No. 11-1231

IN THE
Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

AUBURN REGIONAL MEDICAL CENTER, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST[1]

The American Hospital Association respectfully submits this brief as *amicus curiae*.

The American Hospital Association represents more than 5,000 hospitals, health care systems, and other health care organizations, plus 42,000 individual members. AHA members are committed to

[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than *amicus curiae*, its members, or counsel made any monetary contribution intended to fund the preparation or submission of this brief. All parties have given their consent to this filing in letters that have been lodged with the Clerk.

improving the health of communities they serve and to helping ensure that care is available to, and affordable for, all Americans. The AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health care policy.

Integral to AHA's mission of achieving quality and affordable health care is ensuring that hospitals are promptly and correctly paid for services rendered. A significant portion of those payments come from Medicare and Medicaid, programs overseen by the Secretary of Health and Human Services and the Center for Medicare and Medicaid Services (CMS). In 2011, Medicare covered 48.7 million people and paid $541.3 billion in benefits, $167.8 billion of which went to hospitals. Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report* 10 tbl. II.B.1 (Apr. 23, 2012).[2]

AHA supports CMS's attempts to provide hospitals with a transparent, fair, and streamlined administrative process to correct inaccurate payments. But that administrative process cannot work if it is not properly overseen from the outside. Any administrative system that reviews provider reimbursement—including the Provider Reimbursement Review Board (PRRB)—should also allow for robust judicial review of the system's administrative findings. Limiting judicial review of the reimbursement review process through rigid time limitations—as the Secretary and Court-appointed *amicus* propose—

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[2] *Available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf.

would be contrary to Congress's intent, skew incentives for CMS employees, reduce transparency, and harm hospitals.

SUMMARY OF ARGUMENT

1. As Respondents cogently explain, the 180-day time limit on appeals to the PRRB should be subject to ordinary principles of equitable tolling. " '[J]urisdiction * * * is a word of many, too many, meanings.' " *Arbaugh* v. *Y&H Corp.*, 546 U.S. 500, 510 (2006) (quoting *Steel Co.* v. *Citizens for Better Env't*, 523 U.S. 83, 90 (1998)). Thus, the Court has held that unless Congress itself " 'rank[s] a statutory limitation on coverage as jurisdictional, courts should treat the restriction as nonjurisdictional.' " *Gonzales* v. *Thaler*, 132 S. Ct. 641, 648 (2012) (quoting *Arbaugh*, 546 U.S. at 516). Neither the Secretary nor the Court-appointed *amicus* can point to anything that is a sufficiently "clear[ ] statement," *id.* at 649, to overcome the strong presumption that Congress intended the 180-day time limit on PRRB review to be nonjurisdictional. Thus, ordinary tolling principles, such as equitable tolling, should apply. *See Irwin* v. *Dep't of Veteran Affairs*, 498 U.S. 89, 95-96 (1990).

2. But this case's importance goes well beyond the seemingly technical question of whether the 180-day time limit is "jurisdictional," Court-Appointed Amicus Br. 14-48; "not jurisdictional in the strictest sense of that term," SG Br. 47; or a "claims-processing rule," Respondents' Br. 21. Whether the courts have the power to toll the 180-day time limit will have a profound impact on both outside oversight of the Medicare program and hospitals' ability to serve Medicare beneficiaries.

a. The Medicare Act has been called "among the most completely impenetrable texts within human experience." *Rehab Ass'n of Va.* v. *Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994); *see also Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011) ("lamenting the complexity of" the "regulatory behemoth" that is the Medicare Act). But among all of its complexities, one thing in the Act is perfectly clear: Congress intended for there to be, at the end of Medicare's administrative labyrinth, an opportunity for judicial review. Judicial review ensures that there is a meaningful check on CMS's otherwise complete control of the Medicare system. The Secretary and Court-appointed *amicus*'s constructions of the 180-day appeal period, however, erroneously place finality above all else—even above the federal courts' traditional role in correcting agency errors.

b. Adopting the Secretary or Court-appointed *amicus*'s rule will impose an enormous financial and administrative burden on hospitals. Hospitals already commit tremendous sums to caring for the elderly and vulnerable, covering billions in costs that Medicare does not fully reimburse and providing billions more in charity care. The Secretary and Court-appointed *amicus*'s rules would add to those burdens by forcing hospitals to bear the additional cost imposed by CMS's undetectable mistakes. And it is the safety-net hospitals—which depend the most on government aid to make ends meet and serve the most underserved populations—that will be harmed the most if the Secretary or Court-appointed *amicus*'s rule becomes law.

c. The Secretary's only justification for forcing hospitals to shoulder the additional burden of CMS's

mistakes is that it saves the agency the administrative trouble of reopening older claims. But CMS already reopens supposedly stale claims as part of its efforts to recoup alleged past *overpayments*, imposing significant burdens on hospitals in doing so. This Court should reject an interpretation of the Medicare statute that benefits only CMS and its agents.

ARGUMENT

I. CATEGORICALLY BARRING EQUITABLE TOLLING OF THE 180-DAY PRRB TIME LIMIT WOULD FLOUT CONGRESSIONAL INTENT AND FURTHER OBSCURE THE ALREADY OPAQUE WORKINGS OF CMS.

At the heart of the Medicare Act's administrative- and judicial-review provisions is a balance. On one hand, Congress granted the Secretary authority to decide questions arising from the Medicare Act in the first instance. *See Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 12-13 (2000). On the other, Congress understood that administrative process could only be fair if there was an adequate opportunity for judicial review at the process's end. *See Bowen* v. *Mich. Academy of Family Physicians*, 476 U.S. 667, 670-681 (1986).

The Secretary and Court-appointed *amicus*'s interpretations of the PRRB's jurisdiction upset that balance. Both of their rules lead to the same conclusion: So long as a CMS mistake in payment calculation goes undetected for over 180 days—even if providers could not have discovered the error in that time—the federal courts must stand idly by. That is wrong as a matter of law. And it would create skewed incentives: If no one—or only CMS—can craft a remedy when a CMS mistake remains undis-

covered for over 180 days, it will encourage the agency to discover errors only on the 181st day. Those incentives will further reduce the transparency of CMS's data-collection and payment-calculation processes. And that in turn will only add to the PRRB backlog that the Secretary and Court-appointed *amicus*'s rules purport to reduce. The bottom line of all three of these impacts is a less accountable, less efficient Medicare system—the opposite of what Congress intended.

1. A bedrock principle of administrative law is the "strong presumption in favor of judicial review of administrative action." *INS* v. *St. Cyr*, 533 U.S. 289, 298 (2001); *accord Gutierrez de Martinez* v. *Lamagno*, 515 U.S. 417, 425 (1995). As Chief Justice Marshall himself put it over 170 years ago, it would "excite some surprise if" an administrative officer could "levy * * * any sum he might believe due, leaving to that debtor no remedy, no appeal to the laws of his country, if he should believe the claim to be unjust." *United States* v. *Nourse*, 34 U.S. (9 Pet.) 8, 28-29 (1835). But "this anomaly does not exist." *Id.* Congress has concurred. Denying judicial review for violations of the law, it wrote in its Report on the Administrative Procedure Act, "would in effect" allow "blank checks drawn to the credit of some administrative officer or board." S. Rep. No. 752, at 26 (1945).

To be sure, Congress may *defer* judicial review, channeling it through the administrative agency in the first instance. In such a case, the judicial-review presumption is not immediately implicated. *Thunder Basin Coal Co.* v. *Reich*, 510 U.S. 200, 207 & n.8 (1994). But judicial review in those circumstances is not "ousted, but only postponed." *United States* v.

Philadelphia Nat'l Bank, 374 U.S. 321, 353 (1963). The supervisory role this Court presumes for the judiciary will still be carried out; it just takes place on a different timetable. *See Illinois Council*, 529 U.S. at 23-24.

Congress has chosen this deferred approach to judicial review for the Medicare system. The Medicare Act channels review through the PRRB by replacing the federal courts' general federal-question jurisdiction with a specific jurisdictional grant allowing providers to challenge an adverse PRRB ruling in the district court within 60 days. 42 U.S.C. § 1395oo(f)(1) (PRRB judicial-review provision); *Illinois Council*, 529 U.S. at 16-18. This funneling mechanism gives CMS "the opportunity to reconsider its policies, interpretations, and regulations" in light of the challenges brought by providers. *Illinois Council*, 529 U.S. at 16-18. It also permits the agency to save parties time and money by resolving payment disputes at an early stage and in a less formal setting.

But despite implementing an agency-first dispute-resolution process, Congress still meant for judicial review to serve as an important check on the administrative process. *See Rehab Ass'n of Va.*, 42 F.3d at 1450 (deference to CMS "did not replace Article III of the Constitution"). Indeed, throughout the Medicare Act's history Congress has *expanded* opportunities for providers to obtain administrative and judicial review, and thereby constricted CMS's ability to promulgate contrary regulations. *See, e.g.*, Social Security Amendments Act of 1972, Pub. L. No. 92-603, § 243(a) (codified at 42 U.S.C. § 1395oo) (establishing administrative and judicial review process governing provider payments that displaced previous

CMS-developed regulations); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub L. 108-173, § 932 (codified at 42 U.S.C. § 1395ff(b)(F)) (requiring Secretary to establish process of expedited access to judicial review for challenges to agency regulations, displacing existing regulations on topic).

This Court, too, has recognized that courts must step in to protect judicial review when the Secretary's regulations deny effective relief. In *Michigan Academy*, the Court rejected the Secretary's contention that Congress intentionally left CMS's implementation of Medicare Part B unreviewable by the courts, instead locating a right of action under the general federal-question-jurisdiction statute. 476 U.S. at 680-681. In *Illinois Council*, the Court confirmed that the otherwise absolute channeling requirement of the Medicare Act does not apply where channeling would cause a "complete preclusion of judicial review." 529 U.S. at 22-23 (emphasis omitted). And in implementing these decisions, the lower courts have recognized that CMS's comprehensive process can be bypassed when traversing it would be practically impossible for providers. *See Council for Urological Interests* v. *Sebelius*, 668 F.3d 704, 713-714 (D.C. Cir. 2012); *Nat'l Ass'n of Psychiatric Health Sys.* v. *Shalala*, 120 F. Supp. 2d 33, 38-39 (D.D.C. 2000). All of these decisions acknowledge the paramount importance of ensuring judicial review, even in the face of the Medicare Act's channeling provisions. And they recognize as much even when CMS would otherwise prefer to limit judicial review in the name of administrative efficiency.

In sum, "Congress intends the executive to obey its statutory commands and, accordingly, * * * it expects

the courts to grant relief when an executive agency violates such a command." *Michigan Academy*, 476 U.S. at 681. Thus, Congress intends for the courts, at the end of CMS's administrative process, to have "adequate authority to resolve any * * * contention the agency does not, or cannot, decide." *Illinois Council*, 529 U.S. at 1.

2. The Secretary and Court-appointed *amicus*'s constructions of the 180-day PRRB review deadline would strip the federal courts of that authority. That is because both of their rules amount to this: If a CMS error is concealed for 181 days, even if the affected providers could not discover it on their own, the federal courts are powerless—under any circumstances, regardless of any equities—to step in. This Court should reject such a harsh result. *See Nat'l R.R. Passenger Corp.* v. *Morgan*, 536 U.S. 101, 121 (2002) (equitable tolling is available whenever " 'equity so requires.' ") (citation omitted). Congress's intention that the executive obey its statutory commands is toothless if the executive can insulate its disobedience from review as long as it goes unnoticed for a mere six months—a flash in the pan in hospital reimbursement years.

The Secretary offers assurances that CMS's mistakes will not go unremedied; hospitals, she says, are "sophisticated Medicare-provider recipients" who should be able to spot agency errors quickly. SG Br. 28. But the equitable-tolling doctrine already takes that into account. It requires the claimant to prove both " '(1) that he has been pursuing his rights diligently, and (2) that some extraordinary circumstance stood in his way' and prevented timely filing." *Holland* v. *Florida*, 130 S. Ct. 2549, 2653 (2010)

(quoting *Pace* v. *DiGuglielmo*, 544 U.S. 408, 418 (2005)). In a routine case where the mistake is one the provider could and should have caught, the equitable-tolling question should be an easy one.

The Secretary's back-up response is that a deadline that does not allow for equitable tolling serves "[p]rinciples of finality and repose." SG Br. 30. There is no doubt that "finality and repose" are goals of the Medicare Act. They are goals of any time limitation. *See Am. Pipe & Construction Co.* v. *Utah*, 414 U.S. 538, 554 (1974). Yet the goal of finality "is frequently outweighed * * * where the interests of justice require vindication of the plaintiff's rights." *See Burnett* v. *N.Y. Cent. R. Co.*, 380 U.S. 424, 428 (1965). That is as true in the Medicare Act as anywhere else. *Cf. Bowen* v. *City of New York*, 476 U.S. 467, 480 (1986) (applying equitable tolling to Social Security Act and its similarly intricate channeling provision). As this Court has warned time and again, " 'no legislation pursues its purposes at all costs' "; " 'it frustrates rather than effectuates legislative intent * * * to assume that *whatever* furthers the statute's * * * objective must be the law.' " *Pension Benefit Guar. Corp.* v. *LTV Corp.*, 496 U.S. 633, 646-647 (1990) (quoting *Rodriguez* v. *United States*, 480 U.S. 522, 525-526 (1987)). The Secretary's focus on "finality and repose" violates this cardinal principle.

Equally important as "finality and repose," then, is a judicial check on CMS's payment errors when extraordinary circumstances prevent providers from protesting those errors within six months. And while providers bear the burden of establishing those "extraordinary circumstances," *Pace*, 544 U.S. at 418,

the equities are on providers' side in other respects, for "the Secretary has the capability and duty to prevent the illegal policy" the claimants are challenging. *See City of New York*, 476 U.S. at 487. The 180-day time limitation should not be a bright line that bars courts from correcting " 'particular injustices' " through the doctrine of equitable tolling. *Holland*, 130 S. Ct. at 2563 (quoting *Hazel-Atlas Glass Co.* v. *Hartford-Empire Co.*, 322 U.S. 238, 248 (1944)).

3. That is particularly so because of the incentives that the Secretary and Court-appointed *amicus*'s rules create. There are "hundreds of calculations that go into an annual determination of the amount due to a provider for any given cost reporting period." SG Br. 30. And any one of those calculations—including some that apply to all providers participating in Medicare—can be the subject of a mistake by CMS employees or agents.

For instance, an error in calculating inpatient hospital rates between 1998 and 2007 led CMS to underpay hospitals by an estimated $3 billion. C. Terhune, *Medicare To Settle Hospital Reimbursement Dispute*, L.A. Times, Apr. 12, 2012.[3] A "technical error" in calculating readmissions penalties under the Affordable Care Act led CMS to belatedly tell 1,422 hospitals they owed more in penalties than initially projected. J. Rau, *Medicare Revises Hospitals' Readmissions Penalties*, Kaiser Health News, Oct. 2, 2012.[4] And even apart from these system-

[3] *Available at* http://articles.latimes.com/2012/apr/12/business/la-fi-0413-medicare-settlement-20120412.

[4] *Available at* http://www.kaiserhealthnews.org/Stories/2012/October/03/medicare-revises-hospitals-readmissions-penalties.aspx.

wide miscalculations, smaller mistakes add up. CMS's own contractors identified $61.5 million in underpayments to providers in the second quarter of 2012 alone. CMS, *National Recovery Audit Program Quarterly Newsletter* (Mar. 2012).[5]

Errors big and small are inevitable in a system of Medicare's size. The question is what to do once they become apparent. AHA supports a "simple, transparent, and predictable" system where CMS shares the data underlying its payment calculations with providers. *See, e.g.*, Letter from American Hospital Ass'n to M. Tavenner, Acting Administrator, CMS, 14, 44 (June 19, 2012); *see also* 61 Fed. Reg. 46,166, 46,206 (Aug. 30, 1996) (noting that "[h]ospitals are increasingly frustrated by their inability to monitor" CMS's reimbursement calculations).[6] A transparent system would allow hospitals to double-check CMS's work and point out mistakes well within the 180 days permitted for PRRB review. A transparent system would also allow hospitals and CMS to work together to develop a payment-computation system that avoids both underpayments *and* overpayments.

The Secretary and Court-appointed *amicus*'s rules, however, would undercut these goals in three distinctive ways.

First, the Secretary and *amicus*'s rules would reduce transparency because they create an incentive

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[5] *Available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-2nd-qtr-2012.pdf.

[6] *Available at* http://www.aha.org/advocacy-issues/letter/2012/120619-cl-ipps.pdf.

to conceal mistakes rather than correct them. CMS is under tremendous pressure to contain Medicare costs. *See, e.g.*, CMS, *Affordable Care Act Update: Implementing Medicare Cost Savings* 1-2 (outlining the $418 billion in cost savings required by 2019 to extend the Trust Fund's solvency by 12 years)[7]; Editorial, *Fixing Medicare*, N.Y. Times, Nov. 20, 2011 (observing that politicians seek "big immediate cuts to slow Medicare spending").[8] Under the Secretary and *amicus*'s rules, the Government will retain any cost "savings" from underpayment errors that do not come to light within 180 days of the payment notices being issued. *Cf. Armstrong* v. *Executive Office of the President*, 1 F.3d 1274, 1284 (D.C. Cir. 1993) (" '[A]gencies, left to themselves, have a built-in incentive to dispose of records relating to [their] 'mistakes[.]' ") (citation omitted); *see also* Respondents' Br. 12-13 (detailing CMS's history of concealing the DSH errors at issue in this case).

To be sure, CMS employees generally are conscientious in the performance of their duties. "But agencies are run by people and people make mistakes. Review by a tribunal outside the agency helps correct these * * * errors." *Rodriguez-Roman* v. *INS*, 98 F.3d 416, 433 (9th Cir. 1996) (Kozinski, J., concurring). Equitable tolling gives CMS an incentive to share data so that providers may review their own reimbursement notices and identify costly mistakes *before* they are compounded through repetition. And it gives CMS employees and agents an incentive to

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[7] *Available at* http://www.cms.gov/apps/docs/ACA-Update-Implementing-Medicare-Costs-Savings.pdf.

[8] *Available at* http://www.nytimes.com/2011/11/21/opinion/fixing-medicare.html.

promptly report errors before they become more harmful with time. *See* M.C. Stephenson, *The Price of Public Action*, 118 Yale L.J. 2, 32 (2008) ("[J]udicially imposed procedural requirements * * * increase accuracy by correcting mistakes ex post and by encouraging government decisionmakers to be more thoughtful and careful ex ante."). By contrast, if there were no review of CMS calculations after the 180-day window, it "leaves the problem of how [CMS] will learn from [its] mistakes, and, indeed, how [CMS] will even realize [it] ha[s] made a mistake." M.F. Cuellar, *Auditing Executive Discretion*, 82 Notre Dame L. Rev. 227, 262 & n.138 (2006); *see also* R.W. Parker, *Grading the Government*, 70 U. Chi. L. Rev. 1345, 1369 (2003) ("[A]gencies have little or no incentive to probe, in detail, the possibility of their own prior analytical mistakes.").

Second, allowing CMS to dole out exceptions to the 180-day PRRB review provision solely as a matter of its "grace," SG Br. 29, would create an incentive for CMS to develop administrative procedures that systematically favor it. Hospitals have already seen this incentive in action. After *Monmouth Medical Center* v. *Thompson*, 257 F.3d 807 (D.C. Cir. 2001), where the D.C. Circuit required CMS to reopen previously closed provider reimbursement determinations pursuant to CMS's existing regulations, the agency changed the regulations. The previous regulations required payment intermediaries to reopen a claim any time the Secretary notified them that a prior determination was inconsistent with applicable law. *Id.* at 809. The new rule sharply narrows that class of claims that must be reopened, providing that "[a] change of legal interpretation or policy by CMS * * * in response to judicial precedent * * * is not a

basis for reopening a CMS or intermediary determination." 42 C.F.R. § 405.1885(c)(2); *see also* 67 Fed. Reg. 49,982, 50,096 (Aug. 1, 2002). Similarly, the reopening regulations allow CMS to reopen a closed reimbursement claim past the existing three-year bar for "fraud or similar fault of any party" to the claim, 42 C.F.R. § 405.1885(b)(3), but deny hospitals access to that exception because (at least according to the Department of Justice) CMS is not a "party" to a reimbursement determination. SG Br. 7 n.5.

Doctrines such as equitable tolling counteract this one-way ratchet. They give hospitals a way to present otherwise untimely claims in exceptional circumstances not sufficiently accounted for by CMS's regulations. And the availability of those doctrines encourages CMS to craft more even-handed rules so that providers are not forced to appeal to general equitable principles to obtain relief from the agency's errors. *Cf.* SG Br. 22.

Finally, the Secretary and *amicus*' rules have the potential to increase—not diminish—the backlog at the PRRB. *See id.* at 24-25. That is because if a provider has even the slightest notion of an error in its payment notice, it will have to file an appeal before 180 days or lose its review rights. Such "protective appeals" have the potential to further clog an already jammed administrative system. *See* Letter from American Bar Ass'n, Health Law Section, to M. McClellan, Administrator, CMS 3-4 (Aug. 24. 2004) ("a large portion of the PRRB's backlog is comprised [of] * * * protective appeals").[9] The availability of

[9] *Available at* http://www.americanbar.org/content/dam/aba/migrated/health/04_government_sub/media/PRRB.authcheckdam.pdf.

equitable tolling assures providers that if they genuinely have done their best to ensure the accuracy of their reimbursement notices, they do not need to file a provisional appeal. *Cf. id.* (arguing that *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, 525 U.S. 449 (1999), committing reopening solely to CMS's discretion, led to "providers fil[ing] protective appeals regarding matters that otherwise, and prior to *Your Home*, would have been rectified through the reopening process."). They can rely on the "established" equitable doctrine of tolling, *Credit Suisse Sec. (USA) LLC* v. *Simmonds*, 132 S. Ct. 1414, 1421 (2012), and receive the reimbursement they should have, but did not, receive from CMS.

The bottom line: Permitting the 180-day PRRB appeal deadline to be equitably tolled in appropriate circumstances simultaneously serves the goals of ensuring judicial review and providing the agency incentives to maintain a transparent, fair, and streamlined administrative-review system. It is not a doctrine to be lightly appealed to or lightly applied. But it is an "ordinary background * * * principle[ ]," that "Congress was certainly aware of," *see id.*, and that this Court should apply to the Medicare statute.

II. THE SECRETARY'S RULE WILL HARM HOSPITALS.

The Government has portrayed Respondents' suit as an attempt to opportunistically raid the Medicare Trust Fund based on decades-old claims. Pet. 28. That accusation could not be further from the truth. Hospitals are underpaid by Medicare for their costs even when the program's reimbursements are proper and timely. And safety-net hospitals, which serve the nation's most vulnerable patient populations,

rely on proper Disproportionate Share Hospital (DSH) payments to meet their costs each year. Systematic underpayment errors like those alleged by Respondents exacerbate hospitals' problems. And preventing federal courts from applying traditional equitable doctrines to the PRRB appeal period will make hospitals' already perilous situation even worse.

Hospitals understand perhaps better than anyone that their fates are linked to a healthy and solvent Medicare Trust Fund. In seeking equitable tolling, hospitals simply are attempting to obtain the reimbursements they are owed for the services they provided. And they are doing so in a regulatory environment where CMS employs contractors charged with clawing back payments from hospitals and imposes heavy administrative burdens in the process. Hospitals do not seek preferential treatment through equitable tolling; they seek the fair treatment that lies at the core of the doctrine.

1. Despite the hundreds of billions of dollars the federal government spends on Medicare and Medicaid, hospitals are not getting rich off of those programs. In 2010, Medicare and Medicaid patients accounted for 57 percent of all care provided by hospitals, but hospitals lost a total of $27.9 billion providing that care. American Hosp. Ass'n, *Underpayment By Medicare And Medicaid Fact Sheet* 1-2 (2012).[10] $20.1 billion of that $27.9 billion loss was attributable to Medicare patients and means hospitals receive on average only 92 cents of reimburse-

[10] *Available at* http://www.aha.org/content/12/2012medunderpayment.pdf.

ment for each dollar they spend treating Medicare recipients. *Id.* at 3.

That figure is only the latest in a decade-long history of losses. Losses on Medicare-recipient care have ranged from a low of $1.3 billion in 2000, when AHA began tracking them, to a high of $25.2 billion in 2009. *Id.* Hospitals lost money on Medicare patients in every single one of these years—a total loss of *$152.9 billion* between 2000 and 2010. *See id.* Those consistent deficits, in turn, mean that hospitals effectively underwrite part of the Medicare system by covering costs for government-insured patients that the government does not.

But bridging that Medicare-payment gap is only one of the benefits hospitals provide to their communities. Hospitals also provide significant amounts of uncompensated care to patients for which they are not reimbursed by anyone. That care added up to an additional $39.3 billion in 2010, or 5.8 percent of hospitals' total costs. *See* American Hosp. Ass'n, *Uncompensated Hospital Care Cost Fact Sheet* 4 (Jan. 2012).[11] Indeed, in the last decade, hospitals provided more than *$300 billion* in uncompensated care to the uninsured and under-insured. *Id.*

As these figures show, hospitals already do their part to contribute to the health and welfare of the communities they serve. But the Secretary and Court-appointed *amicus*'s constructions of the 180-day time limitation would ask hospitals to shoulder an even greater burden. Under their rules, hospitals would assume the cost of CMS's mistakes when those

[11] *Available at* http://www.aha.org/content/12/11-uncompensated-care-fact-sheet.pdf.

mistakes are discovered 180 days after the notice of proposed reimbursement is received, even if the error could not have been caught sooner through diligent efforts. Hospitals should not be forced to bear the risk that some systemic administrative mistakes will be impossible to unearth before the PRRB appeal period has run.

2. Forcing hospitals to bear the consequences of CMS's latent errors would be particularly harmful in this case. The Medicare DSH funds at issue here go to hospitals that "serve a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(v). Combined with Medicaid DSH payments, these funds provide assistance to "safety-net hospitals" that serve a large number of low-income patients. *The Basics: Medicaid Disproportionate Share Hospital (DSH) Payments* 1 (June 15, 2009) ("*The Basics*").[12] DSH payments help these hospitals—many of them publicly owned and operated[13]—maintain the resources to care for patients who often have nowhere else to turn for medical assistance. L. Fishman & J.D. Bentley, *The Evolution of Support for Safety-Net Hospitals* 34-35, Health Affairs (July 1997).

The importance of DSH payments to inner-city and rural safety-net hospitals cannot be overstated. In

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[12] *Available at* http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf.

[13] Kaiser Comm'n on Medicaid and the Uninsured, *Stresses to the Safety Net: The Public Hospital Perspective* 1-2, 9 (June 2005), *available at* http://www.kff.org/medicaid/upload/Stresses-to-the-Safety-Net.pdf; *see also* Respondents' Br. 6 (twenty percent of Medicare DSH recipient hospitals are publicly owned and operated).

2009, the federal government allocated $10.1 billion for Medicare DSH payments. *See* Health Industry Distributors Ass'n, *Disproportionate Share Hospital (DSH) Payments*, *Health Care Reform* 1 (Sept. 2010).[14] These payments—together with Medicaid DSH—are the largest source of federal funding for uncompensated care and the largest source of public funding for many hospitals. *The Basics* at 1.

Medicare DSH payments are spread out over more than just safety-net hospitals, but they are an important source of funding for those hospitals in particular. For instance, Medicare DSH paid for five percent of all unreimbursed care at public safety-net hospitals in 2009. National Ass'n of Public Hosp., *2009 Annual Survey: Safety Net Hospitals and Health Systems Fulfill Mission in Uncertain Times* 4 fig.5 (Feb. 2011).[15] And if Medicare DSH were significantly cut, the results would be catastrophic. One study found that a 75 percent cut in Medicare DSH—as mandated by the Affordable Care Act, 42 U.S.C. § 1395ww(r)—would drive the operating margins of the average privately owned California safety-net hospital from a barely positive 1.1 percent to *negative* 2.8 percent. Private Essential Access Community Hospitals, *The Impact of Medicare Disproportionate Share Reductions on Private Safety-*

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[14] *Available at* http://www.hida.org/App_Themes/Member/docs/GA/Reimbursement/Disproportionate%20Share%20Hospital%20(DSH)%20Payments.pdf.

[15] *Available at* http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2009-Characteristics-Survey-Research-Brief.aspx?FT=.pdf.

Net Hospitals in California 5 (Jan. 2011).[16] Another found that the 75 percent cut in Medicare DSH would by itself cause nearly 10 percent of urban safety-net hospitals to go from positive to negative operating margins. National Ass'n of Urban Hosp., *Financial Challenges To Urban Hospitals* (Jan. 2011).[17] Without Medicare DSH payments, many safety-net hospitals could not keep operating.

For these reasons, the argument that allowing equitable tolling in this case and others like it could result in "billions" in additional payments to hospitals, Pet. 28, cuts both ways. Even assuming enough cases would clear the high equitable-tolling bar to add up to billions of dollars in claims, those dollars rightfully belong to struggling hospitals. Every dollar of DSH money that CMS improperly retains is a dollar that should have gone to a hospital already fighting to provide care for the financially vulnerable. The notion that equitable tolling could produce more reimbursements for these hospitals is not a reason to rule out equitable tolling. It is a reason to allow it.

3. The Government dismisses the plight of safety-net and other hospitals. It suggests that this suit and others are driven not by financial necessity, but by "health care consulting firms" that have "every incentive to scour old cost reports looking for asserted reimbursement errors." Pet. 28. Those aspersions are puzzling. Of course hospitals enlist special-

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[16] *Available at* http://www.peachinc.org/wp-content/uploads/2011/03/January-2011-Impact-of-Medicare-DSH-cuts-to-Californias-private-safety-net-hospitals.pdf.

[17] *Available at* http://www.nauh.org/component/option,com_rubberdoc/format,raw/id,1/view,doc/.

ized outside help to navigate the warren of CMS's "exceedingly complex" regulations. SG Br. 15. CMS should in fact be intimately familiar with the need for such specialists, because it does precisely the same thing: It employs contractors whose job it is to "scour old [reimbursement claims] looking for asserted reimbursement errors." Pet. 28.

CMS retains private parties, known as Recovery Audit Contractors or RACs "for the purpose of identifying [Medicare] underpayments and overpayments and recouping overpayments." 42 U.S.C. § 1395ddd(h)(1). RACs review past Medicare claims for compliance with the payment rules. If the RAC determines that a claim resulted in an improper overpayment, it can recover the amount of the overpayment. American Hosp. Ass'n, *Medicare Recovery Audit Contractors (RACs): Permanent Program Basics* 1, 7-8 (Apr. 20, 2009).[18] The provider can challenge the RAC's finding, but the multi-level appeal process is expensive and cumbersome. American Hosp. Ass'n, *Program Integrity and Contractor Overlap* 2.[19]

Medicare RACs are paid for their efforts "on a contingent basis," 42 U.S.C. § 1395ddd(h)(1)(B)(i)—currently, between 9 percent and 12.5 percent of the overpayment amount. 76 Fed. Reg. 57,808, 57,809 (Sept. 16, 2011). Thus, the more claims a RAC reopens and rejects, the more the RAC is paid. And the evidence suggests that RACs improperly deny a

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[18] *Available at* http://www.ashrm.org/ashrm/advocacy/advisories/files/2009rac.pdf.

[19] *Available at* http://www.aha.org/content/12/12-ip-program-integ.pdf.

large number of claims; 74 percent of appealed RAC decisions are ultimately reversed. American Hosp. Ass'n, *Exploring the Impact of the RAC Program on Hospitals Nationwide* 50 (Feb. 15, 2012).[20]

The RAC program—and its attendant demand for archived medical records—has placed tremendous burdens on hospitals. An AHA survey of 1,800 hospitals revealed that 50 percent experienced increased administrative costs as a result of the RAC program. American Hosp. Ass'n, *Medicare & Medicaid Recovery Audit Contractors* 1.[21] Many have had to add new administrative personnel just to handle the demands of RAC audits. *Id.* And even though an overwhelming majority of providers prevail on appeal, many opt not to try. *Id.* The average appeal takes 18-24 months to wind its way through the process, and the cost of the appeal often will be greater than the amount of money clawed back by the RAC audit in the first place. *Id.* Yet hospitals still—as they must—comply with RAC demands.

CMS's attempts to look back at long-closed payments go beyond the RAC program. In a recent proposed rule, CMS sought to place an obligation on hospitals to look back *10 years* and identify possible overpayments so that those overpayments may be returned to the Medicare Trust Fund. 77 Fed. Reg. 9179, 9184 (Feb. 16, 2012). Moreover, CMS has

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[20] *Available at* http://www.aha.org/content/11/11Q4ractracresults.pdf.

[21] *Available at* http://www.aha.org/content/11/racpolicypaper.pdf.

proposed to expand the reopening period from 3 to 10 years to support this new look-back obligation. *Id.*

The administrative burden this proposal places on hospitals is self-evident. It requires hospitals to keep books and records for longer than existing document-retention policies call for and may require them to maintain multiple software and information-technology systems to review and search those older records. *See* Letter from American Hosp. Ass'n to M. Tavenner, Acting Administrator, CMS 8 (Apr. 16, 2012)[22]. And because the proposed rule expands the period beyond which hospitals thought their reimbursements were final and unchallengeable, it will require hospitals to "defend payment claims on their merits * * * that had long since been closed." *Cf.* SG Br. 25. Yet CMS rejected these anticipated concerns by citing the "primary importance" of "protect[ing] the Medicate Trust Fund." 77 Fed. Reg. at 9186.

The point is this: CMS tolerates extensive reimbursement look-backs—including by third-party contractors—and the additional administrative burdens those programs entail when they benefit the agency, but decries those same contractors and burdens when the roles are reversed. *See* SG Br. 23-25. If this Court grants CMS unreviewable discretion over what exceptions to recognize to the 180-day appeal deadline—and if past is prologue—CMS will use that discretion to perpetuate and expand this uneven allocation of benefits and burdens.

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[22] *Available at* http://www.aha.org/advocacy-issues/letter/2012/120416-cl-CMS60037-p.pdf.

CONCLUSION

AHA fully supports responsible efforts to ensure that hospitals receive only what they are owed from Medicare—no more and no less. But the 180-day time limitation on PRRB appeals should not become a Medicare reimbursement cut. It should instead be interpreted as time limits ordinarily have been: subject in appropriate cases to the traditional, well-defined doctrine of equitable tolling.

For the foregoing reasons, the decision below should be affirmed.

Respectfully submitted,

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October 2012