IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASCENSION BORGESS HOSPITAL 1521 Gull Road Kalamazoo, MI 49048 Plaintiff, v. **XAVIER BECERRA,** In his Capacity as Secretary of the U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Washington, D.C. 20201 Defendant.	)	Case No.

COMPLAINT FOR JUDICIAL REVIEW OF FINAL ADVERSE AGENCY DECISION ON MEDICARE REIMBURSEMENT

JURISDICTION AND VENUE

1. This is a civil action brought to obtain judicial review of a final decision rendered on March 31, 2022, by the Provider Reimbursement Review Board ("PRRB"), acting as a component of the United States Department of Health and Human Services ("HHS"). The decision for which judicial review is hereby sought is PRRB Case No. 13-1947.

2. This action arises under Title XVIII of the Social Security Act, as amended (42 U.S.C. §1395 et. seq.), hereinafter referred to as the "Medicare Act" or the "Act", and the Administrative Procedure Act, 5 U.S.C. § 706.

3. This Court has jurisdiction under 42 U.S.C. §1395oo(f), 28 U.S.C. § 1331, and 28 U.S.C. § 1361. Venue lies in this judicial district pursuant to 42 U.S.C. §1395oo(f), and 28 U.S.C. § 1391(e)

4. Provider timely filed its appeal with the Provider Reimbursement Review Board pursuant to 42 U.S.C. §1395oo(a)(3).

5. This civil action is filed within sixty (60) days of the date Provider received that decision of the Board wherein the "...Board hereby dismisses the case *in its entirety* and removes it from the Board's docket", based on, "…the untimely and deficient response and the failure to comply with the CIRP group regulations."

PARTIES

6. Plaintiff, ASCENSION BORGESS HOSPITAL (Medicare Provider Number 23-0177) files this appeal from the final decision of the PRRB dated March 31, 2022, dismissing Plaintiff's appeal of Case No. 13-1947 (true and correct copy attached as Exhibit "B"). The subject of that appeal to the PRRB concerns Fiscal Year Ending June 30, 2008.

7. Plaintiff named herein (hereinafter, "Plaintiff," "Plaintiff Provider" or "Provider") is an acute care, in-patient healthcare facility that serves a disproportionate share of low-income patients. At all relevant times, Plaintiff Provider had a Medicare provider agreement with the Secretary of Health and Human Services and was eligible to participate in the Medicare program.

8. As set forth more fully below, Plaintiff objects to its dismissal of its appeal by the PRRB as arbitrary, capricious and a violation of the rightful and allowing claims of Plaintiff.

9. Also as set forth more fully below, Plaintiff objects in particular to the Board's dismissal of two of the seven appealed issues; to wit: (a) DSH/SSI Percentage (Provider Specific) and (b) DSH/SSI Percentage (Systemic Errors) that had been dismissed in advance of the dismissal of Plaintiff's entire appeal, those two issues dismissed based solely upon jurisdictional grounds.

10. Defendant, Xavier Becerra, Secretary of the U.S. Department of Health and Human Services ("Secretary"), or his predecessors in office, is the federal officer responsible for the administration of the Medicare program. Defendant Becerra is sued in his official capacity.

MEDICARE STATUTORY AND REGULATORY BACKGROUND

11. The Medicare program was established to provide health insurance to the age and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (HHS) charged with administering the Medicare program.

12. Medicare reimburses the operating costs of inpatient Provider services primarily through the Prospective Payment System (PPS). 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust reimbursements based on Provider- specific factors. See 42 U.S.C. §1395ww(d)(5). This case involves the Provider-specific disproportionate share (DSH) adjustment, which requires the Secretary to provide increased PPS reimbursement to Providers that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

13. Whether a Provider qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the Provider's "disproportionate patient percentage (DPP)." 42 U.S.C. § 1395ww(d)(5)(F)(v). The DPP is the sum of two fractions, the "Medicare and Medicaid fractions," for a Provider's fiscal period. 42 U.S.C. §1395ww(d)(5)(F)(vi). Providers whose DSH percentages meet certain thresholds receive an adjustment which results in increased PPS payments for inpatient Provider services. 42 U.S.C. §1395ww(d)(5)(F)(ii).

14. The first fraction's numerator is the number of Provider patient days for such period who (for such days) were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits,

and the denominator is the number of patient days for patients entitled to Medicare Part A. Id. This case involves this first fraction, which is hereinafter referred to as the SSI fraction, or the Medicare fraction.

15. The second fraction's numerator is the number of Provider patient days for patients who (for such days) were eligible for medical assistance under a State Plan approved under Title XIX for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the Provider's patient days for such period. Id. The second fraction is frequently referred to as the Medicaid fraction.

16. The SSI program is administered by the Social Security Administration (SSA); therefore, identifying patients who were entitled to SSI during their Providerization requires access to SSA's SSI data. To implement the DSH legislation, the number of patient days for those patients entitled to both Medicare Part A and SSI is determined by matching data from the MEDPAR file, which is Medicare's database of Provider inpatients, with a file created for CMS by SSA to identify SSI-eligible individuals.

17. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries (hereinafter, the "MAC"). Fiscal intermediaries determine payment amounts due the providers under Medicare law and regulations. 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b). Although the Intermediary calculates the DPP, it is CMS that computes the SSI fraction.

18. At the close of its fiscal year, a provider must submit a cost report to the fiscal Intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal Intermediary reviews the cost report, determines the total

amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803.

19. A provider dissatisfied with the MAC's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (PRRB) or (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

SPECIFIC FACTS PERTAINING TO THIS CASE

20. Plaintiff filed a jurisdictionally proper appeal to the PRRB from the MAC's final determination. The seven (7) issues in this appeal are:

a. DSH/SSI Percentage (Provider Specific);

b. DSH/SSI Percentage (Systemic Errors);

c. DSH Payment - Medicaid Eligible Days

d. DSH Payment – Medicare Managed Care Part C Days

e. DSH Medicaid Eligible – Labor Room Days

f. DSH Dual Eligible Days; Exhausted Part A days

g. Outlier Payments – Fixed Loss Threshold

21. On April 9, 2014, the Medicare Contractor submitted a jurisdictional challenge over issue (a), the realignment issue, and issue (b) the Systemic Errors issue.

22. In regard to issue (a), Plaintiff contended that the MAC did not determine Medicare DSH reimbursement in accordance with the statutory instructions at 42 U.S. C. § 1395ww(d)(5)(F)(i). Specifically, Plaintiff disagreed with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's regulations, in that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in its calculation.

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