IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EJ NOBLE HOSPITAL
77 West Barney Street
Gouverneur, NY 13642

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.

COMPLAINT

Plaintiff EJ Noble 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 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 year that ended December 31, 2011 ("FY 2011"), the Hospital experienced a substantial decrease 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. The Hospital filed a timely application 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 determination on November 21, 2013 approving a VDA payment to the Hospital in the amount of $478,324 (the "Original VDA Approval"). The Hospital did not appeal the Original VDA Approval because it was determined correctly.

4. Over two years later, on February 5, 2016, the MAC notified the Hospital of its intent to "reopen" the Original VDA Approval, *i.e.*, to recalculate the Hospital's original VDA payment. On July 22, 2016, the MAC issued a revised determination which reduced the Hospital's VDA payment to $0 (the "Revised VDA Approval"). As a result of the Revised VDA Approval, and because the Hospital had already received the original VDA payment, the Hospital was required to repay the Medicare program $478,324.

5. The Secretary has conceded that the Hospital experienced a decrease in inpatient volume greater than 5% and is therefore entitled to a VDA payment for FY 2011. The questions to be decided in this appeal are (a) whether the MAC properly reopened the Original VDA Approval; and alternatively (b) whether the VDA payment set forth in the Revised VDA Approval was correctly calculated.

6. The Original VDA Approval was calculated exactly as described in the Medicare Provider Reimbursement Manual ("PRM") and CMS's 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 Approval utilized the Historical VDA Approval Methodology, which correctly applied an apples-to-apples comparison of total costs to total payments. The Revised VDA Approval 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 a significantly smaller VDA payment to the Hospital.

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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).

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 a properly issued final determination and then adopting this new methodology through adjudication, has violated the Medicare statute and the Administrative Procedures Act.

PARTIES

10. Plaintiff EJ Noble Hospital is a Medicare participating acute care hospital located in Gouverneur, 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*. 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 42 U.S.C. § 1395 *et seq*. ("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 CMS. After the MAC makes a final determination, it sends to the provider a Notice of Program Reimbursement ("NPR").

18. In addition to issuing NPRs, a MAC may make other final determinations, including a VDA payment determination. 42 C.F.R. § 412.92(e)(3); 54 Fed. Reg. 36452, 36480 (Sep. 1, 1989).

19. A hospital may appeal the MAC's final determination to the Provider Reimbursement Review Board ("PRRB" or "Board") pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835. The PRRB is a sub-agency within HHS that serves as an administrative review panel for final determinations made by CMS or the MAC. The members of the PRRB must be "knowledgeable in the field of payment to providers of service" under the Medicare program. *See* 42 U.S.C. § 1395oo(h).

20. The decision of the PRRB is final unless the Secretary reverses, affirms, or modifies the PRRB's decision within 60 days of the provider being notified of the PRRB's decision. *See* 42 U.S.C. § 1395oo(f)(1). A hospital has the right to obtain judicial review of any final decision of the PRRB, or any reversal, affirmance, or modification of the PRRB's decision by the Secretary. *See* 42 U.S.C. § 1395oo(f); 42 C.F.R. § 405.1877.

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