

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

THE AMERICAN HOSPITAL ASSOCIATION,
MISSOURI BAPTIST SULLIVAN HOSPITAL,
MUNSON MEDICAL CENTER, LANCASTER
GENERAL HOSPITAL, TRINITY HEALTH
CORPORATION, and DIGNITY HEALTH,

Plaintiffs,

v.

KATHLEEN SEBELIUS, in her official capacity
as Secretary of Health and Human Services,

Defendant.

Case No. 1:12-cv-1770 (CKK)

DECLARATION OF CAROLINE STEINBERG

I, Caroline Steinberg, hereby state as follows:

1. I am over the age of 18, and I am competent to testify on the matters set forth herein.
2. I currently serve as vice president, Trends Analysis, for the American Hospital Association (AHA). I have served at this post since April 2002. The information in this declaration is personally known by me or is derived from information and records maintained by the AHA.
3. The AHA is a national organization that represents and serves nearly 5,000 hospitals, health care systems, and networks, plus 42,000 individual members.
4. Of its members that are non-federal hospitals, health care systems, and networks (hereinafter collectively "hospitals"), 99 percent participate in Medicare.
5. To represent and serve these hospitals, the AHA maintains familiarity with Medicare statutes, regulations, policies, and programs, and collects data from its members related

to hospitals' experiences with Medicare Part A and Part B reimbursement, the Recovery Audit Contractor (RAC) program, and the administrative appeals process, among other things.

6. Beginning in the first quarter of 2010, the AHA began gathering data from members regarding the impact of the RAC program on hospitals and health care systems nationwide, asking that hospitals and health care systems self-report the RAC activity they experience using a free, web-based survey. It has continued to do so every quarter since, making the aggregate results of the data collection available to the public on its website.

7. The AHA's data collection reveals that since the RAC program began, RACs have demanded more than a half-million medical records to audit. The RACs have identified purported overpayments in tens of thousands of those cases.

8. Through the second quarter of 2012, more than 60 percent of those purported overpayments have involved a finding that the *treatment* was appropriate but that the *setting* was incorrect because, according to the RAC, the patient should have been treated as an outpatient.

9. When RACs have deemed the setting of care incorrect, CMS has "clawed back" the entire Medicare Part A payment that the hospital received as reimbursement for the medically necessary services provided.

10. Through the second quarter of 2012, hospitals were forced to repay at least \$267 million in Part A cases that were denied because the RAC later determined that medically necessary care was provided in the wrong setting. That figure includes only data self-reported by hospitals to AHA. Only 26 percent of hospitals report data, so the actual amount hospitals were forced to repay is undoubtedly larger still.

11. In cases where CMS "claws back" the Medicare Part A payment due to a RAC determination that the setting of case was incorrect, some hospitals have requested payment

under Medicare Part B, which reimburses hospitals for medically necessary and reasonable care they provide on an outpatient basis.

12. CMS contractors have refused to issue those Part B payments. They have relied upon a CMS policy that prohibits reimbursement under Medicare Part B for all but a limited set of items and services in situations where a Part A claim has been denied.

13. That limited set of items and services includes mostly low-cost items like splints and casts. It does not include more expensive items and services that typically make up the vast majority of the cost of care in such cases—for example, emergency room services, drugs, and surgical procedures. For that reason, the CMS policy authorizes Part B payment for only a very small portion of the total cost of the services that were provided. An AHA member hospital system has informed me that across their hospitals the payment for this subset of items and services represents 10 percent or less of the payment the hospitals received under Part A for the services before the RAC re-reviewed the claim and denied it and CMS took the payment back.

14. While CMS's policy generally limits payment under Part B to 10 percent or less of the cost of the services provided, full Part B coverage would result in considerably higher payment. For example, an AHA member hospital system has advised me that Part A payment for an average surgical admission across their hospitals is about the same as full Part B payment for the identical procedure.

15. AHA's member hospitals frequently appeal the RACs' decisions. When they do, they win either Part A or Part B reimbursement 75 percent of the time. Administrative adjudicators order Part A reimbursement if they determine that the RAC should not have overruled the treating physician's admission decision. They order Part B reimbursement if they determine—as the Secretary's top appeals panel now has in at least 16 cases—that hospitals in

Part A “clawback” cases are entitled to payment under Part B for the medically necessary services provided.

16. Despite the high success rate on appeal, many hospitals have told the AHA that pursuing appeals often is prohibitively costly. Hospitals have advised the AHA that navigating all four levels of administrative review in a single case can cost a hospital thousands of dollars.

17. All in all, AHA’s data indicate that the AHA’s member hospitals have provided hundreds of millions of dollars’ worth of concededly reasonable and medically necessary care for which they will never be compensated. And hospitals have spent millions more navigating the administrative appeals process in an attempt to overturn those decisions.

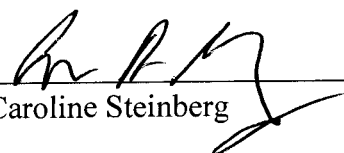
18. In collecting records for this case, I specifically have reviewed materials provided by Plaintiff Missouri Baptist Sullivan Hospital.

19. According to those records, since January 30, 2010, the RAC has asked Missouri Baptist to turn over 418 patient records so the RAC could examine whether the decision to admit the patient as an inpatient was medically necessary. Of those 418 requests for medical records, the RAC determined that 98 patients should not have been admitted as inpatients.

20. These RAC denials have required Missouri Baptist to repay Medicare \$226,501.

21. Moreover, the RAC’s record requests themselves, and subsequent appeals from RAC decisions, place a heavy burden on Missouri Baptist. Among other things, the hospital has hired an external professional review company to pre-review all short-stay decisions.

I make this declaration under penalty of perjury pursuant to 28 U.S.C. § 1746, and I state that the facts set forth herein are true and correct.



Caroline Steinberg

Dated: 12-12-12