IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MASSENA MEMORIAL HOSPITAL
1 Hospital Drive
Massena, NY 13662

Plaintiff,

vs.

XAVIER BECERRA, as SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue, S.W.
Washington, D.C. 20201

Defendant.

Civil Action No. 1:21-cv-3291

COMPLAINT

Plaintiff Massena Memorial Hospital (the "Hospital") brings this action against Defendant Xavier Becerra, in his official capacity as Secretary (the "Secretary") of the United States Department of Health and Human Services ("HHS"), and states as follows:

1. Plaintiff Hospital provides essential acute care hospital services for patients in a rural and economically challenged region of upstate New York. At all relevant times, the Hospital has been designated by the Medicare program as a "Sole Community Hospital" ("SCH").

2. During its fiscal years that ended December 31, 2009 ("FY 2009"), December 31, 2012 ("FY 2012") and December 31, 2013 ("FY 2013"), the Hospital experienced substantial decreases in its inpatient cases due to circumstances beyond its control, which by law required

the Secretary to adjust the Hospital's usual Medicare inpatient payments. This adjustment is known as the Medicare Volume Decrease Adjustment ("VDA") payment.

3. For each of FY 2009, FY 2012 and FY 2013, the Hospital filed timely applications for a VDA payment, and the Secretary, acting through the Centers for Medicare and Medicaid Services ("CMS") and its Medicare Administrative Contractor ("MAC") issued a final determination for each fiscal year. By letter dated February 25, 2015, the MAC approved a VDA payment to the Hospital in the amount of $99,257 for FY 2009. By letter dated September 16, 2013, the MAC approved a VDA payment of $1,175,965 for FY 2012. By letter dated October 23, 2015, the MAC approved a VDA payment of $1,818,093 for FY 2013. These approvals are collectively referred to as the "Original VDA Approvals." The Hospital did not appeal the Original VDA Approvals because they were determined correctly.

4. Well after the Original VDA Approvals were received, by letters dated January 29, 2016, the MAC notified the Hospital of its intent to "reopen" all three Original VDA Approvals, *i.e.*, to recalculate the Hospital's original VDA payments. On October 11, 2016, the MAC issued revised determinations for FY 2009, FY 2012 and FY 2013 which reduced the Hospital's FY 2009 VDA payment to $0, its FY 2012 VDA payment to $558,051 and its FY 2013 VDA Payment to $891,737. These are collectively referred to as the "Revised VDA Approvals." As a result of the Revised VDA Approvals, and because the Hospital had already received the original VDA payments, the Hospital was required to repay the Medicare program $99,257 for FY 2009, $617,914 for FY 2012 and $926,365 for FY 2013.

5. The Secretary has conceded that the Hospital experienced a decrease in inpatient volume greater than 5% and is therefore entitled to a VDA payments for FY 2009, FY 2012 and FY 2013. The questions to be decided in this appeal are (a) whether the MAC properly reopened

the Original VDA Approvals; and alternatively (b) whether the VDA payment set forth in the Revised VDA Approvals was correctly calculated.

6. The Original VDA Approvals were calculated exactly as described in the Medicare Provider Reimbursement Manual ("PRM") and CMS' comments during rulemaking, that is, by subtracting total MS DRG payments (defined and discussed below) from the lesser of (a) the Provider's total Medicare inpatient operating costs (less any adjustment for excess staffing); or (b) the prior year's total Medicare inpatient operating costs updated for inflation (less any adjustment for excess staffing) (the "Historical VDA Approval Methodology"). *See* CMS Pub. 15-1, PRM § 2810.1.D; 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006); 73 Fed. Reg. 48433, 48631 (Aug. 19, 2008). This is the methodology the MAC consistently applied and reported to CMS from the time it began calculating VDA payments until 2016, a period of over 25 years. Because the Historical VDA Approval Methodology compares similar concepts – total costs and total payments – the Hospital refers to this methodology as an "apples-to-apples" approach.

7. In 2016, the MAC abruptly changed its calculation method (the "Revised VDA Approval Methodology"). The MAC continued to subject the Hospital's total Medicare inpatient costs to the "prior year" and "excess staffing" tests, but added a new step which removed from the Hospital's total inpatient operating costs certain costs now alleged to be "variable." However, the MAC continued to subtract from this amount the Hospital's total MS DRG payments, even though a portion of those payments were intended to reimburse the Hospital for its variable costs. As a result, the MAC's Revised VDA Approval Methodology improperly

compares dissimilar concepts – "fixed" costs and total payments. For that reason, the Hospital refers to this methodology as an "apples-to-oranges" approach.[1]

8. The Original VDA Approvals utilized the Historical VDA Approval Methodology, which correctly applied an apples-to-apples comparison of total costs to total payments. The Revised VDA Approvals applied the Revised VDA Approval Methodology, which improperly compared dissimilar concepts – "fixed" costs and total payments. The application of the Revised VDA Approval Methodology resulted in significantly smaller VDA payments to the Hospital.

9. Put more simply, for over twenty-five years, the MAC properly applied the applicable law and program instructions one way and reported the resulting determinations to CMS. Starting in 2016, the MAC began to apply the applicable law and program instructions differently – without any intervening changes to the law or explicit notice from CMS. The Secretary, by allowing the MAC to reopen properly issued final determinations and then adopting this new methodology through adjudication, has violated the Medicare statute and the Administrative Procedures Act.

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[1] As explained herein, in response to the Revised VDA Approval Methodology, the Board fashioned a third approach ("Board's VDA Methodology"). Recognizing that MS-DRG payments include a component designed to reimburse a hospital for its variable costs, the Board's VDA Methodology reduces MS-DRG payments to exclude the "variable" cost component. Because this third methodology compares similar concepts - "fixed" costs and "fixed" payments - a continuation of the first analogy would suggest an "oranges-to-oranges" approach. CMS has adopted this methodology through rulemaking prospectively for fiscal years beginning on or after October 1, 2017. 82 Fed. Reg. 37990, 38179-83 (Aug. 14, 2017).

PARTIES

10. Plaintiff Massena Memorial Hospital is a Medicare participating acute care hospital located in Massena, New York. At all relevant times, the Hospital was classified as a SCH under Section 1886(d)(5)(D)(iii) of the Social Security Act (the "Act").

11. Defendant Xavier Becerra is the Secretary of HHS and is the federal official responsible for administering the Medicare program under Title XVIII of the Act.

JURISDICTION AND VENUE

12. This action arises under the Medicare Act (Title XVIII of the Act, 42. U.S.C. §§ 1395 *et seq*.)(the "Medicare Act") and the Administrative Procedure Act (5 U.S.C. §§ 551 *et seq*.). This court has jurisdiction under 28 U.S.C. § 1331 and § 1361, and 42 U.S.C. § 1395oo(f)(1).

13. Venue is proper in this judicial district under 42 U.S.C. § 1395oo(f)(l) and 28 U.S.C. § 1391(c).

STATUTORY AND REGULATORY BACKGROUND

A. The Medicare Program and the Appeal Process

14. The Hospital is provider of medical services to beneficiaries of the federally administered Medicare Program as set forth in the Medicare Act.

15. CMS is the agency within HHS charged with administrating the Medicare program.

16. CMS's hospital payment functions are contracted to organizations known as MACs.

17. During each cost reporting period, a MAC determines the payment amounts due to providers under the Medicare statutes, regulations, and interpretive guidelines published by

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