UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, *et al.*, Plaintiffs, v. KATHLEEN SEBELIUS, in her official capacity as Secretary of Health and Human Services, Defendant.	Case No. 1:12-cv-1770-CKK

PLAINTIFFS' SUPPLEMENTAL BRIEF REGARDING EFFECT OF FINAL CMS RULE ON DEFENDANT'S MOTION TO DISMISS

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INTRODUCTION

On August 5, 2013, CMS issued a final rule, *Medicare Program: Payment Policies Related to Patient Status*, 78 Fed. Reg. 50, 496, 50,906 (Aug. 19, 2013) (Final Rule). The Final Rule puts to rest one of three primary arguments advanced in the Secretary of Health and Human Services' motion to dismiss—namely, that this case was "unripe" because the rulemaking was pending. *See* ECF No. 31 at 20-23. The Final Rule also significantly undercuts the Secretary's argument that Plaintiffs necessarily are seeking to "reopen" old claims. *See id.* at 24-27. This supplemental brief, filed pursuant to the Court's orders of August 8 and October 18, 2013, explains these points.

BACKGROUND

The CMS Policy. The facts relevant to understand CMS's Final Rule are set forth in Plaintiffs' Second Amended Complaint, ECF No. 26 ¶¶ 32-67, and opposition to the Secretary's motion to dismiss, ECF No. 32 at 7-12. In sum, CMS long adhered to what Plaintiffs call the "Payment Denial Policy": When a hospital treated a patient on an inpatient basis and received payment from CMS under Medicare Part A, but a Recovery Audit Contractor (RAC) later decided the hospital should have treated the patient in the outpatient setting and been paid under Part B, CMS would take back the entire Part A payment and then refuse to let the hospital rebill under Part B for almost all of the services provided. Cmplt. ¶ 45. Instead, CMS permitted hospitals to seek Part B payment only for a few ancillary items like splints and casts—items that amounted to a small percentage of the cost of care. *Id.* CMS enforced this policy even though no one questioned that the care hospitals gave their patients was reasonable and medically necessary; the RACs disagreed only with the *setting* in which care was provided. The end result: Hospitals received no payment for many millions of dollars of services that CMS acknowledged were (i) covered under Part B and (ii) reasonable and medically necessary in the particular case.

Plaintiffs' Suit and CMS's Response. Plaintiffs filed suit late last year, arguing that the Payment Denial Policy was unlawful. *See* ECF No. 1. Soon after that, CMS repudiated the Payment Denial Policy. In March 2013, CMS issued two documents: Ruling 1455-R, which set forth an interim policy to handle rebilling after Part A denials, and a proposed rule to address future claims, *see Medicare Program; Part B Inpatient Billing in Hospitals*, 78 Fed. Reg. 16,632 (Mar. 18, 2013). In those documents CMS effectively conceded that the Payment Denial Policy was unlawful: "Having reviewed the statutory and regulatory basis of our current Part B inpatient payment policy," it now "believe[d] that, under section 1832 of the [Social Security] Act, Medicare should pay all Part B services that would have been reasonable and necessary . . . if the hospital had treated the beneficiary as a hospital outpatient." 78 Fed. Reg. at 16,636.

CMS did not, however, propose to make hospitals whole under either Ruling 1455-R or the proposed rule. Ruling 1455-R authorized hospitals to rebill under Part B *only* for (i) new Part A denials that occurred while the rulemaking was under way and (ii) cases where the Part A denial issued prior to the proposed rule but the time to appeal that denial had not expired or an appeal was still pending. *See* Ruling 1455-R at 7-8. It did not authorize rebilling of Part A denials for which the time to appeal had expired. *See id.* But as CMS was well aware, the vast majority of RAC Part A denials were not live on appeal. Providers had been told over and over by CMS that they could not obtain Part B payment. Cmplt. ¶¶ 53, 60, 75. And while many providers appealed on Part A grounds, arguing that inpatient treatment had been appropriate, most of those appeals were no longer live. *Id.* ¶ 60. Ruling 1455-R thus failed to give hospitals back most of the monies CMS had unlawfully retained under the Payment Denial Policy.

The agency's proposed rule, meanwhile, sought to accomplish the same end—repudiate the Payment Denial Policy but still avoid actually paying hospitals what they are owed—for future

cases. The proposed rule acknowledged that the Payment Denial Policy was unlawful, *see* 78 Fed. Reg. at 16,636, and on the face of things purported to allow Part B rebilling. However, the proposed rule would treat Part B rebilling requests as "new claims"—even though they are for the very same services billed on the original Part A claim—and apply the one-year time limit in 42 U.S.C. § 1395n(a)(1) to those claims. *Id.* at 16,639-40. CMS thus proposed to require that rebilled claims be filed within one year of the date of patient care. *See id.* But that would make CMS's supposed commitment to allow Part B rebilling an empty promise: *Nearly all RAC Part A denials are issued more than a year after the date of care*—often years later—because RACs can select claims for audit up to three years after that date and then it takes months to complete the review. Cmplt. ¶ 65. Under the proposed rule's approach, then, hospitals could almost never rebill.

Plaintiffs filed a Second Amended Complaint challenging Ruling 1455-R in April 2013. ECF No. 26. Plaintiffs alleged, among other things, that the Ruling's refusal to allow rebilling in most Part A denial cases is arbitrary and capricious, Cmplt. ¶¶ 148-173, and that CMS cannot just refuse to compensate hospitals for many millions of dollars of care that CMS concedes was reasonable and medically necessary and concedes it should have paid for under Part B. *Id.*

The Secretary moved to dismiss. ECF No. 31. She advanced three primary arguments: first, that plaintiffs failed to properly present and exhaust their claims; second, that the claims were unripe because the Secretary was "in the midst of a rulemaking that will address" the same issues; and third, that plaintiffs were really seeking reopening of stale claims and that reopening denials are not subject to judicial review. Mot 17-30. Plaintiffs opposed the motion. ECF No. 32.

The Final Rule. On August 5, while the Secretary's motion remained pending, CMS issued its Final Rule. *See* 78 Fed. Reg. at 50,906. The Final Rule adopts, with few changes, the policies CMS had put forth in the proposed rule. As relevant here, those policies are as follows:

First, CMS reiterated what it had said in the proposed rule: It was abandoning the Payment Denial Policy because "under section 1832 of the Act, Medicare should pay" under Part B when a hospital rebills. *Id.* at 50,909. CMS thus determined to "revise [its] existing policy"—the Payment Denial Policy—"to allow payment for additional Part B inpatient services than Medicare currently allows" in the wake of RAC Part A inpatient-care denials. *Id.* Hospitals could now respond to a RAC clawback by "recod[ing] the reasonable and necessary services that were furnished as Medicare Part B services, and bill[ing] them on a Part B inpatient claim." *Id.*

Second, having given with its right hand, CMS took back with its left: It confirmed that it would apply a one-year time limit to rebilled Part B claims, running from the date of treatment—a time limit that makes rebilling after a RAC denial all but impossible. *Id.* at 50,922. CMS acknowledged that "[o]ver 300 commenters" had objected to that approach as illogical and unlawful, while "[o]ne commenter supported the proposal." *Id.* CMS sided with the one over the 300. It rejected suggestions that rebilling should be treated as an adjustment to the original Part A bill—which would not trigger timely-filing requirements—on the ground that the "fundamental nature of the originally filed claim" had been "changed completely (from a Part A claim to a Part B claim)." *Id.* The agency likewise rejected arguments that it should create an exception to the one-year time limit, as it is empowered to do. It wrote that it has created exceptions only where providers would be disadvantaged by application of time limits "through no fault of their own." *Id.* at 50,923. Here, by contrast, "[h]ospitals . . . have the ability to avoid being disadvantaged"; all they have to do is "bill correctly by following Medicare's guidelines for hospital inpatient admissions," and their Part A payments will not be clawed back in the first place. *Id.*

Third, CMS explained that it had made it easier for hospitals to "bill correctly" by revising its guidelines for when hospitals should admit a patient as an inpatient. *Id.* CMS's guidance has

long provided that whether to admit a patient is a complex medical judgment that involves consideration of many factors. Cmplt. ¶ 32. CMS wrote in the Final Rule that it was providing "additional clarity" by instructing admitting physicians and Medicare review contractors that an inpatient admission is "generally appropriate" when the physician expects the patient to require a stay that crosses "2 midnights"—that is, a stay where the patient was admitted prior to midnight and stayed in the hospital that night, the next day, and the next evening until at least midnight. *Id.* at 50,908, 50,949, 50,965. But CMS explained that the physician's expectation should be based on the same "complex medical factors" as in the agency's previous guidance. *Id.* at 50,965. CMS wrote that while it believed its previous multi-factor guidelines "were clear," the two-midnight standard would "provide additional clarification" and thus would (in its view) "significantly reduce[ ] . . . the likelihood that hospitals or physicians will have a different understanding than Medicare's review contractors of what constitutes an appropriate inpatient stay." *Id.* at 50,923.

CMS stated that the interim policies announced in Ruling 1455-R—that the one-year time limit would not apply, and Part B rebilling would be permitted, for newly-issued RAC denials and those with appeals still pending—would remain in place for all inpatient admissions before October 1, 2013. *Id.* at 50,924. For RAC clawbacks involving patients admitted to the hospital after that date, the Final Rule, and the one-year time limit, would apply. *Id.*

ARGUMENT

I. THE FINAL RULE DOES AWAY WITH THE SECRETARY'S RIPENESS ARGUMENT.

The Final Rule's first, and most obvious, impact on the Secretary's pending motion is to supersede her argument that this case is unripe. *See* Mot. 20-23.

The Secretary argued in her motion that Plaintiffs' claims were not yet ripe because "the Secretary is in the midst of a rulemaking that will address the specific subject matter of [plaintiffs']

claims," and the Secretary's "tentative position" was "subject to revision in a rulemaking that is currently underway." Mot. 20. That argument does not survive the issuance of CMS's Final Rule. To begin with, the argument's premise—that the rulemaking is still pending—has evaporated. The Secretary's speculation that rulemaking might result in a "revision" of CMS's relevant positions also turned out to be wrong; the Final Rule largely adopts the policies in the proposed rule.[1] And in any event, the Final Rule has no bearing on Plaintiffs' claims anyway. Plaintiffs challenge the arbitrariness of a policy choice made in *Ruling 1455-R*: allowing hospitals recently wronged by the Payment Denial Policy to obtain payment while the rulemaking was pending, but leaving hospitals with less recent injuries out in the cold. Nothing in the Final Rule affects that claim. Indeed, the Final Rule does not apply to cases arising prior to October 1, 2013—the Final Rule's effective date. The Secretary's ripeness argument has been overtaken by events.

II. THE FINAL RULE UNDERCUTS THE SECRETARY'S "REOPENING" ARGUMENT.

The Secretary's third argument for dismissal proceeds from two premises: (i) Plaintiffs necessarily seek to reopen old claims when they rebill, and (ii) CMS's decision to reject a reopening request in any particular case is a workaday "claims processing decision" not subject to judicial review. Mot. 24-27. The Final Rule undercuts both components of that argument.

1. The Secretary argued in her motion that attempts to *rebill* amount to attempts to *reopen*. Mot. 25. Plaintiffs explained in response that they are not seeking "reopening" of stale claims; they instead seek simply "to adjust or supplement their original, timely filed Part A claims to follow the billing format, coding, and data requirements that CMS requires for payment under Part B." Opp. 32. Plaintiffs further explained that adjustment billing "is a permissible procedure,

[1] In the Final Rule, CMS did reverse its proposal to prohibit hospitals from requesting Part B payment for certain therapy services provided during an inpatient stay. 78 Fed. Reg. at 50,910. It otherwise adopted the proposed rules unchanged.

distinct from reopening, that does not create a new 'claim' and therefore does not trigger . . . time limitations[.]" *Id.* Plaintiffs argued that nothing in CMS's regulations or guidance foreclosed adjustment billing here, and that CMS could not arbitrarily label Plaintiffs' adjusted bills as "reopenings" just to make them unreviewable. *Id.* at 35-36.

The Final Rule confirms that the Secretary's "reopening" argument is a litigation position with no regulatory basis. CMS was unable to point to any Medicare regulation to demonstrate why Plaintiffs cannot file an adjustment bill. Here is CMS's explanation in full:

> [A]n adjustment claim supplements information on a previously submitted claim *without changing the fundamental nature of the original claim*. The concept of adjustment billing employed by the Medicare Appeals Council and many ALJs, and supported by the commenters, is inconsistent with longstanding Medicare policy because, in these situations, *the nature of the original claim is fundamentally changed from a Part A claim to a Part B claim*. When this type of Part A claim denial occurs and a hospital subsequently submits a Part B claim for the denied services, the hospital is submitting a new Part B claim (it is not adjusting the original Part A claim).

78 Fed. Reg. at 50,924 (emphases added). CMS cites no authority for this false syllogism. And it never even attempts to explain why merely re-coding a previously submitted bill so that it includes more detailed data about the same services, provided to the same patient, on the same date, changes the "fundamental nature" of the claim. The assertion is conclusory; indeed, one is left to guess what the phrase even means. This sort of unexplained proclamation does not withstand APA review. *See Owner-Operator Indep. Drivers Ass'n, Inc.* v. *Fed. Motor Carrier*, 494 F.3d 188, 203 (D.C. Cir. 2007) (agency "must cogently explain why it has exercised its discretion in a given manner"). And yet it is the basis on which the Secretary seeks to insulate a generally applicable agency policy from judicial review. Her efforts should be rejected. Unreasoned *ipse dixit* should not trump "the strong presumption that Congress intends judicial review of administrative action." *Council for Urological Interests* v. *Sebelius*, 668 F.3d 704, 709 (D.C. Cir. 2011).

2. Portraying the Plaintiffs' challenge as a mere attempt to reopen a few small, stale claim denials, the Secretary insists she has discretion to put "claims processing decisions" beyond the scope of judicial review. Mot. 24-27. The Final Rule undercuts this assertion, too. The Final Rule describes the lines CMS drew in Ruling 1455-R in a way that makes clear what Plaintiffs have argued all along: The Ruling adopted a sweeping new policy of general applicability. *See* 78 Fed. Reg. at 50,909 ("The Ruling does not apply to Part A hospital inpatient claim denials for which the timeframe to appeal expired . . . . The policy announced in the Ruling superseded any other statements of policy on the issue of Part B inpatient billing following the denial by a [RAC]."). This case is not just about a few small claims. To be sure, Plaintiffs must *present* discrete claims in order to be in a position to challenge the broader policy in federal court, but that does not mean the Secretary can brush the case aside by reciting her "claims processing" mantra. On the contrary, the question presented here is the sort of systemwide legal issue the D.C. Circuit has found appropriate for judicial cognizance. *Tataranowicz* v. *Sullivan*, 959 F.2d 268, 274 (D.C. Cir. 1992); *see* Opp. 30-31.[2]

III. THE FINAL RULE DEMONSTRATES THAT THE SECRETARY'S ARBITRARY POLICY SHOULD NOT ESCAPE JUDICIAL REVIEW.

Finally, the Final Rule demonstrates that the Secretary's position on the merits in this case is weak—a point that is relevant to the motion to dismiss, given that acceptance of the Secretary's jurisdictional arguments would mean her shaky merits position will evade review.

[2] For the same reason, the Secretary is wrong that this Court lacks jurisdiction under 28 U.S.C. § 1331. *See* Reply Br. 4. The Secretary argues that the exception allowing federal-question jurisdiction in cases where otherwise there would be "no review at all" does not apply because "[p]laintiffs could have obtained review of the adverse RAC payment determinations . . . but forfeited that right by not filing timely appeals." *Id.* at 4. That argument ignores that Plaintiffs are challenging a policy of general applicability adopted just this March. Plaintiffs could hardly "forfeit" a challenge to that policy through actions taken before it was adopted.

Plaintiffs have explained that in a circumstance like this one, where (i) CMS long told hospitals they could not obtain payment under Part B after a RAC's Part A denial and (ii) CMS has now concluded that that policy was unlawful, CMS cannot reasonably invoke the one-year timely filing limit to prevent rebilling. *See* Cmplt. ¶¶ 142-44. First, "the one-year time limit is waivable," and "[g]iven that the Secretary could simply allow hospitals to supplement their original Part A claims, it is arbitrary and capricious for the Secretary to refuse to do so and at that same time to refuse to waive the one-year time limit." *Id.* ¶ 143. Second, "where, as here, the Secretary affirmatively induced hospitals not to file for Part B reimbursement or appeal on Part B grounds, it would be arbitrary and capricious for the Secretary not to waive the time limit and allow hospitals to seek the reimbursement to which they are entitled." *Id.* ¶ 144.

CMS's Final Rule has now rejected Plaintiffs' waiver argument in a closely related context—namely, explaining why it would refuse to waive the one-year time limit going forward. And its explanation does not withstand examination. CMS acknowledged that it had "the ability to create exceptions to the 1-calendar year time limit," but opined that the exceptions currently on the books "were created because providers, suppliers, and beneficiaries, through no fault of their own, would be disadvantaged by strict application" of the time bar. 78 Fed. Reg. at 50,923. That was not the situation in RAC Part A denial cases, in the agency's view, because hospitals "have the ability to avoid being disadvantaged . . . if they bill correctly by following Medicare's guidelines for hospital inpatient admissions." *Id.* In other words, if hospitals would just file their claims correctly, there would be no RAC clawbacks and no need to rebill.

That is stunningly disingenuous. The glaring problem with CMS's logic is that—as CMS well knows—hospitals did *not* have "the ability to avoid being disadvantaged," because CMS's multi-factor guidance on when to admit inpatients was (and remains) so woefully unclear that

there was nothing hospitals could do to avoid at least *some* RAC clawbacks. With factors as malleable as the "severity of the patient's signs and symptoms," "risk of an adverse event," and "relative appropriateness of treatment in each setting," Cmplt. ¶ 32, the RAC can (and regularly does) reach a conclusion different from that of the admitting physician.[3]

Indeed, CMS amended its inpatient-admissions guidance through the Final Rule to "*provide additional clarification*" and thus "*significantly reduce[ ] . . . the likelihood that hospitals or physicians will have a different understanding* than Medicare's review contractors of what constitutes an appropriate inpatient stay." *Id.* at 50,923 (emphasis added). CMS can protest all it wants that its guidance was already clear, *see id.*, but its own statements in the very same paragraph belie its assertion; if the rules were already clear, a "clarification" would not "significantly reduce" misunderstandings about what those rules require. When this case reaches the merits—as it should—the agency's rationale for refusing to waive the one-year time limit will not withstand examination.

CONCLUSION

For the foregoing reasons, and those in Plaintiffs' opposition to the Secretary's motion to dismiss, the motion should be denied.

Dated: October 28, 2013

Respectfully submitted,

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[3] That is especially true given that RACs have strong financial incentives to claw back Part A payments, Cmplt. ¶ 46, and nothing in the final rule diminishes those incentives.

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CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of October 2013, I caused the foregoing document to be served on Defendant's counsel of record electronically by means of the Court's CM/ECF system.

/s/ Dominic F. Perella
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