

Medicare and Medicaid Litigation: 2013 Year in Review

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Executive Summary

In 2013, there were 26 significant federal appeals court cases on Medicare. On Medicaid, there were 18 significant federal appeals court cases and 56 significant state appeals court cases. Most of these cases involved questions about agency interpretation of the Social Security Act and challenges to determinations on payment amounts and responsibilities. This white paper takes a closer look at a few of the major federal decisions.

Medicare Litigation

Throughout 2013, Medicare was a widely litigated topic. The opinions released showed that courts still remain highly deferential when asked to review determinations of the Department of Health and Human Services (HHS). The much-awaited Supreme Court decision in *Sebelius v Auburn Regional*, along with several decisions by federal circuit courts, indicate that courts in 2014 will be unlikely to delve too deeply into legislative intent and interpretation, leaving the bulk of the interpretation to HHS and the majority of dispute resolution to the Provider Reimbursement Review Board (PRRB).

Supreme Court

Sebelius v Auburn Regional Medical Center

In January 2013, the United States Supreme Court released a highly anticipated opinion in which it held that the 180-day statutory deadline for filing appeals to the PRRB is not jurisdictional and that the three-year extension applied for “good cause” under the Secretary’s regulation is permissible. Further, the court decided that equitable tolling does not apply in the situation of an administrative appeal by providers under the Medicare Act (*Sebelius v Auburn Regional Medical Center*, January 22, 2013, Ginsburg, R).

Disproportionate Share Hospitals. Providers in the Medicare program are reimbursed for the inpatient services rendered. The reimbursements are given at fixed amounts per patient, regardless of the costs actually incurred. This reimbursement amount is adjusted upward for hospitals that serve a disproportionate share of low-income patients, as low-income patients tend to incur higher per-patient costs. The calculation is driven to some extent by the percentage of Supplemental Security Income (SSI)-eligible patients served by the hospital.

Reimbursement. At the end of each year, Medicare providers are required to submit cost reports to fiscal intermediaries. At the same time, CMS calculates the SSI percentage for eligible hospitals and submits these fractions to the intermediaries. The intermediary determines the total payment due to the provider and issues a Notice of Program Reimbursement (NPR) to inform the provider how much will be paid for the year. If the provider does not agree with the reimbursement amount, within 180 days, the provider has a statutory right to request a hearing before the PRRB, pursuant to Social Security Act sec. 1878(a)(3). After the 180 days, 42 CFR sec. 405.1841(b) allows for an extension upon a showing of good cause, but “no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary’s determination is mailed to the provider.”

Disproportionate Share Miscalculation. In 2006, the PRRB announced that it had previously discovered CMS had omitted certain SSI information from its calculations, resulting in an inaccurate tally of low-income beneficiaries. As a result, the disproportionate share adjustment was found to be systematically undercalculated, and providers were being underpaid for their Medicare services. Within 180 days, the petitioners in *Sebelius v Auburn Regional*, Medicare providers who had been underpaid as a result of the miscalculation, appealed to the PRRB—more than 10 years after the expiration of their original 180-day window.

The hospitals argued that equitable tolling of the statute of limitations was required, as CMS had failed to inform them about the miscalculations. The PRRB held that it did not have jurisdiction over the hospital’s complaint, as the 180-day period had passed and only the Secretary had discretion to grant an extension—however, the three-year limit on extensions had passed. The District Court reviewed the PRRB’s decision and held that nothing suggested that Congress intended to authorize equitable tolling of the statutory period. The Court of Appeals reversed the lower court’s decision, holding that statutory limitation periods are generally subject to equitable tolling, and nothing in the statutory provision showed that Congress intended to disallow such.

On certiorari, the Supreme Court sought to resolve the issue of whether the 180-day time limit on PRRB appeals constricts the PRRB’s jurisdiction. It also faced the issue of whether equitable tolling applies to Medicare reimbursement appeals to the PRRB by providers, notwithstanding the regulation setting a three-year limit on extensions for good cause.

“Jurisdictional.” When a rule is characterized as jurisdictional, objections to the tribunal’s jurisdiction over that rule cannot be raised. If the 180-day time limit were found to be jurisdictional, providers could not under any circumstances seek review of PRRB decisions more than 180 days following notice of the intermediary’s final reimbursement determination. There could be no equitable tolling, and even the Secretary’s regulatory extensions for good cause could not be applied.

However, the Supreme Court found that the language used by Congress did not seem to preclude regulatory extension of the deadline. The provision, the court found, “does not speak in jurisdictional terms,” by using mandatory words such as “shall.” The statute merely instructs that a provider “may obtain a hearing” by the PRRB. Further, the court noted that it has repeatedly held that deadlines are ordinarily not jurisdictional, stating, “This case is scarcely the exceptional one in which a ‘century’s worth of precedent and practice in American courts’ rank a time limit as jurisdictional.”

The court’s *amicus* argued that because Social Security Act sec. 1878(a)(1), which specifies which claims providers may bring to the PRRB, and sec. (a)(2), which sets the amount-in-controversy requirement, are jurisdictional, then 180-day time limit of sec. (a)(3) is also jurisdictional. In response, the court noted that it had previously rejected proximity-based arguments, stating, “A requirement we would otherwise classify as nonjurisdictional, we held, does not become jurisdictional simply because it is placed in a section of a statute that also contains jurisdictional provisions.”

Amicus also argued that the time limit should be deemed to be jurisdictional, as Congress expressly made other time limits in the Medicare Act. However, the court quoted one of its previous opinions, stating, “Congress’s use of ‘certain language in one part of the statute and different language in another’ can indicate that ‘different meanings were intended.’” Thus, the court held the 180-day time limit was not jurisdictional, and the extension contained in the Secretary’s regulation was not barred.

Equitable Tolling. The extensions for good cause allowed under the Secretary’s regulation were put in place with the PRRB’s large caseload in mind. The court stated that it lacked authority to undermine the Secretary’s regulation unless it is “arbitrary, capricious, or manifestly contrary to the statute,” which, according to the court, it was not. Further, the court declined to apply the presumption that equitable tolling should apply to suits against the U.S. by private individuals, as such a presumption was only adopted on the premise that the presumption comports with legislative intent.

Because Congress has revisited the statute and has not made any pertinent changes, the court felt comfortable concluding that Congress did not disapprove of either the 180-day or the three-year time limit.

Practical Application of Auburn Regional

Robert L. Roth, who argued the *Auburn Regional* case before the Supreme Court, said that the practical effect of the decision is that providers no longer have a remedy for underpayments of which they may not be aware and hopes that Congress will develop legislation to address the issue of equitable tolling of the 180-day appeals limitation.

The concurring opinion of *Auburn Regional* also addresses the intent of Congress. Supreme Court Justice Sandra Sotomayor notes in her concurring opinion that the equitable tolling is customarily applicable to limitations periods in administrative settings. However, this dispute involves “repeat players” in the Medicare system. To allow equitable tolling, which is designed to protect the rights of unsophisticated claimants, to the reimbursement process for sophisticated institutional providers, would distort congressional intent.

As claimants are usually required to exhaust administrative relief before seeking judicial review, Justice Sotomayor points out that to allow equitable tolling would create an odd practical effect—it would be within the agency’s discretion to invoke equitable tolling before a claimant could seek judicial review. Particularly, she states that “efforts by an agency to enforce tight filing deadlines in cases where there are credible allegations that filing delay was due to the agency’s own misfeasance may not survive deferential review.” Further, tenets such as equitable estoppel and fraudulent concealment may prevent the agency from enforcing a strict limitations period when a reasonably diligent plaintiff’s timely claim was delayed by the agency’s own deception.

The *Auburn Regional* decision, when practically applied, balances the agency’s need for efficiency with the competing interest of fairness. Further, the “good cause” exception in the Secretary’s regulation allows for some leeway in the application of the appeals deadline—allowing claims of fraudulent concealment and equitable estoppel—while still allowing CMS and its fiscal intermediaries to continue to function.

Court’s Jurisdiction to Review Administrative Decisions

The Supreme Court’s deference to HHS in *Auburn Regional* is not an isolated incident. Litigation spanning

2013 showed that courts are unlikely to undertake judicial review of agency determinations, as well as agency interpretations of federal Medicare statutes. Throughout the year, circuit courts continued to grant agencies deference in their decisions before undertaking judicial review.

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Allcare Hospice v Sebelius

The Tenth Circuit dismissed the appeal of AllCare Hospice, Inc. (AllCare) following the receipt of notice of Medicare overpayments. In this case, the Tenth Circuit agreed with the district court in its decision that the court did not have jurisdiction to address the merits of AllCare’s appeal, as the hospice did not exhaust its remedies under the PRRB in a timely fashion. (*AllCare Hospice v Sebelius*, October 4, 2013, Porfilio, J).

Previously, the PRRB had dismissed the hospice’s appeal because it was not filed within the 180-day time limit and because the hospice did not show the requisite good cause for obtaining an extension for appeal. Having sought judicial review before the federal district court, AllCare’s claims were dismissed based on the reasoning that (1) the denial of the appeal by the PRRB and the finding of no good cause were not final decisions subject to judicial review; and (2) the finding of no good cause was not reviewable, as it was an exercise of the agency’s discretion.

The Tenth Circuit agreed with the district court. Circuit Judge O’Brien concurred, but questioned whether HHS had the right to shield findings of no good cause from judicial review without express statutory authority from Congress.

Acquisto v Secure Horizons

The Eleventh Circuit similarly found that a district court does not have subject matter jurisdiction to review claims under the Medicare Act unless the claimant has extinguished his administrative remedies through the

HHS appeals process. In its opinion, the court pointed out that review by the HHS Secretary is not available for claims with an amount in controversy of less than \$100, and judicial review is not available for claims with an amount of controversy of less than \$1000. Unfortunately, in his claim for breach of contract for Medicare coverage, claimant Paul A. Acquisto only alleged damage was a copayment of \$5, and, even when the court included his premium payments, the \$1000 jurisdictional amount was not met. The court further held that the Acquisto did not have a constitutionally protected interest in appealing grievance determinations by his insurance company (*Acquisto v Secure Horizons*, January 24, 2013, *per curiam*).

Disproportionate Share Hospitals

Largely at issue in the tug-of-war between judicial review and judicial deference is the calculation of the disproportionate patient percentage (DPP) of disproportionate share hospitals (DSHs). As in *Auburn Regional*, Congressional intent is always in the forefront of deference arguments, and where Congress has left ambiguities within the Medicare Act, courts were comfortable granting deference to HHS for interpretation in 2013.

Metropolitan Hospital v HHS

The Sixth Circuit held that the Secretary's interpretation under 42 CFR 412.106(b) of the statutory formula used to reimburse DSHs was reasonable and entitled to deference (*Metropolitan Hospital v HHS*, March 27, 2013, Gilman, R).

To determine the dollar amount of the enhanced reimbursement paid to DSHs, a Medicare fraction is added together with a Medicaid fraction to create the DPP. The numerator of the Medicare fraction is the number of patient days for patients entitled to benefits under both Medicare and Social Security Income, and the denominator is the total number of patient days for the fiscal year that are attributable to people who are entitled to Part A benefits. The numerator of the Medicaid fraction is the number of people eligible for Medicaid but not Part A; the denominator is the total number of patient days for the cost reporting period.

The Secretary's regulation under 42 CFR 412.106(b) interprets "entitled to benefits under Part A" to include patient days of all Medicare beneficiaries, regardless of whether the beneficiary has exhausted their Medicare coverage for a particular day. Thus, if a patient is entitled to SSI, exhausted days of dual-eligible beneficiaries are included both in the denominator of the Medicare

fraction, as well as the numerator. Exhausted patient days of dual-eligible beneficiaries are not included in the Medicaid fraction, as the numerator excludes patient days of beneficiaries entitled to Medicare.

Metropolitan Hospital (Metro) included exhausted patient days of dual-eligible beneficiaries in its Medicaid fraction, resulting in an overpayment to the hospital of more than \$2 million, which was subsequently recovered by HHS. Metro challenged the Secretary's interpretation of the DPP. The district court held that the language of the DPP statute was unambiguous in its statement that dual-eligible benefit days are counted in the Medicaid fraction, but no exhausted benefit days are counted in the Medicare fraction. The district court based this decision on the use of "entitled" by Congress, rather than "eligible," indicating that exhausted benefit days could not be included. This interpretation was pursuant to the decision in *Jewish Hospital v Secretary of Health & Human Services*, which held that "eligible" indicated qualification for benefits regardless of payment, while "entitled" indicated the absolute right to receive payment.

However, the Sixth Circuit disagreed with the lower court, stating that the *Jewish Hospital* decision only addressed the phrase "eligible for Medicaid," but its interpretation of the term "entitled" was dicta and was not binding. Thus, the court refused to foreclose the interpretation of Congress' language in the Secretary's regulation. Because the language of the statute was ambiguous as to the treatment of dual-eligible exhausted days, the Sixth Circuit held that the Secretary's interpretation of the phrase was not arbitrary, capricious, or manifestly contrary to the statute, and granted the HHS regulation deference.

Adventist Health System v Sebelius

The Sixth Circuit ruled that, in light of Congress' clarification in 2005 that the DSH calculation was to include expansion-population patients, Adventist Health System (Adventist) could not be reimbursed retroactively for expansion-population patients it treated between 1995 and 2000, as Adventist never functioned under the impression that it would be reimbursed for patient days attributable to expansion-population patients (*Adventist Health System/Sunbelt, Inc. v Sebelius*, April 22, 2013, Hood, J).

Having completed a waiver that allowed it to include the uninsured and uninsurable population, Tennessee treated both traditional Medicaid patients, as well as patients from this "expansion-population" group. However, while some fiscal intermediaries were including expansion-population patients in Medicare DSH adjust-

ment calculations, the fiscal intermediaries in Tennessee did not. An Interim Final rule was released in January of 2000 that provided that expansion-population patients *were* to be included in the calculation, and in 2005, Congress amended the DSH statute to directly address the inclusion of expansion-population patients.

The PRRB denied Adventist's request for reimbursement for 1,200 patient days in which it provided care to expansion-population patients. The Sixth Circuit held that, because Congress did not address the issue of expansion-population patients until 2005, the PRRB's determination was based on a permissible construction of the statute, which did not require reimbursement for patient days for expansion-population patients.

Medicaid Litigation

Medicaid litigation in 2013 involved many of the same issues as in prior years. Main areas of litigation included provider challenges to Medicaid rates and the rate-setting process; enforceability of liens against beneficiaries' property; eligibility for long-term care assistance after transfers of property; elimination or reduction of services; and beneficiary challenges to coverage based on alleged violations of the Americans with Disabilities Act.

Supreme Court

Wos v E.M.A.

2013's only Medicaid-related Supreme Court decision involved the enforceability of Medicaid agency liens against personal injury settlements. In *Wos v E.M.A.* (March 20, 2013), the beneficiary was a child who would require 12 to 18 hours of skilled nursing care every day for the rest of her life because of medical malpractice during her mother's labor and her birth. Although the beneficiary's damages exceeded \$42 million, the settlement proceeds were only \$2.8 million because of the limits set in the insurance policies. A 2006 Supreme Court decision, *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, held that Soc. Sec. Act *sec. 1917(a)(1)* limited the agency's lien only to the portion of the settlement designated for medical expenses. There was no such designation in E.M.A.'s settlement. A state statute established an irrebuttable presumption that Medicaid's lien extended to 1/3 of the proceeds if no amount had been designated for past medical expenses. The Supreme Court ruled that North Carolina must have a procedure to make a factual determination of

the portion of the settlement attributable to medical expenses in order to comply with the statute.

Case Under Consideration

Several states have passed laws prohibiting any payment of any federal or state funds to entities that perform abortion services. The laws do not address payment for abortion itself; rather, they exclude from Medicaid participation any provider of covered services that also furnishes abortion services. Planned Parenthood and other organizations sued to challenge the laws in Texas, Indiana, and Arizona on the ground that Soc. Sec. Act *sec. 1902(a)(23)* guarantees beneficiaries free choice of providers of family planning services. The Seventh Circuit *upheld* an injunction against enforcement of the Indiana law. In May 2013, the Supreme Court *declined* to consider the state's request for review. However, on August 22, 2013, the Ninth Circuit decided *Planned Parenthood Arizona, Inc. v. Betlach*, which enjoined enforcement of a similar Arizona statute. State officials requested review by the Supreme Court. The Court *denied the petition* on February 25, 2014.

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Medicaid Rate-Setting Process

Because the U.S. Supreme Court declined to rule on the substantive or procedural requirements for rate-setting in 2012 (*Douglas v Independent Living Centers of California*), these questions returned to the lower courts for resolution with somewhat mixed results.

Managed Care Pharmacy v Sebelius

In *Managed Care Pharmacy v Sebelius*, (May 24, 2013), the Ninth Circuit overturned injunctions against rate

reductions. The providers claimed that Soc. Sec. Act sec. 1902(a)(30)(A) required the Medicaid agency and CMS to consider the effects of the reductions on access to services in preparing and considering the state plan amendment (SPA) and that the statute did not permit the Medicaid agency to implement the reduction before CMS approved the SPA. Because CMS had approved the SPA while the litigation was pending, the court considered only the effect of CMS approval on the parties' legal positions. The court ruled that (1) CMS' position that no particular process was required before reducing rates was reasonable and, therefore, entitled to great deference as under the Administrative Procedure Act (APA); and (2) by approving the SPA, CMS determined that the reductions did not violate section 1902(a)(30)(A). CMS' interpretation of the statute also was entitled to great deference; it could not be set aside unless the court found it was arbitrary, capricious, or not in accordance with the law. The court also ruled that the Supremacy Clause of the United States Constitution was not a basis for the court's jurisdiction.

Christ the King Manor v HHS

However, in *Christ the King Manor v HHS* (September 19, 2013) the Third Circuit deferred to the agency's interpretation of the statute but held that that the administrative record did not support the agency's conclusion that sec. 1902(a)(30)(A) was satisfied. The CMS employee's notes indicated that the rates were higher than they would have been without the SPA. But the SPA consisted of a budget adjustment factor that reduced the rates to be paid to nursing homes after the state had determined the rates needed to cover costs. The record reflected that the agency never considered the possible effects of the cuts on either quality or access to care.

New Jersey Primary Care Association, Inc. v NJ DHS

In *New Jersey Primary Care Association, Inc. v NJ DHS* (July 9, 2013), the Third Circuit invalidated a new policy of the New Jersey Medicaid agency whereby the state agency based its supplemental payments to FQHCs solely upon data reported by the patients' Medicaid managed care organizations; the FQHCs must be given the opportunity to present documentation showing the MCOs' reports were in error.

Reductions in Services

Both providers and beneficiaries challenged reductions in covered services in 2013.

Pashby v Delia

In *Pashby v Delia* (March 5, 2013), the Fourth Circuit upheld an injunction against the implementation of more stringent eligibility criteria for individuals with disabilities who had been receiving medically necessary personal care services. The district court found, and the appeals court agreed, that the agency's actions violated the Americans with Disabilities Act (ADA) because they placed the beneficiaries at increased risk of institutionalization.

California Association of Rural Health Clinics v Douglas

In *California Association of Rural Health Clinics v Douglas* (July 5, 2013, amended September 17, 2013), the Ninth Circuit invalidated a California statute that eliminated payment for the services of chiropractors, dentists, podiatrists, and optometrists furnished at rural health centers (RHCs) or FQHCs on the ground that the statutory definition of RHC and FQHC did not limit physician services to Soc. Sec. Act sec. 1861(r)(1), doctors of medicine or osteopathy, but included all of the types of physicians listed in sec. 1861(r)(1) through (5), which included the other four professionals.

Overpayments

In *North East Medical Services v California Department of HHS*, the Ninth Circuit allowed two federally qualified health centers (FQHCs) to sue the state Medicaid agency to challenge its calculations of overpayments that it charged to the providers. However, because of the Eleventh Amendment bar to damages actions against states, the court could not order the state to refund the amounts it had incorrectly collected. The FQHCs' only remedy was an injunction against future collections.

Eligibility for Long-Term Care

In three 2013 cases, federal appeals courts ruled against the Medicaid agency and in favor of spouses who claimed that income was not legally available to pay for any of the cost of the care of their spouses in nursing facilities.

Hughes v McCarthy

The Sixth Circuit ruled in *Hughes v McCarthy* (October 25, 2013) that a community spouse's use of \$178,000 to purchase an annuity before his institutionalized wife was determined eligible for Medicaid was not subject to any penalty period because Soc. Sec. Act sec. 1917(c)(1)

permits unlimited transfers of property to a community spouse before the eligibility determination and makes no reference to the penalty period in Soc. Sec. Act sec. 1924(f), which limits transfers to a community spouse to the amount of the community spouse resource allowance, which was only \$109,000 the year of the transfer.

Geston v Anderson

Similarly, the Eighth Circuit ruled in *Geston v Anderson* (September 10, 2013) that the annuity that the community spouse purchased with a single premium of \$400,000 was not an asset available to pay for the care of the institutionalized spouse. Soc. Sec. Act sec. 1902(a)(10)(C) requires that the state's method of determining eligibility for Medicaid be "no more restrictive" than the federal standard for Supplemental Security Income (SSI). The SSI standard is stated in Soc. Sec. Act sec. 1182, which provides that income from an annuity is considered unearned income and is not countable when determining eligibility. The state statute that treated annuity income over the amount of the community spouse income allowance as countable conflicted with the federal statute and, therefore, was unenforceable.

Gragert v Lake

In *Gragert v Lake* (October 8, 2013), the Tenth Circuit ruled that a promissory note received in exchange for rental property sold to the beneficiary's son was not a resource available to pay for his care because the terms of the note prohibited its transfer or sale. The SSI eligibility regulations at 20 CFR 416.1201 provide that property that a beneficiary has no power or authority to convert to cash is illiquid, and therefore, not countable.

Lien Against Beneficiary's Estate

The Idaho Supreme Court ruled in *In re: Estate of Wiggins* (August 9, 2013) that the Medicaid lien for expenditures for nursing home care extends to property of the beneficiary's surviving spouse. Under Soc. Sec. Act sec. 1917(b)(4), the estate for purposes of the lien includes, in addition to the probate estate, "assets conveyed to

a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement." Therefore, the claim against the widow's estate was proper.

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Conclusion

In 2013, federal courts gave deference to HHS's determinations, allowing the agency to interpret federal Medicare statutes within its area of expertise. The federal courts were deferential to Medicare decisions made by the PRRB, rarely overruling the Board's decisions through judicial review. In contrast, although CMS's interpretations of Medicaid statutes were also given deference, federal courts did not extend the same deference to state agencies. A number of state laws, agency decisions, and policies were invalidated in 2013. These trends are likely to continue in 2014, allowing HHS, CMS, and the PRRB leeway in interpreting and enforcing the Social Security Act.

This white paper is one of a series providing a retrospective look at key health care topics in 2013. The other white papers include "Provider Reimbursement Review Board: 2013 Year in Review," "Drugs and Medical Devices: 2013 Year in Review," and "Food Litigation on Misleading and Deceptive Labeling Claims: 2013 Year in Review."

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