UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASS'N, *et al.*, Plaintiffs, v. SYLVIA MATHEWS BURWELL, Defendant.	Case No. 1:14-cv-00609

DECLARATION OF LESLIE MORGAN

I, Leslie Morgan, hereby declare and state the following:

1. The facts set forth in this declaration are based upon my personal knowledge. If called upon as a witness, I could and would testify to these facts.

2. I am an adult citizen of the United States and reside in Arizona.

3. I am submitting this declaration on behalf of Plaintiff Banner Health in support of Plaintiffs' Supplemental Brief in response to the Court's December 18, 2015 order in *American Hospital Association et al. v. Burwell*, No. 1:14-cv-00609.

4. Banner Health is one of the nation's largest not-for-profit health care systems. Based in Phoenix, Arizona, Banner Health delivers high-quality, efficient care at twenty-nine hospitals and other health care facilities across seven states. These include twenty-one acute care hospitals, three of which are "Sole Community Hospitals"—a Medicare designation for certain

hospitals that fill an important medical need in their rural communities—located in Fairbanks, Alaska; Sterling, Colorado; and Fallon, Nevada.

5. I serve as the Compliance Director for Banner Health. I have served at this post since 2012.

6. In my capacity as Compliance Director it is my responsibility to advise and assist the Senior Director of Revenue Integrity, who oversees the submission of claims for Medicare payment, review denied claims, and file requests for reconsideration and appeals.

7. It is my understanding that the Centers for Medicare & Medicaid Services ("CMS") instructed its Medicare Administrative Contractors ("MACs") to conduct "Probe & Educate" reviews of small samples of each hospital's Part A inpatient claims spanning less than two midnights. These Probe & Educate reviews were conducted on a prepayment basis to assess whether hospitals are in compliance with the admission order requirements and the two-midnights rule. If a MAC finds that a hospital's claim does not meet the new requirements, the MAC determines that the hospital is not entitled to receive Medicare Part A reimbursement and the claim is denied.

8. In February and March 2014, Banner Health's MACs, Noridian Healthcare Solutions, LLC ("NHS") and Wisconsin Physician Services ("WPS"), denied claims based on Banner Health's failure to comply with the two-midnights and physician order rules. This means that Banner Health will not be reimbursed for tens of thousands of dollars of inpatient medical services provided to Medicare beneficiaries across its facilities.

9. In appealing these denials, Banner Health has asserted that both of these new rules are unlawful.

10. Since the Plaintiffs submitted their motion for summary judgment and opposition to the Secretary's motion to dismiss on August 4, 2014, Banner Health has continued to pursue its appeals of these denials. As of January 29, 2016, the current status of the appeals is as follows:

Two-Midnights Rule

11. In July 2014, NHS issued unfavorable decisions based on the two-midnights rule for four of the five claims for which Banner Health had requested a redetermination on behalf of its Boswell Medical Center. NHS issued a favorable redetermination decision on the fifth two-midnights denial on the ground that the procedure at issue appeared on CMS's list of "inpatient only" services and paid Banner Health under Part A for that patient's inpatient stay.

12. On or about July 28, 2014, Banner Health requested reconsideration by the Qualified Independent Contractor ("QIC"), Maximus Federal Services, of the four unfavorable redeterminations that had been issued by NHS on the basis of the two-midnights rule. In its requests, Banner Health again challenged the two-midnights rule, arguing that the rule is unlawful under the Administrative Procedure Act because it is arbitrary and capricious.

13. Banner Health asked the QIC to reverse NHS's unfavorable redetermination and instruct NHS to pay the hospital for the inpatient stay under Medicare Part A. Banner Health also requested that the QIC declare the two-midnights rule unlawful and invalid.

14. In September 2014 the QIC issued unfavorable reconsideration decisions in all four cases.

15. In light of CMS's Part B rebilling policy and the enormous backlog of appeals pending before the Office of Medicare Hearings and Appeals' Administrative Law Judges ("ALJs"), Banner Health elected to withdraw two of its appeals and rebill for those services under Medicare Part B. Banner Health received Part B payment for those two patients.

16. On or about November 12, 2014, Banner Health appealed two of the unfavorable reconsideration decisions to an ALJ.

17. In its requests for an ALJ hearing, Banner Health again challenged the two-midnight rule, arguing that the rule is unlawful under the Administrative Procedure Act because it is arbitrary and capricious, and asked the ALJ to declare that the rule is invalid. Banner Health also submitted additional documentation from the patients' medical records to establish that the two-midnights rule was satisfied in those cases.

Physician Order Denials

18. Of the five claims for which WPS denied Part A reimbursement at Banner Baywood Medical Center, Banner Thunderbird Medical Center, Banner Gateway Medical Center, and Banner Good Samaritan for failure to comply with the technical requirements of the physician order rule, one was appealed by Banner Health to WPS. In its request for a redetermination, Banner Health challenged the validity of the physician order rule.

19. Banner Health elected not to appeal the remaining four denials. Instead, Banner Health billed for those services under Medicare Part B and received Part B payment.

20. On or about August 20, 2014, WPS rejected Banner Health's appeal of the physician order denial on the ground that it was untimely.

21. In all, as a result of these denials on the basis of the physician order rule, Banner Health has lost thousands of dollars in Medicare reimbursement.

22. Banner Health also has devoted significant resources and will continue to need to devote resources to update its medical records system, train its physicians and residents, and revise its workflow processes to reflect the technical requirements of the physician order rule, such as including a physician certification or other documentation in the record regarding the patient's expected length of stay.

Rebilling Under Medicare Part B

23. For each of the appeals described above, the original dates of service for the inpatient stay occurred in late 2013.

24. It is my understanding that under CMS's Part B rebilling policy, Banner Health is permitted to rebill under Part B after Part A payment is denied on the ground that the inpatient admission was not reasonable and necessary, which would include a denial on the basis that the two-midnights rule or physician order rule was not met. It is also my understanding that Banner Health must submit its request for Part B payment within one year of the original dates of service for the inpatient stay.

25. It is my understanding that there is a backlog of more than 800,000 Medicare claim appeals pending before the Office of Medicare Hearings and Appeals' ALJs and that as of October 2015, it is taking on average 765 days for an ALJ to issue a decision on an appeal.

26. As a result of CMS's application of the one-year time-limit to claims that can be rebilled under Part B, Banner Health elected not to pursue some of the Part A appeals described above and instead rebilled them under Part B.

27. The one-year time limit to rebill under Part B already has expired for the two remaining two-midnights denials for which Banner Health is currently pursuing Part A appeals

and that are pending before an ALJ. If the ALJ denies Part A payment, it is my understanding that the ALJ is not permitted to allow Banner Health to rebill under Part B.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 1st day of February, 2016.