IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

PARRISH MEDICAL CENTER
951 North Washington Ave.
Titusville, FL 32796

Case No. 21-cv-1922

NORTHCREST MEDICAL CENTER
100 Northcrest Dr.
Springfield, TN 37172

SPRINGHILL MEMORIAL HOSPITAL
3719 Dauphin St.
Mobile, AL 36608-1798

UF HEALTH JACKSONVILLE
655 8th St. W
Jacksonville, FL 32209

UNIVERSITY OF MISSOURI HEALTH CARE
1 Hospital Dr.
Columbia, MO 65201

BRYAN MEDICAL CENTER
1600 S 48th St.
Lincoln, NE 68506

STORMONT VAIL HOSPITAL
1500 SW 10th Ave.
Topeka, KS 66604

Plaintiffs,

v.

XAVIER BECERRA
Secretary of the United States Department of Health and Human Services,
200 Independence Ave., S.W.
Washington D.C. 20201

Defendant.

COMPLAINT FOR JUDICIAL REVIEW; WRIT OF MANDAMUS

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The above-named Plaintiffs (Plaintiffs or Hospitals), by and through their undersigned counsel, state the following in the form of this Complaint against XAVIER BECERRA, Secretary of the United States Department of Health and Human Services (the Secretary) in his official capacity pursuant to 42 U.S.C. § 1395oo(f):

I. INTRODUCTION

1. Plaintiffs participate in Medicare and Medicaid. In the Affordable Care Act (ACA) (42 U.S.C. § 18001 *et seq*.), Congress "expanded" Medicaid eligibility by requiring all participating states to amend their state medical assistance plans, effective January 1, 2014, to cover persons under 65 years of age with incomes not exceeding 133% of the Federal Poverty Level (FPL) (138% with a statutory set-aside) who were not already eligible for Medicaid or Medicare.

2. For Plaintiffs, Medicaid expansion promised added coverage (and payments) under Title XIX of the Social Security Act (the Act) for services previously furnished to uninsured patients. It also promised increases to their supplemental hospital payments under Medicare (Title XVIII of the Act) for treating a disproportionate share of low-income patients (DSH adjustments), which increase in proportion to the percentage of a hospital's low-income patients, which is relevantly determined based on the number of its patients who are "eligible for Medicaid" (which is a statutory proxy for low-income status).

3. Certain states advanced a broad array of constitutional challenges to the ACA in National Federation of Independent Businesses v. Sebelius, 567 U.S. 519 (2012) (NFIB). The Supreme Court broadly upheld the ACA, including both its expansion of Medicaid coverage and the "individual mandate" for people to enroll in a qualified health plan (QHP), but a plurality of the Court ruled that it would exceed the Secretary's authority under the Spending

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Clause of the Constitution to force states to expand their existing medical assistance plans as prescribed by the ACA through the withholding of federal funds under 42 U.S.C. § 1396c.

4. As a result of the elimination of financial penalties for noncompliance with the Act's Medicaid expansion mandate in NFIB, a minority of states – including Alabama, Florida, Nebraska, Tennessee, Kansas and Missouri, where Plaintiffs are located – refrained from submitting state plan amendments expanding their medical assistance programs to cover additional persons who became eligible for Medicaid coverage under the ACA, limiting Medicaid coverage in "non-expansion States" on a de facto basis to pre-ACA levels.

5. The injury from which Plaintiffs seek relief in this action, however, is not the absence of Medicaid reimbursements from their home states – which the Supreme Court permitted in NFIB – but the Secretary's independent and collateral refusal to recognize patients made "eligible for Medicaid" as a matter of law (based on their low incomes) under the ACA as "low-income patients" for purposes of determining their entitlement to Medicare DSH supplements. In taking this approach, the Secretary declined to recognize statutorily Medicaid-expansion populations as being "eligible for Medicaid" in states that chose not to amend their state plans to extend Medicaid coverage based on a technicality, namely that the Medicare DSH provisions refer to Medicaid eligible patients as those made "eligible for medical assistance under a State plan approved under Title XIX."

6. The mundane reference to eligibility "under a State plan" is part of a broader statutory scheme under which states are *required* to amend their medical assistance plans on a pro forma to cover all eligibility categories that are mandated by Title XIX. To the extent the Supreme Court excused states in NFIB from submitting the state plan amendments (SPAs) presumptively required under the ACA, it was unreasonable for the Secretary to continue to

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condition the recognition of persons directly made eligible for Medicaid under federal law effective January 1, 2014 upon the submission of such SPAs.

7. Despite NFIB, the ACA still literally obligates all states *de jure* to amend their medical assistance plans to cover populations made newly eligible for Medicaid under the ACA. Congress framed the adoption of universal conforming SPAs that would add ACA coverage to all approved state plans as a pro forma and presumed occurrence. NFIB upheld the Medicaid coverage expansion as a whole, and never suggested that individuals who became eligible for Medicaid under the ACA should not be regarded as days of low-income patients (defined to include those eligible for Medicaid) for purposes of determining hospitals' entitlement to Medicare DSH adjustments. See NFIB at 586. It is arbitrary and capricious to continue to place continued reliance on whether expansion coverage has been memorialized under an approved SPA in view of the practical but unanticipated implications of NFIB's excusing the filing of mandated SPAs.

8. The Secretary's post-NFIB approach is arbitrary and capricious and contrary to law based on the simple and obvious fact that it results in patients who are "*eligible for Medicaid"* under mandate of Congress being treated by a federal agency as though they are *not* patients eligible for Medicaid for Medicare DSH purposes. Allowing the inactions of states acting under the shield of NFIB to indirectly negate days of persons statutorily eligible for Medicaid in determining their low-income patient volumes under Medicare is counter-intuitive and produces a result that is diametrically opposite to what Congress expected and intended in enacting the ACA, and yields bizarre results in contravention of congressional intent and controlling principles of statutory construction.

9. The Secretary's approach not only understates the true volume of low-income patients to which Plaintiffs furnish care based on a technicality, but denies Plaintiffs equal

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protection under the law by compensating them less under Medicare than similarly situated hospitals treating equivalent volumes of low-income patients in approximately 34 states that did not take advantage of the unexpected loophole created by the plurality decision in NFIB. It is implausible that Congress never would have wanted the Secretary to further extend NFIB's unanticipated impairment of mandated SPAs into the realm of Medicare DSH subsidies. If anything, Congress would consider it even more imperative to recognize expansion-eligible days in the Medicare DSH calculations for those hospitals being deprived of underlying medical assistance payments for the same patients. The Secretary's contrary approach treats two wrongs as making a right!

10. Acting through BESLER Consulting of Florida (BESLER), Plaintiffs petitioned the Secretary to amend or clarify the regulations to confirm that inpatient days of *statutorily Medicaid eligible* expansion patients of hospitals located in non-expansion states may be counted in their Medicare low-income calculation, regardless of whether coverage was adopted through an approved SPA. After a long delay, the Secretary effectively denied BESLER's petition to amend the rules by inaction by issuing a letter dated December 10, 2020 stating that then-Secretary Azar was neither granting nor denying the Petition.

11. As a consequence of this Secretary's continued literal adherence to the plan amendment requirement that was rendered inoperable under NFIB, Plaintiffs' Medicare Administrative Contractors (MACs) and the Provider Reimbursement Review Board (PRRB) were themselves precluded by regulation from recognizing days of ACA expansion populations. Plaintiffs accordingly seek relief from this Court under the Administrative Procedure Act (APA) and the equal protection clause (as applicable to the Secretary under the Fifth Amendment) in the form of a remand order requiring the Secretary to recalculate Plaintiffs' Medicare DSH

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