UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, 325 Seventh Street, NW, Suite 700 Washington, DC 20004; MISSOURI BAPTIST SULLIVAN HOSPITAL, 751 Sappington Bridge Road Sullivan, MO 63080; MUNSON MEDICAL CENTER, 1105 6th Street Traverse City, MI 49684; LANCASTER GENERAL HOSPITAL, 555 North Duke Street Lancaster, PA 17602; TRINITY HEALTH CORPORATION, 20555 Victor Parkway Livonia, MI 48152; and DIGNITY HEALTH, 185 Berry Street, Suite 300 San Francisco, CA 94107, Plaintiffs, v. KATHLEEN SEBELIUS, in her official capacity as Secretary of Health and Human Services, 200 Independence Avenue, SW Washington, DC 20204, Defendant.	)	Case No. 1:12-cv-1770

SECOND AMENDED COMPLAINT

Plaintiffs the American Hospital Association, Missouri Baptist Sullivan Hospital, Munson Medical Center, Lancaster General Hospital, Trinity Health Corporation, and Dignity

Health ("Plaintiffs") bring this action to ensure they actually receive relief for the harms they suffered for years under a Medicare policy that Medicare now concedes was unlawful.

INTRODUCTION

1. When a patient comes to a hospital for treatment, the attending physician must decide whether the patient should be admitted to the hospital. If the patient is admitted, he or she is treated on an "inpatient" basis; if not, he or she is treated on an "outpatient" basis. There are differences between the two, but in some cases the same services can be provided in both settings. For example, a young, healthy patient may be a good candidate to have surgery in an outpatient setting, while an older patient who has a higher risk of complications should have the same surgery on an inpatient basis.

2. Traditionally, the decision to admit a patient for inpatient treatment has been committed to the expert judgment of the attending physician. But in recent years, the Secretary of Health and Human Services (HHS) acting through the Centers for Medicare & Medicaid Services (CMS) has employed private third parties—known as Recovery Audit Contractors, or RACs—to engage in wide-ranging review of physicians' decisions to admit patients. These contractors are paid based on the amount of Medicare reimbursement they can "claw back" from hospitals. And though they operate with nothing but a cold paper record, they now regularly overrule physicians' expert medical judgments long after the fact, determining that particular Medicare patients—patients whom they have never even seen—should not have been admitted to the hospital to receive inpatient care. CMS then takes back all the payments it made to the hospital for the patients' care and gives the RAC a percentage of those funds.

3. For example, a hospital will care for a Medicare patient on an inpatient basis and submit a bill for reimbursement under Medicare Part A, which covers inpatient hospital care.

CMS will pay the hospital. But months or, typically, years later, a RAC will overrule the physician's decision to admit the patient on the ground that, in the RAC's opinion, the patient could have been treated in the outpatient setting, and will demand that the hospital give back the entire Part A payment amount.

4. The RACs' decisions often are overturned on appeal. But even where they are not, CMS should pay hospitals for the services they provided under Medicare Part B, which covers hospital outpatient services. After all, federal law requires Medicare to reimburse hospitals for reasonable and medically necessary services provided to patients. And no one in these cases questions that the care hospitals gave their patients was reasonable and medically necessary; the RACs that demanded the payments back disagreed only with the *setting* in which the care was provided, concluding that the patients should have been treated as outpatients. At bottom, if payment cannot be made for medically necessary hospital care under Part A, it must be made under Part B.

5. For years, however, CMS categorically refused to provide that Part B reimbursement. CMS adopted a policy—the "Payment Denial Policy"—that prohibited Part B reimbursement for most items and services after a RAC denial of the sort described above. Under the policy, CMS in that circumstance would pay hospitals only for a few ancillary items like splints and casts—items that typically amount to a small percentage of the total cost of care. It would not pay for the actual procedures the patient received, or for other items that make up the vast majority of the typical patient's care.

6. In short, CMS simply refused to pay hospitals for services *that it acknowledged are covered under Medicare Part B and that it acknowledged were reasonable and medically necessary in the particular case*. That policy meant hospitals received no payment whatsoever

for hundreds of millions of dollars' worth of necessary care—surgeries, drugs, observation care, and on and on—that they provided to Medicare beneficiaries.

7. Plaintiffs brought this action last year to put an end to CMS's unlawful Payment Denial Policy. And on March 13, 2013, CMS repudiated that policy, effectively confessing error. CMS agreed to pay hospitals under Medicare Part B. But it agreed to do so only for now, and only for a small subset of claims or appeals that are still live. For the many thousands of hospital claims that are *not* still live—for example, Part A claims that a RAC denied a year or two ago, and on which a hospital did not seek Part B payment, having been told that it could not do so—CMS will not pay what it owes. CMS apparently plans to treat attempts to rebill those claims as untimely because the Part B claims were not filed within a year of the date of treatment.

8. That refusal to make the hospitals whole is both unlawful and fundamentally unfair. Thousands of hospitals, including Plaintiffs, lost many millions of dollars to RAC Part A denials in cases that are no longer live on appeal. CMS told those hospitals over and over again that Part B payment was not available under the Payment Denial Policy. The hospitals reasonably took CMS at its word and never sought to obtain such payment by filing new Part B claims or appealing the Part A denial and seeking payment under Part B. Now CMS admits it should have been paying hospitals under Part B all along. And yet, on information and belief, CMS will refuse to pay those claims, taking shelter under the theory that the time limit for filing Part B claims—the very Part B claims CMS told hospitals *they could not file*—has expired.

9. CMS's refusal to pay is a quintessential example of unlawful arbitrary and capricious agency action in several respects. First, the supposed time-limit issue is a barrier of CMS's own invention. CMS need not require hospitals to file new Part B claims for the very same services that were originally billed under Part A. Instead, CMS can simply use the

previously submitted Part A claims, which everyone agrees were timely filed in the first place, and collect any supplemental information as needed. Nothing in the Medicare Act or regulations prevents CMS from doing so. And there is no question that this approach is practically feasible; administrative law judges (ALJs) and HHS's highest administrative appeals body have already ordered it done many times. The time limits accordingly are irrelevant for these types of claims.

10. Second, if CMS refuses to allow hospitals to supplement their original Part A claims and insists that they file new Part B claims instead, CMS cannot then apply the one-year timely filing limit—a limit CMS has explicit authority to waive—to bar those claims. As explained below, the one-year limit would apply in nearly all RAC Part A denial cases because of how long it takes the RACs to review claims. That would create a situation where CMS admits that it must pay hospitals under Part B and yet makes it impossible, in almost every case, for the hospital to obtain payment. That is the definition of arbitrary and capricious action.

11. Third, the lines CMS has drawn in its new ruling are unlawful. CMS cannot refuse to pay hospitals under Part B in cases where there is no live appeal given that *CMS's own instructions to hospitals* induced those hospitals not to appeal and seek Part B payment after the Part A denial. That approach is arbitrary and capricious. In any event, CMS is equitably estopped from applying the one-year timely filing limit. Similarly, the time limits must be equitably tolled for such claims.

12. CMS's new approach to Part B payment after Part A denials also suffers from other legal defects, as described below.

13. In this Complaint, Plaintiffs ask the Court to order CMS to accept and process rebilling claims in cases like those described above—cases where hospitals billed under Medicare Part A, and those claims subsequently were denied by a contractor on the ground that

the care should have been provided on an outpatient basis. The Court should declare that CMS must accept and process such claims and that CMS may not treat hospitals' attempts to rebill as untimely.

PARTIES

14. Plaintiff the American Hospital Association (AHA) is a national organization that represents and serves nearly 5,000 hospitals, health care systems, and networks, plus 42,000 individual members. Its principal place of business is at 325 Seventh Street, NW, Washington, DC 20004.

15. Plaintiff Missouri Baptist Sullivan Hospital (Missouri Baptist) is a not-for-profit hospital providing primary community hospital services to three counties southwest of St. Louis, Missouri. CMS has designated Missouri Baptist as a "critical access" hospital, *i.e.*, a small hospital that provides crucial services to a typically rural community. It is one of 13 hospitals in the BJC HealthCare network, which covers the spectrum of hospitals in terms of size and specialty. BJC HealthCare includes small rural hospitals, suburban community hospitals, and an academic children's hospital and tertiary care academic hospital, both affiliated with Washington University School of Medicine. Together, BJC HealthCare's hospitals have 3,445 beds and employ nearly 30,000 people in the greater St. Louis, southern Illinois, and mid-Missouri regions.

16. Plaintiff Munson Medical Center (Munson) is a not-for-profit, 391-bed hospital in Traverse City, Michigan. Munson opened its doors in 1915, making it northern Michigan's first general hospital. It is the largest hospital in the Munson Healthcare System, which employs more than 6,500 people and offers a continuum of health care services in 24 counties across northern Michigan.

17. Plaintiff Lancaster General Hospital (Lancaster General) is a 631-bed, community-based, not-for-profit hospital in Lancaster, Pennsylvania that employs 7,500 people. Founded in 1893, Lancaster General is the keystone of an integrated health care delivery system in the Lancaster area that includes a freestanding Women & Babies Hospital, multiple outpatient centers, and 40 other health care-related organizations, such as the Visiting Nurse Association.

18. Plaintiff Trinity Health Corporation (Trinity Health) is one of the largest Catholic health care systems in the United States, owning 35 hospitals and managing 12 more. Those hospitals stretch across the country from Maryland to California and employ more than 56,000 full-time equivalent employees.

19. Plaintiff Dignity Health (formerly known as Catholic Healthcare West) is one of the nation's largest not-for-profit health care systems. Dignity Health encompasses a 16-state network of nearly 10,000 physicians and 56,000 employees who provide patient-centered care at more than 300 care centers, including hospitals (more than 40 in all), urgent and occupational care, imaging centers, home health, and primary care clinics.

20. Defendant Kathleen Sebelius is the Secretary of Health and Human Services (the Secretary). In that capacity, she is responsible for the conduct and policies of HHS, including the conduct and policies of CMS. Secretary Sebelius is sued in her official capacity only.

JURISDICTION AND VENUE

21. This action arises under the Medicare Act, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*; and the Administrative Procedure Act (APA), 5 U.S.C. § 551 *et seq.*

22. This Court has jurisdiction over this action pursuant to 42 U.S.C. § 1395ff(b)(1)(a), which provides for "judicial review of the Secretary's final decision after [a] hearing as is provided in section 405(g) of this title." Section 405(g) in turn provides that "[a]ny

individual, after any final decision of the [Secretary] made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the [Secretary] may allow." 42 U.S.C. § 405(g). As long as a party has presented its claim to the Secretary, this Court may waive the requirement that the Secretary has issued a "final decision" in cases where doing so would not interfere with the purposes of administrative exhaustion and administrative exhaustion would be futile. *Bowen* v. *City of New York*, 476 U.S. 467 (1986); *Tataranowicz* v. *Sullivan*, 959 F.2d 268, 274, 275 (D.C. Cir. 1992).

23. Jurisdiction also exists under the APA, 5 U.S.C. § 706(2), which authorizes a court to "set aside agency action, findings, and conclusions of law found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "without observance of procedure required by law"; and § 704, which provides a right to judicial review of all "final agency action for which there is no other adequate remedy in a court."

24. This Court also has jurisdiction under 28 U.S.C. § 1361, which grants district courts "original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff[s]."

25. This Court may issue a declaratory judgment pursuant to 28 U.S.C. §§ 2201–2202.

26. Venue lies in this judicial district pursuant to 42 U.S.C. § 405(g).

STATUTORY AND REGULATORY BACKGROUND

A. Medicare Act

27. Title XVIII of the Social Security Act establishes a program of health insurance for the aged and disabled, commonly known as Medicare. 42 U.S.C. §§ 1395 *et seq*. The Plaintiff hospitals qualify as providers of hospital services under Title XVIII, commonly known as the Medicare Act.

28. The Medicare program is divided into four parts, A through D. Parts A and B are the only parts relevant to this proceeding. Part A, the hospital insurance program, provides for reimbursement of inpatient hospital services. 42 U.S.C. §§ 1395c–1395i-5. Part B, the supplemental medical insurance program, pays for various "medical and other health services" not covered by Part A, including physician services and hospital outpatient services. 42 U.S.C. § 1395k(a); *id.* §§ 1395j–1395w-4j. Thus, for an individual who receives a particular treatment on an outpatient basis, payment to the hospital may be made under Part B, while for an individual whose risk factors support providing the same treatment on an inpatient basis, payment to the hospital may be made under Part A.

29. To be covered by Medicare Part A or Part B, medical services must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." *Id.* § 1395y(a).

30. Under 42 U.S.C. § 1395hh(a)(1), the Secretary is required to "prescribe such regulations as may be necessary to carry out the administration" of the Medicare program. That statute provides:

> No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1). [*Id.* § 1395hh(a)(2)].

31. The Secretary has implemented the Medicare program through guidance published in various manuals, such as the Medicare Benefits Policy Manual. These manual provisions are not promulgated in accordance with the notice and comment provisions of the APA, and therefore are not binding rules.

B. The RAC Program and CMS's Payment Denial Policy

32. Traditionally, a hospital's decision to admit a patient as an inpatient has been committed to the physician's expert judgment, with hospital oversight and input from the patient. As CMS recognizes, the decision to admit a patient is a complex medical judgment that involves consideration of many factors, such as "the patient's medical history and current medical needs," "the types of facilities available to inpatients and to outpatients," "the hospital's by-laws and admissions policies," "the relative appropriateness of treatment in each setting," "[t]he severity of the [patient's] signs and symptoms," and "[t]he medical predictability of something adverse happening to the patient." Medicare Benefit Policy Manual (MBPM) Ch. 1 § 10.

33. Nonetheless, in order to receive Part A reimbursement, a hospital must establish that admitting the patient for inpatient treatment was medically necessary. 42 U.S.C. § 1395y(a).

34. Physicians' decisions to admit patients began coming under more regular scrutiny with the birth of the RAC program. In 2003, Congress enacted the "RAC Demonstration Project" and tasked the Secretary with implementing it. Acting through CMS, the Secretary began the RAC Demonstration Project in 2005.

35. RACs are private entities that contract with the federal government to audit payments made to providers and suppliers by the Medicare program.

36. RACs typically conduct their audits by reviewing records and opining on the propriety of treatment decisions. RACs receive payment for their auditing services on a contingent basis; the more money they recover from "improper payments" to providers, the more RACs stand to benefit financially.

37. During the three-year RAC Demonstration Project, the RACs claimed to have identified more than $1.03 billion in "improper" payments. Ninety-six percent of those were

overpayments. CMS, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration* 2 (June 2008) ("*Project Evaluation*").

38. The demonstration proved highly cost-effective from CMS's point of view. CMS reported that factoring in underpayments, operating costs, and so forth, the Demonstration Project returned $693.6 million to the Medicare coffers.

39. Congress made the program permanent in 2006. *See* Pub. L. No. 109-432, 120 Stat. 292 (2006), codified at 42 U.S.C. § 1395ddd.

40. The RAC Program has been a continued financial "success" for CMS and the RACs. According to the most recent available data, RACs collected $1.86 billion in overpayments from October 2009 through March 2012. Over that same time period, RACs identified only $245.2 million in underpayments. CMS, *Medicare Fee-for-Service Recovery Audit Program, May 2012*, 1 ("*May 2012 Report*").

41. Because RACs are paid on a contingent basis, they established their claim-review strategies to focus on high-dollar improper payments. *Project Evaluation* 18. One such high-dollar item is inpatient hospital care, which, depending on the care provided, can cost tens of thousands of dollars per patient.

42. During the RAC Demonstration Project, 41 percent of the purported "errors" the RACs found involved situations where medical services supposedly were provided in the wrong setting. *Id.* at 14-15. That often meant that—according to the RACs—hospitals could have provided services on an outpatient basis rather than on an inpatient basis.

43. The RACs have continued to focus on this same type of claim in the permanent RAC program, putting an extraordinary burden on hospitals. In the first quarter of 2012, the most frequently cited "error" that led RACs throughout the country to demand repayment was

the provision of service on an inpatient basis when, according to the RACs, only outpatient treatment was necessary. *May 2012 Report* 1.

44. The RACs are quite frequently wrong in their assertions about what a physician should have done months or years earlier. Indeed, hospitals report that when they pursue appeals through the administrative appeals process—an expensive and burdensome exercise—they are successful in overturning RAC denials *72 percent* of the time.

45. Despite this alarming error rate, when a RAC determines that a provider was paid for inpatient hospital services but that the patient in question should have been treated as an outpatient, CMS takes back the entire Part A payment. And until March 13, 2013, CMS had long taken the position that when an inpatient claim that was paid under Part A was later—usually years later—denied, the hospital could not receive Part B payment except for a few ancillary services. That position is what Plaintiffs refer to as CMS's "Payment Denial Policy."

46. As a result of the Payment Denial Policy, when a RAC concluded that a hospital should have provided items and services on an outpatient, rather than an inpatient, basis, the hospital received little if any reimbursement for the reasonable and medically necessary care provided to the patient. That was so even though in many cases, the intensity and level of care that would have been provided to that patient on an outpatient basis is the same as the care that the patient received as an inpatient, and again, everyone agreed that the particular items and services provided were reasonable and necessary. The RACs fared significantly better: They kept a contingency percentage—9% to 12.5%—of the entire Part A payment.

47. Thus, for example, imagine a situation where a physician decides that a patient needs to be admitted to the hospital for a surgical procedure, and the cost of care provided to the patient—surgery, drugs, and the like—amounts to $20,000. CMS reimburses the hospital under

Part A. Two years later, a RAC employee reviewing hospital records overrules the physician's judgment and decides the patient should have received basically the same care, but on an outpatient basis. That decision, taken together with CMS's Payment Denial Policy, meant the hospital would end up receiving essentially no payment for the surgery and other care it provided. The RAC, by contrast, would receive approximately $2,000 for that one case alone.

48. The only justification CMS ever cited for refusing to reimburse hospitals under Part B for reasonable and medically necessary items and services provided in such cases was Medicare Benefits Policy Manual Chapter 6 § 10. This manual provision, promulgated by CMS without any explanation, provides: "Payment may be made under Part B for . . . *medical and other health services listed below* when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A." (emphasis added). But the services "listed below" include only ancillary services like diagnostic tests, surgical dressings, splints and casts, outpatient physical therapy, and vaccines. The "services listed" do not include the emergency room services, drugs, nursing services and surgical procedures that often comprise the bulk of the care.

49. Upon information and belief, CMS never articulated a reason for reimbursing the ancillary items and services listed in MBPM Chapter 6 § 10, but refusing to reimburse the items and services not on the list. Nor did CMS articulate a reason why it refused to reimburse hospitals for items and services everyone agreed were reasonable and medically necessary.

C. Administrative Appeals

50. RAC decisions are subject to administrative review. A provider can ask for redetermination of a RAC's findings by a Medicare claims processing contractor (known as a fiscal intermediary or Medicare Administrative Contractor (MAC)). If unsatisfied, a provider can seek reconsideration from a Qualified Independent Contractor (QIC), which includes an

independent record review by a panel of physicians or other healthcare professionals. The next step is review by an Administrative Law Judge (ALJ). An ALJ's decision, in turn, can be reviewed by the Departmental Appeals Board Medicare Appeals Council (DAB). 42 C.F.R. §§ 405.940–405.1130. The DAB decision qualifies as the "final" decision of the Secretary for judicial review purposes. 42 U.S.C. § 1395ff(f)(2)(A)(iv).

51. Some hospitals responded to Part A claim denials by appealing and taking the position that even assuming that the patient should have been treated on an outpatient basis, the hospital was entitled to Part B payment for reasonable and medically necessary items and services provided. In at least 16 cases dating back to 2005, the DAB agreed, holding that Part B payment was available to hospitals that provided reasonable and medically necessary services on an inpatient basis when the patient could have been treated in the outpatient setting.[1] On information and belief, this is a uniform line of cases; no DAB decisions come out the other way.

52. Despite these DAB decisions, CMS continued for years to adhere to the Payment Denial Policy set forth in MBPM Chapter 6 § 10. In other words, it told hospitals and CMS contractors over and over again that Part B payment was not permitted after a Part A denial other than for the small subset of ancillary items listed in MBPM Chapter 6 § 10.

[1] *In re: Missouri Baptist Hospital of Sullivan*, No. M-12-2368 (DAB Oct. 23, 2012); *In re: Virtua-West Jersey Hosp.*, No. M-11-1291, 2012 WL 4294308 (DAB Aug. 1, 2012); *In re: Providence Health Ctr.*, No. M-11-1462, 2012 WL 3805722 (DAB July 18, 2012); *In re: Cent. Iowa Hosp. Corp.*, No. M-12-1280, 2012 WL 3805727 (DAB July 18, 2012); *In re: Providence Health Ctr.*, No. M-11-1217, 2012 WL 3780378 (DAB July 13, 2012); *In re: Providence Health Ctr.*, No. M-12-809, 2012 WL 3637361 (DAB June 29, 2012); *In re: St. Mary's Med. Ctr.*, No. M-12-1428, 2012 WL 3303208 (DAB June 11, 2012); *In re: Yale-New Haven Hosp.*, No. M-12-877, 2012 WL 3091657 (DAB May 24. 2012); *In re: Indiana Univ. Health Methodist Hosp.*, No. M-12-872, 2012 WL 3262931 (DAB May 17, 2012); *In re: Maine Gen. Med. Ctr.*, No. M-12-571, 2012 WL 2491654 (DAB May 11, 2012); *In re: Maine Gen. Med. Ctr.*, No. M-12-719, 2012 WL 2491634 (DAB May 7, 2012); *In re: Hendrick Med. Ctr.*, M-11-410, 2012 WL 2324891 (DAB Apr. 23, 2012); *In re: Montefiore Med. Ctr.*, No. M-10-1121, 2011 WL 6960290 (DAB May 18, 2011); *In re: Montefiore Med. Ctr.*, No. M-10-1171, 2011 WL 6960263 (DAB May 10, 2011); *In re: O'Connor Hosp.*, 2010 WL 425107 (DAB Feb. 1, 2010); *In re: UMDNJ-Univ. Hosp.*, 2005 WL 6290383 (DAB Mar. 14, 2005).

53. Accordingly, very few hospitals ever sought payment under Part B after a Part A claim denial. Following CMS's instructions under the unlawful Payment Denial Policy, the vast majority of hospitals did not a submit a new claim for Part B payment, or appeal the Part A denial on the grounds that they should be paid under Part B, reasonably concluding that appeals were too expensive and time-consuming.

E. CMS Repudiates the Payment Denial Policy

54. Plaintiffs brought this action late last year to put an end to CMS's Payment Denial Policy. Plaintiffs asserted in their Complaint that the Payment Denial Policy was unlawful for at least three reasons: (1) it was contrary to the language and purpose of the Medicare Act, (2) it was arbitrary and capricious, and (3) it was invalid for lack of notice and comment rulemaking.

55. After Plaintiffs filed their First Amended Complaint, this Court set a procedural schedule that called for CMS to file the administrative record by March 15, 2013.

56. CMS instead responded by repudiating the Payment Denial Policy. On March 13, 2013, CMS simultaneously issued two documents. The first, denominated CMS Ruling 1455-R, was an interim policy to handle rebilling after Part A denials, effective immediately and remaining in effect until CMS promulgates a new rule. The second was a proposed rule to address these types of claims going forward. *See Medicare Program; Part B Inpatient Billing in Hospitals*, 78 Fed. Reg. 16,632 (Mar. 18, 2013).

57. CMS effectively conceded in these documents that its longstanding Payment Denial Policy was unlawful. It wrote in the proposed rule:

> Having reviewed the statutory and regulatory basis of our current Part B inpatient payment policy, we believe that, *under section 1832 of the [Social Security] Act, Medicare should pay all Part B services that would have been reasonable and necessary (except for services that require an outpatient status) if the hospital had treated the beneficiary as a hospital outpatient rather than treating the beneficiary as an inpatient*, when Part A payment

> cannot be made for a hospital inpatient claim because the inpatient admission is determined not reasonable and necessary under section 1862(a)(1)(A) of the Act. [78 Fed. Reg. at 16,636 (emphasis added)].

That is fundamentally the position Plaintiffs had articulated in their Complaint.

58. Despite repudiating the Payment Denial Policy, however, CMS did not propose to make hospitals whole, either for pre-existing and current claims or in future cases.

59. Pre-Existing and Current Claims. In Ruling 1455-R, CMS announced that it will process Part B rebilling claims—and will not apply the one-year time limit on billing Part B claims—in two categories of cases, thus allowing hospitals to obtain the Part B payment to which CMS itself says they are entitled. First, CMS will allow rebilling in new cases that arise while the rulemaking is under way. (That is, cases where the contractor's Part A denial issues between March 13, 2013 and the effective date of a new rule.) *See* Ruling 1455-R at 7-8. Second, CMS will allow rebilling where the contractor's Part A denial issued prior to March 13, 2013, but the timeframe to appeal that denial has not expired or an appeal is still pending. *See id.*

60. CMS will *not*, however, allow rebilling of Part A denials for which the timeframe to appeal has already expired. *See id.* at 8. On information and belief, such cases make up the vast majority of the denials under the RAC program. In those cases, on information and belief, CMS will deem any attempt to rebill under Part B as untimely and will reject the claim.

61. Moreover, CMS also limited Part B rebilling in a second way: Even for those claims that can be rebilled under Ruling 1455-R, CMS will not pay for certain services that CMS deemed to require an "outpatient status," such as observation services. *See id.* at 6. CMS wrote that even though the Medicare contractor's Part A denial in all of these cases necessarily overturns the physician's decision to admit the patient as an inpatient, the patient nevertheless

technically remains an "inpatient," and thus the hospital cannot bill under Part B for items or services that require an "outpatient status." *Id.*

62. Ruling 1455-R thus fails to give hospitals back most of what they lost under the Payment Denial Policy. For most Part A denials that issued more than a few months ago, hospitals will never be paid for the reasonable and necessary services they provided.

63. Future Claims. In any event, Ruling 1455-R is only a temporary fix; it does not prevent CMS from re-establishing its unlawful refusal to pay in the future. In fact, the proposed rule released on the very same day as Ruling 1455-R makes clear that CMS intends to do just that, albeit by proposing to do indirectly what it cannot do directly.

64. As stated above, the proposed rule acknowledges that the Payment Denial Policy premised on MBPM Ch. 6 § 10 was unlawful. CMS does not propose to renew that policy; on the face of things the proposed rule purports 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 that were billed on the original Part A claim—and apply the one-year time limit found in 42 U.S.C. § 1395n(a)(1) to those claims. CMS thus would require that the rebilled claims be filed within one year of the date when the hospital provided care to the patient. 78 Fed. Reg. at 16,639–40.

65. That application of the one-year filing limit would make CMS's supposed commitment to allow Part B rebilling an empty promise. On information and belief, nearly all RAC Part A denials are issued more than a year after the date the service was provided—often several years later—because of the time it takes RACs to review paid claims. That means that under the approach in the proposed rule, hospitals could almost never rebill. Their Part B claims would be untimely even if filed on the very same day that the contractor issued its Part A denial.

66. In short, CMS's proposed rule (i) squarely recognizes that CMS *must* pay hospitals under Part B after a Part A denial by a RAC and then (ii) makes it impossible for hospitals to obtain that payment.

F. Plaintiffs' Letter to CMS

67. On April 17, 2013, the AHA sent a letter to the Secretary on behalf of all of its members, including the Plaintiff hospitals and health systems in this action. The letter pointed out that Ruling 1455-R fails utterly to make hospitals whole for CMS's longtime application of its concededly unlawful policy. It demanded that CMS permit hospitals in Part A denial situations like those described above to obtain full payment under Part B for all of the reasonable and necessary services they provided.

G. Harms Suffered By Plaintiffs

68. CMS's Payment Denial Policy, and its refusal in Ruling 1455-R to allow rebilling in most Part A denial cases, have harmed each of the Plaintiff hospitals.

Missouri Baptist Sullivan

69. Since January 30, 2010, the RAC has asked Missouri Baptist to turn over at least 517 patient records so the RAC could examine whether the decision to admit the patient as an inpatient was medically necessary. Of those 517 requests for medical records, the RAC determined, based on review of a cold paper record years after the fact, that 111 patients should not have been admitted as inpatients. Another 33 cases are still pending at the RAC. These RAC denials have required Missouri Baptist—a hospital with fewer than 26 acute care beds—to repay Medicare $324,000 (for 87 of the 111 patients), resulting in a payment of approximately $30,748 to the RAC itself based on its 9.49 percent contingency-fee rate.

70. In fact, as a result of the high volume of audited claims relative to the low number of patients treated at such a small, rural hospital, the RAC's clawbacks mean that Missouri Baptist actually has a negative cash flow for the care it currently provides to Medicare beneficiaries. That is to say, the amount of payment the RAC has denied for care provided years ago is more than the total amount of Medicare reimbursement Missouri Baptist would otherwise receive for the services it is currently providing, so CMS simply uses the amount Missouri Baptist would otherwise be paid to offset the RAC's denials.

71. Some of these 111 clawed-back Part A claims are still live or have pending appeals. Missouri Baptist can rebill those claims under Part B pursuant to Ruling 1455-R.

72. However, the majority of Missouri Baptist's Part A RAC denials occurred in 2011 and early 2012, and the time to file an appeal for those claims has long since expired. Those claims will never be repaid under the CMS Ruling.

73. For example, in 2011, a 76-year-old Medicare beneficiary with hypertension arrived at the Missouri Baptist emergency room after a week of dizziness, headaches, nausea and vomiting. (The patient's name, and those of the others discussed below, are omitted to protect confidentiality.) She was admitted as an inpatient and spent one night in the hospital. Missouri Baptist submitted a request for Part A reimbursement on the patient's behalf. A CMS contractor approved the Part A claim and paid the hospital $14,794.60 for the items and services provided.

74. More than a year later, without ever meeting or speaking to the patient or the patient's physicians, the RAC determined that the patient should have been treated on an outpatient basis. No one disputed that the patient needed to have the treatment she received or that the hospital provided only medically necessary items and services while caring for her. And yet the RAC demanded that Missouri Baptist repay the entire $14,794.60.

75. Because of the cost and the lengthy administrative appeals process, Missouri Baptist did not appeal this Part A denial. Missouri Baptist understood that under CMS's Payment Denial Policy, it could not obtain payment under Part B in any event, so it did not pursue an appeal of the Part A denial to seek payment under Part B.

76. In conformance with CMS's instructions under its unlawful Payment Denial Policy, Missouri Baptist Sullivan likewise did not file a "new" claim for payment under Part B for the care that it provided.

77. After CMS repudiated the unlawful Payment Denial Policy on March 13, 2013, Missouri Baptist filed a Part B claim for the reasonable and necessary services provided in the case just described. Because CMS has yet to issue guidance about how these claims should be submitted, Missouri Baptist submitted it to the CMS contractor via facsimile on April 17, 2013.

78. On information and belief, the contractor will deny the claim automatically because it was filed outside the one-year time limit and there is no live appeal. That denial cannot be appealed through the administrative appeals process. 42 C.F.R. § 405.926(n).

79. On information and belief, submitting claims for payment under Part B for each of Missouri Baptist's approximately 52 Part A denials that no longer have live claims or appeals will yield the same result. Missouri Baptist will never be paid for the care provided in those cases. It thus been harmed—on the order of hundreds of thousands of dollars—as a result of the now-withdrawn Payment Denial Policy and the approach adopted in Ruling 1455-R.

Munson Medical Center

80. The RAC also has demanded repayment from Munson hundreds of times. Between July 1, 2007 and April 16, 2013, the RAC asked Munson to turn over 2,581 patient records to examine whether the decision to admit the patient as an inpatient was medically

necessary. Of those 2,581 requests, the RAC determined that 1106 patients should not have been admitted as inpatients. In only 667 cases has the RAC determined that the patient was properly admitted as an inpatient. 808 cases remain pending. The RAC, in other words, has demanded that Munson return all payment—for care that everyone agrees was medically necessary—in nearly half (approximately 42 percent) of the cases it has reviewed.

81. These RAC denials have required Munson to repay Medicare more than $7 million, resulting in payments of approximately $880,662 to the RAC itself based on its 12.5 percent contingency-fee rate.

82. Approximately 407 of these Part A denials have still-live claims or appeals. Munson can rebill those claims under Part B pursuant to Ruling 1455-R.

83. However, the majority of Munson's Part A RAC denials—some 699 claims—are no longer live and will never be repaid under the CMS Ruling.

84. For example, in 2011, an 89-year-old Medicare beneficiary arrived at the Munson Medical Center emergency room with nausea and vomiting that had lasted for more than a day. The patient was placed on observation, and a diagnostic test revealed a small tear, which was repaired. After the procedure, the beneficiary was admitted as an inpatient and spent one night in the hospital. Because the patient was a Medicare beneficiary, Munson submitted a request for Part A reimbursement on her behalf. A CMS contractor approved the Part A claim and paid Munson $4,062.83 for the items and services it provided to the patient.

85. A little more than a year later, after reviewing the patient's medical records, the RAC determined that she should have been treated as a hospital outpatient, rather than an inpatient. The RAC demanded that Munson repay the entire $4,062.83. At no point before,

during, or after the RAC review has anyone disputed that the patient needed the care she received or that the hospital had provided only medically necessary items and services.

86. Told repeatedly by CMS that under the Payment Denial Policy it could not claim Part B reimbursement for the care that it provided, Munson did not file a claim for those items and services. Likewise, because of the Payment Denial Policy, Munson did not pursue an appeal of its Part A denial to seek payment under Part B.

87. After CMS repudiated the unlawful Payment Denial Policy on March 13, 2013, Munson filed a Part B claim in the case just described. Lacking guidance from CMS regarding processing, Munson had multiple conversations with the CMS contractor about how to submit these claims, and had to make multiple electronic submissions in order to ultimately submit the bill to the CMS contractor on April 17, 2013.

88. On information and belief, the CMS contractor will deny the claim because it was filed outside the one-year time limit and there is no live appeal. That denial cannot be appealed through the administrative appeals process.

89. Munson has tried several different methods for claiming Part B payment for the many other Part A RAC denials that are no longer live, all to no avail. For example, in another case, Munson submitted a request for an adjustment to the originally submitted Part A claim, providing additional details about the services delivered to the beneficiary on that date.

90. On information and belief, the CMS contractor will likewise deny that request because it was filed outside the one-year time limit and there is no live appeal. That denial cannot be appealed through the administrative appeals process.

91. On information and belief, Munson's attempts to claim Part B payment for the other 699 Part A denials that no longer have live claims or appeals—using either of the methods

described above—similarly will be denied because they are outside the one-year time limit and there is no live appeal.

92. Munson will never be paid for the services provided in those cases, even though CMS now agrees that hospitals should be paid under Medicare Part B in this circumstance. Munson has suffered significant financial loss because of CMS's unlawful Payment Denial Policy and the approach adopted in Ruling 1455-R.

Lancaster General Hospital

93. Since April 2011, the RAC has asked Lancaster General to turn over 4,089 patient records, many to examine whether the decision to admit the patient as an inpatient was medically necessary. The RAC has determined that 645 of those patients should not have been admitted as inpatients. These RAC denials have required Lancaster General to repay Medicare $3.8 million, resulting in more than $480,000 in payments to the RAC itself based on its 12.5 percent contingency-fee rate.

94. For all of those Part A denials, Lancaster General has not received any Part B payments, despite the fact that the RAC nearly always concludes that the care provided was medically necessary.

95. For the Part A denials that no longer have claims or appeals that are still live and thus are not within the scope of Ruling 1455-R—approximately 57 cases— Lancaster General will never be compensated for the care it provided.

96. For example, in 2008, a 79-year-old Medicare beneficiary went to Lancaster General Hospital for a scheduled cardiac catheterization. He was admitted as an inpatient and spent one night in the hospital.

97. Lancaster General submitted a request for Part A reimbursement on the patient's behalf. A CMS contractor approved the Part A claim and paid Lancaster General $8,646.80 for the items and services it provided to the patient.

98. More than three years later, after reviewing the patient's medical records but without speaking to anyone involved in his care, the RAC determined that he should have been treated as an outpatient. It demanded that Lancaster repay the entire $8,646.80, despite the fact that no one disputed that the care Lancaster provided was medically necessary.

99. Adhering to CMS's Payment Denial Policy, Lancaster General did not file a claim for payment under Part B for the items and services provided and did not pursue an appeal of the Part A denial to claim payment under Part B.

100. After CMS repudiated the unlawful Payment Denial Policy on March 13, 2013, Lancaster General filed a Part B claim for the reasonable and necessary care that it provided to the patient described above. Lacking guidance from CMS, Lancaster General laboriously prepared the bill manually and submitted it to the CMS contractor by directly entering the data into the contractor's financial system, known as the Fiscal Intermediary Standard System (FISS), on April 19, 2013.

101. On information and belief, the CMS contractor will deny the claim because it was filed outside the one-year time limit and there is no live appeal. That denial cannot be appealed through the administrative appeals process.

102. On information and belief, the CMS contractor likewise will deny Lancaster General's attempts to claim payment under Part B for the dozens of other Part A RAC denials that no longer have live claims or appeals.

103. Lancaster General will never be paid for the care provided in those cases, and thus has suffered approximately $294,021 in losses to date because of CMS's Payment Denial Policy and the approach adopted in Ruling 1455-R.

Trinity Health

104. Since January 2010, the RAC has asked Trinity Health to turn over at least 32,148 patient records from 28 hospitals to examine whether payment was appropriate, including whether the decision to admit the patient as an inpatient was medically necessary. Of those 32,148 requests for medical records, the RAC determined, based on review of cold records, that 10,306 Medicare beneficiaries should not have been admitted as inpatients. Thus far, Trinity Health has had to repay Medicare more than $50 million.

105. Only about half of the thousands of Part A RAC denials received by Trinity Health's hospitals are eligible for Part B payment under Ruling 1455-R. The other half are not. Trinity Health will never be compensated for the care provided in those cases.

106. For example, in May 2009, a 74-year-old Medicare beneficiary went to a Trinity Health hospital emergency room with a dislocated shoulder. He was admitted as an inpatient, spent one night in the hospital, and had surgery the next day. The Trinity Health hospital submitted a request for Part A reimbursement on his behalf. A CMS contractor approved the Part A claim and paid the hospital $3,772.02 for the items and services it provided.

107. More than two and a half years later, after reviewing the patient's medical records, the RAC determined that he should not have been admitted as an inpatient; instead, he should have been an outpatient during the procedure and his recovery. The RAC demanded that the Trinity Health hospital repay the entire $3,772.02, despite the fact that no one disputed that the care provided to the patient was medically necessary.

108. Like the other Plaintiffs, Trinity Health followed the Payment Denial Policy and did not file a separate claim for payment under Part B or pursue an appeal of the Part A denial in order to claim payment under Part B.

109. After CMS repudiated the unlawful Payment Denial Policy on March 13, 2013, Trinity Health filed an adjusted Part A claim to supplement the originally-submitted Part A claim with additional details about the reasonable and necessary services provided in this case. Trinity submitted this bill electronically to the CMS contractor on April 17, 2013.

110. On information and belief, the CMS contractor will deny the claim because it was filed outside the one-year time limit and there is no live appeal. That denial cannot be appealed through the administrative appeals process.

111. Trinity Health has also tried another approach to obtain payment under Part B in another case that is not covered by Ruling 1455-R. In that case, a 60-year-old disabled Medicare beneficiary was admitted to a Trinity Health hospital in 2008 for stent placement to treat coronary atherosclerosis, and spent one night in the hospital. The Trinity Health hospital submitted a request for Part A reimbursement on his behalf. A CMS contractor approved the Part A claim and paid the hospital $18,979 for the items and services it provided.

112. Some three years later, after reviewing the patient's medical records, the RAC determined that he should not have been admitted as an inpatient; instead, he should have been an outpatient during the procedure and his recovery. The RAC demanded that the Trinity Health hospital repay the entire $18,979, despite the fact that no one disputed that the care provided to the patient was medically necessary.

113. Trinity Health again followed the Payment Denial Policy and filed a Part B claim only for those few ancillary services, such as laboratory services, that CMS allowed to be billed,

for which it was ultimately reimbursed only $118.25, less than one percent of the cost of the concededly reasonable and necessary care provided. Adhering to the Payment Denial Policy, Trinity Health did not seek payment under Part B for any of the other items or services provided and did not pursue an appeal of the Part A denial in order to claim payment under Part B.

114. After CMS repudiated the Payment Denial Policy, Trinity filed a Part B claim for all of the other reasonable and necessary services provided in this case. Trinity manually prepared a paper bill and submitted it to the CMS contractor via facsimile on April 18, 2013.

115. Trinity anticipates the CMS contractor will deny the claim because it was filed outside the one-year time limit and there is no live appeal. That denial cannot be appealed through the administrative appeals process.

116. On information and belief, Trinity Health's efforts to obtain payment under Part B—using either of the methods described above—for the thousands of Part A denials that no longer have live claims or appeals also will be rejected automatically. Trinity Health will never be paid for the care provided in those cases. It accordingly has suffered millions of dollars in losses because of the Payment Denial Policy and the approach adopted in Ruling 1455-R.

Dignity Health

117. St. John's Regional Medical Center (SJRMC) is a 265-bed, community-based Dignity Health hospital in Ventura County, California. Since the RAC began auditing SJRMC's claims in 2010, the RAC has asked SJRMC to turn over 1,090 medical records so that the RAC could determine whether, in its view, it was medically necessary to admit the patient to the hospital for treatment. The RAC has completed 944 reviews. And it has determined that 649 patients should not have been admitted as inpatients.

118. In total, these RAC denials have required SJRMC to repay Medicare $5,228,935.

119. Nearly all the hospitals in the Dignity Health network have had similar experiences. In total, Dignity Health network hospitals have been required to repay Medicare $114 million as a result of RAC denials of short-stay inpatient admissions.

120. Although some of these denials may be eligible for Part B rebilling under Ruling 1455-R, the majority of SJRMC's Part A RAC denials are not live on appeal and will never be paid under Part B.

121. For example, in 2008 an 80-year-old male beneficiary arrived at SJRMC to have a pacemaker implanted. He was admitted as an inpatient and spent one night in the hospital. SJRMC submitted a request for Part A reimbursement. A CMS contractor approved the Part A claim and paid the hospital $14,103.31 for the items and services it provided to the patient.

122. Approximately three years later, after reviewing the patient's medical records, the RAC determined that the patient should have been treated on an outpatient basis. The RAC demanded that SJRMC repay the entire $14,103.31. Despite this repayment, all agree that the care the patient received was medically necessary.

123. Dignity Health followed the Payment Denial Policy and thus did not file a claim for Part B payment or pursue an appeal of the Part A denial in order to seek Part B payment.

124. After CMS repudiated the unlawful Payment Denial Policy, Dignity Health decided to file a Part B claim for the reasonable and necessary services provided. Dignity Health is in the process of submitting an electronic bill to the CMS contractor for that claim.

125. On information and belief, the CMS contractor will deny the claim because it was filed outside the one-year time limit and there is no live appeal. That denial cannot be appealed through the administrative appeals process.

126. On information and belief, Dignity Health's efforts to obtain payment under Part B for the several hundred other Part A denials that no longer have live claims or appeals also will be rejected automatically. Dignity Health will never be paid for the care provided in those cases. It accordingly has suffered millions of dollars in losses because of the Payment Denial Policy and the approach adopted in Ruling 1455-R.

Harms Nationwide

127. CMS's Payment Denial Policy, and the approach adopted in Ruling 1455-R, have inflicted similar harms on hospitals across the nation.

128. Plaintiff AHA collects data and evidence from member hospitals regarding the RAC program. As of September 2012, those data show the following: More than 95 percent of the general medical-surgical hospitals that provided information have been targeted by RACs. The RACs have demanded more than 600,000 records to audit. Many of those audits result in RAC determinations of "overpayment." And of those overpayment determinations, more than 60 percent relate to one- to two-day inpatient admissions that RACs deem medically unnecessary.

129. Hospitals thus have been required to give back hundreds of millions of dollars per year due to RAC determinations that services should have been provided in an outpatient, rather than inpatient, setting. From the beginning of the RAC program through the third quarter of 2012, information provided to AHA shows that hospitals were forced to repay hundreds of millions of dollars for medically necessary items and services that RACs deemed should have been provided on an outpatient, rather than an inpatient, basis. And this amount does not include the millions of dollars recovered from hospitals that did not report data to the AHA.

130. Under the Payment Denial Policy, hospitals that repaid these amounts were not eligible to be reimbursed under Part B, except for a few ancillary services.

131. Even though CMS now admits that the Payment Denial Policy was unlawful, Ruling 1455-R does not apply to most of the claims that were denied and never paid as a result of that policy. The data and anecdotal evidence collected by the AHA show that hospitals often choose not to appeal RAC Part A denials to seek the denied Part A payment, in part because of the time and expense associated with such appeals. And hospitals typically did not attempt to appeal their Part A denials to seek Part *B* payment, because CMS's Payment Denial Policy instructed them that such an appeal would have been futile. Thus many hospitals that suffered RAC clawbacks do not have live claims or appeals.

132. Accordingly, hospitals will never be compensated for hundreds of millions of dollars' worth of care that CMS (i) concedes was reasonable and medically necessary and (ii) concedes that it should have paid for under Part B.

F. Applicable Law

133. The majority of dollars recouped by CMS for "improper" inpatient admissions should have been repaid to the hospitals under Medicare Part B.

134. As CMS now admits, the Medicare Act requires this result. The Act "entitle[s]" hospitals to payment for all reasonable and necessary "medical and other health services" provided to beneficiaries, 42 U.S.C. § 1395k(a)(2), except for services the statute specifically excludes, *see id.* § 1395y. The services at issue in these RAC cases—emergency room services, drugs, surgical procedures, and the like—are covered under those definitions. The services are "medical and other health services" under 42 U.S.C. § 1395x(s)(2), which defines that term to include hospital services. And the services do not fall within the exclusions listed in § 1395y.

135. CMS has now acknowledged that the Payment Denial Policy did not comport with these requirements and accordingly has withdrawn it. *See* 78 Fed. Reg. at 16,636.

136. And yet CMS proposes to remedy the harm caused by the unlawful policy, and make the required payments under Part B, for only a few claims. For the rest, CMS will invoke an unfounded administrative "requirement" that hospitals submit new Part B claims for the very same services that were originally billed under Part A, and a waivable one-year time limit for filing such new claims, to refuse to pay.

137. That approach is arbitrary and capricious, and otherwise unlawful, for several reasons. First, CMS can and should allow hospitals to supplement their original claims instead of forcing them to file "new" ones. Second, even if new claims were required, CMS could not on these facts invoke the one-year time limit. Third, the limitation Ruling 1455-R places on claims that *are* eligible under the Ruling—namely, refusing to pay for services that "require an outpatient status"—is contrary to the requirements of the Medicare Act.

138. Supplementing Claims. Nothing in the Medicare statute or regulations requires hospitals to submit new Part B claims. To the contrary, hospitals could simply amend or supplement their initial Part A claims to make clear that they now seek Part B payment, furnishing additional information about the items and services provided as needed.

139. Congress has recognized some claims for payment may need to be supplemented with additional information before they are paid, *see* 42 U.S.C. §§ 1395g(a), 1395*l*(e); 42 C.F.R. § 424.5(a)(6), and that not all claims will be "clean claims" that will be paid promptly as billed, *see* 42 U.S.C. §§ 1395h(c), 1395u(c). Congress also recognized the need for a process to allow hospitals an opportunity to correct "minor errors or omissions" in their previously submitted claims without requiring them to initiate an appeal, and directed the Secretary to establish a process which "shall include the ability to resubmit corrected claims." Medicare Modernization Act of 2003, Pub. L. 108-273 § 937, 117 Stat. 2412.

140. To address such circumstances, CMS has issued regulations and policy statements allowing for claim adjustment by Medicare claims processing contractors and providers alike. *See, e.g.*, 42 C.F.R. § 421.100(a)(2); Medicare Claims Processing Manual, CMS Pub. 100-04 Ch. 1 § 130; Medicare Financial Management Manual, CMS Pub. 100-06 Ch. 3 § 170. And the DAB and many ALJs have used this adjustment process to allow payment under Part B after Part A denials in cases just like the ones at issue here.

141. In short, amending or supplementing an initial reimbursement request would not require the hospital to submit a new claim, and thus would not run afoul of the general requirement that hospitals submit reimbursement requests within one year of the date services were provided. Neither the Medicare Act nor its implementing regulations prevent CMS from making full Part B payment following a Part A denial.

142. The One-Year Time Limit. If CMS refuses to allow hospitals to supplement the originally-submitted Part A claims, and insists that they submit "new" requests for Part B payment, the Secretary cannot invoke the one-year timely filing requirement on these facts.

143. First, the one-year time limit is waivable. *See* 42 U.S.C. §§ 1395n(a)(1), 1395u(b)(3)(B). Given 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.

144. 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.

145. Likewise, equitable estoppel applies against government agencies where (i) there was a definite representation to the party claiming estoppel, (ii) the party relied on the agency's conduct in such a manner to change its position for the worse, (iii) the party's reliance was reasonable, and (iv) the agency engaged in affirmative misconduct. That is the case here.

146. The doctrine of equitable tolling also applies against CMS where it is consistent with Congress' intent under the Medicare Act and where the government's secretive conduct prevents plaintiffs from knowing of a violation of rights. Again, that is the case here.

147. Limitation on Payment for Certain Services. The Medicare Act requires CMS to reimburse hospitals under Part B for *all* reasonable and necessary "medical and other health services" provided to beneficiaries, 42 U.S.C. § 1395k(a)(2), except for the services the statute specifically excludes, *see id.* § 1395y. CMS's insistence that once admitted, beneficiaries in these types of cases must retain their "inpatient" status—even though the RAC has determined that the patient should have been an outpatient all along—and its refusal to allow hospitals to rebill for services that require an "outpatient status" provided after the point of admission on that basis, cannot be reconciled with the Medicare Act.

COUNT I

VIOLATION OF ADMINISTRATIVE PROCEDURE ACT
CMS's Refusal to Pay on Past Part A Claims Is Arbitrary and Capricious

148. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

149. The Administrative Procedure Act prohibits Defendant from implementing the Medicare Act via actions, findings, or conclusions that are arbitrary and capricious.

150. Nothing in the Medicare Act or regulations requires CMS to make hospitals submit new, separate claims for payment under Medicare Part B after a Part A denial. And there is no question that it is administratively feasible instead simply to require hospitals to amend or

supplement the original Part A claims as needed. The ALJs and the Medicare Appeals Council have ordered hospitals to follow that procedure many times.

151. If Plaintiffs are allowed to amend or supplement their original Part A claims, none of those claims will run afoul of the one-year time limit for filing payment claims. That is so because the original Part A claims were submitted within one year of the date of service.

152. CMS nonetheless is choosing to create administrative requirements that trigger a time-bar that would not otherwise exist. It is doing so to avoid paying for services that it concedes should be paid under Medicare Part B.

153. CMS's refusal to let hospitals amend or supplement their original Part A claims, and its concomitant refusal to pay for the reasonable and medically necessary services provided by Plaintiffs, is arbitrary and capricious and therefore unlawful under the APA.

COUNT II

VIOLATION OF ADMINISTRATIVE PROCEDURE ACT
CMS's Application of the One-Year Time Limit Is Arbitrary and Capricious

154. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

155. If CMS refuses to let Plaintiffs supplement their original Part A claims and requires them to file new Part B claims in order to rebill, it is arbitrary and capricious to apply the one-year time limit to those claims.

156. As CMS knows, in nearly every case, RAC Part A denials do not issue until more than one year has passed since the date the patient was treated. Thus if the one-year time limit is applied, it will be impossible in almost every case for hospitals to claim Part B payment after a Part A denial. The time limit already will have expired on the very first day the hospital learns of the Part A denial.

157. CMS acknowledged in Ruling 1455-R that the Medicare Act requires CMS to pay hospitals under Part B after a Part A denial.

158. Having so acknowledged, CMS cannot both (i) arbitrarily decide that hospitals must file new claims, instead of supplementing existing ones, and (ii) apply a waivable time limit to those new claims that makes it *impossible for hospitals to seek the very payments CMS says it must make*.

159. That bait-and-switch is by definition arbitrary and capricious agency action and therefore unlawful under the APA.

COUNT III

VIOLATION OF ADMINISTRATIVE PROCEDURE ACT
CMS's Underinclusive Exception to the One-Year Time Limit in Ruling 1455-R is Arbitrary and Capricious Given its Representations to the Plaintiff Hospitals

160. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

161. CMS's application of the one-year time limit also is arbitrary and capricious for a second reason.

162. Through its unlawful Payment Denial Policy, CMS has long told hospitals that they could not rebill under Part B, or appeal on Part B grounds, after a Part A denial. Hospitals followed CMS's instructions and never sought payment for such services.

163. CMS now acknowledges that it should have been paying hospitals under Part B all along. And yet it proposes to remedy its unlawful action only with respect to hospitals whose appeals from Part A denials happen to still be live. For hospitals that did not appeal, CMS will apply the one-year time limit to reject their claims.

164. If CMS had not issued longtime, explicit guidance telling hospitals not to seek Part B payment after a Part A denial, many hospitals would have appealed those denials and

asked for payment under Part B. Many of those appeals would still be live, and thus the hospitals would be eligible for payment under Ruling 1455-R.

165. The APA prohibits Defendant from implementing the Medicare Act through actions, findings, or conclusions that are arbitrary and capricious.

166. CMS cannot induce hospitals not to file appeals and then refuse to pay what it owes to hospitals that followed CMS's guidance. That is arbitrary and capricious government action.

COUNT IV

DECLARATORY RELIEF/EQUITABLE ESTOPPEL
CMS Is Estopped from Applying the Timely Filing Limit to New Part B Claims

167. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

168. CMS made definite representations to the Plaintiff hospitals that under the Payment Denial Policy, they could not obtain Part B payment after denials of Part A claims on the ground that the services could have been provided on an outpatient basis.

169. Plaintiffs reasonably followed CMS's instructions and accordingly never sought payment under Part B for such claims, either by rebilling or by appealing the Part A denial and seeking Part B payment.

170. CMS deliberately misled Plaintiffs not to submit Part B claims for the reasonable and necessary care that they provided by its repeated adherence to the Payment Denial Policy—which it now concedes was contrary to the Medicare Act.

171. But even though CMS admits it should have been paying Plaintiffs under Part B in these cases all along, it now seeks to avoid making such payments by relying on the Medicare Act's one-year time limit for filing such claims.

172. This pattern of agency instructions and actions constitutes affirmative misconduct.

173. The Secretary must be equitably estopped from using the one-year time limit to bar Plaintiffs from submitting the very claims that CMS long told them they could not submit.

COUNT V

DECLARATORY RELIEF/EQUITABLE TOLLING
The Medicare Act's One Year Time Limit Is Equitably Tolled

174. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

175. CMS deliberately misled Plaintiffs not to submit claims for payment under Part B after denials of Part A claims, by repeatedly asserting that such claims could not be submitted under its unlawful Payment Denial Policy.

176. Plaintiffs reasonably followed CMS's instructions and accordingly never sought payment under Part B for such claims.

177. Plaintiffs could not reasonably have known that their Part B claims were cognizable until CMS acknowledged that its policy was unlawful on March 13, 2013.

178. Plaintiffs are entitled to equitable tolling of the Medicare Act's one-year time limit to file new claims for payment under Medicare Part B, until the date on which CMS admitted that such claims are cognizable, or March 13, 2013.

COUNT VI

VIOLATION OF ADMINISTRATIVE PROCEDURE ACT
Ruling 1455-R Is Not in Accordance with the Medicare Act

179. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

180. The APA prohibits Defendant from implementing the Medicare Act in a manner that is not in accordance with law.

181. As CMS now admits, the Medicare Act entitles hospitals to be reimbursed under Part B for all covered, reasonable and necessary medical and health services, without limitation.

182. Nonetheless, CMS purports not to pay hospitals for certain services that require an "outpatient status"—even where those services were reasonable and necessary for the particular patient—based on a bizarre assertion that patients must forever retain their "inpatient" status, even after a RAC has determined that the patient should have been treated on an outpatient basis.

183. That assertion has no basis in law and contradicts the Medicare Act.

184. Ruling 1455-R is therefore invalid under the APA because it violates the Medicare Act.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court issue judgment in its favor and against Defendant and issue the following relief:

A. A declaratory judgment that Plaintiffs are entitled to reimbursement under Medicare Part B for all reasonable and necessary services provided to a patient in cases in which the original Part A claim for services provided during an inpatient stay was denied on the ground that the inpatient admission was not reasonable and necessary and the same care should have been provided on an outpatient, rather than an inpatient basis;

B. A declaratory judgment that CMS's refusal to process Plaintiff hospitals' rebilled claims in such cases using the original timely-submitted Part A claims is arbitrary and capricious;

C. A declaratory judgment that CMS's application of the one-year filing limit to any new Part B claims is arbitrary and capricious;

D. A declaratory judgment that the Secretary is equitably estopped from applying the one-year time limit to any such new Part B claims;

E. A declaratory judgment that the one-year time limit is likewise equitably tolled for any such new Part B claims;

F. A declaratory judgment that Ruling 1455-R is contrary to the Medicare Act insofar as it purports not to allow hospitals in these cases to claim payment under Part B for reasonable and services provided to beneficiaries after they were admitted on the basis that those beneficiaries must remain "inpatients" and certain services require an "outpatient" status;

G. An order that the Secretary must direct CMS and its contractors to accept and process the original Part A claims, supplemented or amended as needed, in order to pay them under Part B, for all of Plaintiffs' timely-filed Part A claims that were later denied on the ground that the inpatient admission was not reasonable and necessary;

H. An order that the Secretary must extend or waive the one-year time limit for any new Part B claims that CMS or its contractors require Plaintiffs to submit in order to rebill for these types of Part A denials;

I. An order that the Secretary must either direct CMS and its contractors to accept and process *all* hospitals' original Part A claims, supplemented or amended as need, or extend or waive the one-year time limit for any new Part B claims that CMS or its contractors require hospitals to submit in these cases, and accordingly ensure that all hospitals that have received Part A denials based upon the wrong setting of care likewise be paid full Part B reimbursement for the reasonable and necessary services provided,;

J. An order vacating or setting aside the portion of Ruling 1455-R that purports not to allow hospitals to rebill for services that require an "outpatient status";

K. An award of such other temporary and permanent relief as this Court may deem just and proper.

Dated: April 19, 2013

Respectfully submitted,

/s/ Catherine E. Stetson

Sheree R. Kanner (D.C. Bar No. 366926)
Catherine E. Stetson* (D.C. Bar No. 453221)
Dominic F. Perella* (D.C. Bar No. 976381)
Margia K. Corner (D.C. Bar No. 1005246)
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5600

Melinda Reid Hatton (D.C. Bar No. 419421)
Lawrence Hughes (D.C. Bar. No. 460627)
AMERICAN HOSPITAL ASSOCIATION
325 Seventh Street, NW
Washington, DC 20001
(202) 638-1100

**Counsel of record*