UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION,
325 Seventh Street, NW, Suite 700
Washington, DC 20004;

BANNER HEALTH,
1441 N. 12th Street
Phoenix, AZ 85006;

MOUNT SINAI HOSPITAL,
One Gustave L. Levy Place
New York, NY 10029;

EINSTEIN HEALTHCARE NETWORK,
5501 Old York Road
Philadelphia, PA 19141;

WAKE FOREST BAPTIST MEDICAL CENTER,
1 Medical Center Boulevard
Winston-Salem, NC 27103;

GREATER NEW YORK HOSPITAL ASSOCIATION,
555 West 57th Street, #1500
New York, NY 10019;

HEALTHCARE ASSOCIATION OF NEW YORK STATE,
One Empire Drive
Rensselaer, NY 12144;

NEW JERSEY HOSPITAL ASSOCIATION,
760 Alexander Road
Princeton, NJ 08543-0001; and

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA,
4750 Lindle Road
Harrisburg, PA 17111,

Case No. _____

Plaintiffs,

v.

KATHLEEN SEBELIUS, in her official capacity as Secretary of Health and Human Services,
200 Independence Avenue, SW
Washington, DC 20204,

Defendant.

COMPLAINT

Plaintiffs the American Hospital Association, Banner Health, Mount Sinai Hospital, Einstein Healthcare Network, Wake Forest University Baptist Medical Center, Greater New York Hospital Association, Healthcare Association of New York State, New Jersey Hospital Association, and The Hospital & Healthsystem Association of Pennsylvania, bring this action to challenge an unlawful Medicare policy: Medicare has cut the reimbursement rates it pays to the nation's hospitals, without any reasoned basis for doing so. That unlawful payment reduction already is harming the Plaintiff hospitals. And all told, it will cost the nation's hospitals more than $200 million this year alone.

INTRODUCTION

1. When a patient comes to a hospital for treatment, the attending physician must decide whether the patient should be admitted. If the patient is admitted, he or she is treated on an "inpatient" basis; if not, he or she is treated on an "outpatient" basis. There are differences between the two, but in some cases treatment for the same condition can be provided in either setting. For example, a young, healthy patient may be a good candidate to have a particular

surgery on an outpatient basis, while an older patient with a higher risk of complications should have the same surgery on an inpatient basis.

2. Whether a patient is treated on an "inpatient" or an "outpatient" basis affects the amount of reimbursement a hospital receives. Hospitals caring for Medicare patients on an inpatient basis submit bills for reimbursement under Medicare Part A. Hospitals caring for Medicare patients on an outpatient basis submit bills for reimbursement under Medicare Part B. Part A and Part B are funded separately and utilize different formulae to calculate payment.

3. Traditionally, the decision to admit a patient for inpatient treatment has been committed to the expert judgment of the attending physician. But in August 2013, the Secretary of Health and Human Services ("HHS"), acting through the Centers for Medicare & Medicaid Services ("CMS"), adopted new Part A payment rules for federal fiscal year 2014 that supplant physician judgment as the touchstone for making this complex medical decision.

4. In particular, CMS adopted a time-based rule for who is an inpatient and who is not. CMS instructed admitting physicians and Medicare review contractors that an inpatient admission is "generally appropriate" when the physician expects the patient to require a stay that crosses "two midnights"—that is, a stay where the patient was admitted prior to midnight and stayed in the hospital that night, the next day, and the next evening until at least midnight. Conversely, for hospitals stays in which the physician expects the patient to require care for less than two midnights, hospital admission is "generally inappropriate."

5. Using the new two-midnights rule as a fig leaf, CMS also decided to cut the payments hospitals receive for treating Medicare patients. CMS claimed—without setting forth its actuaries' reasoning or calculations—that the two-midnights rule and other related policy changes would result in a net increase in the number of inpatient hospital stays that Medicare

covers under Part A. And it claimed that the net increase would cost the Medicare program $220 million in fiscal year 2014. CMS accordingly cut its payments to hospitals by that amount. Specifically, it reduced payments by 0.2 percent across the board for beneficiary discharges occurring on or after October 1, 2013 (the "0.2 Percent Payment Cut").

6. CMS's decision to take this money from hospitals is unlawful. To begin with, CMS's cost estimate was deeply flawed: It grossly underestimated the volume of encounters that would shift from inpatient to outpatient status, and profoundly overestimated the number of cases that would shift from outpatient to inpatient. Moreover, CMS's calculations and analysis were wholly unexplained—a textbook violation of the Administrative Procedure Act ("APA"). And as a result of CMS's failure to explain its actuaries' analysis, hospitals and other interested parties were not able to critique the actuaries' estimates, thereby precluding the meaningful participation in the notice-and-comment process that the APA requires.

7. CMS's arbitrary and capricious decision to cut hospital reimbursement rates already has harmed the Plaintiff hospitals. To date, they have been deprived of hundreds of thousands of dollars in much-needed Medicare reimbursement, and will continue to suffer losses if the cut is not reversed.

8. In this Complaint, Plaintiffs ask the Court to set aside the 0.2 Percent Payment Cut on the grounds that it is arbitrary and capricious, invalid for failure to undergo adequate notice and comment, and contrary to federal law. Plaintiffs also seek an order that CMS must revise the relevant payment rates for federal fiscal year 2014 and reimburse the Plaintiff hospitals for monies they have lost under the 0.2 Percent Payment Cut since October 1, 2013. CMS cannot cut reimbursement to hospitals while hiding behind faulty assumptions and violating federal law.

PARTIES

9. Plaintiff the American Hospital Association ("AHA") is a national not-for-profit organization that represents and serves nearly 5,000 hospitals, health care systems, and networks, plus 43,000 individual members. Its mission is to advance the health of individuals and communities by leading, representing, and serving the hospitals, health systems, and other related organizations that are accountable to the community and committed to health improvement. The AHA provides extensive education for health care leaders and is a source of valuable information and data on health care issues and trends. It also ensures that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters.

10. Plaintiff Banner Health is one of the nation's largest not-for-profit health care systems. Based in Phoenix, Arizona, Banner Health delivers high-quality, efficient care at twenty-four hospitals and other health care facilities across seven states. Sixteen of its acute care hospitals are affected by the policy challenged in this lawsuit. Among those, three are "Sole Community Hospitals"—so defined under Medicare based on their rural location and distance from other hospitals—located in Fairbanks, Alaska; Sterling, Colorado; and Fallon, Nevada. These community hospitals fill an important medical need in their rural communities. Fairbanks Memorial Hospital, for example, is designated as a Sole Community Hospital for a surrounding area that spans 250,000 square miles.

11. Plaintiff Mount Sinai Hospital is a 1,171-bed, not-for-profit, tertiary-care teaching facility in New York City. Mount Sinai Hospital is part of a large academic medical center that provides numerous specialty services on its campus, such as cardiology care and research at Mount Sinai Heart and pediatric care at the Kravis Children's Hospital at Mount Sinai. It also

serves as the teaching hospital to the Icahn School of Medicine at Mount Sinai, which trains some 550 medical students, 540 graduate students, and 598 post-doctoral research fellows each year.

12. Plaintiff Einstein Healthcare Network ("Einstein") is a private, not-for-profit organization committed to providing compassionate, high-quality health care to the greater Philadelphia, Pennsylvania region. Einstein operates several major facilities and many outpatient centers. These include Einstein Medical Center, a tertiary-care teaching hospital with a Level One Trauma Center in Philadelphia, and Einstein Medical Center Montgomery, a new hospital that opened in 2012.

13. Plaintiff Wake Forest University Baptist Medical Center ("Wake Forest") is a fully integrated, not-for-profit, academic medical center and health care delivery system. It operates 1,004 acute care, rehabilitation, and psychiatric care beds as well as outpatient and community health clinics and information centers in Winston-Salem, North Carolina. Wake Forest also operates Lexington Medical Center, a facility with 94 acute-care beds in Lexington, North Carolina, and Davie Medical Center, which has facilities in Bermuda Run and Mocksville, North Carolina.

14. Plaintiff Greater New York Hospital Association ("GNYHA") is a regional, not-for-profit trade association that represents nearly 150 hospitals in New York, New Jersey, Connecticut, and Rhode Island. GNYHA's core mission is to help hospitals deliver the finest patient care in the most cost-effective way. To do so, GNYHA engages in a wide range of educational activities, such as helping its members implement safety initiatives and sharing information about health care finance, health insurance, and graduate medical education.

GNYHA also educates policymakers and State and Federal legislators on the complexities and constraints hospitals face in delivering care.

15. Plaintiff Healthcare Association of New York State ("HANYS") is a not-for-profit statewide organization that represents and advocates at the state and federal level on behalf of all New York State hospitals and health systems, across the continuum of care. HANYS also provides its members with data and intelligence on health care policy and operations, and has created a Data Academy to provide training in the tactical and strategic application of health care data.

16. Plaintiff New Jersey Hospital Association ("NJHA") is New Jersey's oldest and largest not-for-profit trade association dedicated to hospitals and their patients. NJHA represents nearly 400 healthcare organizations including hospitals, health systems, nursing homes, home health agencies, hospice providers, and healthcare-related business and educational institutions. NHJA provides extensive educational programming on diverse, substantive topics. Through the NJHA Institute for Quality and Patient Safety, NHJA unites healthcare providers and engages nationally renowned experts in collaborative efforts to improve healthcare quality. In 2010, NHJA's Institute was designated a "patient safety organization" by the U.S. Agency for Healthcare Research and Quality. Through the Health Research and Educational Trust of New Jersey, NJHA also develops research projects and educational initiatives to promote quality, affordable, and accessible healthcare and raises awareness about vital healthcare issues.

17. Plaintiff The Hospital & Healthsystem Association of Pennsylvania ("HAP") is a statewide not-for-profit organization that advocates at the state and federal level for nearly 240 Pennsylvania acute and specialty care, primary care, subacute care, long-term care, home health, and hospice providers, as well as the patients and communities they serve. HAP provides

services to the hospital community beyond traditional issue advocacy. The initiatives HAP offers include engaging health care professionals, public-private partnerships, relationship-building with others interested in improving health care, and strategic planning. For example, HAP develops resources to assist not-for-profit hospitals complete community health assessments, works with the Pennsylvania Department of Health to support and enhance emergency preparedness and response efforts across the state, and assists hospitals and stakeholders in implementing health information technology that will improve patient quality and reduce health care errors and costs.

18. Defendant Kathleen Sebelius is the Secretary of Health and Human Services (the "Secretary"). In that capacity, she is responsible for the conduct and policies of HHS, including the conduct and policies of CMS. The Secretary is sued in her official capacity only.

JURISDICTION AND VENUE

19. This action arises under the Medicare Act, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq*.; and the APA, 5 U.S.C. §§ 551 *et seq*.

20. This Court has jurisdiction over this action pursuant to 42 U.S.C. § 1395oo(f), which provides for "judicial review of any final decision of the [Provider Reimbursement Review] Board, or of any reversal, affirmance, or modification by the Secretary" and "which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines . . . that it is without authority to decide the question[.]" When the Provider Reimbursement Review Board ("PRRB") determines that it is without authority to decide the question, providers shall commence a civil action "within sixty days of the date on which notification of such determination is received." 42 U.S.C. § 1395oo(f).

21. This Court may issue a declaratory judgment pursuant to 28 U.S.C. §§ 2201–2202.

22. Venue lies in this judicial district pursuant to 42 U.S.C. § 1395oo(f)(1).

STATUTORY AND REGULATORY BACKGROUND

A. Medicare Act

23. Title XVIII of the Social Security Act establishes a program of health insurance for the aged and disabled, commonly known as Medicare. 42 U.S.C. §§ 1395 *et seq*. The Plaintiff hospitals qualify as providers under Title XVIII, also known as the Medicare Act.

24. The Medicare program is divided into four parts, A through D. Parts A and B are the only parts relevant to this proceeding. Part A, the hospital insurance program, provides for reimbursement of inpatient hospital services. 42 U.S.C. §§ 1395c–1395i-5. Part B, the supplemental medical insurance program, pays for various "medical and other health services" not covered by Part A, including physician services and hospital outpatient services. *Id.* § 1395k(a); *id.* §§ 1395j–1395w-4j. Thus, for an individual who receives a particular treatment on an outpatient basis, payment to the hospital may be made under Part B, while for an individual whose risk factors support providing the treatment on an inpatient basis, payment to the hospital may be made under Part A.

25. Under 42 U.S.C. § 1395hh(a)(1), the Secretary is required to "prescribe such regulations as may be necessary to carry out the administration" of the Medicare program. That statute provides:

> No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1). [*Id.* § 1395hh(a)(2)].

26. The Plaintiff hospitals are reimbursed on a prospective basis for the inpatient care they provide to Medicare beneficiaries according to a detailed formula that is prescribed by the

Medicare Act. *See* 42 U.S.C. § 1395ww(d)(5). CMS implements this formula to calculate the prospective payment amount paid for each Medicare discharge. *See generally* 42 C.F.R. §§ 412.60, 412.64, 412.100-.374. The Medicare Act further specifies that the Secretary "shall provide by regulation for such other exceptions and adjustments" to those prospective payment amounts. 42 U.S.C. § 1395ww(d)(5)(I)(i).

B. Administrative Procedure Act

27. The APA governs the way in which federal administrative agencies, including CMS, must propose and establish regulations.

28. The APA provides that a "reviewing court shall hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A), (C).

29. Likewise, courts may "hold unlawful and set aside agency action, findings, and conclusions" when they have been accomplished "without observance of procedure required by law." *Id.* § 706(2)(D).

30. The APA prescribes the relevant procedure requiring agencies to afford notice of a proposed rulemaking and an opportunity for public comment prior to a rule's adoption. *Id.* § 553. An agency rule promulgated "without observance of procedures required by law" is invalid. *Id.* § 706(2)(D).

C. Payment Rates

31. After a Medicare beneficiary is discharged from a hospital, the hospital receives Part A payment based on the Medicare Severity Diagnosis-Related Group ("MS-DRG") that corresponds to the beneficiary's clinical condition and treatment that was provided. *See* 42 U.S.C. § 1395ww(d); 42 C.F.R. §§ 412.60, 412.64, 412.100-.374.

32. The MS-DRG payment is based on two national base payment rates or "standardized amounts," one for operating expenses and one for capital expenses, which are adjusted to account for the beneficiary's clinical condition and market conditions in the hospital's location. *See* 42 C.F.R. §§ 412.60, 412.64(c).

33. The operating portion of the per-discharge amount for Sole Community Hospitals (such as Plaintiff Banner Health's Fairbanks Memorial Hospital, Sterling Regional MedCenter, and Banner Churchill Community Hospital) is calculated using either the national base payment amount or one of several "hospital-specific rates" pertaining to the hospital, whichever yields the greatest aggregate payment for the hospital's fiscal year. *Id.* §§ 412.90(a), 412.92(d).

34. The capital portion of the per-discharge amount for a new hospital, such as Einstein Medical Center Montgomery, is eighty-five percent of the hospital's allowable capital-related costs, rather than the standardized amount. *See id.* §§ 412.300(b), 412.304(c)(2).

35. For some hospitals, amounts are added to the MS-DRG payment amount to reflect the higher indirect patient care costs associated with teaching medical residents ("indirect medical education" or "IME" payments), *id.* § 412.105, and the costs associated with treating a disproportionate share of low-income patients ("disproportionate share hospital" or "DSH" payments), *id.* § 412.106. IME and DSH payments are calculated by multiplying an adjustment factor by the standardized amounts. *Id.* §§ 412.64, 412.105, 412.106, 412.312, 412.322.

36. As a result, the 0.2 Percent Payment Cut—which reduces the standardized amounts for operating and capital expenses and the hospital-specific rates—flows through many different components of the Plaintiff hospitals' reimbursement under Medicare Part A. The 0.2 Percent Payment Cut reduces the amount that the Plaintiff hospitals will be reimbursed for every

Medicare beneficiary they discharge from October 1, 2013 through September 30, 2014 (*i.e.*, during federal fiscal year 2014).

D. The 0.2 Percent Payment Cut

37. On May 10, 2013, CMS published proposed rules governing Medicare payment policy under the inpatient prospective payment system ("IPPS") for federal fiscal year 2014 ("IPPS Proposed Rule").

38. Among other things, the IPPS Proposed Rule included a proposal to provide "additional clarity" to CMS's guidelines about when a Medicare beneficiary should be admitted to the hospital as an inpatient. CMS has long recognized that the decision to admit a patient is a "complex medical judgment" that involves the consideration of many factors. CMS, Medicare Benefit Policy Manual ("MBPM") Ch. 1 § 10. CMS has instructed hospitals and physicians that "generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed, even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a bed overnight." *Id.* Thus, according to CMS, a physician or other practitioner should "use a 24-hour period as a benchmark, i.e., [physicians] should order admission for patients who are expected to need hospital care for 24 hours or more." *Id*. But in the IPPS Proposed Rule CMS proposed to establish a presumption, whereby admission is "generally appropriate" when the physician expects the patient to receive care in the hospital for a period spanning two midnights—i.e., more than 24 hours, and depending on the time the patient arrives at the hospital, in some cases nearly *48 hours*. Conversely, CMS wrote that hospital admission is "generally inappropriate" when the physician expects the patient to require care for less than two midnights. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term

Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates, 78 Fed. Reg. 27,486, 27,648 (proposed May 10, 2013).

39. CMS also proposed to establish a rule that hospitals cannot obtain payment under Medicare Part A (for inpatient care) unless the patient's record contains a physician's order admitting the patient as an inpatient. *Id.* at 27,646.

40. As a result of these new policies, CMS predicted—but did not substantiate—that Medicare would be required to spend an additional $220 million to reimburse hospitals for those inpatient stays. For this reason, CMS said that it proposed the 0.2 Percent Payment Cut. *Id.* at 27,649.

41. On August 19, 2013, CMS published the IPPS final rule in the Federal Register ("IPPS Final Rule"), adopting, with few changes, the proposed policies described above, including the 0.2 Percent Payment Cut. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates, 78 Fed. Reg. 50,496, 50,508 (Aug. 19, 2013).

42. Rather than codifying the 0.2 Percent Payment Cut in the Code of Federal Regulations, however, CMS only discussed the reduction in the preamble to the IPPS Final Rule. *Id.* at 50,952–54.

43. CMS wrote that its actuaries examined fiscal year 2009 through fiscal year 2011 Medicare claims data and estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net shift of 40,000 encounters to inpatient status. *Id.*

44. After the IPPS Proposed Rule was published, hospitals and other commenters—including many of the Plaintiffs here—questioned CMS's estimates and asked CMS to explain

how a policy that makes it *harder* to justify inpatient treatment and requires an inpatient stay to last longer could result in *more* inpatient cases. Commenters also noted that CMS had not revealed its data, methodology, or assumptions underlying the payment cut. They asked CMS to reveal that information so they could provide informed comments and critiques of CMS's analysis.

45. In the preamble to the IPPS Final Rule, CMS did none of these things.

46. CMS did, however, identify—but not explain—two major limitations on its actuarial analysis.

47. First, in estimating the number of encounters that would shift from outpatient to inpatient, CMS's actuaries examined only "outpatient claims for observation or a major procedure. Claims not containing observation or a major procedure were excluded." *Id.* at 50,953.

48. Second, in estimating the number of claims that would shift from inpatient to outpatient, CMS wrote that its actuaries examined only "claims containing a surgical MS-DRG. Claims containing medical MS-DRGs were excluded." *Id.*

E. Substantive Flaws in the 0.2 Percent Payment Cut

49. Upon information and belief, CMS's actuarial assumptions are inherently flawed.

50. To begin, when CMS's actuaries estimated how many encounters would shift from inpatient to outpatient, they examined only "claims containing a surgical MS-DRG. Claims containing medical MS-DRGs were excluded." 78 Fed. Reg. at 50,953. In other words, CMS's calculations ignored *an entire category of cases*—medical cases that do not involve a surgery.

51. Perhaps CMS assumed that surgical cases and medical cases will behave the same way under its new policies in terms of the percentage that will shift. But if that is CMS's logic, it

does not hold; there is no reason to assume the two kinds of cases will behave the same way, and good reason to think they will not.

52. In surgical cases it often is easier for doctors to predict how long a patient will be hospitalized, and therefore to meet the new CMS criterion that physicians may "order admission if [they] expect[ ] that the beneficiary's length of stay will exceed a 2-midnight benchmark[.]" *Id.* at 50,944. In medical cases, by contrast, the patient often is hospitalized with symptoms that have not yet been diagnosed. In such cases it often will be more difficult for a physician to definitively predict how long the patient needs to be hospitalized.

53. Simple logic therefore suggests that medical cases are *more* likely to shift from inpatient to outpatient—and that CMS undercounted the shifts in that direction by considering only surgical cases in its modeling.

54. There are numerous other reasons to believe that CMS undercounted the number of cases that will shift from inpatient to outpatient.

55. For example, in federal fiscal year 2011, five medical MS-DRGs accounted for nearly 160,000 short inpatient stays (zero and one-day stays). Many of these cases would be likely to shift from inpatient to outpatient under the new policy.

56. In fact, according to statistics on the CMS website, there were a total of 1,569,693 inpatient stays of one day or less in calendar year 2011. This number is fairly typical. Per CMS's data files, there are about one million zero- or one-midnight stay inpatient cases each year.

57. CMS has stated in guidance regarding the new two midnight policy that it expects that a "*majority* of short (total of zero- or one-night) Medicare hospital stays will be provided as outpatient services." CMS, FREQUENTLY ASKED QUESTIONS *2 Midnight Inpatient*

Admission Guidance & Patient Status Reviews for Admission on or after October 2013, Question 13 (emphasis added).[1] Taking CMS at its word, this means that more than 500,000 short-stay cases will shift to outpatient status under the new policy. Yet, the preamble to the rule predicts that only 360,000 encounters will shift.

58. As one group of commenters on the IPPS Proposed Rule explained, even assuming that CMS were to subtract the 90,173 patients who died during an inpatient stay, the 87,572 patients who were transferred to another hospital, the 39,931 who left against medical advice, and the 50,448 who were discharged to a skilled nursing facility, from the 1.5 million zero- or one-day stays in 2011, that would still leave more than 1.2 million short stays.[2] If more than half of those cases shifts to the outpatient setting as CMS expects (some 600,000 cases), then there would be a net increase in *outpatient* cases of approximately 200,000 cases, rather than a net increase in inpatient cases as CMS claims.

59. CMS's analytical approach regarding the shift from outpatient to inpatient also is inherently flawed.

60. For example, CMS did not impose a surgical-cases-only limitation when it counted how many encounters would shift from outpatient to inpatient. Instead, CMS examined "outpatient claims for observation or a major procedure." 78 Fed. Reg. at 50,953. That approach does not track the approach CMS used in counting inpatient-to-outpatient shifts because it *includes* observation cases—cases involving not-yet-diagnosed conditions that are most like the medical MS-DRGs that were categorically *excluded* from the inpatient-to-outpatient count.

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[1] *Available at* http://cms.gov?Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf.
[2] *Available at* https://www.noticeandcomment.com/CMS-2013-0084-0450-fcod-366975.aspx.

61. That disconnect is critical. After all, CMS's decision to impose the 0.2 Percent Payment Cut turns *entirely* on its conclusion that more encounters would shift from outpatient to inpatient than vice versa. *See id.* If CMS used a smaller bucket of cases when it counted the subset shifting from inpatient to outpatient than it did the subset shifting the other direction, then the underpinnings supporting the payment reduction collapse.

F. Procedural Flaws in the 0.2 Percent Payment Cut

62. Even if CMS could explain its assumptions and results, it failed to do so. CMS's failure to include sufficient detail in the IPPS Proposed Rule precluded hospitals from engaging in any meaningful notice and comment process.

63. But CMS knows that. It acknowledged in the preamble to the IPPS Final Rule that "[c]ommenters generally did not support the proposed -0.2 percent payment adjustment." 78 Fed. Reg. at 50,953. Commenters expressed that "CMS actuaries' estimated increase in IPPS expenditures of $220 million was unsupported and insufficiently explained to allow for meaningful comment." *Id.*

64. In response, CMS rejected these comments and simply re-stated its bare-bones description of its actuaries' findings. But tellingly, CMS also, for the first time, identified—but did not explain—the two major limitations on its actuarial analysis: (1) in analyzing the shift from outpatient to inpatient, it excluded claims not containing observation or a major procedure; and (2) in analyzing the shift from inpatient to outpatient, it excluded claims containing medical MS-DRGs. *Id.*

65. Upon information and belief, CMS's findings are factually incorrect. But even if they were correct, CMS refused to reveal its data—or even explain its calculations—in sufficient detail for commenters to join issue with them.

66. The 0.2 Percent Payment Cut also is invalid for another reason: CMS did not promulgate the reduction as a "regulation," codified in the Code of Federal Regulation, as is required by the express language of the Medicare Act. The Act requires that all rules, requirements, and statements of policy that establish or change a substantive legal standard governing the scope of benefits or payment for services be promulgated via regulation, 42 U.S.C. § 1395hh(a), and in particular, specifies that any time the Secretary makes "such other exceptions and adjustments" to the prospective payment amounts paid to most hospitals, including Plaintiffs, for inpatient care, she "shall" do so "by regulation," *id.* § 1395ww(d)(5)(I)(i). The failure to do so renders the 0.2 Percent Payment Cut invalid.

THE PLAINTIFFS HAVE SUFFERED HARM

67. All told, according to CMS's own estimates, the unlawful 0.2 Percent Payment Cut will deprive hospitals of $220 million in Medicare reimbursement.

68. The 0.2 Percent Payment Cut also has harmed each of the Plaintiff hospitals:

Banner Health

69. As of April 4, 2014, Banner Health already has suffered more than $728,000 in damages as a result of the 0.2 Percent Payment Cut. Banner Health estimates that over the course of federal fiscal year 2014, the 0.2 Percent Payment Cut will mean a loss of $1,144,553 in Medicare reimbursement.

70. Banner Health has exhausted its administrative remedies.

71. On January 23, 2014, Banner Health requested a group hearing by the PRRB regarding the 0.2 Percent Payment Cut. The appeal was filed timely, within 180 days of the Secretary's final determination, which was published in the Federal Register on August 19, 2013, 78 Fed. Reg. 50,496.

72. Banner Health challenged the substantive and procedural validity of the 0.2 Percent Payment Cut. It also requested expedited judicial review on the basis that while the PRRB had jurisdiction over the appeal, the only issue raised was a pure question of law that the PRRB lacked the authority to decide. In addition, Banner Health sought a remedy—revision of the standardized amounts and hospital-specific rates for federal fiscal year 2014 and additional reimbursement for the flow-through effects of eliminating the 0.2 Percent Payment Cut—that the Board lacked the power to grant.

73. On March 20, 2014, the PRRB granted Banner Health's request for expedited judicial review.

Mount Sinai Hospital

74. As of April 4, 2014, Mount Sinai Hospital already has suffered more than $301,000 in damages as a result of the 0.2 Percent Payment Cut. Mount Sinai Hospital estimates that over the course of federal fiscal year 2014, the 0.2 Percent Payment Cut will mean a loss of more than $600,000 in Medicare reimbursement.

75. Mount Sinai Hospital has exhausted its administrative remedies.

76. On January 23, 2014, Mount Sinai Hospital requested an individual hearing by the PRRB regarding the 0.2 Percent Payment Cut. The appeal was filed timely, within 180 days of the Secretary's final determination.

77. Mount Sinai Hospital requested expedited judicial review of the only issue raised in its appeal: the substantive and procedural validity of the 0.2 Percent Payment Cut. In addition, Mount Sinai Hospital requested a remedy that the Board lacks the power to grant: a revision of the standardized amounts and hospital-specific rates for federal fiscal year 2014 and additional

reimbursement for the flow-through effects of eliminating the 0.2 Percent Payment Cut for Medicare discharges occurring on or after October 1, 2013.

78. On March 20, 2014, the PRRB granted Mount Sinai Hospital's request for expedited judicial review.

Einstein

79. As of April 4, 2014, Einstein already has suffered more than $88,000 in damages as a result of the 0.2 Percent Payment Cut. Einstein estimates that over the course of federal fiscal year 2014, the 0.2 Percent Payment Cut will mean a loss of more than $176,000 in Medicare reimbursement.

80. Einstein has exhausted its administrative remedies.

81. On January 23, 2014, Einstein requested a group hearing by the PRRB regarding the 0.2 Percent Payment Cut. The appeal was filed timely, within 180 days of the Secretary's final determination.

82. Einstein challenged the substantive and procedural validity of the 0.2 Percent Payment Cut. It also requested expedited judicial review on the basis that while the PRRB had jurisdiction over the appeal, the only issue raised was a pure question of law that the PRRB lacked the authority to decide. In addition, Einstein sought a remedy—revision of the standardized amounts and hospital-specific rates for federal fiscal year 2014 and additional reimbursement for the flow-through effects of eliminating the 0.2 Percent Payment Cut—that the Board lacked the power to grant.

83. On March 20, 2014, the PRRB granted Einstein's request for expedited judicial review.

Wake Forest

84. As of April 4, 2014, Wake Forest has suffered thousands of dollars in damages as a result of the 0.2 Percent Payment Cut. Wake Forest estimates that over the course of federal fiscal year 2014, the 0.2 Percent Payment Cut will mean a loss of $405,008 in Medicare reimbursement.

85. Wake Forest has exhausted its administrative remedies.

86. On January 23, 2014, Wake Forest requested a group hearing by the PRRB regarding the 0.2 Percent Payment Cut. The appeal was filed timely, within 180 days of the Secretary's final determination.

87. Wake Forest challenged the substantive and procedural validity of the 0.2 Percent Payment Cut. It also requested expedited judicial review on the basis that while the PRRB had jurisdiction over the appeal, the only issue raised was a pure question of law that the PRRB lacked the authority to decide. In addition, Wake Forest sought a remedy—revision of the standardized amounts and hospital-specific rates for federal fiscal year 2014 and additional reimbursement for the flow-through effects of eliminating the 0.2 Percent Payment Cut—that the Board lacked the power to grant.

88. On March 20, 2014, the PRRB granted Wake Forest's request for expedited judicial review.

89. The 0. 2 Percent Payment Cut also has harmed and will continue to harm the AHA, NJHA, GNYHA, HANYS, HAP and their respective member hospitals. Each of the hospital associations has been forced to devote significant time and money to respond to the new rule, thereby diverting resources from its educational activities.

90. On June 19, 2013, the AHA submitted comments to CMS in response to the IPPS Proposed Rule. The AHA submitted the letter on behalf of its members nationwide, including the Plaintiff hospitals. It explained its opposition to the IPPS Proposed Rule and expressed disappointment that CMS believed the 0.2 percent reduction to be appropriate. Letter from Rick Pollack, AHA, to Marilyn Tavenner, CMS Administrator, *Comments on IPPS Proposed Rule* (June 19, 2013), http://www.noticeandcomment.com/CMS-2013-0084-0152-fcod-366412.aspx.

91. Despite the objections raised by the AHA and many other hospitals and hospital associations that are harmed by the policy, including many of the Plaintiffs in this case, CMS adopted the 0.2 Percent Payment Cut.

COUNT I

VIOLATION OF ADMINISTRATIVE PROCEDURE ACT
The CMS Policy Is Arbitrary and Capricious Because CMS Relied on Indefensible Assumptions

92. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

93. The APA prohibits Defendant from implementing the Medicare Act via actions, findings, or conclusions that are arbitrary and capricious. 5 U.S.C. § 706(2)(A).

94. The 0.2 Percent Payment Cut is arbitrary and capricious because CMS relied on indefensible assumptions in adopting the policy.

95. CMS undercounted the volume of cases that would shift from inpatient to outpatient status.

96. CMS overestimated the number of cases that would shift from outpatient to inpatient status.

97. CMS's faulty assumptions render the 0.2 Percent Payment Cut arbitrary and capricious and thus invalid under the APA.

COUNT II

VIOLATION OF ADMINISTRATIVE PROCEDURE ACT
The CMS Policy Is Arbitrary and Capricious Because CMS Failed to Explain Its Assumptions

98. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

99. The APA prohibits Defendant from implementing the Medicare Act via actions, findings, or conclusions that are arbitrary and capricious. 5 U.S.C. § 706(2)(A).

100. The 0.2 Percent Payment Cut is arbitrary and capricious because CMS did not explain the assumptions and methodology used in its actuaries' assumptions.

101. This failure to provide any explanation is a classic APA violation.

102. CMS's unexplained analysis renders the 0.2 Percent Payment Cut arbitrary and capricious and thus invalid under the APA.

COUNT III

VIOLATION OF ADMINISTRATIVE PROCEDURE ACT
CMS Failed to Comply with the Notice and Comment Procedure

103. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

104. The APA prohibits Defendant from implementing the Medicare Act via actions, findings, or conclusions accomplished without observing the procedures required by law. 5 U.S.C. § 706(2)(A).

105. The APA requires agencies to afford notice of a proposed rulemaking and an opportunity for public comment prior to a rule's promulgation, amendment, modification, or repeal. *Id.* § 553.

106. CMS's failure to include sufficient detail in the IPPS Proposed Rule precluded hospitals from engaging in any meaningful notice and comment process.

107. CMS's failure to do so violates the APA.

108. This constitutes an independent reason why the 0.2 Percent Payment Cut is unlawful and must be set aside.

COUNT IV

VIOLATION OF ADMINISTRATIVE PROCEDURE ACT
The CMS Policy Is Not Codified in the Code of Federal Regulations

109. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

110. The APA prohibits Defendant from implementing the Medicare Act via actions, findings, or conclusions accomplished without observing the procedures required by law. 5 U.S.C. § 706(2)(A).

111. The Medicare Act requires that all rules, requirements, and statements of policy that establish or change a substantive legal standard governing the scope of benefits or payment for services be promulgated via regulation. 42 U.S.C. § 1395hh(a).

112. The Medicare Act further specifies that any time the Secretary makes "such other exceptions and adjustments" to the prospective payment amounts paid to most hospitals, including Plaintiffs, for inpatient care, she "shall" do so "by regulation." *Id.* § 1395ww(d)(5)(I)(i).

113. The 0.2 Percent Payment Cut changes the scope of payment for services under the Medicare Act and is an adjustment to payment amounts.

114. CMS did not promulgate the 0.2 Percent Payment Cut as a regulation and therefore its action is without observance of procedure required by law.

115. The 0.2 Percent Payment Cut would be invalid even if promulgated as a regulation because it is arbitrary and capricious and was adopted without the notice and comment procedure required by the APA. The failure to promulgate the 0.2 Percent Payment Cut as a regulation nonetheless constitutes an additional, independent reason why the policy cannot stand.

COUNT V

VIOLATION OF THE MEDICARE ACT
The CMS Policy Is Not Codified in the Code of Federal Regulations

116. Plaintiffs reassert and incorporate by reference each of the above paragraphs.

117. CMS's failure to promulgate the 0.2 Percent Payment Cut as a regulation also violates the Medicare Act, for the reasons set forth in Count IV.

118. The Medicare Act requires that all rules, requirements, and statements of policy that establish or change a substantive legal standard governing the scope of benefits or payment for services be promulgated via regulation. 42 U.S.C. § 1395hh(a).

119. The Medicare Act further specifies that any time the Secretary makes "such other exceptions and adjustments" to the prospective payment amounts paid to most hospitals, including Plaintiffs, for inpatient care, she "shall" do so "by regulation." *Id.* § 1395ww(d)(5)(I)(i).

120. The 0.2 Percent Payment Cut changes the scope of payment for services under the Medicare Act and is an adjustment to payment amounts.

121. Defendant did not promulgate the 0.2 Percent Payment Cut as a regulation.

122. Defendant's failure to do so violates the Medicare Act. This constitutes an additional, independent reason why the policy cannot stand.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court issue judgment in their favor and against Defendant and issue the following relief:

A. A declaratory judgment that the 0.2 Percent Payment Cut is arbitrary and capricious and thus violates the APA;

B. A declaratory judgment that the 0.2 Percent Payment Cut is invalid because CMS failed to comply with the notice and comment procedure required by the APA;

C. A declaratory judgment that the 0.2 Percent Payment Cut is invalid under the APA for failure to codify the policy in the Code of Federal Regulations;

D. A declaratory judgment that the 0.2 Percent Payment Cut is invalid under the Medicare Act for failure to codify the policy in the Code of Federal Regulations;

E. An order vacating or setting aside the 0.2 Percent Payment Policy;

F. An order that Plaintiff hospitals be reimbursed for the flow-through effects of eliminating the 0.2 Percent Payment Cut for Medicare discharges occurring on or after October 1, 2013;

G. An award of such other temporary and permanent relief as this Court may deem just and proper.

Dated: April 14, 2014

Respectfully submitted,

/s/ Sheree R. Kanner

Sheree R. Kanner (D.C. Bar No. 366926)
Dominic F. Perella* (D.C. Bar No. 976381)
Margia K. Corner (D.C. Bar No. 1005246)
Jennifer D. Brechbill (D.C. Bar No. 1011454)

HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5600

Melinda Reid Hatton (D.C. Bar No. 419421)
Lawrence Hughes (D.C. Bar. No. 460627)
AMERICAN HOSPITAL ASSOCIATION
325 Seventh Street, NW
Washington, DC 20001
(202) 638-1100

**Counsel of record*