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Litigator of the Week: Morgan Lewis' Geri Edens Wins a Lifeline for Children's Hospitals

By Jenna Greene

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Lit Daily: Tell us a little about your clients.

Geri Edens: The clients are free standing children's hospitals that offer specialized care to patients not provided by other hospitals, such as treating chronic and complex conditions including severe anomalies, heart ailments, cancer, and low birth weight.

Because of their expertise, these hospitals treat children from throughout the United States and do so regardless of whether their families have health insurance coverage or the ability to pay for their care. In the truest sense, they are safety-net hospitals for poor and medically needy children. As such, these hospitals treat large numbers of Medicaid children; as many as 60 to 70 percent of their patient populations.

Congress recognized decades ago that Medicaid is a poor payer and hospitals like our clients need supplemental payments in order to continue to provide the same high quality health care services to Medicaid patients. Thus, it created the Disproportionate Share Hospital (DSH) program to help offset the significant financial losses hospitals incur treating such large numbers of Medicaid patients.

What is at stake in this fight?

Without getting into the complexities of Medicaid, generally DSH payments are calculated as the difference between the amount Medicaid allows for hospital services and the amount it actually pays. Our clients have historically received supplemental DSH payments on a yearly basis, which vary from year-to-year, but for the larger hospitals they can be in excess of $20 million a year. In 2008, CMS promulgated a rule implementing new reporting and auditing provisions for DSH payments to ensure compliance with

Geraldine E. Edens, partner with Morgan, Lewis & Bockius.

the Medicaid Act. Those regulations are consistent with the Act and set forth with specificity how DSH payments should be calculated.

Despite the specificity of the regulations, CMS issued guidance that modified the calculation in a way that would force the states to recoup all of the DSH payments our clients received over a six-year period. For just the hospitals in Virginia and Minnesota, this totaled almost $200 million. Having to repay such large sums of money threatened the hospitals' ability to provide health care services, and for some, their very existence.

Government agencies have well-defined procedures for making changes to rules or regulations. What happened here?

We have struggled to understand the basis of the government's position. Monies recouped from our DSH hospitals would not be returned to the federal government. Rather, they would be redistributed by the state to other hospitals that in most cases would treat fewer Medicaid patients than our clients or the state would use the funds for other Medicaid purposes. The government has emphasized in its briefing that it has the discretion to interpret its regulations through guidance, which may be the principal motivation.

When you and your team were hired, what was the lay of the land?

Shortly after the guidance was issued in 2010, my partner Susan Feigin Harris identified immediately its impact on our children's hospital clients and worked diligently to make CMS aware of the problems and identify ways its impacts could be mitigated. CMS rejected any effort to resolve the issues.

I joined Susan in the fight in 2014 when one of our clients was facing the imminent recoupment of $27 million and another was being shut out of the DSH program altogether, which we successfully preliminarily enjoined on December 29, 2014.

What were some of the key legal issues in challenging the new Medicaid payment regime?

The government maintained that through guidance they were merely interpreting the regulations, which they argued they have complete discretion to do, and that their interpretation furthered the intent of the DSH program. This was the core of the Administrative Procedures Act claims. We had to show that the guidance was a substantive amendment to the regulations and was directly contrary to the intent of the program, which we successfully did.

When you sue the government, you're asking taxpayers to bear the cost. How has this informed your strategy?

As noted above, our clients provide valuable health care services to government program beneficiaries, which CMS's actions threatened. We have questioned why the government continues to litigate these cases when every court that has decided the issues, has ruled against them.

You came into this fight with momentum. How have the prior cases unfolded?

We have now had both the Fourth and Eighth Circuits affirm the Virginia and Minnesota cases. The pending in D.C. district court case was also decided in our favor and is now on appeal. Overall, we have won four district court cases—three regarding the FAQ guidance and one regarding the rule that codified the guidance, with two of the district court cases affirmed by the appellate courts.

What were some personal high points during the litigation?

The high point of the litigation was obviously obtaining a favorable decision for our clients, but the wins are even more meaningful because of the clients and the children they serve. Before I became a lawyer, I was a nurse, so representing these clients has been a particular high point of my entire career.

What happens next? Are more cases pending?

We are 6-0 with two more to go. Next up is the Texas Children's Hospital, et al. v. Burwell, No. 14-cv-2060 (D.D.C. June 1, 2018) appeal. The D.C. rule case will be significant as it will determine whether CMS has the authority even through rulemaking to implement the policy.

Also, our initial litigation has spawned more than a dozen other cases with the ones that have so far decided largely relying on our judgments. Several of these cases are also stayed pending the D.C. Circuit ruling on our last two cases.

What's significant about this win, and these cases in general?

This victory is a significant win, not only for our clients, but for hospitals across the United States, including rural and critical-access hospitals, that will no longer be denied the supplemental DSH funding so critical to the care and treatment they provide to their patients.