UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASCENSION BORGESS HOSPITAL 1521 Gull Road Kalamazoo, MI 49048 ASCENSION GENESYS HOSPITAL 1 Genesys Parkway Grand Blanc, MI 48439 ASCENSION MACOMB-OAKLAND HOSPITAL, MADISON HEIGHTS CAMPUS 27351 Dequindre Road Madison Heights, MI 48071 ASCENSION MACOMB-OAKLAND HOSPITAL, WARREN CAMPUS 11800 East 12 Mile Road Warren, MI 48093 ASCENSION PROVIDENCE HOSPITAL – SOUTHFIELD CAMPUS 16001 West 9 Mile Road Southfield, MI 48075 ASCENSION SAINT JOHN HOSPITAL 22101 Moross Road Detroit, MI 48236 ASCENSION SETON MEDICAL CENTER AUSTIN 1201 West 38th Street Austin, TX 78705 ASCENSION ST. VINCENT'S RIVERSIDE HOSPITAL 1 Shircliff Way Jacksonville, FL 32204 ASCENSION RIVER DISTRICT HOSPITAL 4100 River Road East China Township, MI 48054	Case. No. 1:24-cv-2058

DELL SETON MEDICAL CENTER AT THE UNIVERSITY OF TEXAS
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GUTHRIE LOURDES HOSPITAL
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SAINT JOHN DETROIT RIVERVIEW HOSPITAL
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SAMARITAN HOSPITAL - SAINT MARY'S CAMPUS
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USA HEALTH PROVIDENCE HOSPITAL
6801 Airport Boulevard
Mobile, AL 36685

Plaintiffs,

v.

XAVIER BECERRA, in his official capacity, Secretary of the United States Department of Health and Human Services,	)
Defendant.	)

COMPLAINT FOR JUDICIAL REVIEW

Plaintiff Providers sue Defendant in his official capacity as Secretary of HHS, for judicial review of the Provider Reimbursement Review Board's dismissal of its appeal under 42 5 U.S.C. § 1395oo(f)(1). In support of its appeal, Plaintiffs allege:

INTRODUCTION

1. This is an action for judicial review, of a final decision of the Board finding that Case No. 13-0779GC should be dismissed. The Providers assert the Board's dismissal violated the law, an abuse of discretion or an arbitrary and capricious application of its own rules and regulations.

2. Providers filed the underlying Group Appeal before the Board challenging the Secretary use of a legally flawed method to count the patient days included in the numerator of Providers' respective Medicare fractions that inform the Providers' Disproportionate Share Hospital (DSH) payments.

3. In enacting the statute at issue in the main appeal for this group, Congress intended the Medicare DSH payment to compensate hospitals that serve a disproportionate share of low-income and needy patients. 88 Fed. Reg. 37772 (June 9, 2023). The DSH payment is based on a proxy measure for a hospital's low-income

patient use population that is the sum of two fractions expressed as a percentage. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi); 42 C.F.R. § 412.106(b).

4. As the DSH statute is construed by the Secretary, a hospital patient is "entitled" to Medicare Part A benefits so long as they are enrolled in Part A and regardless of whether Medicare covers or pays for his or her hospitalization, but that same patient is "entitled" to Social Security Income (SSI) benefits only if he or she receives an SSI payment from the Social Security Administration (SSA) during the month of their hospitalization.

5. The Board dismissed Providers' Group Appeal after the Providers responded to a status request from the Board. That status request was inconsistent with the Board's orders, rules, and regulations and when the Board used the timeliness of Providers' update to dismiss the appeal, the Board acted in a manner inconsistent with the law and thereby improperly dismissed the action below.

6. As a result of the Board's decision to dismiss this Group Appeal, Providers have been denied their statutorily provided appeal rights to challenge their dissatisfaction with Medicare DSH payments to which they are lawfully entitled. The Providers therefore seek an order vacating Board's invalid dismissal and directing the Board to reinstate Case No. 13-0779GC. This would allow the Providers named in this Group Appeal to receive a fair hearing to assess the validity of their initial appeal.

PARTIES

7. At dismissal, 19 Medicare-participating hospitals in the federal Medicare program were members of this CIRP Group:

- Providence Hospital
- St. Mary's – Carondelet
- St. Vincent's Medical Center
- St. Vincent's Medical Center
- Providence Hospital Southfield
- Borgess Medical Center
- St. John Health
- St. John Hospital and Medical Center
- St. John Macomb-Oakland Hospital
- Genesys Regional Medical Center
- St. John Oakland Hospital
- St. John River District Hospital
- St. John North Shores Hospital
- Our Lady of Lourdes Hospital
- Mount St. Mary's Hospital
- Seton Saint Mary's Hospital
- Seton Saint Mary's Hospital
- Seton Medical Center
- University Medical Center Brackenridge

8. Defendant, Xavier Becerra, is the Secretary of HHS. The Secretary, as the federal official responsible for administration of the Medicare program, has delegated that responsibility to CMS.

JURISDICTION AND VENUE

9. This Court has jurisdiction under 42 U.S.C. § 1395oo(f) (appeal of an agency's final decision about Medicare reimbursement).

10. Venue is proper under 42 U.S.C. § 1395oo(f)(1) (review of a final Board decision) and 28 U.S.C. § 1391(e) (action against an officer or employee of United States acting in his official capacity).

BACKGROUND

A. General Background of the Medicare Program

11. Congress established the Medicare program to provide health insurance for the aged, disabled, and individuals with end-stage renal disease. 42 U.S.C. § 1395c.

12. The Medicare program is federally funded and administered by the Secretary through the CMS and its contractors. 42 U.S.C. § 1395kk; 42 Fed. Reg. 13,282 (Mar. 9, 1977). Congress granted to HHS rulemaking authority to implement the Medicare program. 42 U.S.C. § 1395hh(a).

13. The Medicare program is divided into several parts. Relevant to this appeal, Part A of the Medicare program provides for coverage and payment for inpatient hospital services on a fee-for-service basis. 42 U.S.C. § 1395c *et seq.*

14. The DSH add-on payment available to qualifying hospitals depends on the hospital's disproportionate patient percentage. The disproportionate patient percentage is determined by adding two fractions, the Medicare and the Medicaid fractions, as proxies for the hospital's low-income patient population. 42 U.S.C. § 1395ww(d)(5)(F)(vi).

15. The issue in the underlying appeal to the Board involves the Medicare fraction, which includes Supplemental Security Income days in its numerator. The numerator of the Medicare fraction is defined as:

> the number of such hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, but who were not entitled to benefits under part A of this subchapter,

> and the denominator…is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

B. Procedure for Administrative and Judicial Review

16. A hospital has an undeniable statutory right to appeal to the Board if it is dissatisfied with a final determination. 42 U.S.C. § 1395oo(a)(1)(A)(i).

17. A hospital may take an appeal to the Board individually or they may pursue a group appeal of an issue that is common to two or more hospitals. 42 U.S.C.§ 1395oo(a)(b); 42 C.F.R. §§ 405.1835 & 405.1837.

18. A hospital may obtain judicial review of a final administrative decision, whether substantive or jurisdictional, by suing in the United States District Court for the judicial district that the hospital is located or in the District Court for the District of Columbia within 60 days of receipt of the final determination in the administrative appeal . 42 U.S.C. § 1395oo(f).

19. In any such action, the Secretary is the proper defendant because the Secretary, acting through CMS, "is the real party of interest in any litigation involving the administration of the [Medicare] program." 42 C.F.R. § 421.5(b).

20. Interest is to be awarded in favor of a hospital that prevails in such an appeal. 42 U.S.C. § 1395oo(f)(2).

21. Judicial relief is also available under the equitable remedy of mandamus if a hospital has a clear right to the relief sought and the Secretary has a defined and

duty to honor that right. *City of New York v. Heckler,* 742 F.2d 729 (2d Cir. 1984); *Monmouth Med. Ctr. v. Thompson,* 257 F.3d 807 (D.C. Cir. 2001).

C. The Medicare Act and the Administrative Procedure Act (APA)

22. The Medicare Act allows for judicial review of the Board's jurisdictional dismissal and adopts the standards set by the APA. 42 U.S.C. § 1395oo(f)(1). Thus, agency actions which are arbitrary, capricious, an abuse of discretion, contrary to the law, must be held unlawful and vacated. 5 U.S.C. § 706.

D. PRRB Hearing Procedures and the Procedure for Administrative and Judicial Review of PRRB Decisions

23. A hospital dissatisfied with a final determination of the amount of its Medicare IPPS payment, may appeal to the Board. *See* 42 U.S.C. § 1395oo(a). Along with having the authority to make substantive decisions about Medicare reimbursement appeals, the Board can decide questions relating to its own jurisdiction.

24. A notice of program reimbursement (NPR) constitutes a final determination that may be appealed to the Board under this authority.

25. The decision of the Board on substantive or jurisdictional matters constitutes final administrative action unless the Secretary reverses, affirms, or modifies the decision within 60 days of a hospital's notification of the Board's decision. The Secretary has delegated his authority under the statute to review such decisions to the CMS Administrator.

26. A hospital may obtain judicial review of a final administrative decision, whether substantive or jurisdictional, by filing suit within 60 days of receipt of the final

action in the administrative appeal in the United States District Court for the judicial district in which the hospital is located or in the United States District Court for the District of Columbia. 42 U.S.C. § 1395oo(f). In any such action, the Secretary is the proper defendant because the Secretary, acting through CMS, "is the real party of interest in any litigation involving the administration of the [Medicare] program." 42 C.F.R. § 421.5(b).

STATEMENT OF THE CASE

E. Providers' Appeal before the Board

27. This action arises under the Medicare Act and APA. 42 U.S.C. § 1395oo(f)(1); 5 U.S.C. §§ 701 & 702. The issue being appealed is the Board's wrongful dismissal of Providers claims.

28. On February 6, 2013, Providers timely initiated this CIRP Group Appeal by filing with the Board. The Board's Group Acknowledgment letter was issued on February 20, 2013. All but one of the Group Participants were added in 2013. The final Group Participant was added to the Group in 2019.

29. The Providers' appeal satisfied all jurisdictional requirements under the Medicare Act. *See* 42 U.S.C. § 1395oo.

30. On March 25, 2020, the Board issued Alert 19, suspending Board-set deadlines from March 13, 2020, because of the COVID-19 pandemic.

31. On November 7, 2022, the Board issued Alert 23 which explained that the Board was resuming its Board-set deadlines and would issue revised Notices of

Hearing or Notices of Critical Due Dates over the next six months. The Board stated that the goal was to establish new deadlines consistent with current Board Rules.

32. These Notices of Critical Due Dates were to set deadlines for partes – including when the Board would require members of a CIRP group to verify whether it was fully formed with the Board.

33. The Board failed to follow its own order and Alert with the Providers. It never issued a Critical Due Date Notice or a Notice of Hearing for Case 13-0779GC.

34. On July 31, 2023, The Group Representative received a "Group Status Request" pertaining to the status of their CIRP group. This letter requested that the Group Representative advise the Board as to whether this CIRP group was fully formed based on the existing participants by August 30, 2024.

35. The Providers submitted a response to the letter request on September 1, 2023.

36. Forty minutes after the submission the Board dismissed Case No. 13-0779GC for failure to meet the requested timeline in its letter, citing 42 C.F.R. § 405.1868.

37. In their dismissal letter, the Board asserted the Board "full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings…The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. Specifically, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice."

38. On October 12, 2023, Providers submitted a Motion for Reconsideration.

39. On May 17, 2024, the Board responded to this Motion for Reconsideration and denied this Request for Reconsideration.

40. The Board's denial of the Providers' Request for Reconsideration The PRRB's decision was final. 42 U.S.C. § 1395oo(f). The Hospitals timely filed this appeal within 60 days of the PRRB's notice. Id.

41. The Board's dismissal of this matter was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

BASIS FOR APPEAL:

Violation of the Medicare Act an APA

42. The Providers incorporate by reference the above paragraphs as though fully set forth here.

43. The Court should hold unlawful and set aside the PRRB's decisions dismissing the Hospitals' appeals because the dismissals were:

- Arbitrary, capricious, an abuse of discretion or not in accordance with the law, 5 U.S.C. § 706(2)(A);
- In excess of statutory jurisdiction, authority, or limitations, or short of a statutory right, 5 U.S.C. § 706(2)(C);
- Without observance of procedure required by law, § 706(2)(D); or
- Unsupported by substantial evidence or unwarranted by the facts, 5 U.S.C. § 706(2)(E)-(F).

44. The Board's dismissals of the Hospitals' appeals were unlawful agency action.

45. The Hospitals' appeals satisfied all requirements—including jurisdictional requirements—of the Medicare Act. 42 U.S.C. § 1395oo.

46. The statute requires that the Hospitals timely file their appeals, with appropriate amounts in controversy, and notify the PRRB of their dissatisfaction with their Medicare reimbursement determined by the MACs.

47. Thus, the Board's dismissal of the properly filed appeals was contrary to the unambiguous language of 42 U.S.C. § 1395oo in that it, among other things, imposed additional requirements on the hospitals not found in statute, abridged their statutory rights to a Board hearing, and limited the Board's powers as expressly set forth in the law.

48. The Board improperly applied the requirements of 42 U.S.C. § 1395oo and imposed "dissatisfaction" requirements not required by the statute.

49. The dismissed appeal properly challenged CMS's calculation of the Medicare Fraction used to compute the disproportionate patient percentage. This calculation violated congressional mandate because CMS did not include all SSI-eligible patients in the numerator of the Medicare Fraction. Having met all statutory and regulatory requirements and complied with all Board Rules, the Providers are entitled to a hearing on the merits of this challenge.

50. The Board's interpretation of its own rules was "plainly erroneous or inconsistent with the regulation" when it dismissed Providers' appeal. *See Thomas Jefferson University v. Shalala*, 512 U.S. 504, 512, 114 S.Ct. 2381 (1994).

51. Further, the Board's interpretation of the regulation and application of its rules contradicted the law as it failed to follow the best meaning of both the statute and regulations applicable to the appeal. *Loper Bright Enterprises v. Raimondo*,---S. Ct. ---, 2024 WL 3208360, at *16 (June 28, 2024) (slip op.) (overruling *Chevron U.S.A. Inc. V. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1981)).

52. The Board must adhere to its own rules and regulations and failure to comply with them may result in the action by the Board being set aside as arbitrary and capricious. As noted in *Mercy Health,* "Although an agency may amend or repeal its own regulations, it may not ignore or violate its regulations while they remain in effect." *Mercy Health-St. Vincent Med. Ctr. LLC v. Becerra*, No. 22-CV-3578 (TNM), 2024 WL 519602 (D.D.C. Feb. 9, 2024). The Board's summary dismissal of Providers' appeal was arbitrary and capricious because it did not "articulate a satisfactory explanation for its action including a rational connect between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43, 103 S.Ct. 2856 (1983).

53. The Board's dismissal of Providers' appeal was an abuse of its discretion and was unfair surprise given the contradictory guidance provided by the Board following the repeal of Alert 23 and subsequent orders.

REQUEST FOR RELIEF

Therefore, Providers respectfully request relief as follows:

1. Declaring invalid and vacating the Board's final decision dismissing for untimely filing the Providers' appeal,

2. Remanding for reinstatement the Providers appeal to the Board, and

3. Providing all other relief as this Court deems appropriate.

Respectfully submitted,

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