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High Court Gives HHS The Upper Hand In Medicare Fights

By Rachel Slajda

Law360, New York (January 22, 2013, 8:26 PM ET) -- The Supreme Court's refusal Tuesday to allow for deadline extensions on Medicare reimbursement appeals effectively shuts down the hospital industry's pursuit of hundreds of millions of dollars' worth of alleged Medicare underpayments and shores up the agency's authority in limiting such appeals even when its own miscalculations are to blame, attorneys say.

Had the high court gone the other way in Sebelius v. Auburn Regional Medical Center et al., it would have opened the doors to hospitals challenging their annual Medicare reimbursements from more than a decade back. Experts estimated the value of those potential appeals, if successful, at hundreds of millions of dollars.

But the Supreme Court upheld the status quo, ruling that the U.S. Department of Health and Human Services was well within its rights to limit extensions of the statutory 180-day deadline to three years, in limited circumstances and at the agency's discretion, and no more.

It was a disappointing ruling for hospitals.

“It will foreclose opportunities for appeals that [providers] had hoped to be able to pursue after the 180-day time limit is expired — specifically, the type of appeals they're coming across lately, with allegations that there were inaccuracies in internal agency calculations that were not discoverable for nearly a decade,” said Mark Polston, a partner at King & Spalding and a former deputy associate general counsel at the Centers for Medicare and Medicaid Services.

The Auburn case began in 2006, after another provider successfully showed that CMS had calculated reimbursements in the 1980s and 1990s using inaccurate data. CMS did not release such data, and therefore, providers allege, they could not have known that they were being underpaid.

The 180-day clock, Auburn argued, shouldn't have started until the related case was decided in 2006, after extensive litigation and a ruling by the Provider Reimbursement Review Board that found Medicare was knowingly using bad data.

Experts say that there are a number of cases pending at the PRRB and in district court awaiting the Supreme Court's decision, and potentially more that providers would have filed had the court ruled in Auburn's favor.

Those cases are now done for, experts say.

The lesson hospitals should take away is that they should pay close attention to their reimbursements and file appeals “early and often,” said Daniel Hettich of King & Spalding, who represents providers before the PRRB and in court.

However, the Supreme Court's decision comes four years after HHS tightened up the appeals process in new regulations that limited when providers could add issues to their appeals. The end result is that providers must be specific in why they think a reimbursement is too low — no help, experts say, when such information may stay hidden for years.

“In light of the 2008 changes to the regulations governing Medicare reimbursement appeals, hospitals have had to be increasingly vigilant about identifying actual and possible payment errors and filing appeals to seek correction of those errors timely and properly. The Auburn decision makes those steps, including filing appeals within the standard 180 day window, all the more important,” said Stephanie Webster, a partner at Akin Gump Strauss Hauer & Feld LLP who formerly worked in the HHS general counsel's office.

But there is a silver lining for providers. The court did not rule, as a court-appointed amicus had argued, that the 180-day deadline is jurisdictional. If it had, HHS would not be able to offer any exceptions, including the current three-year extension in the case of good cause.

“The silver lining for providers here is that the statute was determined not to be jurisdictional. The secretary can allow for an exception,” Polston said, adding, “Providers can argue to the secretary that the exceptions should be expanded.”

Besides its ruling on the procedural details, the court also took aim at the hospitals' arguments that the 180-day limit is fundamentally unfair, when CMS can reopen any reimbursement decision from any year if there is a suspicion of fraud.

However, Justice Ruth Bader Ginsburg wrote in the opinion that the imbalance was fair considering that CMS had a “few dozen fiscal intermediaries” looking at thousands of reimbursement decisions, while each provider was only looking at its own payments.

That, Polston and others argued, does not reflect the current state of CMS, which employs a range of contractors whose goal is to detect overpayments and fraud.

“In today's world, we now have recovery audit contractors, zone program integrity contractors. The government has a phalanx of contractors it's using to try to identify patterns of data that show where there may be overpayments,” he said. “So it's not quite true that the government's resources to detect overpayments are as limited as what Justice Ginsburg was alluding to.”

Attorneys found some hope for future appeals in Justice Sonia Sotomayor's concurring opinion, which noted a question that had not been addressed in the case: whether, had the hospitals brought the appeal within the three-year extension deadline, their case would be treated as having “good cause” and therefore eligible for an extension.

“We would face a different case if the secretary’s regulation did not recognize an exception for good cause or defined good cause so narrowly as to exclude cases of fraudulent concealment and equitable estoppel,” she wrote.

The hospitals are represented by Robert L. Roth and John R. Hellow of Hooper Lundy & Bookman PC and Patricia A. Millett, Ruthanne M. Deutsch, Hyland Hunt and John B. Capehart of Akin Gump Strauss Hauer & Feld LLP.

The case is Sebelius v. Auburn Regional Medical Center et al., case number 11-1231, in the U.S. Supreme Court.

--Editing by Elizabeth Bowen and Sarah Golin.