Case No. 10-56529

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PALOMAR MEDICAL CENTER,

Appellant,

v.

KATHLEEN SEBELIUS, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

Appellee.

On Appeal from the United States District Court
for the Southern District of California

BRIEF OF AMICI CURIAE AMERICAN MEDICAL ASSOCIATION AND STATE MEDICAL SOCIETIES FOR ALASKA, ARIZONA, CALIFORNIA, HAWAII, IDAHO, MONTANA, NEVADA, OREGON, AND WASHINGTON IN SUPPORT OF APPELLANT PALOMAR MEDICAL CENTER'S PETITION FOR A REHEARING EN BANC

Douglas H. Hallward-Driemeier
ROPES & GRAY LLP
One Metro Center
700 12th Street, NW, Suite 900
Washington, DC 20005-3948
Phone: (202) 508-4600
Facsimile: (202) 508-4650

Attorney for American Medical Association and State Medical Societies

RULE 26.1 COMPLIANCE

In compliance with Fed. R. App. P. 26.1, amicus the American Medical Association ("AMA") states that it is a nonprofit corporation organized and operating under the laws of the State of Illinois. It has no parent corporation, and no publicly held company owns 10% or more of its stock.

Each state medical society is incorporated as a nonprofit corporation in its respective state and has no parent corporation and no publicly held company owns 10% or more of any of their stock.

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INTEREST OF AMICI

The American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty area and in every state, including California. The additional amici are nine state medical societies, from each State within the Ninth Circuit, which have similar purposes in their respective states.[1] As further detailed below, amici seek to protect their physician members from efforts to reopen, without any basis for doing so, payments for Medicare services that were rendered, paid, and closed years earlier. Reopening claims long after the services in question were rendered imposes significant administrative burdens on physicians. Because files may be lost, memories can fade, and witness may no longer be available, unwarranted delay in reopening Medicare payments risks *less* accurate administrative rulings.

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[1] These state societies are: the Alaska State Medical Association, the Arizona Medical Association, the California Medical Association, the Hawaii Medical Association, the Idaho Medical Association, the Montana Medical Association, the Nevada State Medical Association, the Oregon Medical Association and the Washington State Medical Association. Amici appear herein in their own capacities and as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition of the AMA and state medical societies to represent the views of organized medicine in the courts, in accordance with AMA policies and objectives. Amici have sought this Court's leave to file this amicus brief, pursuant to Circuit Rule 29-2(a), through a separate motion.

The Secretary's own regulations recognize as much, and therefore limit auditors' authority to reopen Medicare payments. The issue presented is whether a private auditor's self-interested decision to disregard those limits is immune from administrative and judicial check.

INTRODUCTION

Palomar Medical Center ("Palomar") seeks rehearing en banc of the Panel's holding that Medicare auditors, including Recovery Audit Contractors ("RACs"),[2] that reopen Medicare claims in violation of the Secretary's regulations are immune from administrative and judicial review. Although it recognized that this "is not an easy case," Panel Opinion ("Op.") at 11036, ECF No. 59-1, the Panel declined to apply the well-established presumption in favor of administrative and judicial review. That principle should apply with special force where, as here, the action in question is that of a private party exercising delegated governmental authority. The Panel's decision will have broad consequences, as it applies to all types of Medicare contractors and all types of claims among the "more than one billion Medicare claims … processed each year." *Id.* at 11017; s*ee id.* at 11019 n. 11 (recognizing that this case has "implications for other claims"). Moreover,

[2] As Palomar's petition observes, the Panel's decision applies not just to RACs, but as well to other entities, including contractors of all types. *See* 42 C.F.R. § 405.980(a); 42 C.F.R. § 405.902 (defining "contractor"). Amici, however, focus primarily on the RACs as they best illustrate the perils of not subjecting good cause determinations to administrative and judicial review.

although the present appeal concerns an auditor's disregard of the "good cause" requirement for reopening a payment within four years of the initial determination, the Panel's decision effectively vitiates as well the four-year period of repose. Despite the regulatory guarantee that *no* payment can be reopened more than four years after the initial determination absent evidence of fraud or similar misconduct, physicians and other providers throughout the Ninth Circuit are now at risk that any payment can be reopened at any time for any reason, or for no reason at all, no matter how much time has passed. The regulatory limits on reopenings were adopted for good reasons, but those limits cannot accomplish their purposes if providers cannot rely on them and contractors are free to disregard them at their whim. The Panel's decision therefore presents a question of exceptional importance that warrants further review by the en banc court.

More than mere procedural formalities, the "good cause" requirement for reopening claims between one and four years after determination and the fraud standard for reopening claims more than four years old are critical to giving providers some degree of finality with respect to payments under the highly complex Medicare program. Finality, in turn, allows providers to close their financial books, purge dated files, and make plans for future expenditures. Providers will, by necessity, become more cautious in all of these respects if their Medicare payments from long ago are forever subject to being reopened and

rejected because, due to the passage of time, the care can no longer be documented or justified. The ultimate cost of the Panel's ruling will be a less efficient healthcare system.

Rather than giving effect to the purposes that animated the Secretary in the first place to impose limits on contractors' ability to reopen stale claims, the Panel deferred to the Secretary's stated need for efficiency in the reopening process. Of course, it will always be true that the administrative process concerning a particular claim is more efficient if limits are not enforced, but efficiency in an individual case has never been an end in itself. Rather, the administrative system is best served when regulations that are adopted for good reasons are followed. The Panel disregarded the well-establish presumption that an agency's failure to adhere to its self-imposed limits is subject to administrative and judicial review. And the Panel did so in a context that provides a paradigmatic example why such review is necessary. RACs are private entities that are paid on a contingency basis. They lack any incentive to follow the good cause requirement and every incentive to disregard it, and the four-year period of repose as well, in search of claims that providers can no longer document, which results in greater revenue to the RAC. The data demonstrates the adverse effects of this skewed incentive structure –

RACs have a poor record with respect to overpayment determinations generally and with respect to good cause determinations in particular.[3]

Therefore, for the reasons stated in Palomar's petition and those set forth in more detail below, the Court should grant the petition and rehear the case en banc.

ARGUMENT

I. THE "GOOD CAUSE" AND FRAUD REQUIREMENTS FOR REOPENING ARE ESSENTIAL TO ENSURE THE FINALITY OF MEDICARE CLAIMS DECISIONS

The regulations promulgated by the Secretary set forth very detailed rules governing when Medicare claims can be reopened. In particular, the regulations state that, absent evidence of fraud or a few other circumstances not relevant here,[4] no determination may be reopened between one and four years after the date of the initial determination unless there is "good cause." 42 C.F.R. § 405.980(b)(2). "Good cause," only exists when:

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[3] The problems associated with the RAC program potentially extend beyond RACs' application of the good cause requirement. On November 1, 2012, the American Hospital Association, along with several hospitals, sued the Secretary and alleged that after RACs demand repayment for inpatient services that supposedly could have been provided on an outpatient basis, providers are then unable to even receive reimbursement for outpatient services. *American Hospital Association v. Sebelius*, 1:12-cv-01770 (D.D.C. November 1, 2012).

[4] A reopening can take place "anytime" if it is to correct an initial determination that is "unfavorable" and due to a "clerical error," or if it is "to effectuate a decision issued under the coverage appeals process." 42 C.F.R. § 405.980(b)(4)-(5).

> (1) There is new and material evidence that" was "not available or known at the time of the determination or decision" and "[m]ay result in a different conclusion; or
>
> (2) The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

42 C.F.R. § 405.986(a). After four years, a contractor's ability to reopen claims is even more circumscribed. After that point, providers are generally entitled to full repose in their Medicare payments absent "reliable evidence … that the initial determination was procured by fraud or similar fault." 42 C.F.R. § 405.980(b)(3).

The reason for the "good cause" and fraud requirements was that medical providers should have "a reasonable expectation as to the administrative finality of a decision on a claim or claims in question." Medicare Program: Changes to the Medicare Claims Appeal Procedures: Interim Final Rule, 70 Fed Reg. 11420, 11453 (Mar 8, 2005). Indeed, as even the Panel here recognized, the good cause requirement protects the provider's "legitimate interest in finality of determinations on its revenue for medical services." Op. at 11013. It does so in two ways:

First, the "good cause" and fraud requirements prevent providers from being forced to defend claims submitted four years prior without good reason. Often, reopenings, like the one in the present case, revolve around the medical necessity of the treatment provided. Over time, memories will fade, employees will leave, and the key decision-makers responsible for any given claim will either be

unavailable or unable to defend their decisions. Just as statutes of limitation exist in the civil context "to protect . . . against stale or unduly delayed claims," *Credit Suisse Sec. (USA) LLC v. Simmonds*, 132 S. Ct. 1414, 1420 (2012) (internal quotation marks omitted), so too the "good cause" and fraud requirements exist to ensure that providers are not placed at a disadvantage in any reopening proceedings. Likewise, requiring providers constantly to defend old claims forces those providers to devote more resources to those reopenings (or to preserving outdated files, out of fear for reopenings) and fewer resources on patient care.[5]

Second, the good cause and fraud requirements enable providers to move forward with their financial plans. Doctors and hospitals have to make a wide array of hiring and purchasing decisions, and in order to do so it is essential that they have confidence in their financial situation. If, however, claims can be opened four or more years after an initial Medicare payment determination, years of prudent planning can suddenly be thrown asunder. Such unpredictability can either result in sudden financial shortfalls or in providers taking an overly cautious approach with respect to planning and declining to make critical investments in

[5] In a survey of over 1800 hospitals, 50% responded that they had higher administrative costs as a result of the RAC program generally. American Hospital Association, *Medicare & Medicaid Recovery Audit Contractors* (July 1, 2011), http://www.aha.org/content/11/racpolicypaper.pdf (hereinafter *Medicare & Medicaid Recovery Audit Contractors*). Forcing providers to respond to stale claims only exacerbates these costs.

healthcare infrastructure. In either event, the level of care will be diminished, and patients will ultimately suffer.

These burdens are bad enough when imposed on large hospitals, but are even worse when visited on small medical practices. The RAC program is not limited to large institutions; any physician who accepts Medicare payments is potentially subject to audits over long-closed Medicare claims under the Panel's decision. The "good cause" and fraud requirements play a particularly critical role in ensuring finality and repose for physicians with few resources, who cannot afford to spend limited time and resources disputing stale claims.

II. THE PANEL'S HOLDING THAT PRIVATE CONTRACTORS' APPLICATION OF THE GOOD CAUSE REQUIREMENT IS UNREVIEWABLE IS CONTRARY TO THE LONG-STANDING PRESUMPTION IN FAVOR OF REVIEW AND INVITES ABUSE

Although the Secretary had good reasons to adopt "good cause" and fraud limitations on reopenings, simply having those requirements on the books is insufficient to achieve their purposes. Perhaps even more than other regulatory requirements, the finality interests served by the limitations on reopenings can only serve their purposes if they are enforced. If providers cannot rely upon the period of repose, because it can be disregarded with impunity and without recourse, then it provides no repose at all. The Panel's reliance on the Secretary's ad-hoc, after-the-fact enforcement of the reopening limitations through the threat of a contractor's termination renders those limits effectively null and void from the

perspective of providers. In so holding, the Panel ignored the well-established presumption in favor of review of administrative actions. That holding is even more troubling because it leaves practical enforcement of the reopening limitations in the hands of the very private auditors who have every incentive to disregard those limits on their authority.

A. There is a Strong Presumption of Reviewability

There is a strong presumption that non-discretionary agency action is subject to judicial review. *See, e.g., Abbott Labs. v. Gardner*, 387 U.S. 136, 141 (1967). This presumption applies as well to administrative review of agency determinations. *See Dep't of the Navy v. Egan*, 484 U.S. 518, 526-27 (1988) (recognizing doctrine in context of administrative review by Merit Systems Protection Board of agency employment actions). The lack of oversight (administrative or judicial) countenanced by the Panel is all the more concerning where, as here, the decision-maker is a private entity. When a decision is entrusted to a private entity, there is a constant risk that the entity may "pursue goals inconsistent with those of the agency and the underlying statutory scheme." *United States Telecom Ass'n v. Fed. Commc'n. Comm'n*, 359 F.3d 554, 566 (D.C. Cir. 2004).

B. Review is Particularly Critical in Light of the Incentives for Contractor Abuse Under the RAC Program

RACs provide a paradigmatic example of why the presumption of reviewability is so critical, particularly with respect to private entities. Under the RAC program, private profit-seeking entities are paid "on a contingent basis," 42 U.S.C. § 1395ddd(h)(1)(B)(i), and currently receive between 9 and 12.5 percent of any amounts they recover. Medicaid Program; Recovery Audit Contractors: Final Rule, 76 Fed. Reg. 57, 808, 57,809 (September 16, 2011). For that reason, RACs have an incentive to reopen as many claims as they can, and if there is no risk that the RAC's disregard of the "good cause" or fraud requirement will preclude recovery on the claims in question, then RACs likely will not bother to adhere to it. *Cf.* U.S. Gov't Accountability Office, GAO-10-143, Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight 4 (2010), http://www.gao.gov/assets/310/302559.pdf (noting that providers had complained "that the contingency fee payment structure created an incentive for RACs to be aggressive in determining that paid claims were improper"). If anything, older claims will be even more attractive to RACs because healthcare providers will be less able to defend the medical necessity of services provided long ago, as to which the evidence may have deteriorated. *See supra* Section I; *see also* Ca. Hosp. Ass'n. Amicus Br. at 8, ECF No. 18-2 (observing that, in the experience of

California hospitals, "[v]irtually all RAC denials were made" with respect to claims for which the initial payment was more than a year earlier).

The available data demonstrates the adverse effects of these skewed incentives. With little regard for the good cause requirement RACs reopen and reject numerous claims without a sufficient basis for doing so. It would seem, in fact, that the good cause standard receives little, if any, attention by RACs. In over 50 administrative cases review by the California Hospital Association, ALJs found that RAC's lacked "good cause" to reopen well over half of the claims considered. Ca. Hosp. Ass'n. Amicus Br. at 9. Likewise, in another matter also involving Palomar, the ALJ determined that "'[t]he procedural documents . . . wholly fail[ed] to indicate that either fraud or good cause was established or even considered.'" *Palomar Medical Center*, 9 (MAC Jan. 11, 2008), Dist. Ct. Doc. No. 19-4 (quoting the ALJ decision) (brackets and emphasis in original). And, for many of these wrongly reopened claims, the RACs' substantive determinations are also flawed. As of March 2010, an astonishing **64.4%** of appealed RAC reopenings resulted in decisions *favorable to the provider*. *See* Center for Medicare and Medicaid Services ("CMS"), *The Medicare Recovery Audit Contractor (RAC)Program: Update to the Evaluation of the 3-Year Demonstration*, 2 (June 2010),

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/DemoAppealsUpdate61410.pdf.[6]

C. The Secretary's Interest in Administrative Efficiency Does Not Justify the Absence of Administrative or Judicial Review of a Contractor's Disregard of Reopening Limitations

The Panel's reliance on the Secretary's purported interest in efficient reopening proceedings was misplaced. As an initial matter, neither the Panel nor the Secretary has explained the inconsistency in the Secretary's asserted need for efficient (meaning unreviewable) reopenings in the Medicare context and the contrary position the Secretary has taken in the Social Security context. As Palomar notes, the Secretary has construed nearly identical regulatory provisions in the Social Security context (indeed the very regulations from which the CMS regulations derived) to permit administrative review of a decision to reopen. *See* Pet. for Rehr'g En Banc at 3-4, ECF No. 66-1. The Secretary has not explained why "efficiency" precludes review in one context but not the other.

Nor, contrary to the Panel's understanding, has Congress placed the "efficiency" of reopening proceedings above other interests, such as fairness and finality. The Panel reasoned that "Congress gave the Secretary discretion . . . to

[6] Although few reopenings are actually appealed, this is likely due to the fact that the amounts in most cases are insufficient to justify the effort. For example, the average appeal costs a hospital around $2,000, *Medicare & Medicaid Recovery Audit Contractors* at 1, which is more than 25% of the money at stake in the present appeal.

structure the means of enforc[ement] . . . so as to achieve efficiency and accuracy." Op. at 10034. But Congress further specified that reopenings should be pursued "under guidelines established by the Secretary in regulations." 42 U.S.C. § 1395ff(b)(1)(G). This clearly reflects that Congress also recognized the need for, and directed the Secretary to establish, binding rules that would limit the discretion of contractors when to reopen a closed Medicare claim.

The Panel's apparent confidence that the regulatory limits can be enforced adequately through "'audits and evaluations of the contractors' performance'" is also misplaced. (Op. at 11028) (quoting Medicare Program, 70 Fed. Reg. at 11,453). The Secretary has failed to point to a single instance in which an RAC was reprimanded for reopening a claim older than a year without good cause. And this apparent failure of enforcement is not surprising. Because RACs who reopen stale claims may thereby generate greater recoveries for the Medicare program (because providers are less able to document the medical necessity of long-forgotten procedures), the Secretary's own incentives are at the very least mixed. To the extent that the good cause requirement has been enforced at all, it has been ALJ's, operating via the usual channels of administrative review, who have been responsible.

Finally, even on its own terms, the claim of efficiency gains from prohibiting the review of RAC good cause determinations is overstated. Although

the Panel expressed concern over requiring "the government to state its best case [for good cause] . . . on every reopening," Op. at 11025, that concern seems unwarranted. By the Secretary's own account, RACs must be prepared to demonstrate to CMS their compliance with the good cause requirement, and RACs presumably maintain adequate documentation for that purpose. Requiring RACs to provide that documentation to the ALJ or a district court hardly seems an undue burden. Nor would having ALJs consider "good cause" questions necessarily result in lengthier reopening proceedings. Providers, after all, are already permitted to appeal the substance of RAC overpayment determinations, and here Palomar simply asks that ALJs be permitted to consider questions of good cause at the same time. More fundamentally, if contractors knew that their reopening decisions were subject to review for compliance with the "good cause" and fraud restrictions, they would not be so tempted to reopen claims without a basis to do so. Because RACs pursue reopenings on a contingency fee basis, they have an incentive (under the Panel's opinion) to disregard these limitations because a stale claim is more likely to lead to recovery and to the RAC receiving payment. If, however, the RAC were at risk of having its reopening of outdated claims overturned on review, and the RAC would go away empty handed, the RAC would have the incentive to focus its efforts on those reopenings that comply with the Secretary's regulations. In other words, greater efficiency would result from RACs

knowing that the regulations are enforceable, not from the free pass to ignore those regulations that the Panel decision endorses.

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By prohibiting the administrative and judicial review of RAC good cause determinations, the Panel wrongly ignored the presumption in favor of reviewability. In service of an illusory need for efficiency, the Panel's decision strips the good cause and fraud limitations of virtually any of force, and thereby defeats the important purposes that the limitations were intended to serve.

CONCLUSION

The Panel recognized that this was a close case with far-reaching implications. The Panel's holding conflicts with the well-established presumption of administrative and judicial review and defeats healthcare providers' conceded interest in finality and repose. The Court should grant the petition for rehearing en banc to correct the Panel's error.

Respectfully submitted,
s/ Douglas H. Hallward-Driemeier

Douglas H. Hallward-Driemeier
ROPES & GRAY LLP
700 12th Street, NW, Suite 900
Washington, DC 20005-3948
Phone: (202) 508-4600
Facsimile: (202) 508-4650

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on November 5, 2012.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

s/ Douglas H. Hallward-Driemeier

ROPES & GRAY LLP
Douglas H. Hallward-Driemeier
One Metro Center
700 12th Street, NW, Suite 900
Washington, DC 20005-3948
Phone: (202) 508-4600
Facsimile: (202) 508-4650

Attorney for the American Medical Association and State Medical Societies

Dated: November 5, 2012

RULE 29(C)(5) STATEMENT

Pursuant to Fed. R. App. P. 29(c)(5), amici state:

- No party's counsel authored this brief in whole or in part.
- No party or party's counsel contributed money that was intended to fund preparing or submitting this brief.
- No person other than amici contributed money that was intended to fund preparing or submitting this brief.

s/ Douglas H. Hallward-Driemeier

Douglas H. Hallward-Driemeier
ROPES & GRAY LLP
One Metro Center
700 12th Street, NW, Suite 900
Washington, DC 20005-3948
Phone: (202) 508-4600
Facsimile: (202) 508-4650

Attorney for the American Medical Association and State Medical Societies

Dated: November 5, 2012

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Circuit Rule 29-2(c)(2) because this brief contains **3,500** words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Times New Roman type style.

s/ Douglas H. Hallward-Driemeier

ROPES & GRAY LLP
Douglas H. Hallward-Driemeier
One Metro Center
700 12th Street, NW, Suite 900
Washington, DC 20005-3948
Phone: (202) 508-4600
Facsimile: (202) 508-4650

Attorney for the American Medical Association and State Medical Societies

Dated: November 5, 2012