claims that HCFA had intentionally
sought to choke off the PRRB's independence, and indeed they questioned
the limits of that vaunted independence.\textsuperscript{120}

The GAO did find that, in the late 1980s, the PRRB and HCFA needed to
establish an accurate case inventory, which would separate the active cases
from the suspected large number of inactive cases.\textsuperscript{121} Without an inventory
that distinguished active from inactive cases, the GAO cautioned, it would
remain difficult for the PRRB and HCFA to determine "the proper number
of staff necessary to effectively operate the Board."\textsuperscript{122} Further, the report
noted that the House Committee on Appropriations, which had requested the
investigation, "does not receive routinely the information needed to monitor
the resources provided PRRB."\textsuperscript{123} This is because HHS's budget appro-
priations request does not separately identify the PRRB's monetary needs.\textsuperscript{124}

\textsuperscript{117} Id. The GAO did acknowledge that HCFA had denied requests for additional
staff on the basis of agency-wide reductions: "HCFA officials indicated that most compo-
nents, including PRRB, had experienced decreases in their staffing levels" for fiscal year
1988, and most components "have been forced to do more with less." Id. HCFA did not
increase staff for the PRRB but did increase contract support, which the PRRB largely
applied to computerize its data processing. Id.
\textsuperscript{118} Id. at 22,792.
\textsuperscript{119} Id.
\textsuperscript{120} Id.
\textsuperscript{121} Id. at 22,793.
\textsuperscript{122} GAO Report, supra note 14, at 22,798.
\textsuperscript{123} Id.
\textsuperscript{124} Id.
By the time the draft GAO report was distributed for comment, HCFA had already worked with the PRRB to implement a number of changes initiated by then-PRRB Chairman Elise E. Smith and the first Executive Director of the PRRB, Lester Cohen. HCFA believed these modifications in PRRB procedures and staffing had rendered much of the GAO findings moot. Among other changes, the PRRB’s appellate process was restructured to give providers and intermediaries more responsibility for determining jurisdiction and preparing cases for hearing. The chief purpose of the PRRB changes in procedures was “to establish an environment where the parties will meet and seriously attempt to resolve their dispute before position papers are developed and hearings scheduled.” The Board also obtained authorization and funds to hire more lawyers or legally trained analysts, and it hired a contractor to enter and update cases in its automated data system.

In response to a draft of the GAO Report, HHS asked Congress to increase the Board membership to six, which would allow it to hear cases in two panels of three members each. Beyond that, the department took the position that, by instituting the Chairman’s changes, the two entities were already cooperating to achieve the mutual goal: timeliness and fairness for providers seeking full hearings of their disputes with HCFA. Although the “[r]esponse from the intermediary and provider communities [was] extremely positive,” HCFA and the PRRB noted that only after the system had operated for a period of time would one be able to assess its effectiveness in reducing case backlog and increasing decision output.

Both the GAO report and the comments of HHS failed to address squarely the nature of the cases the PRRB hears and how those cases have evolved over time. The simpler issues that predominated in cases appealed during the early years of the Board’s existence and that were often decided in bulk through group appeals no longer inflate the Board’s statistics on output. Instead, the Board now faces intricate, time-consuming individual cases presenting increasingly complex matters of law, accounting, and

125. *Id.* at 22,799.
126. *Id.*
128. GAO REPORT, supra note 14, at 22,799.
129. HHS Comments, supra note 127, at 22,805.
130. *Id.*
131. *Id.*
132. For a more detailed discussion of this issue, see *infra* Part II.B.
fiscal responsibility. These cases can be especially challenging when few hard and fast guides for adjudication exist—that is, when the Board must decide in a gray area of interpretive rules, not substantive regulations.

2. The April 1994 Reorganization

Current apprehension about the provider appeal process—its slowness and lingering questions about inappropriate influence by HCFA—may have their roots in how PRRB operations are organized, with Board members appointed by the Secretary and support staff allocated by HCFA. This alone might generate a struggle for control between the Board and the staff—a fairly common situation among government agencies headed by political appointees directing civil servants. In April 1994, however, the inherent, usually inchoate, tension increased when HCFA instituted a reorganization of PRRB operations. The reorganization placed the second Executive Director of the PRRB under the direct control of the Administrator of HCFA, instead of the Chairman of the PRRB. The reorganization also gave the new Executive Director administrative authority over disciplinary, adverse, and unacceptable performance actions, leave and overtime, performance management, work schedules, and budget allocations, but it did not grant the authority to appoint and dismiss Board members. The Executive Director’s job description was also revised to provide that the Executive Director

[attends PRRB/MGCRB Board meetings and hearings and serves as a source of background data on the basis of research performed in preparation for the meetings and conferences. Approves agendas for each meeting/hearing and arranges for presence of high-level technical staff to support the PRRB/MGCRB Chairpersons when required. Participates in, and makes substantive contributions to top-level discussions and planning sessions on health care coverage, delivery, eligibility, and payment.]

In addition, the Executive Director must keep the Secretary and HCFA “informed of the PRRB/MGCRB’s needs and activities and any unusual circumstances encountered that might affect the quality and efficiency of the Board’s decision making processes.” In carrying out his responsibilities, the Executive Director is authorized to undertake “highly complex and sen-

133. See generally Reorganization Statement, supra note 100.
134. Letter from Steven A. Pelovitz, Associate Administrator, HCFA, to Carolyn Parmer, Chapter President, HealthCare Financial Management Association (undated) (on file with author) (describing responsibilities of PRRB Executive Director in attachment).
135. HCFA Administrator’s Memorandum, supra note 89, at 1.
136. Id.; see also infra text accompanying note 378 (discussing MGCRB).
137. Letter from Pelovitz, supra note 134 (attachment).
sitive assignments” for the Administrator, HCFA, and the PRRB and MGCRRB chairpersons. More typically, the Executive Director on a day-to-day basis assures that the staff has completed its work, by “developing assignments, establishing priorities, timetables, and standards and guides, and reviewing completed assignments.”

Some members of the health care provider community have complained, both formally and informally, that this reorganization relegates Board members to mere figureheads and puts real control over PRRB operations in the hands of HCFA, via the Executive Director. The reorganization seems to contradict a 1974 memorandum opinion of the Office of the General Counsel of the Department of Health, Education, and Welfare (HEW) regarding the proper relationship between the PRRB’s staff and HCFA’s predecessor, the Bureau of Health Insurance. In the early 1970s, when HEW was establishing the PRRB, an organizational composition similar to the 1994 arrangement had been proposed. The BHI’s support staff would have served the PRRB under the direction of a BHI “liaison officer.” The Board would have had “no direct access to ‘its’ staff except through the BHI liaison officer.” Responding forcefully at that time, the Office of the General Counsel stated that

[t]he opportunities for BHI influence over the deliberations and decisions of the Board under the proposed arrangement are obvious. In spite of the proposal’s stated good intentions as to respecting the Board’s independence, the appearances of agency domination are unmistakable. These appearances are a plain invitation to providers to litigate adverse Board decisions on due process grounds, and for the courts to find jurisdiction to review such allegations . . . .

Twenty years later, when HCFA instituted the arrangement largely unaltered from the original proposal, providers indeed challenged the involve-

138. Id.
139. Id.
140. See, e.g., letter from Carolyn Parmer, Chapter President, HealthCare Financial Management Association, to Donna E. Shalala, Secretary of HHS (May 23, 1994); letter from Jack Martin, Chairman, PRRB, HHS, to Donna E. Shalala, Secretary of HHS (reference to Board hearing on Apr. 26, 1994) (on file with author).
142. Id. at 1.
143. Id. at 2.
144. Id. at 2-3.
145. The 1974 proposal was not blind to considerations of due process and independence. Rather, it identified (building on language in the enabling legislation) a difference between the Secretary’s obligation to provide administrative support staff for the Board.
ment of the Board’s technical staff because after the reorganization, the work of these paralegal specialists—which includes delineating legal issues, analyzing opposing positions, describing the procedural and jurisdictional history of the case, suggesting evidence or testimony to be developed at the Board hearing, participating in the Board decision conference, and drafting the Board decision—was subject to direct control by HCFA, not the Board. In addition, the new position description of the Executive Director includes taking part in PRRB deliberations as an agent of the HCFA Administrator. 146 Lastly, there was concern that, in the name of quality control, the Executive Director might replace neutral standards for work evaluations with standards more favorable to HCFA. 147 Also, the Executive Director might revise staff work, such as draft decisions, to accord with HCFA’s interpretive guidelines, despite a Board determination to the contrary. Less crassly, providers were apprehensive that performance evaluations by the Executive Director might be based largely upon compliance with HCFA policies, whether binding or not. 148 Even more subtly—yet perhaps more realistically—providers were concerned that the reorganization would erode the intellectual separation of functions between HCFA, as investigator/advocate, and the PRRB, as independent adjudicator, to the point where the staff of the PRRB would perceive themselves as part of HCFA. 149 This was precisely what the Office of the General Counsel had inveighed against in 1974. 150

and the Secretary’s obligation to provide technical support staff for the Board. 42 U.S.C. § 1395oo(i) (1994). The proposed demarcation between the two is murky, although apparently the technical support staff would have provided health insurance and cost accounting expertise. In the proposal that the Office of the General Counsel countermanded, the BHI had stated that “we do not see an ‘independent’ support staff as an indispensable element in the Board’s operation. So long as the support staff is under the direct control of and fully accountable to the Board, basic principles of due process should be met.” Letter from Gaines, supra note 141, at 2. That conceded independence, however, appeared to be limited to administrative staff. Technical staff, under the 1974 proposal, were to come from the BHI. Notwithstanding this concession to Board control, the 1974 proposal sought to “combine the administrative support staff and technical support staff . . . not under the Board, but within the Bureau of Health Insurance,” and the Board would have only indirect access to the combined staff “through the BHI liaison officer.” Id.

146. Letter from Pelovitz, supra note 134 (attachment).
147. See supra note 17 (concerning interviews).
148. Id.
149. Id.
150. The Office of the General Counsel wrote that
[one of the main reasons for the creation of the Board was to answer the complaint voiced by providers that they were . . . unable to obtain an objective review of the issues by the intermediary . . . .] If the support staff is separate and apart from [the Social Security Administration] and, therefore, only responsible to the Board, providers should be much less inclined to raise due process challenges. . . . In consid-
Jack Martin, Chairman of the PRRB at the time of the reorganization, requested that HHS Secretary Donna E. Shalala obtain a new opinion from the Office of the General Counsel to advise the Board about how to handle situations where provider attorneys formally objected to the Board’s technical advisor “having any involvement in the deliberation or processing” of the case and cited the reorganization as the basis for the objection. While the Administrator and counsel to HCFA have attempted to allay such fears with detailed letters responding to the concerns raised, the providers’ wariness remains. This is not surprising, given the relatively long history of uneasy relations between the provider community, HCFA, and the PRRB.

3. The PRRB Caseload and Staff Productivity

The trends causing greatest concern are the substantial increases in appeals filed and the increasing number of cases in inventory (the backlog). The average number of appeals filed annually from 1975 to 1990 was 1,523. The number of appeals filed annually peaked in fiscal year (FY)

Letter from Gaines, supra note 141, at 2-7.
151. Letter from Martin, supra note 140; see letter from Parmer, supra note 140; letter from Mary Susan Philp, law firm of Powers, Pyles, Suter & Verville, P.C., to Acting Chairman, PRRB (June 23, 1994) (on file with author).
153. See supra note 17 (concerning interviews).
154. Due to a severe computer failure in the fall of 1993, the last year of reliable statistics on PRRB workload available as of this writing are for fiscal years 1975 through 1993. Statistics for fiscal year (FY) 1994 are estimated based on the last ten months of FY 1993.
155. PRRB WORKLOAD STATISTICS, supra note 13.
1991, when 3,062 cases were filed, more than double the previous 15-year average.\textsuperscript{156} Since then, the number of appeals filed seems to have leveled out, at roughly 2,240 to 2,500 per year.\textsuperscript{157}

The increase in filings exacerbated an existing backlog of cases, which averaged 3,831 per year from FY 1975 through FY 1990.\textsuperscript{158} By 1990, the backlog had grown to 6,000 cases.\textsuperscript{159} It rose to nearly 7,000 cases in FY 1991, decreased slightly for a few years to around 6,750,\textsuperscript{160} but then rose to 9,100 cases.\textsuperscript{161}

One of the critical areas of concern for the PRRB and HCFA, which was identified by the GAO, is the lack of information about what constitutes this backlog. There are no firm data on which cases in inventory are active and which have little, if any, likelihood of being pursued. Board members and the current Executive Director believe that many of the cases have been filed merely to preserve appeal rights, which the provider does not intend to exhaust.\textsuperscript{162} Instead, the provider may expect to dispose of the matter through settlement negotiations with the intermediary. Meanwhile, the appeal remains in stasis as part of a case backlog.\textsuperscript{163}

If, however, a substantial portion of the inventory consists of real cases, it will take several years to work through the backlog, despite recent improvements in productivity. From 1975 to 1990, the number of decisions and dismissals averaged 967 per year, but in the 1990s the average has more than doubled, despite a twenty percent decrease in allotted staff hours.\textsuperscript{164}

Some of the improvement reflected in these statistics apparently derives from the streamlined appeals processes that Chairman Smith initiated in 1988.\textsuperscript{165} While those procedural changes began to remove from the PRRB’s inventory those cases that were not actively being pursued,\textsuperscript{166} the streamlin-

\textsuperscript{156} \textit{Id.}
\textsuperscript{157} \textit{Id.}
\textsuperscript{158} \textit{Id.}
\textsuperscript{159} \textit{Id.}
\textsuperscript{160} \textit{Id.}
\textsuperscript{161} Letter from Streimer, \textit{supra} note 15, at 1.
\textsuperscript{162} \textit{See supra} note 17 (concerning interviews).
\textsuperscript{163} According to PRRB statistics developed on December 1, 1993, PRRB “aged appeals” dating from before 1991 constitute 17\% of the inventory; those received in FY 1991 constitute 22\%; appeals received in FY 1992 constitute 27\%, and appeals received in FY 1993 constitute 29\%. \textit{PPRB WORKLOAD STATISTICS, supra} note 13 (figure titled “PPRB Aged Appeals”).
\textsuperscript{164} \textit{Id.} (figures titled “PPRB Workload Statistics: FY75-90 (Avg) Through FY94” and “Staff Productivity—FY84-FY94 (Est)”).
\textsuperscript{165} \textit{See supra} text accompanying notes 125-28 (describing streamlining).
\textsuperscript{166} As HCFA noted in its response to the GAO investigation, in FY 1989 “overall productivity increased significantly over the previous year,” with 75 decisions being issued.
ing proved insufficient to meet the sharp increase in filings. Thus, the backlog has remained three times larger than the numbers of cases filed and disposed of each year.\textsuperscript{167}

It is also possible that the new appeals procedures for docketing cases could slow down the process. The very fact that the provider receives an initial hearing date four years in the future suggests a war of attrition: The protracted delay discourages providers from pursuing valid claims against the government. The long waiting period could easily be perceived as a means of rationing justice.

A crucial problem in achieving both efficiency and fairness in adjudications at the PRRB was highlighted in the comments of HHS to the GAO report: The Board is trying to improve the efficiency of a process over which it has only limited control.\textsuperscript{168} Although the Board may schedule a large number of cases for hearing, often the providers and intermediaries settle the matter at the last minute, after the docket has been set. For example, in FY 1989, of 114 hearings docketed, forty-five percent of those scheduled for a live hearing were canceled, usually “on the eve of the scheduled hearing.”\textsuperscript{169} Last-minute cancellations do not give the Board sufficient time to reschedule other cases. Thus, the Board has advocated increasing the number of Board members to six, hearing cases in panels of three, and double-scheduling hearings.\textsuperscript{170}

According to HHS, the reason for so many last-minute resolutions is that “providers and intermediaries rarely seriously attempt to settle a case until after it has been scheduled by the Board,”\textsuperscript{171} perhaps because of their own workload problems. Notwithstanding their reasons, the fact that providers have not engaged in structured negotiations toward settlement has seriously undermined the Board’s ability to reach maximum productivity.\textsuperscript{172}

In 1992, the Board began a pilot project to promote negotiated settlements

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\item and 76 hearings and 132 conferences being held. \textit{HHS Comments, supra} note 127, at 22,805. These represented increases of 87%, 41%, and 21%, respectively, compared to FY 1988. The Board at that time determined that with five members it was capable of hearing annually a maximum of 123 cases live or on the record, given the available days and the average length of hearings and conferences. \textit{Id.} Since 1989, the Board has approached ever closer to that maximum. For example, in FY 1993 it held 97 hearings and issued 105 decisions. \textit{PRRB Workload Statistics, supra} note 13 (figure titled “PRRB Hearings and Decisions—FY 1993 vs. FY 1994”).
\item \textit{PRRB Workload Statistics, supra} note 13 (figure titled “PRRB Workload Statistics: FY75-90 (Avg) Through FY94”).
\item \textit{HHS Comments, supra} note 127, at 22,805.
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\end{itemize}
through the use of alternative dispute resolution.\textsuperscript{173} Unfortunately, the ADR effort failed from the start, apparently because of the distrust between providers and intermediaries, who could not reach agreement on how to select and pay for the services of a neutral mediator.\textsuperscript{174} Thus, settlement efforts remain a matter of persuasion rather than process,\textsuperscript{175} and the backlog remains undiminished.

The continuing and increasing backlog is considered by some to be sufficient justification for the PRRB’s existence. This rationale must not be accepted, however. If traditional adjudicatory mechanisms have proven ineffective for dealing efficiently with the cases under the PRRB’s jurisdiction, then alternative processes must be developed.

II. THE LEGAL FRAMEWORK FOR ANALYSIS OF PRRB OPERATIONS

A. The Board’s Context:

Sui Generis in the Federal Administrative Judiciary

The PRRB appears to be unique in the federal administrative judiciary in several respects. While it shares certain features with other federal administrative tribunals,\textsuperscript{176} the PRRB stands alone in terms of the appointment of adjudicators and the relationship between the Board and the staff.

1. Appointment of Members and Responsibilities

The Secretary of HHS appoints the members of the PRRB.\textsuperscript{177} This distinguishes PRRB members from members of other panels, such as the Occupational Safety and Health Review Commission (OSHRC) or the federal Mine Safety and Health Review Commission (MSHRC), who are appointed


\textsuperscript{174} See supra note 17 (concerning interviews).

\textsuperscript{175} HHS’s Departmental Appeals Board may be able to offer substantial assistance in turning the rhetoric of ADR into reality. The DAB has a long and successful history of facilitating dispute resolution processes within HHS. The DAB has implemented an office-wide policy and practice of orienting itself to serve consumers’ needs by making its procedures as responsive to the public as possible. These attitudinal differences may hold the key to the successful development of a negotiated settlement program to handle those disputes traditionally adjudicated before the PRRB. See discussion infra Part III.G.

\textsuperscript{176} To obtain a sense of how the PRRB fits within the context of other federal adjudicatory bodies, consider its structure in light of the 1992 study on the federal judiciary, prepared by Paul Verkuil, Daniel Gifford, Charles Koch, Richard Pierce, and Jeffrey Lubbers for ACUS. Verkuil, supra note 28, at 771.

\textsuperscript{177} 42 U.S.C. § 1395oo(h) (1994).
by the President with the advice and consent of the Senate. The five-member PRRB and MSHRC bodies are authorized to hear cases in panels, unlike OSHRC, which has only three members.

Like OSHRC and MSHRC members, PRRB members serve set terms fixed by statute: OSHRC and MSHRC members serve for six years, while PRRB members serve three years. PRRB members can be removed "by the Secretary . . . for cause," the meaning of which is unclear, whereas the enabling acts of OSHRC and MSHRC specify that cause for removal "by the President" includes "inefficiency, neglect of duty, or malfeasance in office." What could constitute cause for removal from the Board has become a more sensitive issue since the April 1994 reorganization, which gave the Executive Director, who now answers to the HCFA Administrator, authority to reprimand but not to remove Board members. The concern is that an Executive Director might evaluate the Board members' performance according to their compliance with HCFA policy and thus unduly influence their decisions, even though they are supposed to be able to exercise independent, neutral judgment. These concerns, however, are based on assumptions that have yet to materialize. Nevertheless, they evidence an uneasiness about the proper degree of independence of PRRB members—an uneasiness that sounds familiar to scholars of OSHRC and MSHRC.

178. 29 U.S.C. § 661 (1994); 30 U.S.C. § 823 (1994). Although the PRRB has no apparent analog in the federal administrative judiciary, OSHRC and MSHRC seem the most similar.


180. 29 U.S.C. § 661. One could also attempt to draw a comparison with the Board of Veterans' Appeals (BVA), where the Chairman is appointed by the President and other members are appointed by the Secretary of Veterans Affairs. However, the other appointments are based upon the Chairman's recommendations. Review of the members' performance is provided for by statute and is conducted by the Chairman and two other members of the BVA. 38 U.S.C.A. § 7101A (West Supp. 1995).


182. 42 U.S.C. § 1395oo(h).

183. "Id.


185. See discussion supra Part I.B.2.

Also like OSHRC and MSHRC, the PRRB bears the responsibility of performing a neutral, third-party review of the facts concerning agency decisions. However, OSHRC and MSHRC enjoy the benefit of enabling legislation that clearly places upon their respective chairmen the responsibility for “the administrative operations” of the tribunal and for appointing “such administrative law judges and other employees as [the chairmen] deem[] necessary to assist in the performance” of the tribunals’ functions. 187 Furthermore, the chairmen also have authority “to fix compensation” for ALJs and employees of OSHRC and MSHRC “in accordance with” federal statutory requirements for classification and general pay rates. 188 With these two key features of control, Congress created for the chairmen of OSHRC and MSHRC islands of autonomy that are separate from the regulatory agencies they review yet still within the larger structure of the Department of Labor.

By contrast, the PRRB Chairman’s authority does not derive from specific language in a statute or regulation. Instead, he or she has such authority as fellow Board members delegate. The enabling legislation is silent on the Chairman’s role; the regulations merely state that “one member of the Board shall be designated as Chairman thereof and shall coordinate and direct the administrative activities of the Board, and shall have such other authority which may be granted to him by the Board.” 189 The curiously laconic legislation raises a further issue concerning authority, which the other tribunals have avoided. While OSHRC and MSHRC have indisputable statutory authority over their own staff and operations, the PRRB’s authority is not so clear-cut. The statute authorizes the Board “to engage such technical assistance as may be required to carry out its functions.” 190 The statute then requires the Secretary—without specifying the Bureau of Health Insurance or its successor, HCFA—to “make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.” 191 Yet, the authority for the Board fully to oversee its

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188. 29 U.S.C. § 661(e); 30 U.S.C. § 823(b)(2).
189. 42 C.F.R. § 405.1845(c) (1996).
191. Id.
staff and operations lacks the strong congressional imprint enjoyed by the other tribunals. Thus, over the years, HCFA and the PRRB have engaged in an almost cyclical struggle to determine the degree and nature of authority over the tribunal’s actual work.

2. The Split-Enforcement Model

The PRRB resembles OSHRC and MSHRC in that the PRRB does not, itself, promulgate the substantive or interpretive regulations that it reviews. Instead, HCFA develops the payment policies that the PRRB reviews as applied in actual cases. Thus, OSHRC, MSHRC, and the PRRB employ a “split-enforcement” model of regulation as their adjudicatory functions and regulatory and enforcement functions are relegated to separate, independent offices. From time to time, members of each of the three tribunals have voiced concern about the appropriate degree of independence that should be accorded the tribunals. In 1986, the Administrative Conference of the United States (ACUS) examined OSHRC and MSHRC and found that the split-enforcement model failed to perform well due to certain factors, some of which also exist in the ambiguous relationship between the PRRB and HCFA. A lack of coordination of the policies of the Occupational Safety and Health Administration (OSHA, the rulemaking body) and OSHRC (the adjudicatory body) led to frequent litigation between the agencies. Granted, one might question the degree to which coordination was possible without compromising the integrity of the quasi-judicial function. Nevertheless, ACUS cautioned that certain fundamental decisions needed to be reached concerning the division of authority and responsibility between the two agencies for them to function efficiently.

192. See Johnson, supra note 186 (explaining split-enforcement model).
193. See generally id.
195. Id. at 19.
196. Id. While strains between the PRRB and HCFA have not yet erupted into the type of cases described by Johnson, supra note 186, the seeds of such strains are present. Johnson described frequently flaring “turf” conflicts between OSHA and OSHRC concerning proper interpretation, which have required resolution by the U.S. Courts of Appeals. Id. at 325. Most, but not all, circuits reviewing the conflicts have determined that Congress did not intend for OSHRC to exercise broad policymaking powers. See Donovan v. A. Amoreno & Sons, 76 F.2d 61 (1st Cir. 1985) (holding that OSHA’s interpretation of regulation is controlling as long as it is reasonable); Brennan v. Occupational Safety and Health Review Comm’n, 513 F.2d 533 (10th Cir. 1975) (same); Brennan v. Southern Contractor’s Serv., 492 F.2d 498 (5th Cir. 1974) (same). Under the statutory scheme, OSHA was intended to make policy through rulemaking and enforcement. Johnson, supra note 186, at
When Congress established MSHRC$^{197}$ ten years after it established OSHRC, the legal grounds for dissension between these split-enforcement agencies had narrowed. Perhaps learning from its experience with OSHRC and OSHA, Congress addressed the issue of deference in the legislative history. The Senate report directed the courts to give "weight" to the Secretary’s interpretations, as rendered through the Mine Safety and Health Administration.$^{198}$

The PRRB, unfortunately, does not benefit from the legislative lessons applied to MSHRC. Congress has not spoken clearly, either in statute or in legislative history, about the proper allocation of authority between the PRRB and HCFA concerning gray and emerging areas of payment policy. Instead, such matters have been left for the federal courts to resolve on a case-by-case basis—or, perhaps, for HCFA to resolve managerially.

PRRB decisions must follow the Medicare statute,$^{199}$ HCFA regulations, and policy determinations as embodied in HCFA rulings.$^{200}$ The Board must "afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, and practice established by HCFA."$^{201}$ Although regulations oblige the Board to notify HCFA promptly when an interpretation of law or regulation is at issue,$^{202}$ the Board ostensibly has discretion to interpret gray areas of policy not expressly covered by HCFA publications.$^{203}$

These gray areas probably should be colored either black or white for the Medicare Part A adjudicatory process to function appropriately in the future. Either the PRRB should be vested with clear authority and members should have the legal expertise necessary to interpret Medicare finance policy within the interstices of the law, or its jurisdiction should be significantly curtailed or eliminated entirely. At the time that this study was conducted, the provider and intermediary communities preferred that the Medicare guidelines embodied in HCFA manual provisions be submitted to notice-

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325. This left OSHRC to apply its expertise in adjudicating facts. On policy matters, the courts held that, OSHRC should defer to OSHA’s interpretation. See cases cited supra. The Supreme Court in Martin v. Occupational Safety and Health Review Comm’n, 499 U.S. 144 (1990), settled the matter firmly in favor of the Secretary’s interpretation (through OSHA).


201. Id.

202. Id. § 405.1863.

203. For a survey of legal issues brought before the PRRB, including conflicts between the PRRB and HCFA concerning policy interpretation, see infra Part II.B.
and-comment rulemaking and republished as substantive rules. This process would eliminate many gray areas in the law. Whether HCFA’s policy position as embodied in the substantive rule would favor providers or the government was not the focus of concern. Instead, both providers and intermediaries sought consistency, clarity, and simplicity in the Medicare payment rules. Among providers of all types—hospitals, skilled nursing facilities, and home health agencies—predictable results for which they could plan mattered more than affirming sometimes arcane legal principles in a hit or miss fashion. Therefore, their representatives expressed confidence that, with such clarification embodied in substantive rules, providers and intermediaries could negotiate settlements to most, if not virtually all, claims currently presented before the PRRB.

Provider and intermediary representatives recognize that some cases might require an adjudicator, not merely a neutral to assist in negotiating a settlement. However, providers and intermediaries agree that the agency factfinder need not necessarily be the PRRB as currently constituted. In fact, none of the representatives interviewed appeared wedded to the concept of requiring PRRB input on matters of policymaking. To the extent that providers sought to challenge the regulation or statute itself—for example, challenging the methodology rather than merely the application of the methodology—such cases could move directly to federal court, in accordance with current procedures.


Another critical point that distinguishes the PRRB from OSHRC and MSHRC is that the former two tribunals utilize ALJs to hear cases, but the PRRB does not. PRRB members hear cases as “administrative judges” (AJs), not as ALJs. Thus, according to ACUS’s 1992 analysis of the federal administrative judiciary, although PRRB regulations establish an elaborate hearing procedure indistinguishable in format from the formal, trial-type adjudication of the APA, a PRRB hearing may be technically an in-

204. See supra note 17 (concerning interviews).
205. Id.
206. Id.
207. Id.
208. Id.
209. Id.
210. See supra note 17 (concerning interviews).
212. PRRB Manual, supra note 34, ¶¶ 7717-7717G.
formal proceeding.\textsuperscript{214}

What does this distinction signify? The use of ALJs preserves the uniformity of process and of qualifications of presiding officers contemplated by the APA for on-the-record agency adjudications.\textsuperscript{215} To this end, ACUS has recommended that Congress consider converting current AJ positions to ALJ positions when the "procedures established by statute or regulation for the cases heard and decided are . . . the functional equivalent of APA formal hearings."\textsuperscript{216}

PRRB cases typically do not involve the type of personal liberty issues, findings of criminal-like culpability, and substantial economic sanctions that give rise to the need for ALJs at OSHRC and MSHRC.\textsuperscript{217} Nonetheless, PRRB cases involve substantial dollar amounts (an average of $300,000 per case)\textsuperscript{218} and are subject to hearing procedures that at a minimum are the functional equivalent of the APA on-the-record, trial-type adjudication. Moreover, PRRB cases sometimes raise legal and policy issues that require "specialized expertise on the part of adjudicators or on panels of adjudicators"\textsuperscript{219}—expertise that attorney ALJs with additional training in Medicare payment policies may readily provide.

Another critical apprehension is whether non-ALJ adjudicators can be expected to render impartial decisions.\textsuperscript{220} AJs have been described as a "hidden judiciary" that operates with "less prestige, compensation, and job security" than do ALJs.\textsuperscript{221} This may be true for other agencies, but the members of the PRRB enjoy a three-year, renewable term of office.\textsuperscript{222} They can be removed only for cause,\textsuperscript{223} and their compensation and prestige are at least as high as those of most ALJs, if not higher.

Yet, the Board remains subject to concerns about impartiality due to the arguably "formal-informal" nature of its hearings.\textsuperscript{224} Without the clear, unequivocal status of formal APA adjudications,\textsuperscript{225} PRRB hearings cannot

\textsuperscript{214} Verkuil, supra note 28, at 795.
\textsuperscript{216} Id.
\textsuperscript{217} See id. (listing factors Congress should consider when making determination to convert AJ positions to ALJ status).
\textsuperscript{219} See supra note 215.
\textsuperscript{220} Id. at 28-29.
\textsuperscript{221} Verkuil, supra note 28, at 788.
\textsuperscript{222} 42 U.S.C. § 1395oo(h) (1994).
\textsuperscript{223} Id.
\textsuperscript{224} Verkuil, supra note 28, at 786.
easily claim the mantle of separation of functions that protects the integrity of administrative appeals heard by ALJs. If an ALJ heard the initial case, subject to review by the Board (as is the case in most comparable federal tribunals), HCFA clearly would be required to maintain a physical and philosophical distance from PRRB operations and staff. Similarly, if PRRB members were ALJs instead of AJs, HCFA would be compelled to provide truly independent staff under the Board’s control. Statutory amendments might provide equivalent protections. Improved separation of prosecutorial (HCFA) and quasi-judicial (PRRB) functions would significantly increase the perceived independence and integrity of the PRRB process.

Most Board members (past and present), provider representatives, and intermediary representatives interviewed for this article agreed that the ALJ structure has worked sufficiently well in other contexts to be a worthwhile option to pursue with the PRRB. Some have expressed apprehension, however, about the use of Social Security ALJs who lack Medicare Part A experience. On the other hand, those accustomed to dealing with current Medicare ALJs and with ALJs in other state health care payment systems (e.g., Maryland, New York) were guardedly optimistic about the applicability of this model to the larger financing issues before the PRRB. A major concern is whether the ALJs would be able to make the “cultural transition” to the more sophisticated, complex nature of the claims brought by institutional providers under Medicare Part A.

It may well be that the adjudicatory model developed in the early days of the PRRB fit well enough to accommodate the due process concerns that arose from Medicare payment law as it existed at that time. It may also be that, as Medicare laws have evolved, the need for an adjudicatory tribunal such as the currently constituted PRRB has diminished. Administrative and judicial review has been largely foreclosed with the advent of prospective payment systems. Moreover, prospective payments increasingly will overtake retrospective cost-based reimbursement for all institutional providers. Indeed, over the next five to ten years, it is clear that ever larger amounts of Medicare payments will be made to managed care systems. This may, sooner rather than later, render obsolete the entire body of financing issues appealed to the PRRB.

B. The Board’s Content: The Evolution of PRRB Issues

In reviewing the adjudicatory structure of any agency, a simple but critical question arises: Does the structure fit the tasks required? Given the
types of legal issues and policy determinations the PRRB must review daily, is its structure more formal than necessary for due process, quality decisionmaking, and efficiency? Or, is its structure perhaps less formal than necessary to assure integrity and independence? Answering this allegedly simple question requires a somewhat involved look at the types of legal and policy issues the Board faces.

1. An Overview

Medicare adjudications initially sprang from the need for providers to obtain a determination of whether the costs of services provided to beneficiaries were "necessary and proper." Medicare pays not only the direct costs of providing necessary and proper care, but also indirect "overhead" costs, such as the cost of developing, maintaining, and operating the facility. Given the elastic standards set forth in the Medicare statute, providers not surprisingly brought before the PRRB a wide array of contentions about the amount of overhead for which the government should pay.

Issues that loomed quite large in the days before the PPS and generated a large volume of cases for the PRRB and the federal courts, structured as state hospital association group appeals, have now been rendered moot. Those cases tested whether nonprofit providers should receive a return on equity capital, whether hospitals should be reimbursed for the costs incurred in fulfilling their obligation to provide free or below-cost care under the hospital construction loan program, and whether Medicare beneficiaries, who underutilize labor and delivery room days and file fewer medical malpractice claims, should bear the same burden of labor-delivery and malpractice premium costs as other patients. These issues have faded from sight as the policy issues were resolved in other arenas.

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230. See id. at 775-76 (describing unsuccessful challenge for return of equity capital).
231. See id. at 777-79 (discussing treatment of uncompensated care costs under Hill-Burton Act).
232. See id. at 779-82 (discussing challenges to labor-delivery and malpractice premium cost calculation methodology).
233. Congress enacted legislation that barred hospitals from claiming an offset of Hill-Burton allowances. Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. §§ 291-296 (1994)), noted in Kinney, supra note 229, at 777 n.118. The reimbursement issues themselves are now moot, having been settled or superseded, and therefore this report will not reiterate the arguments and
Other issues have remained lively and may now be of greater importance to small providers, such as nursing homes, home health agencies, and rehabilitation agencies, than to general acute care hospitals. Because hospitals generally are paid under the prospective payment system, they no longer dispute retrospective cost-based issues, such as proper documentation of certified versus uncertified beds for long-term patients, billing costs, limits on costs and services, costs for services, rentals and supplies to related cases. See Eleanor D. Kinney, Medicare Payment to Hospitals for a Return on Capital: The Influence of Federal Budget Policy on Judicial Decision-Making, 11 J. CONTEMP. L. 453 (1985) (discussing issue of financing inpatient hospital services for beneficiaries of Medicare program by looking in case law); Sabrina M. Wrenn, Should Medicare Reimburse Nonproprietary Hospitals for a Return on Equity Capital?, 28 St. Louis U. L.J. 469 (1984) (examining problem of failing to reimburse nonproprietary hospitals as compared with proprietary hospitals); Deborah K. Berk, Presbyterian Hospital of Dallas v. Harris: A Dubious Consequence of Piecemeal Health Care Legislation, 9 AM. J.L. & MED. 205 (1983) (examining problem of piecemeal legislation and judicial policymaking); Kenneth P. Morrison, Medicare Reimbursement of Financial Transactions: Do Present Policies Promote Efficiency?, 9 AM. J.L. & MED. 45 (1983) (evaluating Medicare reimbursement policies for common financial transactions); Comment, The Propriety of Reimbursement by Medicare for Hill-Burton Free Care, 130 U. Pa. L. Rev. 892 (1982) (analyzing conflict between Medicare and Hill-Burton Acts as related to propriety of reimbursement).


236. See, e.g., Guyan Valley Hosp. v. Blue Cross & Blue Shield Ass'n, [1989 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 37,973 (P.R.R.B. June 12, 1989) (involving...
organizations, and compensation of owners. These issues, however, are still very germane for non-hospital providers.

The cases that have garnered the lion’s share of attention are, naturally, those with the largest dollar amounts at issue, involving providers with the largest financial and operational presence in the health care industry: hospitals. Those issues include payment for depreciation, interest expenses, and amortizing versus expensing losses incurred in advance refunding of debt. These issues may fade in importance, however, because they are capital-related costs now included in the DRG prospective payment for hospital services.

Still evolving are reviewable disputes under the prospective payment sys-
tem. These cases include jurisdictional disputes and factual situations that neither regulators nor legislators generally foresaw: highly technical, somewhat idiosyncratic situations that seem to fall between the cracks of PPS jurisdictional and payment guidelines.

The evolution of PRRB cases, especially under the PPS, suggests that the Board’s tasks may be changing, and its structure should change accordingly. Although the volume of cases in backlog and the dollar amounts at issue suggest the need for an administrative system of resolution, the types of legal issues involved do not necessarily demand the current adjudicatory structure.\(^{241}\)

2. Foundational Issues

The original Medicare amendments to the Social Security Act were adopted without any provision specifying whether judicial review—or, indeed, any review beyond an informal face-to-face meeting with the intermediary—was mandated.\(^{242}\) Neither did the statute expressly preclude review.\(^{243}\) However, within five years after Medicare became operational, the Supreme Court began unequivocally to expand rights to administrative and judicial review. Attorneys representing the interests of institutional providers of health care services successfully argued the rationales of *Goldberg v. Kelly*\(^{244}\) and *Abbott Laboratories v. Gardner*\(^{245}\) to convince federal courts in four landmark cases that when the intermediary, after an audit, recouped major amounts of alleged Medicare overpayments, the harm suffered by the provider constituted final, reviewable agency action entitled to a hearing.\(^{246}\)

These cases form the bedrock for the PRRB’s very existence and continue to provide an important foundation for further study. The due process issues that created the need for a PRRB will likely remain—although perhaps in a different factual form—irrespective of whether the PRRB itself continues to exist. These due process issues can be categorized based on the types of challenges they present: challenges to intermediary factfinding and meth-

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241. *See infra* Part III (giving author’s suggestions for alternative models of administrative adjudication).


odology; challenges to regulatory interpretation as applied to the facts; and challenges to statutory interpretation.

a. Challenges to Intermediary Factfinding and Methodology

In the early case of Aquavella v. Richardson,247 prior to the establishment of the PRRB, two doctors owned and operated a small, 60-bed extended care facility known as the Glen Oaks Nursing Home.248 In the manner followed by the pre-PPS Medicare program, Aetna Insurance Company, the Medicare intermediary, paid Glen Oaks a biweekly estimate of reimbursements due for costs incurred in providing services to Medicare beneficiaries.249 At the end of the cost-reporting period, Aetna audited Glen Oaks’s cost report and determined that the nursing home had incurred “unusually large amounts of ancillary services”250—services not included in the daily rate for bed and board and regular nursing services. The intermediary began withholding from Glen Oaks’s biweekly payments the amounts necessary to recoup the alleged overpayment.251 Some ninety-eight percent of Glen Oaks’s revenue came from Medicare.252 Hence, as the Second Circuit found, “Glen Oaks was quickly forced out of business after substantially all of its revenues were suspended.”253

It is easy to imagine the types of questions Glen Oaks would have raised if it had had an opportunity to challenge the intermediary’s action in an adjudication: Who determined what was “usual” as compared to “unusual” in terms of the amount of ancillary services? What standards did the intermediary employ? Did those standards take into consideration medical necessity? Might the residents of Glen Oaks have been sicker on average than residents of other nursing homes in the comparison group? If residents of other nursing homes were receiving fewer ancillary services, was that perhaps because they received care of a lower quality than that provided by Glen Oaks?

After a searching review of the Medicare statute’s legislative history, the Aquavella court found that Glen Oaks had a constitutional right to ask just such questions before a neutral decisionmaker.254 And Aquavella was not an anomaly. The following year, the Southern District of Florida followed Aq-

247. 437 F.2d 397 (2d Cir. 1973).
248. Id. at 399.
249. Id.
250. Id. at 399-400.
251. Id. at 400.
252. Id.
253. Aquavella, 437 F.2d at 404.
254. Id.
unavella in a similar case involving the Coral Gables Convalescent Home, which had lost fifty percent of its revenues in an Aetna recoupment. Recognizing that these cases indicated the beginning of a change in constitutional and administrative law relating to Medicare, Congress created the PRRB in 1972 to provide a forum that responded to the courts’ concerns about due process by giving providers a forum for challenging major intermediary recoupments in live, full adjudicatory hearings.

Challenges to how the intermediary developed facts and applied its methodology have remained viable. For example, cases have addressed

- costs that were out of line compared to costs at similarly situated facilities in a selected peer group;
- reasonable compensation for owners of nursing homes and home health agencies, compared to other owners similarly situated; and
- whether costs for management services, facilities, or supplies paid to related organizations were reasonable and reimbursable.

257. A typical, and more recent example is shown in Memorial Hosp./Adair County Health Ctr., Inc. v. Bowen, 829 F.2d 111 (D.C. Cir. 1987). This tiny, 50-bed rural hospital contracted with a national pharmacy service to provide inpatient pharmacy services, using prepackaged “unit doses,” which were more expensive than having a salaried pharmacist on site—which in itself was a struggle for rural facilities. Id. at 113-14. The disallowance resulted in a loss of $30,000 annually, a significant loss to so small a facility. Id. at 114. The comparison group that the intermediary compiled did not include any hospitals using a similar system for providing pharmacy services. Id. at 113. The PRRB upheld the intermediary’s disallowance, holding that Memorial Hospital had not conducted its choice as a “cost-conscious buyer” would, as required by Medicare policy. Id. at 118. The D.C. Circuit remanded, requiring the intermediary to reconstruct the peer group to develop a truly comparable base. Id. at 119.
258. See cases cited supra note 238.
259. Early cases usually presented fairly straightforward issues of cost comparisons and control to determine whether “sweetheart deals” had caused the Medicare program to pay more than a prudent buyer would in an arm’s-length transaction. Alacare Home Health Servs. Inc. v. Sullivan, 891 F.2d 850 (11th Cir. 1990), graphically illustrates the type of “gaming” that the related organizations principle was designed to protect against. Before 1980, Alacare occupied space in a building owned by an unrelated party. Id. at 853. The cost of this space to Medicare in 1979 was $13,782. Id. In 1980, Alacare moved its headquarters to a building owned by E&T Realty, a related organization owned by the president of Alacare and his children. Id. Alacare occupied only 21.3% of the building, and most of the remainder was unoccupied. Id. Because of the relocation, Alacare claimed space occupancy costs to Medicare of $41,796 in 1980 and $47,658 in 1981. Id. Despite the dramatic increase in space occupancy costs, the number of Alacare’s patient visits and full-time employee equivalents remained fairly constant from 1979 to 1981. Id. Later cases
b. Challenges to Regulatory Interpretation as Applied to Facts

The case of Temple University v. Associated Hospital Service of Philadelphia\(^\text{260}\) presents an intriguing look at due process concerns in the pre-PRRB process for deciding disputes between providers and intermediaries over unsettled questions of social policy. The case concerned the degree to which the federal government, state and local governments, the private educational sector, and third-party payers should underwrite the enormous and growing cost of training physicians.\(^\text{261}\) What is Medicare’s fair share of this load? The statute and regulations were, and continue to be, opaque.

Temple University is perhaps best known for its nearly blow-by-blow re-counting of factors cited by Temple University Hospital as ways in which the Blue Cross Association hearing process denied it procedural due process.\(^\text{262}\) Temple University owned both a hospital and medical school, which shared the same complex in an economically depressed area of north Philadelphia.\(^\text{263}\) As occurs with most university medical schools and their teaching hospitals, Temple University occasionally would authorize contributions from the medical school to the hospital.\(^\text{264}\) As described by the Comptroller, these were “purely bookkeeping transaction[s]” made “so that the Hospital’s books didn’t look so bad.”\(^\text{265}\) The hospital needed the money because it “had been incurring substantial losses because of caring for indigent persons for whom no reimbursement of any kind was available.”\(^\text{266}\) More formally, the contribution was a means for the medical school partially to recognize its indebtedness to the hospital for “permitting students to have free access to it thereby aiding their general sophistication and savvy.”\(^\text{267}\) The university recognized that this was merely an estimate, arrived at somewhat arbitrarily, based on the number of medical students in attendance.\(^\text{268}\) Nevertheless, it bore some reasonable relationship to student utilization of hospital facilities.\(^\text{269}\)


\(^{263}\) Id. at 272.

\(^{264}\) Id. at 265.

\(^{265}\) Id. at 272

\(^{266}\) Id.

\(^{267}\) Id.

\(^{268}\) Temple Univ., 361 F. Supp. at 272.

\(^{269}\) Id.
Under Medicare regulations, restricted gifts were to be deducted from operating costs in computing the costs that were reimbursable. Unrestricted gifts were not to be deducted. The intermediary, the Associated Hospital Service of Philadelphia, interpreted the $600,000 transfer that Temple made in 1967 as a restricted gift and deducted that amount from reimbursable Medicare costs. When the district court reviewed Temple's documentation, it found that there was "not a scintilla [sic] of evidence that the book transfer was to be applied or utilized in any particular or restricted way." As further evidence of its unrestricted nature, the court noted that the "accountants treated it as non-operating income, assigned to no particular department or branch of the Hospital."

In a more sophisticated form, cases where providers have challenged the intermediary's application of Medicare regulations to the facts of the provider's particular situation continue unabated. In regard to the reimbursability of medical education costs, this issue recently came before the Supreme Court in *Thomas Jefferson University v. Shalala*. Unlike Temple, Thomas Jefferson University Hospital did not attempt crude, barely documented transfers of funds between the hospital and the medical school to support its training programs for interns and residents. Instead, the hospital hired a national accounting firm to identify all its allowable graduate medical education costs. The study demonstrated that for a number of years, the hospital had been under-reporting its graduate medical education costs and was due additional payment from the Medicare program. The intermediary disallowed the claimed additional costs because the hospital had attempted to redistribute costs from the educational unit—the medical school—to the patient care unit—the hospital.

A key motivation for the hospital's attempt to obtain reimbursement for costs forgone in prior years was to include in the base year costs that would be used in the future to calculate the new average cost per graduate medical

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270. Id. at 270 (citing 20 C.F.R. § 405.423).
271. Id.
272. Id. at 271-73.
273. Id. at 274.
274. Temple Univ., 361 F. Supp. at 274. Another, more contemporary version of this issue has frequently been litigated before the PRRB and the courts, as exemplified in the case Loyola Univ. v. Bowen, 905 F.2d 1061 (7th Cir. 1990), where the intermediary had construed faculty practice plan revenues as "gifts" to research and education accounts, which would have reduced Medicare reimbursable costs. Id. at 1068.
277. Id.
278. Id. at 2385-86.
resident. 279  This would, in turn, be used for paying medical education costs, replacing the former retrospective, cost-based reimbursement. 280  Because FY 1985 was chosen as the base year for calculating future graduate medical education payments, 281 the Secretary’s position on this issue mattered greatly to all teaching hospitals. Not only did the costs affect the year immediately under appeal, but the decision as to whether they would be recognized as reimbursable would have a significant long-term impact on the hospitals. 282

After an extensive hearing before the PRRB, during which members were able to hear and question witnesses and see the documentary evidence, the Board determined that the hospital had not engaged in prohibited cost-shifting; rather, the hospital had simply claimed additional support costs for the graduate medical education programs it had historically operated. 283 The Administrator of HCFA reversed on the rationale that the failure to claim these costs in prior years demonstrated community support for those operations. 284 Because of such community support, the Medicare program should not, under its regulations, be required to provide reimbursement. 285 The federal district court found the Secretary’s interpretation of her regulations to be reasonable and entitled to deference. 286 The Third Circuit affirmed without opinion, 287 and the Supreme Court also affirmed. 288

This case, like others decided in the latter 1980s and early 1990s, has stretched the related organizations principle 289 and similar policy issues to their interpretive limits. The American Bar Association Preview of the United States Supreme Court Cases encapsulated the problem,

There has been a policy debate concerning public support for medical education. Medical education clearly benefits the entire community and, accordingly, costs for such education should not be paid by hospitals, patients, and third-party payers. However, if hospital charges do not reflect the costs of those programs, the programs would not be funded. . . . What this policy choice means in dollars and cents is what this case is all about . . . . The battle over reimbursement focuses on the language of

279. Id. at 2385.
280. Id.
281. Id.
282. See Nancy E. Roman, Medicare Dispute with Hospitals to Be Settled by Supreme Court, WASH. TIMES, Jan. 11, 1994, at A5.
284. Id.
286. Id.
287. Id.
288. Id. at 2389.
289. See supra note 259 (discussing related organizations principle).
42 C.F.R. § 413.85 and the competing policies reflected in this regulation.290

The proving ground for this policy battle was the PRRB. The PRRB heard *Thomas Jefferson University*, not as a determiner of broad policy on behalf of the Secretary, but as a factfinder to determine whether the provider or the intermediary had applied the relevant regulations more accurately and more consistently to identify the actual costs incurred by the Medicare program. Through extensive briefing and questioning, not limited by the Federal Rules of Civil Procedure or Evidence, a substantial record developed detailing how the regulations were applied to the facts of the hospital’s particular situation. At the PRRB, both the evidence and the theory enjoyed the benefit of testing before a panel of persons expert in health care finance, a panel unlike any other that would hear the issues.

Those other fora, however, possessed the authority to make broad policy determinations that the Board lacked. Thus, the Administrator of HCFA overturned the Board’s decision, acting on behalf of the Secretary to interpret and reinterpret acceptable tolerances in Medicare payment policy.291 Neither the federal district court nor the Supreme Court were swayed from their support of the Secretary’s discretion to interpret and reapply the regulation concerning public support of medical education.

Was a useful purpose served by testing a theory such as this before the PRRB first, when ultimately the decision turned on policy matters outside the Board’s discretion and power? This is a recurring quandary that recently resurfaced for two major issues: Medicare’s policies on when and how to reimburse for “loss on defeasance” costs incurred in advance refunding of bonds;292 and Medicare’s policies on providers’ entitlement to reim-

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292. *Shalala v. Guernsey Mem’l Hosp.*, 115 S. Ct. 1232 (1995), addressed the critical issue of whether Medicare accounting policies or generally accepted accounting principles (GAAP) would control when determining what Medicare shall pay for capital costs. The Secretary had not adopted substantive regulations stating which should control in advance refunding of debt. Thus, the provider argued that HCFA was required to follow GAAP, as elsewhere required by regulations at 42 C.F.R. §§ 413.20-413.24. *Id.* at 1234. In *Guernsey Memorial Hospital*, the debate focused on whether it could claim all bond refinancing costs when incurred, including the cost of borrowing increased principal to satisfy escrow requirements for repaying the debt at a new, lower rate of interest. *Id.* HCFA argued those costs had to be amortized over the life of the refinanced bond, while Guernsey sought a large lump sum reimbursement when the costs were incurred, to be consistent with the economic reality of the transaction. *Id.* The refinancing at a lower rate of interest saved the Medicare program some $12 million. *Id.* At least 44 other hospitals were in a position similar to Guernsey’s with claims outstanding against the Medicare program. Those cases
burssement for bad debts incurred because of nonpayment of Medicare
deductibles and copayments. 293

Ventilating such issues in a full adjudicatory hearing before persons
knowledgeable in the nuances of this highly complex financial arena may be
the provider’s best opportunity to prove that a novel or innovative approach
has merit. Thus, an administrative tribunal like the PRRB clarifies the ob-
scure and sifts through the specious in the arguments by both sides for the
federal court of general jurisdiction to review subsequently. Even if the

reportedly totaled some $100 million in Medicare payments due. See David Burda, Case
Could Be Worth $100 Million to Hospitals, MODERN HEALTHCARE, August 8, 1994, at 28.
Although the circuit court agreed with the PRRB and overturned the Administrator to rule
in favor of the provider, the Supreme Court agreed with the Secretary’s position (as ex-
pressed in the Administrator’s reversal) that the Secretary enjoyed broad discretion to ap-
ply any reasonable interpretation of agency policy, whether that policy was found in a
regulation or an interpretive rule. Guernsey Mem’l Hosp., 115 S. Ct. at 1234-36. For a
further discussion of this case and the implications for other areas where GAAP and Medi-
care accounting policies conflict (e.g., depreciation, goodwill, stock maintenance costs),
see Robert L. Roth, Medicare and GAAP: Understanding the Decision of the Sixth Circuit
in Guernsey Memorial Hospital v. Secretary of Health and Human Services, 3 ANNALS OF
HEALTH L. 29 (1994).

293. Three recent cases, Hennepin County Med. Ctr. v. Shalala, [1993-1994 Transfer
Binder] Medicare & Medicaid Guide (CCH) ¶ 41,948 (D. Minn. Nov. 1, 1993), aff’d in
part, rev’d in part, 81 F.3d 743 (8th Cir. 1996), St. Paul-Ramsey Med. Ctr. v. Shalala, 50
F.3d 522 (8th Cir. 1995), and Harris County Hosp. Dist. v. Shalala, 863 F. Supp. 404
(S.D. Tex. 1994), illustrate some of the recent tension that has existed between the PRRB
and HCFA on Medicare payment policy. Prior to the implementation of PPS in 1983,
HCFA rarely spotlighted nonpayment of Medicare deductibles and copayments because the
amounts were so small relative to general acute care hospital’s overall Medicare Part A
reimbursement. After PPS, capital costs, graduate medical education costs, and Medicare
bad debts remained the only reimbursement issues not folded into the DRG payment and
thus drew greater scrutiny. The inquiry required by regulation—had the provider made
reasonable collection efforts?—now was explored in exhausting detail.

In 1987, the Office of the Inspector General for HHS began auditing Medicare
cost reports already accepted, reviewed, and closed by fiscal intermediaries. Bernard, su-
pra note 45, at 348-49, n.11; Ronald N. Sutter, Courts Reverse HCFA on Bad-Debt Issue,
48 HEALTHCARE FIN. MGMT. 74 (1994). HCFA directed intermediaries to disallow reim-
bursements on a previously unheard of level. This prompted Congress to adopt legislation
each year from 1987 through 1989 to bar reopenings and reauditings based upon policy
changes made subsequent to the end of the cost-reporting period. The PRRB sometimes
accepted the provider’s position and other times upheld the intermediary’s disallowance.
Nonetheless, the HCFA Administrator consistently favored the intermediaries. The federal
district courts, however, have upheld the providers. An earlier PRRB case, University of
Cincinnati v. Heckler, 733 F.2d 1171 (6th Cir. 1984), offers an even better insight into the
adjudicatory role of the PRRB, as the Board explored with attorneys for both sides what
constitutes a “reasonable” collection effort for an inner-city hospital with a large indigent
care population. Id. at 1172-73.
administrative tribunal lacks authority to render a decision that sets aside current agency rulings, regulations, or the enabling legislation, it can—if it sees fit—set out a virtual road map for the Article III court to follow. The PRRB has repeatedly served this function for providers. 294

c. Challenges to Statutory Interpretation

The third type of due process challenge that brought the PRRB into existence originally—and one that the PRRB neither then nor now has authority to resolve—is challenges to statutory interpretation. Kingsbrook Jewish Medical Center v. Richardson295 raised an issue that turned not so much on the facts as on the interpretation of the Medicare statute. The Kingsbrook Jewish Medical Center consisted of a general acute care hospital and a chronic care facility.296 Medicare’s share of costs for the chronic division was far higher than for the acute care portion. Nevertheless, the intermediary required all costs to be combined and then averaged, thus diluting Kingsbrook’s reimbursement.297 Shortly thereafter, the Bureau of Health Insurance (HCFA’s predecessor) changed its accounting policy for providers with distinct parts, such as Kingsbrook, so that separate facilities in the same complex would receive separately calculated reimbursements,298 thus curing the underpayment problem. Kingsbrook sought a retroactive corrective adjustment for the cost-reporting periods in which it had been underpaid.299 Kingsbrook considered this adjustment clearly due under the express language of section 1395x(v)(1) of the Medicare statute.300

294. See infra Part II.B.3 (exploring this series of cases).
295. 486 F.2d 663 (2d Cir. 1973).
297. Id. at 665.
298. Id.
299. Id.
300. Id. In many ways, one could construe Kingsbrook’s legal strategy as an attempt to claim what later became known as “self-disallowed” costs. These were costs that the provider, following Medicare policy as it existed at the time, had forgone; yet subsequent changes in Medicare guidelines or in interpretations of those policies would have allowed the provider to claim those forgone costs as proper overhead expenses. The ability of a provider to claim for its benefit a retroactive corrective adjustment was attempted later in Athens I (successfully) and Athens II (unsuccessfully). See Athens Community Hosp. v. Schweiker, 514 F. Supp. 1336 (D.D.C. 1981), rev’d, 686 F.2d 989 (D.C. Cir. 1982) (Athens I), modified on réh’g, Athens Community Hosp. v. Schweiker, 743 F.2d 1 (D.C. Cir. 1984) (Athens II). Athens laid the groundwork for Bethesda Hosp. Ass’n v. Bowen, 485 U.S. 399 (1988), which accepted as a matter of procedural law that a provider’s cost report could be reopened at the provider’s request in order to claim self-disallowed costs. Id. at 402-03. Nevertheless, Good Samaritan Hosp. v. Shalala, 113 S. Ct. 2151 (1993), significantly narrowed the ability of providers to claim retroactive corrective adjustments.
The critical feature of the *Kingsbrook* decision may well be Chief Judge Kaufman’s statement, in dicta, that where a dispute turns on a purely legal issue such as this, the newly created PRRB might be irrelevant:

There is no real disagreement here over what method of cost determination is more accurate and, therefore, more ‘reasonable’. . . . [Rather, the] controversy has arisen over the interpretation of the statutory command . . . . [W]hile the former question may warrant expertise not possessed by a court, the latter is well within the traditional sphere of judicial competence.  

Today, such matters probably would not come before the PRRB at all but, rather, would move directly to federal court by exercise of 42 C.F.R. section 405.1842, which provides for “expedited judicial review.” Under these provisions, a provider may petition the PRRB for a determination that the Board lacks authority to rule on a question of law and that only a matter of law remains to be determined. In such circumstances, the Board may permit the provider to waive its right to a PRRB hearing and deem the provider’s administrative remedies exhausted without a formal decision.

Expedit ed judicial review has been used effectively in cases where the issues are fairly limited. For example, in *Tucson Medical Center v. Sullivan*, the four plaintiff hospitals, which had won increased reimbursement after the Supreme Court invalidated the wage-index used to calculate the hospitals’ labor costs, sought the interest due on the new reimbursements. As an administrative tribunal, not an Article III court, the PRRB had no authority to grant the relief sought. However, the hospitals won at least paper satisfaction through the D.C. Circuit.

Other cases well-suited for expedited judicial review include those that focus on the relatively narrow question of whether a regulation is valid—not

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The Court there held that, where the statutory language is ambiguous and the Secretary’s interpretation is “at least as plausible as competing ones, there is little, if any, reason not to defer to its construction”—even if that means the Secretary’s cost method produces an inequitable result in a particular case. *Id.* at 2161.

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301. *Kingsbrook*, 486 F.2d at 668 n.15.
302. 42 C.F.R. § 405.182 (1996) (expediting final PRRB decisions, subject to judicial review, when determining that court does not have authority to decide question).
303. *Id.*
304. *Id.*
305. 947 F.2d 971 (D.C. Cir. 1991).
308. *Id.* at 976. Appellants sought expedited review by the PRRB pursuant to 42 C.F.R. § 405.1842. The Board, however, found that it did not have authority to resolve the question and appellants filed in the U.S. District Court for the District of Columbia within the 60-day time limit. *Id.* at 974 n.2.
309. *Id.* at 983.
merely whether the regulation has been applied or interpreted correctly based on the facts. *Macon County Samaritan Memorial Hospital v. Sullivan*, 841 F. Supp. 917 (E.D. Mo. 1992). For example, challenged the validity of the Secretary’s new regulation, which defined a “sole community hospital” largely in terms of distance from other hospitals, without taking into consideration unusual local circumstances, such as physician admitting practices. While the prior regulatory and statutory scheme for granting sole community hospital status did take such other factors into account, the post-PPS regulations did not. Because obtaining this status entitled hospitals to more generous Medicare payments, for rural hospitals, having it likely meant the difference between barely maintaining an operating margin and closing. A number of other courts also reviewed the new regulations and came up with differing results. The magistrate reviewing Macon County Samaritan Hospital’s arguments properly focused on the policy issues that informed the Secretary’s discretionary choice of how to define a sole community hospital for purposes of Medicare reimbursement.

The provider had shown that some disagreement existed within HHS over the new sole community hospital designation. The Prospective Payment Assessment Commission (ProPAC), which monitors the implementation of Medicare’s prospective payment system, prepared a study that indicated the new regulation would decrease the number of such designations. The magistrate, however, recognized that the Secretary is not bound to accept either the recommendations or the caveats of ProPAC but need merely con-

311. 42 C.F.R. § 412.92(a)(3).
313. *Id.* at 920; see 42 C.F.R. § 412.92.
314. *See Macon County Samaritan Mem’l Hosp.*, 841 F. Supp. at 919 (explaining how sole community hospitals are exempt from reasonable cost limitations under 42 C.F.R. § 405(f)(4)).
317. *Id.* at 922.
sider them when setting policy that is within the Secretary's discretion.\textsuperscript{318} Here, the Secretary elected to develop a set of uniform, firm, objective criteria "to resolve inconsistencies between HCFA regional offices."\textsuperscript{319}

Cases since Kingsbrook have presented the Article III courts with an increasingly complicated set of statutory and regulatory issues. While the typical PRRB case requires the resolution of mathematical adjustments, expedited judicial review cases ask the courts to resolve the applicable method itself. Some of the procedural issues are sufficiently intricate that expedited judicial review might not be granted. For example, in French Hospital Medical Center v. Shalala,\textsuperscript{320} the hospital had requested expedited judicial review to challenge the routine cost limit formula.\textsuperscript{321} Did the PRRB have jurisdiction to hear disputes concerning the entire cost report, even those that were not the subject of a revised notice of program reimbursement? Or did the PRRB have jurisdiction only over the specific issues in the revised NPR? The payment methodologies that the provider sought to challenge were not included in the specific auditor's adjustments referenced in the revised NPR.\textsuperscript{322} Could the provider use the revised NPR as a means of "bootstrapping" itself into the courts to force a review of the formulas? The Board asked French Hospital to brief the jurisdictional issues and, upon consideration of the briefs, determined that it lacked jurisdiction to grant the hospital's request for expedited judicial review because there were no audit adjustments from the revised NPR under dispute.\textsuperscript{323} The provider could have elected to continue its exception appeal before the PRRB but did not.\textsuperscript{324}

While expedited judicial review might suggest that the PRRB is irrelevant in policy disputes, it is no more irrelevant than any other administrative adjudicatory body in similar legal circumstances.\textsuperscript{325} Since the PRRB's role is limited in matters of pure law or conflicting policy, the Board arguably has served an important function by giving providers a forum to develop extensive records of their disputes. The PRRB also has benefited the courts by culling through the technical jargon, terms of art, and implied industry standards. These are the traditional functions of such an adjudicatory body. Despite the administrative tribunal's lack of power to grant the remedy that the complainant has requested, the PRRB's decisions may offer a guide to

\textsuperscript{318} Id.

\textsuperscript{319} Id.

\textsuperscript{320} 841 F. Supp. 1468 (N.D. Cal. 1993).


\textsuperscript{322} Id. at 1472.

\textsuperscript{323} Id.

\textsuperscript{324} Id. at 1479.

\textsuperscript{325} See generally 30 U.S.C. § 815(c) (1994) (providing expedited judicial review under Mine Safety and Health Act).
the courts.

3. Growing Complexity in Theory and Practice

The Provider Reimbursement Review Board became operational in 1974, hearing appeals of disputes arising from cost-reporting years ending in 1973 and thereafter. From 1974 until the PPS became fully operational in 1987, disputed issues evolved from relatively straightforward matters requiring proof of accounting facts to much more complicated matters of testing accounting theory as it intersected with limitations of the law. The financing and legal issues often did not meet squarely, leaving a critical gap between current industry practice and regulatory policies, which trailed sometimes by several years.

The health care industry in the 1980s grew in size and complexity, as relatively small, simple, free-standing hospitals expanded and merged to become parts of multi-hospital systems. Integrated health delivery systems encompassed not only hospitals but also nursing homes and medical supply joint ventures. During this tumultuous period of change, Medicare payment policies struggled to keep ahead of economic realities. Some observers might argue that this illustrated the best use of the PRRB vis-à-vis HCFA: That during a time of transition, when regulatory policy and statutory policy had not yet matched the innovative, entrepreneurial changes in the industry, the PRRB could try to fill the gaps in payment policy that Congress and HCFA's regulatory office had failed to address.

In many ways, the PRRB took upon itself—without formal, express delegation by the Secretary—the task of filling those gaps on an ad hoc, case-by-case basis. Others might criticize the Board as having arrogated to itself powers that it did not possess under the regulatory scheme: The Board should not have attempted to take unto itself the role of policymaking, which properly belonged to HCFA, the regulatory body vested with authority to issue substantive rules.

In this section, two major types of cases are examined that demonstrate the best and worst of the PRRB. The first are the group appeals cases brought by state hospital associations concerning return-on-equity capital for nonprofit providers; reimbursement of charity care obligations; and allocation of costs for labor-delivery room days and for medical malpractice insurance premiums. The second group of cases involves the impact of corporate restructuring on Medicare payments.

326. See Kinney, supra note 15, at 387.
a. The Group Appeals Cases: Mixed Messages?

The group appeals cases still hold implications regarding the proper role of the PRRB: They demonstrate the independence of the Board in the group appeals issues. The Board’s position in general in these appeals was eventually vindicated through the courts and through HCFA’s tardy acquiescence. On the other hand, the group appeals cases also may support those who believe that such vaunted independence represented inappropriate overreaching ab initio. Those who argue on behalf of a more limited role for a supposedly independent tribunal would remark that the Secretary’s policy alterations were based not upon the PRRB’s decisions, but instead on those of the D.C. Circuit. Of course, the debate can become circuitous because the favorable federal court decisions often reinstated or otherwise adopted the factfinding and reasoning of the PRRB.

The legal theories proposed by the state hospital associations in these appeals were novel, audacious, and potentially extremely expensive to the federal government. For example, in the late 1970s and early 1980s, hospitals sought reimbursement for the charity care provided as fulfillment of their loan obligation to the Hill-Burton program. HHS estimated that if the hospitals succeeded, the Medicare and Medicaid programs would be required to reimburse from fifty to eighty percent of the $400 million worth of free care provided annually in satisfaction of Hill-Burton obligations nationwide.

The PRRB initially resisted the novel theory that Hill-Burton free care costs should be reimbursed by Medicare in a handful of cases decided in the late 1970s. By 1980, the Board had begun to split, two to two over the issue. (The Board, as so often has occurred, lacked its full five-member complement.) Because a split decision sustains the intermediary’s adjustment, the reimbursement for Hill-Burton charity care was disallowed. In 1981, however, the Fifth Circuit gently but thoroughly upbraided the PRRB for denying reimbursement to Presbyterian Hospital of Dallas, Inc., for its claimed Hill-Burton costs. After the Supreme Court denied certiorari,
the Board began consistently to rule in favor of providers, three to one.

The Fifth Circuit's decision indicated that the court expected the PRRB, serving as factfinder, to decide policy issues—even those issues that the Secretary (or Congress) would ultimately need to resolve through rulemaking or statutory amendment.\textsuperscript{332} The court examined the Board's decision and identified a rationale founded squarely on the Medicare statute and implementing regulations: Although "the cost of rendering the free care is a cost to the facility," it is not necessarily a cost that should be borne by the Medicare program because the direct beneficiaries of the free care are, by definition, non-Medicare patients.\textsuperscript{333}

The court nevertheless expressed concern that the Board's approach was too simplistic.\textsuperscript{334} The PRRB had failed to evaluate whether the hospital's legal obligation to provide free care represented an indirect cost of doing business that the Medicare program regularly reimbursed.\textsuperscript{335} The court appeared to suggest that even if the PRRB eventually determined that the providers' theory was not tenable, the Board should have tested the theory by exploring whether sufficient facts existed to support Presbyterian Hospital's reimbursement claim.\textsuperscript{336} Yet, the PRRB had failed to find the facts in the case to determine the amount of free or below-cost care that Presbyterian Hospital had provided in the cost-reporting period at issue, and it had failed to determine how much of those costs had already been reimbursed.

Conceivably, the court's expectations may have aimed higher than the PRRB could achieve as congressionally designed. No statutory or regulatory provision requires that any member of the PRRB be an attorney.\textsuperscript{337} This again raises the question of whether an ALJ with appropriate education and training in the intricacies of Medicare financing (and hospital cost accounting) could develop a better record for review by the judiciary. In fact, an ALJ could develop the necessary record for judicial review simply through the use of expert testimony, as is done regularly in other administrative fora.

Thus, in 1981, the Fifth Circuit and the PRRB adopted a legal theory that could have been a true "budget buster." In response, state hospital associations developed large groups of hospitals to pursue their Hill-Burton claims. However, the favorable decisions these groups received from the PRRB were overturned by the Administrator of HCFA and had to be appealed to a

\textsuperscript{332} Presbyterian Hosp. of Dallas v. Harris, 638 F.2d at 1389.
\textsuperscript{333} Id. at 1388 n.5.
\textsuperscript{334} Id.
\textsuperscript{335} Id. at 1387.
\textsuperscript{336} Id. at 1388.
federal court. HCFA moved quickly to end the adjudicatory dance on this issue by introducing legislation to prohibit Medicare reimbursement for Hill-Burton charity care. The amendment included in Section 106 of the Tax Equity and Fiscal Responsibility Act of 1982 brought the Hill-Burton group appeals to a close.

At the same time, another federal circuit was taking the PRRB to task for having done, not too little, but too much. The U.S. Court of Appeals for the Seventh Circuit reviewed the PRRB’s decision to accept the Indiana Hospital Association’s novel theory that nonprofit hospitals should be paid a return on the equity capital invested in their operations (just as for-profit hospitals had received in the early days of Medicare). Both the district court and the court of appeals checked the PRRB for overstepping its bounds in rendering a decision construing constitutional and statutory law to define Medicare policy in contravention of the position taken by the Administrator of HCFA. The hospitals had argued before the district court that the HCFA Administrator had no authority to reverse the PRRB’s decision and that great deference should be accorded the Board’s decision. However, the Seventh Circuit pointed out that courts are supposed to give “deference to the interpretation of the agency charged with administration of the statute” and that “[f]inal responsibility for rendering a decision lies in the agency itself, not with subordinate hearing officers.” With that, the momentum that had been building among nonproprietary hospital associations to pursue reimbursement for a return on equity capital faded.

Despite the mixed and possibly discouraging messages that the Board received from the federal courts during this period, the PRRB also received significant encouragement through a series of group appeals cases challenging other issues. The landmark issue was the apportionment of labor-delivery room costs to Medicare beneficiaries: Would the program pay its equal share of these costs, which rarely if ever were used by Medicare patients (due, obviously, to age) or would Medicare use a specialized calculation to minimize its share of such costs? The PRRB consistently favored the providers’ position and opposed HCFA’s revised method of calculating labor-delivery room costs.

341. Id. at 877-78.
342. Id., 714 F.2d at 873.
343. Id. at 874.
In *Saint Mary of Nazareth v. Schweiker*, the D.C. Circuit described the adjudicatory history of this issue:

The labor/delivery issue has produced a flood of appeals to the PRRB, leading one service to conclude that it is "one of the most controversial issues facing Medicare reimbursement." The PRRB announced a policy in favor of the hospitals in its first case, and it has continued to adhere to that position in the face of repeated reversals by the Deputy Administrator. . . . The Deputy Administrator has been nearly equal in his opposition to the PRRB and the hospitals . . . . In fact, the two sides became so entrenched that the looseleaf service stopped reproducing their discussions of the labor/delivery issue "because the issues raised and the decisions rendered were virtually identical to those raised and decided in previous decisions regarding this issue."

The D.C. Circuit found that the Secretary’s position, as articulated by HCFA, did not demonstrate sufficient expertise, thought, or analysis as to merit deference. Rather, the court found "there [was] nothing that went into the development of the policy in Manual § 2345 that require[d] expertise for one to understand. In sum, neither consistency nor timing nor expertise weigh[ed] heavily in favor of deferring to HHS in this matter."

A number of district courts did not agree with the D.C. Circuit’s position and split on the labor/delivery issue. However, because jurisdiction was always available in the forum of the Secretary’s headquarters, a victory in the D.C. Circuit boded well for providers throughout the nation. Indeed, all other circuit courts reviewing the issue concurred in the position taken by the D.C. Circuit in *Saint Mary of Nazareth*. Despite this overwhelming support for the position taken by the providers and the PRRB, HCFA held fast in its determination to require each hospital to appeal and obtain satisfaction through the federal courts before acquiescing to a direct order for payment. Not until 1987, after a change in personnel in the office of the HCFA coun-

344. 718 F.2d 459 (D.C. Cir. 1983).
345. Id. at 465 n.11 (citations and footnotes omitted).
346. Id. at 466.
347. Id. at 465-66.
349. See, e.g., Sioux Valley Hosp. v. Bowen, 792 F.2d 715, 718 (8th Cir. 1986); Chartier Peachford Hosp. v. Bowen, 803 F.2d 1541, 1545 (11th Cir. 1986); Community Hosp. of Roanoke Valley v. Dep’t of Health and Human Servs., 770 F.2d 1257, 1264 (4th Cir. 1985); Central DuPage Hosp. v. Heckler, 761 F.2d 354, 356 (7th Cir. 1985); Baylor Univ. Med. Ctr. v. Heckler, 730 F.2d 392 (5th Cir. 1984); Beth Israel Hosp. v. Heckler, 734 F.2d 90,91 (1st Cir. 1984); University of Tenn. v. Dep’t of Health and Human Servs., 737 F.2d 580 (6th Cir. 1984); International Philanthropic Hosp. Found. v. Heckler, 724 F.2d 1368, 1369 (9th Cir. 1984).
sel, did the Department concede and change its position uniformly. 350

It is difficult to assess what, if any, role the PRRB played in producing the reversal seen in HCFA Ruling 87-3. Supporters of the split-enforcement model would see these events as a demonstration of how necessary an independent tribunal can function as a critical firewall between overzealous, overly aggressive, budget-driven policies and justice. Detractors would characterize the PRRB’s role as merely creating another inefficient step in an adjudicatory process that is riddled with conflicts and inconsistencies and increases litigation costs unnecessarily.

Would it have been possible to reverse a legally improper payment policy without the input of the PRRB? The treatment of the medical malpractice insurance premium rule offers one demonstration. This was the last of the great group appeals of the late 1970s and 1980s, when HCFA had adopted a regulation designed with the bald objective of reducing Medicare payments virtually irrespective of past policies, the Medicare statute, and cost-accounting methods. Again, several courts of appeals forcefully rejected the manipulation of costs embodied in the new rule. In time, following the decision of the D.C. Circuit in Georgetown University Hospital v. Bowen351 and that of the Supreme Court in Bowen v. Georgetown University Hospital,352 Deputy Chief Counsel Henry R. Goldberg announced another reversal in HCFA Ruling 89-1. 353

Beginning with the first group challenge to the medical malpractice rule in 1983, the PRRB’s role was quite minimal. The initial case, Walter O. Boswell Memorial Hospital v. Heckler,354 was not even heard by the PRRB but instead was brought directly to federal court under expedited judicial review. Because the PRRB did not develop a record below, the district court and the court of appeals found themselves confronting an incomplete and confusing “miscellany” of agency memoranda and affidavits.355 As the D.C. Circuit stated, “nothing purporting to be the complete administrative record was submitted by either party.”356 It also appeared that “the plaintiffs were unaware of a number of items included in the eleven-volume version of the record compiled by the government after the District Court hearing.”357 Included in that record were documents “quite critical of the single study that

351. 862 F.2d 323 (D.C. Cir. 1988).
356. Id.
357. Id. at 793.
the Secretary cites as a basis for the Malpractice Rule."\textsuperscript{358} The D.C. Circuit found this omission sufficiently egregious to require remand to the district court "for consideration using the eleven-volume administrative record submitted as Appendix B of the \textit{amicus} brief in this case."\textsuperscript{359}

It is interesting to note that the court did not order remand to the PRRB apparently because the court discerned that no particular technical expertise was required to compile the record. If this was so in the case of the medical malpractice apportionment rule, it could also be true of many more such challenges to agency methodology. And, if the federal courts would be unnecessarily overburdened by compiling such administrative records, another HHS administrative tribunal could serve that function; it need not be the PRRB. Thus, although the PRRB might have seen its role in the group appeals cases as keeping a check on policymakers run amok, in retrospect that role seems to have diminished in significance. In time, the agency conceded control not to the Board, but to the courts.

\textit{b. Medicare Payments Meet the Brave New World of Provider Reorganizations}

The 1980s were a time of heavy capital investment and corporate restructuring. "Privatization" and "synergy" were the watchwords of the decade in health care. Hospitals underwent substantial changes, developing parent-subsidiary structures far more sophisticated than anything attempted during the 1970s. Medicare payments, however, would cover only the costs of services provided to Medicare beneficiaries. Costs could not shift between payers. Furthermore, Medicare expected hospitals to reduce their claimed overhead expenses by the revenues available to the hospital from other sources.\textsuperscript{360}

The group appeals cases involving Medicare payments between related organizations evolved into intricate explorations of ownership and control in the 1980s. For example, in \textit{Forsyth County Hospital Authority v. Bowen},\textsuperscript{361} a newly privatized nonprofit hospital corporation owned both the former public hospital and an apartment house. The Hawthorne Apartments housed hospital employees and served as an inducement for recruiting physicians. The parent-subsidiary structure also included the standard supporting foundation, a popular means of raising funds for hospitals in such a restructured system. The Forsyth Memorial Hospital Foundation's charter provided

\textsuperscript{358} Id.
\textsuperscript{359} Id.
\textsuperscript{361} 856 F.2d 668 (4th Cir. 1988).
"that it use its income "for the exclusive benefit of or in furtherance of the purposes" of the hospital." The parties stipulated that the hospital and foundation were "related organizations" as defined by Medicare regulations.

The foundation existed to serve purposes other than mere fundraising. In 1982, the hospital gave the apartments to the foundation, and the foundation sold the apartments to a third party "for more than double their cost" to the hospital. The foundation used the proceeds to purchase "a surgical supply firm and a surgery center, with the balance invested in interest-bearing bank accounts." By generating revenue from other activities, the hospital could improve services and facilities without raising rates.

Forsyth and similar facilities used the foundation mechanism in part because of federal income tax and local property tax exemption laws. However, much of the reason lay in Medicare reimbursement law. Hospitals such as Forsyth sought to raise revenue in ways that would not be directly attributed to the hospital so as not to reduce the hospital's Medicare reimbursable overhead. When the provider sought reimbursement for interest expenses incurred by the hospital, the intermediary reduced those expenses by the interest earned by the foundation. Providers undergoing corporate reorganizations perceived such interest offsets as an inequitable, irrational penalty for innovations that on the whole benefited all patients, including Medicare beneficiaries, by offering better services more cheaply than would otherwise be possible.

The PRRB analyzed the facts and virtually set aside the interpretive rule that the intermediary (at HCFA's direction) had relied on to define such activities as so related as to require offset. The Administrator of HCFA uniformly reversed those judgments, and the federal courts often split. Generally, the Board lacked in this area both the consistency and the boldness that marked its treatment of the group appeals issues.

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363. Id. (citing 42 C.F.R. § 405.427 (1982)).
364. Id.
365. Id.
366. Id. at 670.
367. Id.
368. Biloxi Regional Med. Ctr. v. Bowen, 835 F.2d 345 (D.C. Cir. 1987) (overturning findings of PRRB and district court that city of Biloxi and medical center were related due to City's retained power to influence hospital); Monongahela Valley Hosp., Inc. v. Sullivan, 945 F.2d 576 (1991) (directly tackling challenge of interpreting Medicare reimbursement policy "in the interstices of the Medicare regulatory scheme," where there was no evidence of self-dealing or hidden windfalls, but nevertheless Medicare required offset of hospital's interest expense).
The subsequent history of the related organizations cases testifies to the minimal impact the PRRB had. With the enactment of the PPS in 1983 and with the inclusion (or fold-in) of capital-related costs in 1991, these payment issues for hospitals were mooted by statute. As prospective payment supersedes cost-based reimbursement for other Medicare providers and, arguably, as managed care overtakes even PPS, these issues will have little importance for non-hospital providers, too.

4. The PRRB After the Prospective Payment System

The PPS wrought an enormous change in the content of PRRB work. Most overhead costs, which had formed the backbone of the PRRB caseload, no longer could be appealed. The PPS amendments expressly barred administrative or judicial review to obtain any adjustment in DRG rates or even to challenge the methodology. To cushion the impact of the new system, hospitals were paid a blended rate of DRG payments and cost-based payments for a brief period of time in the mid-1980s. However, by 1989, most hospitals had made the transition to the new system of a fixed, per-patient payment, which included all overhead expenses.

Other than psychiatric hospitals, cancer referral hospitals, rehabilitation hospitals, which were excluded from the PPS in its initial stages, most hospitals and intermediaries no longer clashed over the terms of management contracts with related organizations or cost limitations on pharmacy services. Nevertheless, the overwhelming majority of providers paid under Part A of the Medicare program now found their basic overhead costs essentially capped on a per-patient basis. Costs that exceeded the DRG payment simply went unreimbursed by Medicare. Costs below the DRG level represented savings. As in managed care, the real answer to a hospital’s Medicare payment problem under the PPS would be found in fiscal and operational management, not in adjudication. HHS moved slowly in developing a methodology for including capital costs and medical education costs in the DRG payment. Nevertheless, by the early 1990s, a legislative formula existed for including both in the nonappealable PPS payment.

HHS continues to include as many institutional providers of care as possible in a PPS of some sort. Thus, a relatively small number of payment

370. Id. § 1395hh; 42 C.F.R. § 412.1 (1996).
373. 42 U.S.C. § 1395ww(g) & (h) (1995 Supp.).
374. At the time of this writing, HCFA’s Office of Research and Demonstrations was conducting a demonstration relating to the PPS for home health agencies. To ease the
situations remain outside the PPS system or involve questions of status within the system, particularized adjustments, or jurisdiction. The critical, fundamental jurisdictional issues presented at the inauguration of the PPS have now been resolved through the agency’s issuance of HCFA Ruling 89-1. Intricate, unexpected questions of PRRB jurisdiction sometimes arise but are resolved fairly expeditiously by the Board’s increasingly sophisticated legal staff, without significant input from the Board members themselves. The key cases that seem to remain post-PPS are those involving whether a hospital qualifies as a rural provider, a sole community hospital, a Medicare-dependent hospital, an essential access hospital, or a disproportionate share provider, as defined by the PPS statute and implementing regulations.

Among these categories of possible cases, the largest number of cases seems to involve the geographic classification of a facility. Under the prospective payment formula, the wage index used to calculate labor costs varies depending on the facility’s urban or rural location. Thus, a hospital in a suburban area could face a big difference in payments depending upon its classification by HCFA. Congress established the Medicare Geographic Classification Review Board (MGCRB) specifically to provide such hospitals with an administrative forum to present their protests against alleged in-accuracies in reclassification.

The enabling legislation clearly canalized the MGCRB’s discretion by statute and regulation it could perform only a limited review, according to fairly strict guidance. However, the format of an MGCRB hearing was made very flexible. Oral hearings became the exception, not the norm. Although parties submit evidence and sworn testimony (oral or written), most meetings and hearings of the MGCRB are telephonic. MGCRB members are part-time and serve at the discretion of the Secretary. Thus, the lines of authority and control were unquestionably established from the outset.

transition toward a prospective system, HCFA adopted new payment methodologies for home health agencies on a per-case basis. 60 Fed. Reg. 8389 (1995). A similar study was under way in HCFA’s Division of Skilled Nursing Care to develop a PPS for skilled nursing facilities. 59 Fed. Reg. 59,410, 59,416 (1994). Skilled nursing facilities with fewer than 1,500 Medicare patient days per year already have the option of filing on a prospective pay basis. 59 Fed. Reg. 57,532 (1994); 59 Fed. Reg. 52,178 (1994).

375. See Bernard, supra note 45, at 402-06.
379. Id.; 42 C.F.R. § 412.230.
The success of the MGCRB poses an intriguing invitation for those previously wedded to the PRRB model of adjudication: Could the future adjudicatory model for PPS cases follow the lead of the MGCRB? When legislation and legislative rules conclusively define the reviewable issues, it is no longer appropriate to encourage the time-consuming, resource-intensive model of a live, trial-type adjudication. There are a number of different options.

III. SUGGESTED MODELS FOR RESTRUCTURING PRRB FUNCTIONS

The six models described here represent the results of many hours of discussion with representatives of hospitals, nursing homes, home health agencies, rural hospitals, urban hospitals, and their attorneys, as well as present and former members and Executive Directors of the PRRB. Focus groups were formed to consider the following questions: How independent should the adjudicatory body be? Should we be concerned about separation of functions, and if so, how should that separation be protected? Are ex parte communications a threat, and if so, how should proper insulation be assured? Which of these models would promote the consistency in decision-making that parties expect in a just system?

A. Key Factors in Evaluating the Proposed Models

The sections below summarize the major advantages and disadvantages of each model, according to the confidential responses received. Almost none of those interviewed at the time of the study seemed bound to the PRRB adjudicatory model. Much flexibility and willingness to experiment were evident at that time. Moreover, all sides apparently desired to cooperate in creating whatever model might best serve the needs of fairness and efficiency. Unfortunately, some Board members and the Executive Director have hardened their positions as internal tensions have increased.

Each person was asked what part of the system was most critical and should be retained even if the rest were lost. Both provider and intermediary interests converged on the need for rulemaking to promulgate substantive standards. Both sides strongly agreed that they could negotiate rapid settlements of the remaining cost-based disputes on their own, without significant PRRB involvement, if the soft guidelines now embodied in the Provider Reimbursement Manual were fixed as firm legislative rules. There was little apparent concern on either side for achieving a particular benefit under the newly promulgated rules. The chief concern expressed was for consistency, not for special favors.

Finally, providers stressed that they still required judicial review as a safety valve to permit necessary challenges to changes in administrative...
policy that threaten constitutional or statutory rights.\textsuperscript{381} However, they did not suggest that the PRRB was an essential part of pursuing judicial appeals. Instead, some avenue for extra-agency review by an Article III court was desired as a check on administrative action.

This bold counsel from the consumers of PRRB services formed the basis of the recommendations presented here for restructuring Medicare appeals. The most vocal opposition to these recommendations came from those currently invested in PRRB operations. This opposition is quite understandable because, in essence, the consumers are saying they have little continuing need for the administrative tribunal. This is a revolutionary message from the regulated to the regulator.

\textbf{B. Model No. 1: Retain the PRRB as Currently Configured}

Model No. 1 proposes maintaining the status quo, including the April 1994 reorganization, as shown in a simplified Figure 1, below.\textsuperscript{382} As diagrammed, this model shows in solid lines the reporting channels that appear clear and in broken lines those that appear more questionable.

\textsuperscript{381} For example, in 1994, HCFA proposed to revise the Medicare Provider Reimbursement Manual, Part 1, § 2139, “Political and Lobbying Activities.” \textsc{PRRB Manual, supra} note 34, ¶3997H. Health care providers expressed great concern that the proposed definition of “lobbying” was “exceedingly broad in scope and the terms [were] very imprecise, making it extremely difficult to distinguish between activities that occur in ‘the normal course of business’ from those that constitute lobbying. Without providing adequate guidance, HCFA leaves the intermediary with the discretion to determine whether or not the activity is lobbying.” Letter from Jordan J. Cohen, M.D., President, Association of American Medical Colleges, to John Eppinger, HCFA, Bureau of Policy Development (October 12, 1994) (on file with author). \textit{See} letter from Frederic J. Entin, Senior Vice President and General Counsel, American Hospital Association, to John Eppinger, Chief, Payment Policy Branch, Bureau of Policy Development, HCFA (Oct. 10, 1994) (expressing similar concerns); letter from Val J. Halamandaris, President, National Association for Home Care, to John Eppinger, Chief, Payment Policy Branch, etc. (Oct. 3, 1994) (same); and memorandum from William A. Dombi, Director, Center for Health Care Law, \textit{re} Medicare Disallowance of Lobbying Costs (Sept. 6, 1994) (same) (all on file with author).

\textsuperscript{382} The finer distinctions of title and office designations have been omitted for the sake of clarity.
The interviews both preceded and followed the April 1994 reorganization. Most of the provider community expressed caution but no impassioned outrage about the change. Rather, they appeared much more concerned about the future of health care reform. After Darrel Grinstead, Chief Counsel of the Health Care Financing Division, had issued assurances that the Executive Director would not usurp proper Board functions and, in particular, would not participate in Board decisionmaking, the provider community seemed ready to wait and see how things took shape. Indeed, some seemed ready to acknowledge that, if the Executive Director could, through oversight of the staff, improve the quality of Board opinions, he would be doing them a service. Quality, of course, is a subjective matter. In this situation, the providers indicated that they sought improved explanation of the rationale, better citation of legal support, and quicker turnaround.

On the other hand, those with long experience in dealing with HCFA saw the increased authority of the Executive Director as yet one more emblem of how increasingly futile and irrelevant the PRRB is becoming. Providers had little doubt that in time the Board staff would come to see their role as explaining HCFA’s policies—not as providing an independent forum for hearing provider claims, which might present innovative tests of those policies.

The greatest opposition to the current structure—focusing on the April 1994 reorganization—came from the Board members themselves. For those who were immured in the former structure of the PRRB and cost-based reimbursement, the change seemed an anathema. They perceived the increased power of the Executive Director as an indefensible breakdown in the separa-
tion of functions between HCFA and the PRRB. They believed *ex parte* contacts between PRRB staff and HCFA staff would be unavoidable, especially given the relocation of the PRRB to HCFA's main campus.

On the other hand, those Board members who have no shared memory of the PRRB's geographic and philosophical independence from HCFA saw little amiss. Instead, they appeared to see the changes as a welcome means of improving efficiency and clearing the legendary backlog of cases.

C. Model No. 2: Return to the PRRB's Configuration Pre-April 1994

Figure 2 (below) shows how members of the PRRB who served prior to 1993 perceived the relationships between HCFA, the Secretary, and the Board. The solid lines of authority and communication here represent the activist Board of the 1980s.

![Diagram of lines of authority at the PRRB before the April 1994 reorganization]

Figure 2. Lines of Authority at the PRRB Before the April 1994 Reorganization

A majority of the members of that Board remained deeply involved in the cases and actively supervised the Board advisors in case development and opinion writing. Furthermore, they shared with the Chairman the duties of jurisdictional review and staff management, and as a group they pressed for administrative and budget changes to benefit the Board.

The broken lines represent the Board's perceived status vis-à-vis the HCFA Administrator and the Secretary. The Board unquestionably saw itself as answering only to the Secretary and to the courts. The Board saw itself as judging the correctness of HCFA's actions in various cases and
rarely conceded that HCFA might have authority over it.

Is it possible to return to such a model? A number of parties felt that the feisty, aggressive Board of the 1980s was defunct. It seemed most unlikely that the PRRB of today wished to become as intimately involved in Board operations as prior Boards had. Some part of the slowdown in productivity in the 1980s may have been caused by the close tending of cases and micro-managing of the office that Board members engaged in during that period. If the PRRB is to eliminate its current backlog, it probably cannot return to this model because it does not delegate authority sufficiently.

D. Model No. 3: Eliminate the Administrator's Own Motion Review

This model could be diagrammed either as one that retains the pre-April 1994 configuration or as one that employs Model No. 1. Either way, the model's critical feature is the elimination of *sua sponte* review of PRRB decisions by the HCFA Administrator. Thus, in Figure 3 below, the broken line that previously linked the Board and the HCFA Administrator has been deleted.

![Diagram](image)

**Figure 3.** The PRRB's Previous Lines of Authority Without *Sua Sponte* Review by HCFA's Administrator

This model was suggested in a focus group of provider attorneys. The broad discretion of the HCFA Administrator to reverse PRRB decisions has caused many to be skeptical about the value of the entire agency-level process. The number of reversals (perceived as reversals of PRRB decisions that had favored the provider) and the unpredictability of the reversals present a
disincentive to pursuing valid claims.

Over the years, provider attorneys, health care trade publications, and the PRRB itself have tried to compile the numbers of reversals and appeals of PRRB decisions.\(^{383}\) It is virtually impossible to track these decisions because each case typically brings before the Board several different issues, which are decided on their own merits. Thus, a PRRB decision may uphold a provider on one out of three issues; the Administrator may reverse on two out of four. But which counts for which? Do a split decision and split affirmance count as one or several issues? On which issues does the Administrator reverse consistently? Is there any consistency at all?

A reexamination of these hundreds of decisions highlighted one consistent reason for reversal: When providers lost, they had typically failed to develop the facts necessary to support their case. Losing a challenge to the regulations or the manual—which would actually be resolved in federal court—was unusual. Therefore, it might be preferable to eliminate the Administrator’s \textit{sua sponte} review as applied to the post-April 1994 configuration. With the Executive Director’s position intact, the quality of Board opinions should rise and thereby diminish or largely eliminate the need for \textit{sua sponte} review.

\textbf{E. Model No. 4: Reconfigure the Appeals Process to Include Alternative Dispute Resolution}

This model, as diagrammed in Figure 4, does not refer to the role of the Executive Director of the PRRB nor to HCFA. It was created to function without regard to the other relationships within and without the PRRB. Instead, the core of this configuration is alternative dispute resolution, which in this context is perhaps better defined as “appropriate” dispute resolution.

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383. For this article, I reviewed all PRRB decisions reported in the CCH Medicare & Medicaid Guide and attempted to track the pattern of Administrator reviews. After the list was compiled, I analyzed it more closely and discovered that the same error undermines all the other attempts at assessing whether the HCFA Administrator has—as alleged—overturned more PRRB decisions that favored providers than not.
Third-party neutrals would serve as mediators to facilitate negotiated settlements of Part A disputes. HHS's Departmental Appeals Board has offered its services in this role. Apart from its expertise and willingness, the DAB is already highly respected throughout the agency and the public for its integrity and fairness. This reputation would be important in overcoming the reluctance parties might encounter when beginning an ADR program.

The dollar limits on the size of disputes that would go to ADR are mere suggestions. Many seemed to believe that matters of $50,000 or less would be negotiated easily because disputes of that size often are not worth pursuing before the Board given the high expense of case preparation. On the other hand, thorough case preparation is essential to negotiating a good settlement. Therefore, preparation costs may be just as high for a well-done ADR session as for a trial-type adjudication.

As one current Board member pointed out, however, people are often more likely to settle cases when large dollar amounts are at stake and there is room for both sides to give something and still leave the negotiations satisfied with what they take. Hence, another suggestion is to place no arbitrary dollar limit on matters going to ADR.

Most of those interviewed agreed that ADR should be made mandatory, not voluntary, at least at some level. Both provider and intermediary representatives understood that compliance would be achieved with much greater ease if neither side appeared "weaker" than the other just because that party had offered to accept mediation instead of litigation. Few of those interviewed wanted ADR to replace entirely all PRRB appeals; the desire for an appellate body remained.

F. Model No. 5: Replace the Board Advisors with ALJs

The diagrammed model in Figure 5 strips away much of the administrative structure previously discussed. Paralegals would be replaced by ALJs,
who would hear all PRRB cases. Appeal could be made to the Board members. In order not to create further duplicative layers of review and bureaucracy, the Administrator’s *sua sponte* review would be eliminated.

![Diagram](image)

Figure 5. The Board Hears Appeals from Cases Heard by Administrative Law Judges

ALJs in the Social Security Administration who have previously handled Medicare appeals might be ideal choices for this new position. Most of the people interviewed thought that, with education and training in the more intricate issues of institutional cost accounting, these ALJs could handle the cases. Indeed, those who have had experience with ALJs in state payer systems seemed quite comfortable with the paradigm as applied to the PRRB.

**G. Model No. 6: Eliminate the PRRB and Transfer All Functions to the DAB**

This model, as diagrammed in Figure 6, is conceptually the simplest yet politically the most challenging. In this reconfiguration, the PRRB is eliminated entirely and all of its functions are transferred to the Departmental Appeals Board within HHS.
Figure 6. Transfer PRRB Functions to the Departmental Appeals Board

This proposal met with surprising initial acceptance by virtually all of the people interviewed, including some past and present members of the PRRB. Unfortunately, as the PRRB “turf wars” increased, opposition emerged. Nevertheless, it is difficult to find a better fit between the types of cases the two agencies hear, both of which often involve much financial and policy complexity. The staff of highly trained attorneys, paralegals, and ALJs that would be needed to carry the PRRB caseload already exists at the DAB. The use of ALJs would eliminate any confusion about the formal nature of the hearings and the protections due the decisionmakers’ independence. Moreover, the DAB has a seasoned ADR staff and a reputation for programmatic integrity. The DAB appears to have found and maintained the appropriate balance between institutional independence and recognition that it serves as a delegate of the Secretary. The Secretary has reinforced that balance by respecting the insulation that the DAB maintains within the department. Moreover, the DAB has expressed confidence that it could, if required, take on the task. Finally, the DAB has a long-standing policy of consumer-orientation in its services, especially through its ADR processes.

CONCLUSION

In its time, the Provider Reimbursement Review Board served an important role in shaping the procedures for emerging Medicare payment policies. In particular, the PRRB provided a critical forum for institutional providers to alert HCFA to problems that its intermediaries could not effectively address. When the PRRB functioned at its best, it gave providers the oppor-

384. In-person and telephone interviews with members of the Departmental Appeals Board in May 1995 revealed considerable concern for consumer service and no discernable interest in competing for agency “turf.” Members of the DAB offered to work with the PRRB Office of Hearings to implement an effective ADR program.
tunity to develop a searching, thorough administrative record from which to launch an appeal to the federal courts.

Notwithstanding the sometimes significant contributions of the PRRB in the past, the Board’s function in the future is undeniably more limited. Changes in Medicare payments have superseded much of the rationale for the Board’s existence. Simply because an agency has been useful in the past does not mean that it should continue to exist in the future, especially if other agencies can serve its function with greater efficiency, perceived fairness and integrity, and sensitivity to consumer interests.

Since the April 1994 reorganization, the PRRB has served little meaningful function as an independent tribunal. The control of the staff rests not with the Board but with HCFA’s appointee, the Executive Director. The Board itself serves at the peril of conflict with the Executive Director because, despite disingenuous protestations to the contrary, his negative recommendation can lead to a Board member’s removal. If the Board is not to be vested with genuine authority to control its operations, including development of cases and opinion writing, then it should be significantly reduced in size and operation. This option would scale the PRRB back to the size of the MGCRB and place virtually all cases in ADR. Alternatively, the Board should be eliminated entirely, and all its functions, including ADR, should be vested in the DAB.

Replacing most PRRB functions with negotiated settlement—whether at the PRRB itself or after transferring those functions to the DAB—would represent a major step toward implementing President Clinton’s Executive Order 12,988. It would put into bold practice the promise now inchoate in his order for civil justice reform. It would also provide a response to the critical question posed by Chief Justice Warren Burger nearly fifteen years ago when he looked at American legal structures and asked: “Isn’t there a better way?” If these recommendations were implemented, “a better way” would have been found in at least one area of administrative law. As Justice Burger implored in his 1982 Annual Report on the State of the Judiciary, “we should provide mechanisms that can produce an acceptable result in the shortest possible time, with the least possible expense and with a minimum of stress on the participants. That is what justice is all about.” The current process for adjudicating Medicare hospital payments fails on all three counts. It is time for new “tools.” As Chief Justice Burger said,

The law is a tool, not an end in itself. Like any tool, particular judicial mechanisms, procedures, or rules can become obsolete. Just as the carpenter’s handsaw was re-

387. Id.
placed by the power saw and his hammer was replaced by the stapler, we should be alert to the need for better tools to serve our purposes. 388