UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CATHOLIC HEALTH INITIATIVES COLORADO d/b/a
CENTURA HEALTH – PENROSE – ST. FRANCIS
HEALTH SERVICES
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Englewood, CO 80112

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Philadelphia, PA 19141

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d/b/a ALEGENER HEALTH BERGAN MERCY
MEDICAL CENTER
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Omaha, NE 68154

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Pittsfield, MA 01201

BETH ISRAEL DEACONESS MEDICAL CENTER, INC.
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STEWARD HOLY FAMILY HOSPITAL, INC. d/b/a
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f/k/a PARK PLACE MEDICAL CENTER, LP
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VALDESE GENERAL HOSPITAL, INC.
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Plaintiffs,

v.

KATHLEEN SEBELIUS, Secretary
United States Department of
Health and Human Services,
200 Independence Avenue, S.W.
Washington, D.C. 20201,

Defendant.

COMPLAINT FOR EXPEDITED JUDICIAL REVIEW UNDER THE MEDICARE ACT

NATURE OF ACTION

1. This is an action for expedited judicial review, pursuant to section 1395oo(f)(1) of the Medicare Act, of a determination of the Secretary of the Department of Health and Human Services ("Secretary" or "HHS") concerning the disproportionate share hospital ("DSH") payments owed to the plaintiff hospitals for the costs they incurred to treat low-income patients in fiscal years ending in 1991-2004.

2. Each of the plaintiff hospitals filed appeals with the Secretary's review board challenging the Secretary's payment determinations for the fiscal years at issue on the ground that errors and omissions in HHS' calculation of one component of the DSH payment formula
wrongfully reduced the resulting DSH payments made to the hospitals for the 1991-2004 fiscal years at issue. In 2008, while those appeals were pending, this Court issued a memorandum opinion and order finding that several systemic errors and omissions in HHS’s calculation of that component of the DSH payment formula tended to systematically reduce and understate the resulting DSH payments to hospitals. *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, amended by 587 F. Supp. 2d 37 (D.D.C. 2008). The Court required the Secretary to revise HHS’s calculations and pay the hospital the additional DSH payments due as a result of those corrections. The Secretary did not appeal that decision.

3. Two years later, in 2010, HHS issued a ruling, Ruling 1498-R, acquiescing in the *Baystate* decision. Ruling 1498-R required HHS to make the corrections required under the *Baystate* decision with respect to all pending appeals on this issue, including the periods at issue in this case. At the same time, however, Ruling 1498-R attempted unilaterally to impose offsetting penalties that would dilute the favorable impact of the *Baystate* corrections on the revised DSH payments made under the Ruling. The offsetting penalties would be applied under Ruling 1498-R through its retroactive application of new policies that were not in effect during the earlier periods at issue.

4. Both this Court and the Court of Appeals have recently issued decisions invalidating the Secretary’s retroactive application of her new policies in the calculation of the DSH payment. *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 13-17 (D.C. Cir. 2011); *Catholic Health Initiatives - Iowa, Corp. v. Sebelius*, No. 10-411, 2012 WL 255275 at *7-12 (D.D.C. Jan. 30, 2012), *appeal docketed*, No. 12-5092 (D. C. Cir. Apr. 5, 2012). Following the decisions in *Northeast* and *Catholic Health Initiatives*, it is established that the provisions of Ruling 1498-R that would retroactively apply the new payment policies are invalid. Accordingly, for that reason
and the additional reasons set forth below, the plaintiff hospitals request an order declaring invalid and setting aside the portions of Ruling 1498-R that seek wrongfully to apply new payment policies retroactively in the calculation of revised DSH payments for the 1991-2004 fiscal years at issue.

5. HHS improperly denied the plaintiff hospitals a substantial part of the DSH payments properly due them for services furnished to Medicare beneficiaries in the fiscal years at issue. The plaintiff hospitals filed appeals of the Secretary’s disallowance with the Secretary’s Board. In April 2010, the Acting Administrator of the Secretary’s agency issued a directive in Ruling 1498-R that unilaterally and arbitrarily declared plaintiffs’ long-pending appeals moot. Ruling 1498-R purports to acquiesce in this Court’s 2008 decision in Baystate Medical Center, which required the Secretary to correct numerous errors and omissions in her calculation of the Medicare DSH payment. At the same time, Ruling 1498-R directs the Secretary’s review board to remand the hospitals’ appeals to the Secretary’s audit contractors so that they can recalculate the hospitals’ DSH payments by not only making the corrections required by Baystate but by also applying new payment policies retroactively to periods when those policies were not in effect. These additional aspects of the Ruling contradict the Secretary’s express representations to this Court in Baystate and are otherwise invalid for the reasons recently decided in Northeast Hospital and Catholic Health Initiatives.

6. HHS rulings, like Ruling 1498-R, are published under the authority of the Administrator of a component of HHS, the Centers for Medicare & Medicaid Services (“CMS”), By regulation, these Rulings are made “binding on all CMS components” and “on all HHS components that adjudicate matters under the jurisdiction of CMS.” 42 C.F.R. § 401.108. Unlike a regulation, however, HHS rulings are not issued through notice and comment
rulemaking and do not have the force and effect of law. Accordingly, a ruling that violates a statute or a regulation that has been issued through notice and comment rulemaking is invalid.

7. The recalculation required by Ruling 1498-R would not resolve the hospitals’ claim or redress their claimed injury in this case. The recalculation would not be performed under Ruling 1498-R in the way the hospitals contend the DSH payment should be calculated. The hospitals’ calculation would increase the DSH payments previously made to them for the fiscal years at issue. The recalculation required under Ruling 1498-R could reduce the DSH payments previously made to the hospitals and require the hospitals to repay to the Secretary amounts previously paid to them for the periods at issue.

8. Two fractions are used to calculate the Medicare DSH payment at issue: the “Medicaid fraction” and the “Medicare Part A/SSI fraction.” The fractions are intended to measure the proportion of a hospital’s patients who are low-income and, therefore, more costly to treat. The statute, see 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I)-(II), defines the two fractions as follows:

<table>
<thead>
<tr>
<th>Patient Days For A Hospital Cost Reporting Period</th>
<th>Medicare Part A/SSI Fraction subclause (I)</th>
<th>Medicaid Fraction subclause (II)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>“entitled to benefits under [Medicare] part A” and “entitled to supplemental security income benefits”</td>
<td>“eligible for [Medicaid]” and “not entitled to benefits under [Medicare] part A”</td>
</tr>
<tr>
<td>Denominator</td>
<td>“entitled to benefits under part A”</td>
<td>“total number of the hospital’s patient days”</td>
</tr>
</tbody>
</table>

9. The hospitals contend that days for patients who were enrolled in Medicare part A, but who were not entitled to have part A benefits paid for those days must be excluded from
the Medicare Part A/SSI fraction and should be included in the numerator of the Medicaid fraction when the patient was eligible for Medicaid. These patient days would include (i) the days for Medicare beneficiaries who had exhausted their benefits under part A ("part A exhausted days"), (2) the days for Medicare beneficiaries that were paid by another payer who had primary liability ("Medicare secondary payer days"), and (3) Medicare beneficiary days that were otherwise not covered and paid by Medicare part A ("noncovered days").

10. Through the Ruling at issue here, HHS would add all part A exhausted days, Medicare secondary payer days, and noncovered days to the denominator of the Medicare Part A/SSI fraction for periods before an October 2004 policy change, when the Secretary determined to start counting these days in the Medicare Part A/SSI fraction after October 1, 2004. To the extent that those patients were receiving supplemental security income payments on the days they were hospitalized, the patients would be included in the numerator of the Medicare Part A/SSI fraction. Most Medicare secondary payer and noncovered days, as well as many part A exhausted days, are incurred by people who do not meet the requirements for supplemental security income payments. Therefore, the inclusion of these patients in the Medicare Part A/SSI fraction would almost always reduce that fraction and therefore reduce the DSH payments to the hospitals.

11. The hospitals also contend that days for patients who were enrolled in a Medicare+Choice or Medicare Advantage plan under part C of the Medicare Act ("Medicare part C days") must be excluded from the Medicare Part A/SSI fraction. Ruling 1498-R indicates that the Secretary would add Medicare part C days to the Medicare Part A/SSI fraction on remand, at least for periods on or after October 1, 2004. Medicare part C days were not previously counted.
in the Medicare Part A/SSI fraction for any period prior to 2007, except for a miniscule number that were counted due to an editing error by a CMS employee.

12. The resolution of this dispute will either require the Secretary to make additional DSH payments to hospitals, if the hospitals prevail on their claims, or will require some hospitals to repay a portion of the DSH payments they previously received from the Secretary, if the Secretary’s current position is accepted. For periods prior to October 1, 2004, the hospitals’ DSH payments would be reduced because the addition of (1) part A exhausted, (2) Medicare secondary payer and (3) noncovered days to the Medicare Part A/SSI fraction, where those days were not previously included, would in almost all cases dilute that fraction. Part A exhausted, Medicare secondary payer and noncovered days were already included in hospitals’ Medicare Part A/SSI fractions for federal fiscal years beginning on or after October 1, 2004; thus, the Ruling only applies to these types of days for periods prior to October 1, 2004. Similarly, for periods on or after October 1, 2004, the inclusion of Medicare part C days in the Medicare Part A/SSI fraction where they were not previously included would in almost all cases dilute that fraction.

13. Ruling 1498-R imposes new substantive payment standards retroactively and in violation of the plain meaning of the statute with no more process than the “signing of the pen” (in the words of the Secretary’s counsel in a related case challenging the Ruling). In *Northeast Hospital Corp. v. Sebelius*, the Court of Appeals held that the Secretary’s current position, requiring Medicare part C days to be counted in the Medicare Part A/SSI fraction, cannot be applied to periods that began before the Secretary adopted a change in policy in October 2004. *Northeast Hospital Corp.*, 657 F.3d at 13-17. The Court’s ruling on Medicare part C days is equally applicable to part A exhausted, Medicare secondary payer and noncovered days. Indeed,
in January 2012, this Court issued a decision in Catholic Health Initiatives holding that the Secretary’s current position, requiring part A exhausted and MSP days to be counted in the Medicare part A/SSI fraction, cannot be applied retroactively to periods prior to the Secretary’s change in policy. See Catholic Health Initiatives, 2012 WL 255275, at *7-12. As with Medicare part C days, under the Ruling, the Secretary is attempting to apply her current position with respect to these other types of days retroactively to periods that began before October 2004.

14. Ruling 1498-R’s ostensible purpose is to comply with this Court’s 2008 decision in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20. The Ruling, however, does not comply with that decision. The Baystate decision requires the Secretary to correct several systemic errors in her agency’s calculation of the DSH payment, which tended universally to produce “potentially enormous” underpayments to hospitals that treat low-income patients. The parts of Ruling 1498-R at issue here conflict with the express representations made to this Court by the Secretary in Baystate regarding how the DSH payment should be calculated for the periods at issue and with how the Secretary actually recalculated Baystate’s Medicare Part A/SSI fractions in 2009 on remand. Ruling 1498-R, if allowed to stand, will offset additional DSH payments that the hospitals should receive as a result of the corrections required by the Baystate decision. Thus, Ruling 1498-R’s ostensible acquiescence in the Baystate decision is not acquiescence at all. Rather, it is an attempt to do what the Secretary could not convince the Court in Baystate to do. It negates the Baystate decision with the stroke of a pen.

15. The provisions of Ruling 1498-R at issue here also conflict with the plain language of the statute governing the calculation of the DSH payment, 42 U.S.C. § 1395ww(d)(5)(F)(vi). As shown below, the Ruling not only violates the plain meaning of the DSH statute but is also inconsistent with the DSH regulation and the Secretary’s interpretation of
the regulation that was in effect for the periods at issue here. It also violates the appeal provisions of the Social Security Act as well as the rulemaking requirements in the Social Security Act and Administrative Procedure Act.

16. Considering itself bound by Ruling 1498-R, notwithstanding that Ruling’s obvious legal infirmities, the Secretary’s review board granted the hospitals’ request for expedited judicial review of the provisions of the Ruling that would apply to the appeals at issue. Consistent with case law from this Circuit as well as the Supreme Court, the Secretary’s board concluded that its decision to grant expedited judicial review of the contested provisions of Ruling 1498-R is a proper exercise of the tribunal’s inherent jurisdiction to determine its own jurisdiction because expedited judicial review of the Ruling maintains the status quo in the appeals pending before the Board while this Court reviews the validity of the contested provisions of the Ruling.

17. Plaintiffs bring this action pursuant to the Board’s decision granting expedited judicial review of the Ruling. The plaintiff hospitals respectfully request, for the reasons set forth below, that this Court set aside the provisions of the Ruling that declare the hospitals’ appeals to the Secretary’s board moot and that require the board to remand the appeals to the Secretary’s contractors for recalculation of the hospitals’ DSH payments. By requiring recalculation of the DSH payments for the fiscal years at issue under the Ruling, the Secretary would offset the positive impact of the correction of the errors and omissions found by this Court in Baystate with a penalty that would result in the Secretary recouping DSH payments previously made to hospitals.

18. It thus appears that the Administrator of the Secretary’s agency would force the hospitals through the Ruling into a Hobson’s choice: (1) move to dismiss their appeals on this
aspect of the DSH payment calculation before they are remanded for recalculation or (2) run the risk of incurring unknown liabilities for recoupments of DSH payments previously made to them on remand pursuant to the Ruling. Recoupments would arise from the retroactive application of new payment policies established in the Ruling, contrary to the DSH statute and to the Secretary’s representation to this Court in *Baystate*. See *Northeast Hosp.*, 657 F.3d at 13-17 (prohibiting the Secretary from retroactively applying the 2004 rule requiring inclusion of Medicare part C days in the Medicare Part A/SSI fraction to periods beginning prior to the October 1, 2004 effective date of that rule); *Catholic Health Initiatives*, 2012 WL 255275, at *7-12 (prohibiting Secretary from retroactively applying 2004 rule requiring inclusion of part A exhausted and MSP days in the Medicare part A/SSI fraction to periods prior to the Secretary’s change in policy. But, by dismissing their appeals to avoid the risk of recoupment on remand, the hospitals would forever forfeit their long-pending claims for additional DSH payments, above the amounts previously paid to the hospitals for the fiscal years at issue, and calculated in accordance with the plain meaning of the DSH statute. The law, elementary principles of due process, and notions of fundamental fairness compel the conclusion that the contested provisions of the Ruling must be set aside.

**JURISDICTION AND VENUE**


**PARTIES**

22. The plaintiffs in this action are:

2. Alegent Health – Bergan Mercy Health System d/b/a Alegent Health Bergan Mercy Medical Center, Medicare Provider No. 28-0060, fiscal year ending June 30, 2003;

3. Alegent Health – Bergan Mercy Health System d/b/a Alegent Health Mercy Hospital, Council Bluffs, Iowa, Medicare Provider No. 16-0028, fiscal years ending June 30, 2000, June 30, 2001, June 30, 2002 and June 30, 2003;


5. Allegheny General Hospital, Medicare Provider No. 39-0050, fiscal year ending June 30, 2004;

6. Alle-Kiski Medical Center d/b/a Allegheny Valley Hospital, Medicare Provider No. 39-0032, fiscal year ending June 30, 2004;


8. Banner Health d/b/a Banner Mesa Medical Center, Medicare Provider No. 03-0018, fiscal years ending December 31, 2000 and December 31, 2001;

9. Banner Health d/b/a Banner Desert Medical Center, Medicare Provider No. 03-0065, fiscal years ending December 31, 2000 and December 31, 2001;


11. Banner Health d/b/a Banner Thunderbird Medical Center, Medicare Provider No. 03-0089, fiscal year ending December 31, 2001;

12. Baystate Franklin Medical Center, Medicare Provider No. 22-0016, fiscal year ending September 30, 2004;

13. Baystate Mary Lane Hospital Corporation, Medicare Provider No. 22-0050, fiscal year ending September 30, 2004;


17. Bon Secours - St. Francis Xavier Hospital, Inc. d/b/a Bon Secours St. Francis Hospital, Medicare Provider No. 42-0065, fiscal years ending December 31, 2001, December 31, 2002 and December 31, 2003;


19. Boston Medical Center Corporation f/d/b/a Boston City Hospital, Medicare Provider No. 22-0104, fiscal years ending September 30, 1997 and September 30, 1998;


22. Carilion Medical Center d/b/a Carilion Roanoke Memorial Hospital, Medicare Provider No. 49-0024, fiscal years ending September 30, 1992, September 30, 1993, September 30, 1994 and September 30, 2000;

23. Carilion Medical Center f/d/b/a Community Hospital of Roanoke Valley, Medicare Provider No. 49-0100, fiscal years ending September 30, 1992, September 30, 1993 and September 30, 1994;

24. Catholic Health Initiatives - Iowa, Corp. d/b/a Mercy Medical Center - Des Moines, Medicare Provider No. 16-0083, fiscal years ending June 30,

25. Catholic Health Initiatives Colorado d/b/a Centura Health – Penrose – St. Francis Health Services, Medicare Provider No. 06-0031, fiscal years ending June 30, 2002 and June 30, 2003;


29. Catholic Health Initiatives Colorado d/b/a Mercy Regional Medical Center, Medicare Provider No. 06-0013, fiscal years ending June 30, 2002 and June 30, 2003;

30. Catholic Health Initiatives Colorado d/b/a St. Thomas More Hospital, Medicare Provider No. 06-0016, fiscal years ending June 30, 2001, June 30, 2002 and June 30, 2003;


32. Catholic Health Initiatives, successor in interest to St. Joseph Medical Center, Medicare Provider No. 32-0009, fiscal years ending June 30, 1997, June 30, 2000, June 30, 2001 and August 31, 2002;


34. Charleston Area Medical Center, Inc., Medicare Provider No. 51-0022, fiscal years ending December 31, 2001 and December 31, 2003;

35. CHRISTUS Health Ark-La-Tex d/b/a CHRISTUS St. Michael Health System, Medicare Provider No. 45-0801, fiscal year ending June 30, 2003;
36. CHRISTUS Health Northern Louisiana d/b/a CHRISTUS Schumpert Health System, Medicare Provider No. 19-0041, fiscal year ending June 30, 2003;

37. CHRISTUS Santa Rosa Health Care Corporation d/b/a CHRISTUS Santa Rosa Hospital - Medical Center, Medicare Provider No. 45-0237, fiscal year ending June 30, 2003;

38. CHRISTUS Spohn Health System Corporation d/b/a CHRISTUS Spohn Memorial Hospital, Medicare Provider No. 45-0046, fiscal year ending June 30, 2003;

39. CHRISTUS St. Joseph’s Health System d/b/a CHRISTUS St. Joseph’s Medical Center, Medicare Provider No. 45-0196, fiscal year ending June 30, 2003;

40. Citrus Valley Medical Center, Inc. d/b/a Citrus Valley Medical Center - Inter-Community Campus, Medicare Provider No. 05-0382, fiscal years ending June 30, 1992 and December 31, 1994;

41. Citrus Valley Medical Center, Inc. d/b/a Citrus Valley Medical Center - Queen of the Valley Campus, Medicare Provider No. 05-0369, fiscal year ending December 31, 1994;

42. City of Haverhill f/d/b/a Hale Hospital, Medicare Provider No. 22-0041, fiscal years ending June 30, 1997, June 30, 1998 and June 30, 1999;

43. Cleveland County HealthCare System d/b/a Cleveland Regional Medical Center, Medicare Provider No. 34-0021, fiscal years ending December 31, 2000 and December 31, 2001;


45. Crozer-Chester Medical Center, Medicare Provider No. 39-0180, fiscal years ending June 30, 2001, June 30, 2002 and June 30, 2003;

46. Davis Hospital and Medical Center, Medicare Provider No. 46-0041, fiscal year ending March 31, 2001;

47. Delaware County Memorial Hospital, Medicare Provider No. 39-0081, fiscal year ending June 30, 2003;

48. East Carolina Health-Heritage, Inc. d/b/a Heritage Hospital, Medicare Provider No. 34-0107, fiscal year ending September 30, 2002;
49. Essent Healthcare of Massachusetts, Inc. f/d/b/a Merrimack Valley Hospital, Medicare Provider No. 22-0174, fiscal year ending September 30, 2002;

50. Fairview Hospital, Medicare Provider No. 22-0038, fiscal years ending September 30, 2001 and September 30, 2002;

51. Florida Health Sciences Center Inc dba Tampa General Hospital, Medicare Provider No. 10-0128, fiscal year ending September 30, 2002;

52. Fort Sanders Regional Medical Center, Medicare Provider No. 44-0125, fiscal years ending December 31, 2002 and December 31, 2003;

53. Franciscan Health System f/k/a Franciscan Health System – West d/b/a St. Clare Hospital, Medicare Provider No. 50-0021, fiscal years ending June 30, 1998, June 30, 2001 and June 30, 2003;

54. Franciscan Health System f/k/a Franciscan Health System – West d/b/a St. Francis Community Hospital, Medicare Provider No. 50-0141, fiscal years ending June 30, 1998, June 30, 2000, June 30, 2001, June 30, 2002 and June 30, 2003;


56. Good Samaritan Hospital, Medicare Provider No. 36-0052, fiscal years ending December 31, 1997, December 31, 2001, December 31, 2002 and December 31, 2003;

57. Good Samaritan Hospital, Kearney, Nebraska, Medicare Provider No. 28-0009, fiscal year ending June 30, 2002;

58. Grace Hospital, Inc. d/b/a Grace Hospital, Medicare Provider No. 34-0075, fiscal years ending December 31, 1999, December 31, 2000, December 31, 2001 and December 31, 2002;


61. Hallmark Health System, Inc. f/d/b/a Malden Hospital, Medicare Provider No. 22-0092, fiscal years ending September 30, 1996, September 30, 1997 and September 30, 1998;


65. HealthOne d/b/a The Colorado Health Foundation, successor in interest to Presbyterian St. Luke's Medical Center, Medicare Provider No. 06-0014, fiscal year ending October 31, 1995;

66. Holy Redeemer Health System, Medicare Provider No. 39-0097, fiscal year ending June 30, 2003;


68. Jefferson Health System d/b/a Thomas Jefferson University Hospital, Medicare Provider No. 39-0174, fiscal years ending June 30, 2002, June 30, 2003 and June 30, 2004;

69. Jewish Hospital & St. Mary's HealthCare, Inc. d/b/a Jewish Hospital, Medicare Provider No. 18-0040, fiscal years ending December 31, 1996, December 31, 2000, December 31, 2001 and December 31, 2003;

70. Jewish Hospital & St. Mary's Healthcare, Inc., successor in interest to Caritas Medical Center, Medicare Provider No. 18-0037, fiscal years ending June 30, 2001, June 30, 2002 and June 30, 2003;

72. Jordan Valley Hospital Holdings, Inc., successor in interest to Pioneer Valley Hospital, Inc., Medicare Provider No. 46-0008, fiscal year ending March 31, 2001;

73. Lake Cumberland Regional Hospital, LLC, Medicare Provider No. 18-0132, fiscal year ending December 31, 1999;


77. Magee-Womens Hospital of UPMC, Medicare Provider No. 39-0114, fiscal year ending June 30, 2004;


79. Memorial Hospital, Medicare Provider No. 39-0101, fiscal year ending June 30, 2003;

80. Memorial Hospital of Tampa, LP, Medicare Provider No. 10-0206, fiscal year ending November 30, 2001;

81. Mercy Hospital, Inc. d/b/a Carolinas Medical Center - Mercy, Medicare Provider No. 34-0098, fiscal years ending December 31, 2000 and December 31, 2001;

82. Mesa General Hospital, LP, Medicare Provider No. 03-0017, fiscal year ending September 30, 2001;

83. Mississippi Baptist Medical Center, Inc., Medicare Provider No. 25-0102, fiscal years ending August 31, 1999 and August 31, 2001;

84. Montgomery Hospital, Medicare Provider No. 39-0108, fiscal years ending June 30, 1999 and June 30, 2003;

86. New England Deaconess Hospital Corporation, Medicare Provider No. 22-0118, fiscal years ending September 30, 1995 and September 30, 1996;

87. Newport Hospital, Medicare Provider No. 41-0006, fiscal year ending September 30, 2002;


89. North Broward Hospital District d/b/a North Broward Medical Center, Medicare Provider No. 10-0086, fiscal year ending June 30, 1995;

90. North Philadelphia Health System d/b/a St. Joseph Hospital, Medicare Provider No. 39-0132, fiscal year ending June 30, 2003;

91. North Shore Medical Center, Inc. f/d/b/a Union Hospital, Medicare Provider No. 22-0035, fiscal year ending September 30, 1997;

92. North Shore Medical Center, Inc. f/k/a The Salem Hospital, Medicare Provider No. 22-0006, fiscal year ending September 30, 1997;

93. Northeast Hospital Corporation d/b/a Beverly Hospital, Medicare Provider No. 22-0033, fiscal years ending September 30, 2000, September 30, 2001 and September 30, 2002;

94. Oconee Regional Medical Center, Inc., Medicare Provider No. 11-0150, fiscal years ending September 30, 2000 and September 30, 2001;

95. Parkwest Medical Center, Medicare Provider No. 44-0173, fiscal year ending August 31, 2003;

96. Pitt County Memorial Hospital, Incorporated, Medicare Provider No. 34-0040, fiscal years ending September 30, 1999, September 30, 2000, September 30, 2001 and September 30, 2002;


98. Rhode Island Hospital, Medicare Provider No. 41-0007, fiscal years ending September 30, 1996, September 30, 1997, September 30, 1998,
99. Rockford Health System d/b/a Rockford Memorial Hospital, Medicare Provider No. 14-0239, fiscal years ending December 31, 2002 and December 31, 2003;

100. Roger Williams Medical Center, Medicare Provider No. 41-0004, fiscal years ending September 30, 1997, September 30, 1999, September 30, 2000 and September 30, 2001;


102. Roper Hospital North, Inc., Medicare Provider No. 42-0088, fiscal year ending December 31, 2000;

103. Sacred Heart Hospital of Allentown d/b/a Sacred Heart Hospital, Medicare Provider No. 39-0197, fiscal years ending June 30, 1997 and June 30, 2003;


106. Saint Francis Medical Center, Medicare Provider No. 28-0023, fiscal year ending June 30, 2002;


111. Santa Barbara Cottage Hospital, Medicare Provider No. 05-0396, fiscal years ending December 31, 1998, December 31, 1999, December 31, 2000, December 31, 2001 and December 31, 2002;

112. Shands Medical Center, Inc. d/b/a Shands Jacksonville, Medicare Provider No. 10-0001, fiscal years ending June 30, 2000, June 30, 2001 and June 30, 2002;


117. Southcoast Hospitals Group, Inc. d/b/a Charlton Memorial Hospital, Medicare Provider No. 22-0055, fiscal years ending September 30, 1996 and September 30, 1997;

118. Southcoast Hospitals Group, Inc. d/b/a St. Luke's Hospital, Medicare Provider No. 22-0021, fiscal year ending September 30, 1996;

119. Southwest General Hospital Limited Partnership, Medicare Provider No. 45-0697, fiscal year ending September 30, 2001;


123. St. Joseph Regional Health Network d/b/a St. Joseph Medical Center, Medicare Provider No. 39-0158, fiscal years ending June 30, 1996 and March 31, 1997;

124. St. Luke's Medical Center, LP, Medicare Provider No. 03-0037, fiscal year ending May 31, 2001;

125. St. Luke's Medical Center, LP f/d/b/a Tempe St. Luke's Hospital, Medicare Provider No. 03-0019, fiscal year ending May 31, 2001;


127. St. Vincent Infirmary Medical Center d/b/a St. Vincent Medical Center-North, Medicare Provider No. 04-0137, fiscal year ending June 30, 2002;


130. Steward Health Care System LLC f/d/b/a Southwood Hospital, Medicare Provider No. 22-0079, fiscal years ending September 30, 1997, November 29, 1997 and September 30, 1999;


135. The Chambersburg Hospital, Medicare Provider No. 39-0151, fiscal year ending June 30, 2002;

136. The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center, Medicare Provider No. 34-0113, fiscal years ending December 31, 1998, December 31, 1999, December 31, 2001 and December 31, 2002;

137. The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center - Lincoln, Medicare Provider No. 34-0145, fiscal year ending September 30, 2002;

138. The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Medical Center - University, Medicare Provider No. 34-0166, fiscal years ending December 31, 2001 and December 31, 2002;


140. The Good Samaritan Hospital of Cincinnati, Ohio d/b/a Good Samaritan Medical Center, Medicare Provider No. 36-0134, fiscal years ending June 30, 1998, June 30, 2000, June 30, 2001, June 30, 2002 and June 30, 2003;


142. The Medical Center of Southeast Texas, LP f/k/a Mid-Jefferson Hospital, LP, Medicare Provider No. 45-0514, fiscal year ending September 30, 2001;

143. The Medical Center of Southeast Texas, LP f/k/a Park Place Medical Center, LP, Medicare Provider No. 45-0518, fiscal year ending September 30, 2001;

144. The Memorial Hospital d/b/a Memorial Hospital of Rhode Island, Medicare Provider No. 41-0001, fiscal years ending September 30, 1999, September 30, 2000 and September 30, 2001;

145. The Miriam Hospital, Medicare Provider No. 41-0012, fiscal years ending September 30, 1999, September 30, 2001 and September 30, 2002;
146. The Western Pennsylvania Hospital, Medicare Provider No. 39-0090, fiscal year ending June 30, 2004;

147. Town & Country Hospital, LP, Medicare Provider No. 10-0255, fiscal year ending December 31, 2001;

148. Trustees of Mease Hospital, Inc. d/b/a Mease Dunedin Hospital, Medicare Provider No. 10-0043, fiscal year ending September 30, 2003;


150. UMass Memorial Health Care, Inc. f/d/b/a UMass Memorial Hospital, Medicare Provider No. 22-0057, fiscal years ending March 31, 1998, September 30, 1998 and September 30, 1999;

151. UMass Memorial Health Care, Inc., d/b/a Marlborough Hospital, Medicare Provider No. 22-0049, fiscal year ending September 30, 2002;


153. Union Memorial Regional Medical Center, Inc. d/b/a Carolinas Medical Center - Union, Medicare Provider No. 34-0130, fiscal years ending December 31, 1999 and December 31, 2000;

154. Unity Family Healthcare d/b/a St. Gabriel's Hospital, Medicare Provider No. 24-0013, fiscal years ending June 30, 2002 and June 30, 2003;

155. UPMC Braddock, Medicare Provider No. 39-0128, fiscal years ending November 30, 1996 and June 30, 2004;

156. UPMC Horizon, Medicare Provider No. 39-0178, fiscal year ending June 30, 2004;

157. UPMC Lee, Medicare Provider No. 39-0011, fiscal year ending June 30, 2004;

159. UPMC Mercy f/k/a UPMC South Side, Medicare Provider No. 39-0131, fiscal year ending June 30, 2004;

160. UPMC Northwest, Medicare Provider No. 39-0091, fiscal year ending June 30, 2004;


162. UPMC Presbyterian Shadyside f/k/a UPMC Shadyside, Medicare Provider No. 39-0055, fiscal years ending June 30, 1999, June 30, 2000, June 30, 2001, June 30, 2002 and May 30, 2003; and


23. The defendant is Kathleen Sebelius in her official capacity as Secretary of the United States Department of Health and Human Services ("HHS"), the federal agency that administers the Medicare program. References to the Secretary herein are meant to refer to her, her subordinates, and her official predecessors or successors as the context requires.

24. The Centers for Medicare and Medicaid Services ("CMS") is a component of HHS with responsibility for day-to-day operation and administration of the Medicare program. At some times relevant to this case, CMS was known as the Health Care Financing Administration ("HCFA"). References to CMS herein are meant to refer to the agency and its predecessors.

**MEDICARE REOPENING AND APPEALS PROCESSES**

25. The Secretary contracts with private organizations (usually insurance companies) to perform certain audit and payment functions under part A of the Medicare program. These organizations are commonly referred to as "intermediaries" or, more recently, as "Medicare Administrative Contractors." References herein to intermediaries are meant to refer to those contractors.
26. After the close of each fiscal year, a hospital is required to file a cost report with its designated intermediary. 42 C.F.R. §§ 413.20, 413.24.

27. The intermediary analyzes the cost report and issues a determination, called a notice of program reimbursement or "NPR," that informs the hospital of the intermediary's final determination as to the amount of Medicare reimbursement due the hospital for that cost reporting period. See 42 C.F.R. § 405.1803. See also In re Medicare Reimbursement Litig., 309 F. Supp. 2d 89, 92 (D.D.C. 2004), aff'd, 414 F.3d 7 (D.C. Cir. 2005), cert. denied, 547 U.S. 1054 (2006).

28. The Medicare statute and regulations provide for a horizontal "reopening" process for review and revision of an intermediary's final payment determination for a hospital cost reporting period as well as a vertical appeals process. See In re Medicare Reimbursement Litig., 414 F.3d at 8-9.

29. An intermediary may reopen and revise a payment determination either on its own motion or upon a hospital request made within three years of the payment determination. See 42 C.F.R. § 405.1885. After three years, the intermediary's determination may not be reopened, absent a showing of fraud or similar fault. See id. § 405.1885(b)(3).

30. The Secretary's reopening regulations provide that an intermediary may not reopen its determination for a cost reporting period, and that CMS may not direct an intermediary to reopen such a determination, due to a "change of legal interpretation or policy by CMS in a regulation, CMS Ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure or practice established by CMS, whether made in response to judicial precedent or otherwise." See id. §§ 405.1885(c)(1) and (c)(2).
31. Apart from the reopening process, a hospital may appeal an intermediary’s determination in a notice of program reimbursement to the Provider Reimbursement Review Board ("PRRB" or "Board"), if the hospital is dissatisfied with the intermediary’s determination. See 42 U.S.C. § 1395oo; 42 C.F.R. §§ 405.1835 - 405.1877.

32. The Board is an administrative tribunal appointed by the Secretary. See 42 U.S.C. § 1395oo(h). The members of the Board must be "knowledgeable in the field of payment to providers of service" under the Medicare program. Id.

33. Hospitals may take appeals to the Board individually for a single cost reporting period or together in a group appeal on an issue in common to two or more hospitals and for one or more cost reporting periods. See 42 U.S.C. §§ 1395oo(a) and (b); 42 C.F.R. §§ 405.1835 and 405.1837.

34. The amount in controversy required for an individual hospital appeal to the Board is $10,000 at the time the appeal is filed. See 42 U.S.C. § 1395oo(a)(2); 42 C.F.R. §§ 405.1835(a)(2), 405.1839(a)(1)-(2) and (c)(5).

35. The amount in controversy for a group appeal to the Board is $50,000 in the aggregate for all hospitals and cost reporting periods included in the group appeal. See 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1837(a)(3), 405.1839(b) and (c)(5).

36. A "settlement or partial settlement of an issue" in an individual or group appeal to the Board "does not deprive the Board of jurisdiction" if the amount in controversy changes to an amount that is less than $10,000 for an individual hospital appeal or $50,000 for a group appeal. See 42 C.F.R. § 405.1839(c)(5).

37. The Secretary’s regulations provide that the Board is bound by "CMS Rulings." See 42 C.F.R. §§ 401.108, 405.1867. Those regulations state that CMS Rulings are "binding on
all CMS components” and “on all HHS components that adjudicate matters under the jurisdiction of CMS.” See 42 C.F.R. § 401.108.

38. In 1980, Congress amended the Medicare statute to permit a hospital to obtain expedited judicial review of a “question of law or regulations relevant to the matters in controversy” in an appeal to the Board when “the Board determines . . . that it is without authority to decide the question.” See 42 U.S.C. § 1395oo(f)(1).

39. The statute provides that a Board decision granting expedited judicial review “shall be considered a final decision and not subject to review by the Secretary.” 42 U.S.C. § 1395oo(f)(1). When the Board decides to grant expedited judicial review of a question of law or regulations, the hospital may initiate an action in this Court, within 60 days of the Board’s determination, for review of the question of law or regulations. Id.

40. The Secretary originally construed the statutory provision for expedited judicial review to mean that a Board decision granting expedited judicial review “will allow the provider to seek judicial review without any intervening Secretary’s review.” See 47 Fed. Reg. 31686, 31690-91 (July 22, 1982) (final rule with comment period).

41. In 2008, the Secretary amended her regulations on expedited judicial review to provide for review by the CMS Administrator of “the jurisdictional component” of a Board decision granting expedited judicial review. See 73 Fed. Reg. 30190, 30255, 30262 (May 23, 2008) (amending sections 405.1842 and 405.1875(a)(2)(iii) of the Secretary’s regulations).

42. In the 2008 rulemaking amending the regulations on expedited judicial review, the Secretary neither acknowledged nor explained the change in interpretation of the statute’s preclusion of review by the Secretary of a Board decision granting expedited judicial review. See 73 Fed. Reg. at 30214-15, 30228-30, 30255, 30262.
THE ENTITLEMENT TO BENEFITS UNDER MEDICARE PART A

43. The Medicare Act, in title XVIII of the Social Security Act, provides health insurance for the aged, disabled, and certain individuals with end-stage renal disease. 42 U.S.C. § 1395 et seq.


PART A EXHAUSTED, MEDICARE SECONDARY PAYER, AND NONCOVERED DAYS

45. The Medicare part A benefit for inpatient hospital services consists of the right to have Medicare payment made on a beneficiary’s behalf for a limited number of days of inpatient hospital care in a spell of illness. See 42 U.S.C. §§ 426(c), 1395d(a)(1). The Medicare part A benefit entitles an individual to have payment made on his or her behalf for 90 days of inpatient hospital services in a spell of illness, with a “lifetime reserve” of 60 additional days. See 42 U.S.C. § 1395d(a)(1); 42 C.F.R. § 409.61(a).

46. Because the Medicare part A entitlement to benefits is limited, an individual who is enrolled in Medicare part A, and is thus eligible for Medicare part A benefits, is not entitled to have Medicare part A benefits paid on his behalf for inpatient hospital services furnished to him if he has exhausted part A benefits for inpatient hospital services in a spell of illness and he does not have, or elects not to use, available lifetime reserve days. These exhausted benefit days for which no Medicare part A payment is made are referred to herein as “Medicare eligible” days.

47. An individual who is enrolled in, and thus eligible for benefits under, Medicare part A is not entitled to have Medicare part A benefits paid on his behalf when another payer has primary liability for the inpatient hospital services furnished to him. See 42 U.S.C. § 1395y(b)(2)(A). These Medicare secondary payer days for which no Medicare part A payment
is made on a Medicare part A beneficiary’s behalf are also referred to herein as “Medicare eligible” days.

48. An individual who is enrolled in, and thus eligible for benefits under, Medicare part A is not entitled to have Medicare part A benefits paid on his behalf for a noncovered service. For example, cosmetic surgery is generally a noncovered service under Medicare. Thus, if a Medicare beneficiary had cosmetic surgery as a hospital inpatient, Medicare part A would not pay for that service and there would be no liability by the Medicare program. These “noncovered” days are also referred to herein as “Medicare eligible” days.

49. References herein to “Medicare eligible” days are meant to refer to exhausted benefit days, including the days for which an individual elects not to use available lifetime reserve days, Medicare secondary payor days, and noncovered days for which no Medicare part A payment is made on a beneficiary’s behalf.

50. Medicare part A eligibility does not necessarily mean that an individual is entitled to Medicare part A benefits for inpatient hospital services furnished to him. Once Medicare part A benefits are exhausted, for example, no Medicare part A payment is made for additional inpatient hospital days in the same spell of illness unless the individual elects to use available lifetime reserve days. If lifetime reserve days are not available, or the individual elects not to use available reserve days, then no Medicare part A payment is made for those inpatient hospital days and those days are not charged against the individual’s utilization of Medicare Part A benefits. But, while the beneficiary receives no part A benefits and is not charged with utilization of any part A benefits for those days, the Secretary nevertheless maintains that the individual should be counted as entitled to benefits for the same days for purposes of calculating Medicare DSH payments to the hospital.
51. For purposes of the DSH payment calculation, described below, the Secretary now contends that Medicare eligible days (for which no Medicare benefits are paid) should be counted as days for patients who were entitled to benefits under part A for those days. For example, if a patient is admitted to the hospital for cosmetic surgery, which is not covered by the Medicare program, Medicare will not make payment for that service and those days will not be charged against the patient's utilization of benefits. Nevertheless, the agency will include those days in the denominator of the Medicare Part A/SSI fraction as days for which the patient was entitled to benefits under part A, while those same days would almost certainly be excluded from the numerator of the Medicare Part A/SSI fraction because a patient who can afford cosmetic surgery is unlikely to receive SSI benefits. The common denominator of the Secretary's inconsistent position is that the agency counts the same days as "not entitled" for purposes of payment of benefits on the individual's behalf and as "entitled" for purposes of making DSH payments to the hospital, thereby avoiding payments in both respects.

**MEDICARE PART C DAYS**

52. As with part A exhausted and Medicare secondary payer days, an individual who is enrolled in a Medicare+Choice or Medicare Advantage plan under part C of the Medicare statute is not entitled to have Medicare part A benefits paid on his behalf. The Medicare Act provides that a Medicare beneficiary may elect to receive Medicare benefits either "through the original [M]edicare fee-for-service program under parts A and B of [the Medicare statute], through enrollment in a Medicare+Choice [or Medicare Advantage plan] under this part," *i.e.*, part C, of the Medicare statute. 42 U.S.C. § 1395w-21(a)(1) (emphasis added); 42 C.F.R. § 422.50; see also 63 Fed. Reg. 34968 (June 26, 1998).

53. Part C of the statute governs Medicare payments made for services furnished to M+C enrollees. *See* 42 U.S.C. §§ 1395w-21(i), 1395w-23(a)(1)(A) ("the Secretary shall make
monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part [i.e., part C]”) (emphasis added), 1395w-23(f) (“The payment to a Medicare+Choice organization under this section for individuals enrolled under this part [C] . . . shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.”) (emphasis added).

54. Section 1395w-21(i) requires the Secretary to make payments to the M+C plan “instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B [of the Medicare statute] for items and services furnished to the individual.” Id. § 1395w-21(i)(1). Except as otherwise provided in section 1395w-21(i), the M+C plan is the only person or entity “entitled to receive payments from the Secretary under this subchapter for services furnished to the individual.” Id. § 1395w-21(i)(1)-(2).

55. Payments from the Secretary to part C plans are made from the Federal Hospital Insurance Trust Fund, which is established on the books of the Treasury pursuant to 42 U.S.C. § 1395i. Part C of the Medicare Act expressly authorizes expenditures by the Secretary from the Hospital Insurance Trust Fund for payments to a Medicare+Choice organization for individuals “enrolled under this part [i.e., part C] with the organization.” 42 U.S.C. § 1395w-23(f).

56. The Secretary contends that Medicare part C days (for which patients were receiving benefits under part C of the Act) should be counted in the Medicare Part A/SSI fraction as days for patients who were entitled to benefits under part A for those days.

**THE MEDICARE DSH PAYMENT**

57. Since 1983, the Medicare program has paid most hospitals under a prospective payment system for inpatient hospital services furnished to an individual who is entitled to benefits under Medicare part A. 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
58. Under the prospective payment system, Medicare pays hospitals predetermined, standardized amounts per discharge.

59. Upward percentage adjustments may be applied to the standard rate paid under the prospective payment system for discharges by certain qualifying hospitals. See, e.g., 42 U.S.C. § 1395ww(d)(5).

60. One of those hospital-specific payment adjustments is the DSH payment for hospitals that serve a disproportionate share of low-income patients. See 42 U.S.C. § 1395ww(d)(5)(F); 42 C.F.R. § 412.106.


62. Since the DSH payment was mandated by Congress in 1986, this Court and others have repeatedly found failures on the Secretary’s part to implement the DSH payment in accordance with Congress’s intent. See, e.g., Samaritan Health Ctr. v. Bowen, 646 F. Supp. 343, 344, 347 (D.D.C. 1986); Cabell Huntington Hosp. v. Shalala, 101 F.3d 984, 990 (4th Cir. 1996) (characterizing the Secretary’s original, restrictive interpretation of the DSH statute as an attempt “to rewrite the will of Congress” by “an agency [that has been] hostile from the start to the very idea of making the [DSH] payments at issue”); Clark Reg’l Med. Ctr. v. U.S. Dep’t of Health & Human Servs., 314 F.3d 241, 249 (6th Cir. 2002) (commenting that the Secretary “cannot simply interpret the [DSH] regulation to vary so as to always disadvantage the subject hospital”); Baystate Med. Ctr. v. Leavitt, 545 F. Supp. 2d 20, 37, 54 n.35 (D.D.C. 2008) (observing that the Secretary overlooked systemic errors in the agency’s calculation of one of the two major
components of the DSH payment calculation, which had "potentially enormous" payment impacts, by mere "administrative fiat").

**The DSH Payment Calculation**

63. A hospital’s “disproportionate patient percentage” determines both the hospital’s qualification for the DSH payment and the amount of the DSH adjustment that a qualifying hospital receives. See 42 U.S.C. § 1395ww(d)(5)(F); 42 C.F.R. §§ 412.106(c)-(d).

64. The disproportionate patient percentage is defined as the sum of two fractions expressed as percentages. 42 U.S.C. § 1395ww(d)(5)(F)(vi).

65. Generally, the greater the two percentages, the greater the DSH payment made to a hospital.

**The Medicare Part A/SSI Fraction**

66. The first fraction that is used to calculate the DSH payment is referred to herein as the “Medicare Part A/SSI” fraction. The statute defines this first fraction as:

the fraction (expressed as a percentage), the numerator of which is the number of such hospital’s patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital’s patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter...


67. HHS calculates the Medicare Part A/SSI fractions for all hospitals, and the Secretary’s intermediaries apply them to determine the DSH payments made to qualifying hospitals in notices of program reimbursement for hospital cost reporting periods. See 42 C.F.R. § 412.106(b).
THE MEDICAID FRACTION

68. The second fraction that is used to compute the DSH payment is referred to herein as the “Medicaid” fraction. The statute defines the Medicaid fraction as:

the fraction (expressed as a percentage), the numerator of which is the number of the hospital’s patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital’s patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added); see supra ¶ 8.

69. The Secretary’s intermediaries determine the Medicaid fractions and apply them to determine the DSH payments made to hospitals in notices of program reimbursement for hospital cost reporting periods. See 42 C.F.R. § 412.106(b).

SIGNIFICANCE OF THE TERM “ENTITLED TO BENEFITS UNDER PART A”

70. The plaintiff hospitals’ challenge to the Secretary’s Ruling turns on the question of whether Medicare eligible and Medicare part C days - i.e., days for patients who were not entitled to have part A benefits paid for those days - should be counted as days for patients who were “entitled to benefits under part A” of Medicare.

71. If “entitled to benefits under part A” means entitled to have Medicare part A benefits paid for the patient days in question, as four federal circuit courts of appeals have held, then all Medicare eligible and Medicare part C days must be excluded from the Medicare Part A/SSI fraction, and they must be included in the numerator of the Medicaid fraction for patients who were also eligible for Medicaid. See Jewish Hosp. Inc. v. Sec’y of Health & Human Servs., 19 F.3d 270, 275 (6th Cir. 1994); Cabell Huntington Hosp., 101 F.3d at 987-88; Legacy Emanuel Hosp. & Health Ctr. v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996); Deaconess Health Servs. Corp. v. Shalala, 83 F.3d 1041 (8th Cir. 1996) (per curiam), aff’d 912 F. Supp. 438, 447 (E.D. 51
Mo. 1995). This interpretation of "entitled" would result in an increase in the DSH payments previously made to the plaintiff hospitals for the periods at issue.

72. If "entitled to benefits under part A" means eligible for or enrolled in Medicare part A, as the Secretary now contends, then Medicare eligible and Medicare part C days must be included in the Medicare Part A/SSI fraction and excluded from the numerator of the Medicaid fraction, even for those patients who were dually eligible for Medicaid and Medicare. This interpretation of "entitled" would result in a reduction in the DSH payments previously made to the plaintiff hospitals for the periods at issue.

SECRETARY’S ORIGINAL INTERPRETATION OF “ENTITLED TO BENEFITS UNDER PART A”

73. When the Secretary first adopted rules implementing the DSH statute in 1986, and for about 18 years after that, the Secretary interpreted the term "entitled to benefits under part A" to mean entitled to have payment made under part A for the specific days when an individual was an inpatient of a hospital. See Northeast Hosp. Corp., 657 F.3d at 13-17 (discussing the Secretary’s 2004 change in policy on the treatment of Medicare part C days in the DSH calculation); Catholic Health Initiatives, 2012 WL 255275, at *7-12 (discussing the history of the Secretary’s position regarding part A exhausted and MSP days in the DSH calculation).

74. In 1986, the Secretary promulgated an interim final rule and a final rule implementing the DSH statute. See 51 Fed. Reg. at 16772 (May 6, 1986) (interim final rule); 51 Fed. Reg. 31454 (Sept. 3, 1986) (final rule). The Secretary’s 1986 interim final rule defined the numerator of the Medicaid fraction to include days for patients who were “entitled to Medicaid but not to Medicare Part A,” 51 Fed. Reg. 16788 (emphasis added), and the 1986 final rule further explained that the Secretary’s use of the term “entitled to” in the regulation meant “paid by” Medicaid or Medicare part A, respectively. 51 Fed. Reg. at 31460-61.

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75. The Secretary’s 1986 rules restricted the numerator of the Medicaid fraction by including only those Medicaid-eligible patient days that were paid by Medicaid and excluding other Medicaid eligible patient days that were not paid for by Medicaid. This had the effect of reducing DSH payments to hospitals by billions of dollars. See In re Medicare Reimbursement Litig., 414 F.3d at 13.

76. In defense of litigation challenging the Secretary’s restrictive interpretation of the Medicaid fraction, the Secretary represented to the courts that she consistently construed the DSH statute by counting only Medicaid-paid days in the Medicaid fraction and counting only Medicare-paid days in the Medicare Part A/SSI fraction. See, e.g., Legacy Emanuel Hosp., 97 F.3d at 1265 (noting the Secretary’s position that “the [Medicare Part A/SSI fraction] only counts patient days paid by Medicare” while the numerator of the Medicaid fraction counted only those patient days paid by Medicaid). The Secretary’s representations to the courts meant that the numerator of the Medicaid fraction included all patient days that were paid by Medicaid when a dual-eligible patient had exhausted Medicare part A benefits. Because these dual-eligible days were paid by Medicaid and were not paid by Medicare part A, they were counted in the numerator of the Medicaid fraction (which included Medicaid-paid days) and were not counted in the Medicare Part A/SSI fraction (which excluded days not paid by Medicare part A). And, this was fully consistent with the Secretary’s determination in the 1986 rulemaking that a patient day for dual-eligible patients should only be counted as one type of day depending on which program (Medicaid or Medicare) made payment for the day as reported on the hospital’s cost report. See 51 Fed. Reg. at 31460.

77. The Secretary also reiterated the same interpretation of the term “entitled to benefits under part A” in a 1990 rulemaking construing the next subparagraph (G) of the same
statute (§ 1395ww(d)(5)) that prescribes the DSH payment calculation in subparagraph (F). See 55 Fed. Reg. 35990, 35996 (Sept. 4, 1990). In that rule, the Secretary interpreted “entitled to benefits under part A” to mean entitled to have Medicare part A payment made and confirmed that Medicare eligible patient days occurring after an individual had exhausted Medicare part A benefits would not be counted as patient days for which the individual was “entitled to benefits under part A.” Id. In other words, the Secretary determined that a Medicare beneficiary who has lifetime reserve days available to apply to inpatient hospital days occurring after he has exhausted part A benefits, but elects not to use them, should not be counted as “entitled to benefits under part A” for those days. When a Medicare eligible patient elects not to use available lifetime reserve days, no part A benefits are paid for those days and none of those days are charged against the individual’s utilization of part A benefits because the individual is not “entitled to benefits” for those days.

78. The Secretary once again applied the same interpretation of “entitled” in a 1996 ruling that Medicare eligible days that were billed to and paid for by Medicaid, after a patient had exhausted Medicare part A benefits, should be counted in the numerator of the Medicaid fraction. See Presbyterian Med. Ctr. of Philadelphia v. Aetna Life Ins. Co., CMS Adm’r Dec., reprinted in MEDICARE & MEDICAID GUIDE (CCH) ¶ 45,032 at p.4 (Nov. 29, 1996); see also Catholic Health Initiatives, 2012 WL 255275, at * 9-10 (discussing Administrator’s decision in Presbyterian Medical Center).

79. The effect of Ruling 1498-R is to reverse the Secretary’s longstanding policy in effect during these periods.

1997 RULING ON MEDICAID ELIGIBLE DAYS

80. By 1996, four consecutive federal appellate courts had invalidated the Secretary’s original rule interpreting “eligible” for Medicaid to mean paid by Medicaid on the ground that
the Secretary’s narrow interpretation of the term “eligible” violated the plain meaning of the DSH statute by conflating “eligible” with “entitled.” See Jewish Hosp. Inc., 19 F.3d at 275; Cabell Huntington Hosp., 101 F.3d at 987-88; Legacy Emanuel Hosp., 97 F.3d at 1265; Deaconess Health Servs. Corp., 83 F.3d 1041 (8th Cir. 1996) (per curiam).

81. Following those losses, in February 1997, CMS issued Ruling 97-2, acquiescing in the courts’ holdings as to the meaning of “eligible” for Medicaid for purposes of calculating the DSH payment. In Ruling 97-2, CMS determined to count all patient days for individuals who are enrolled in Medicaid as days for patients who are “eligible” for Medicaid, regardless of whether Medicaid made payment to the hospital for the services furnished to the patient. See Ruling 97-2, available at https://www.cms.gov/Rulings/downloads/hcفار972.pdf. Ruling 97-2 did not change the Secretary’s interpretation of the term “entitled,” which she had previously interpreted as meaning entitled to have payment made on the individual’s behalf.

82. In 1998, the Secretary amended the DSH regulation, 42 C.F.R. § 412.106, to incorporate the policy change announced in the 1997 ruling. 63 Fed. Reg. 40954, 40984-85, 41004 (July 31, 1998). The 1998 amendment to the regulation also did not change the Secretary’s interpretation of the term “entitled,” which she had previously interpreted as meaning entitled to have payment made on the individual’s behalf.

83. Neither the 1997 ruling nor the 1998 amendment to the DSH regulation altered or discussed any change to the agency’s pre-existing interpretation of the term “entitled” to mean entitled to have Medicare part A payment made on the individual’s behalf.

SECRETARY’S LATER CHANGE IN POSITION WITH RESPECT TO MEDICARE ELIGIBLE DAYS

84. Not long after CMS issued Ruling 97-2, the agency attempted to change its interpretation of the term “entitled” sub silentio in order to pare back the numerator of the Medicaid fraction, and thus reduce DSH payments to hospitals, in another way.
85. In 2000 and 2003, the CMS Administrator issued two decisions asserting that Medicare eligible patient days (for patients who are also eligible for Medicaid) cannot be counted in the numerator of the Medicaid fraction because these days "are counted" in the Medicare Part A/SSI fraction, as days for patients entitled to benefits under Medicare part A, even after patients have exhausted Medicare part A benefits. See Castle Med. Ctr. v. Blue Cross Blue Shield Ass’n, reprinted in MEDICARE & MEDICAID GUIDE (CCH) ¶ 80,525 at p.8 (Sept. 12, 2003); Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass’n, reprinted in MEDICARE & MEDICAID GUIDE (CCH) ¶ 80,525 at p.7 (June 19, 2000).

86. The CMS Administrator’s decisions in Castle and Edgewater neither acknowledged nor explained the Secretary’s prior, inconsistent interpretation of the DSH statute and regulation. Each of these decisions was based on a false premise that CMS counted Medicare eligible days (for which no Medicare part A benefits were paid) in the Medicare Part A/SSI fraction. As discussed below, the agency later acknowledged that this factual premise, upon which the Castle and Edgewater decisions were based, was not true.

87. In 2003, the Secretary published notice of a proposed rule, again stating that Medicare eligible “patient days are counted in the Medicare fraction before and after Medicare coverage is exhausted.” 68 Fed. Reg. 27154, 27207 (May 19, 2003). Prior to that time, because of disclosures made in the context of the Baystate case, CMS knew that the Medicare Part A/SSI fraction had always excluded Medicare eligible patient days that were not covered and paid for by Medicare part A. For example, before the 2003 proposed rule was issued, a CMS attorney had acknowledged in writing that the Medicare Part A/SSI fraction had always excluded days that were not covered and paid by part A and did not include Medicare eligible days.
88. In a final rule adopted in 2004 without proper notice and comment, CMS acknowledged that the Medicare Part A/SSI fraction had never before included Medicare eligible days for patients who were not entitled to have Medicare part A payments made on their behalf because they had exhausted Medicare part A benefits for inpatient hospital services. See 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004).

89. The preamble to the Secretary’s August 2004 rulemaking said that the agency was “adopting a policy” and “revising our regulation” to begin counting Medicare patient days in the Medicare Part A/SSI fraction “whether or not the beneficiary has exhausted Medicare Part A hospital coverage.” See id. at 49099.

90. The preamble to the August 2004 rule also said that CMS’s policy change with respect to Medicare part A exhausted benefit days would be effective prospectively “for discharges occurring on or after October 1, 2004.” Id.

91. On January 30, 2012, this Court issued a decision in Catholic Health Initiatives holding that the Secretary’s current position, requiring part A exhausted and MSP days to be counted in the Medicare part A/SSI fraction, cannot be applied retroactively to periods prior to the Secretary’s change in policy. See 2012 WL 255275, at * 7-12.

SECRETARY’S TREATMENT OF MEDICARE PART C DAYS IN THE DSH CALCULATION

92. In a 2003 notice of proposed rulemaking relating to several aspects of the DSH payment, the Secretary addressed “questions whether patients enrolled in a [Medicare+Choice] Plan should be counted in the Medicare fraction or the Medicaid fraction . . . .” 68 Fed. Reg. 27154, 27208 (May 19, 2003).

93. In response to these questions, the Secretary stated that “once a beneficiary has elected to join an M+C plan, that beneficiary’s benefits are no longer administered under Part A.” Id. Thus, the Secretary proposed to “clarify” that:
once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient’s days for the [Medicare+Choice] beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

Id.

94. The Secretary proposed no amendment to the existing DSH regulation to effectuate this clarification of the existing rule. See id. at 27229-30 (proposing other amendments to DSH regulation at § 412.106 to implement other proposed changes to the rule). Id. This and other aspects of the 2003 proposed rule relating to the DSH payment were not included, however, in the final rule that was published on August 1, 2003. See 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).


96. The Secretary’s August 2004 final rule regarding Medicare+Choice enrollees was the opposite of what she had proposed to clarify in May 2003 and was adopted without affording hospitals the opportunity for notice and comment. In the preamble to the August 2004 final rule, the Secretary stated that CMS had “adopt[ed] a policy” and “revis[ed]” the DSH regulation to begin to count Medicare+Choice patient days as Medicare part A patient days in the SSI fraction, effective October 1, 2004. 69 Fed. Reg. at 49099.

97. The only change made to the text of the regulation in the August 2004 final rule was that the Secretary deleted the word “covered” where it previously appeared in the definition of the numerator (but not the denominator) of the Medicare Part A/SSI fraction in 42 C.F.R. §
412.106(b)(2)(i). See id.; compare 42 C.F.R. § 412.106(b)(2)(i) (2002) with 69 Fed. Reg. at 49246 (revised text of § 412.106(b)(2)(i)). The Secretary’s sole explanation for the modification to the rule was to state that Medicare+Choice enrollees “are still, in some sense entitled to benefits under Medicare Part A.” See 69 Fed. Reg. at 49099. The August 2004 final rule did not articulate in what “sense” Medicare+Choice enrollees are “entitled to benefits under Part A.”

98. In 2007, the Secretary published in the Federal Register notice of a further change to the DSH regulation, which was adopted without advance notice or opportunity for comment. See 72 Fed. Reg. at 47384. The 2007 notice stated that the agency “inadvertently” forgot to change the text of the regulation in 2004 to the extent necessary “to conform to the preamble language” in the 2004 rulemaking relating to Medicare+Choice days in the DSH calculation. Id. Accordingly, the Secretary decided to make what the agency characterized as a “technical correction” to the text of section 412.106(b)(2) in order to effectuate “the policy iterated in that [2004] rule.” Id. Following that amendment, the portion of the DSH regulation defining the numerator and denominator of the SSI fraction referred to patients who are “entitled to Medicare Part A (or [Medicare+Choice] (Part C)).” Id. at 47411 (amending § 412.106(b)(2)(i)(B) and (iii)(B)) (emphasis added).

99. The Secretary further amended that regulation on August 16, 2010 by replacing the word “or” with the word “including” so it refers to patients who are “entitled to Medicare Part A (including Medicare Advantage (Part C)).” 42 C.F.R. § 412.106(b)(2)(i)(B) and (iii)(B) (2010) (emphasis added); see also 75 Fed. Reg. 50042, 50285.

100. On September 13, 2011, the United States Court of Appeals for the District of Columbia Circuit issued a decision in Northeast Hospital Corp. v. Sebelius, holding that the Secretary’s current position, requiring Medicare part C days to be counted in the Medicare Part
A/SSI fraction, cannot be applied to periods that began before the Secretary adopted a change in policy in October 2004, including the fiscal years at issue in this case. *Northeast Hospital Corp. v. Sebelius*, 657 F.3d at 13-17.

**THIS COURT’S 2008 DECISION ON THE SSI FRACTION**


102. One of the contested issues in the *Baystate* case concerned the types of Medicare patient days that should be included in the Medicare Part A/SSI fraction. In that case, the Secretary represented to this Court that, for periods before October 1, 2004, CMS properly excluded Medicare eligible patient days from the Medicare Part A/SSI fraction for patient days in which the patient had exhausted Medicare part A benefits or for which Medicare part A did not make payment because Medicare was a secondary payor. See Defendants’ Memorandum of Points and Authorities in Support of Defendant Leavitt’s Motion for Summary Judgment and in Opposition to Plaintiff’s Motion for Summary Judgment at 24 & n.14, *Baystate*, 545 F. Supp. 2d 20. As discussed below, the 2010 Ruling at issue contradicts those representations.

103. The *Baystate* case also addressed the Secretary’s calculation of the numerator of the Medicare Part A/SSI fraction. The Court, in its memorandum opinion, observed that the Secretary had, by “administrative fiat,” dismissed evidence of systemic errors in the agency’s calculations of the Medicare Part A/SSI fraction, which had “potentially enormous” payment impacts adverse to hospitals. See *Baystate*, 545 F. Supp. 2d at 37, 54 n.35. Thus, the Court ultimately entered final judgment in December 2008, directing the Secretary to correct errors and recalculate the hospital’s Medicare Part A/SSI fractions for the four hospital cost reporting periods at issue in that case. 587 F. Supp. 2d at 44.
104. Several months later, CMS recalculated the Medicare Part A/SSI fractions for the hospital cost reporting periods at issue in the *Baystate* case. Consistent with its representations to this Court in that case, CMS did not include Medicare eligible days (for which no Medicare part A benefits were paid) in those revised Medicare Part A/SSI fractions.

105. In *Northeast Hospital*, the Secretary represented to this Court in November 2009 that she had engaged in a “systematic retooling” of the process her agency used to calculate the Medicare Part A/SSI fraction in the *Baystate* case. See Memorandum in Support of Defendant’s Cross-Motion for Summary Judgment and in Opposition to Plaintiff’s Motion for Summary Judgment at 42, *Northeast Hosp. Corp. v. Sebelius*, No. 09-180 (D.D.C.), ECF No. 15. Further, the agency represented that it “fully intend[ed]” to use that same process to recalculate the hospital’s Medicare Part A/SSI fraction in the *Northeast Hospital* case. Defendant’s Reply Memorandum in Support of Defendant’s Motion for Summary Judgment at 20. The Secretary further represented to this Court that she did not intend to require hospitals generally to continue to proceed through protracted litigation to obtain corrections to their Medicare Part A/SSI fractions, because that “would be a staggering waste of time for everyone involved.” *Id.* at 21.

106. Nevertheless, only a few months after making these representations to the court in the *Northeast Hospital* case, the Secretary’s agency issued Ruling 1498-R, under which the Secretary will recalculate the Medicare Part A/SSI fractions in a manner that is contrary to her representations to this court in *Baystate* and *Northeast Hospital*, and that is inconsistent with the methodology that she actually used to recalculate the Medicare Part A/SSI fractions for Baystate. Thus, the Secretary has ensured that the Secretary’s Board and the judicial system will continue to engage in what the Secretary herself has characterized as a “staggering waste of time for everyone involved” for several more years.
THE SECRETARY'S 2010 DSH RULING

107. In April 2010, CMS issued Ruling 1498-R. While Ruling 1498-R purports to acquiesce in the Court's decision in Baystate, it also includes another attempt by CMS to reduce DSH payments to hospitals with a new offset while purporting to acquiesce in the courts' decisions invalidating prior errors by CMS.

108. The Acting Deputy Administrator of CMS issued Ruling 1498-R on or about April 28, 2010, with a stated effective date of April 28, 2010.

109. Ruling 1498-R was issued without advance notice to the public and without affording hospitals an opportunity to have CMS consider comments on the Ruling, either before or after the agency issued the Ruling.

110. Ruling 1498-R applies to three types of claims in pending appeals on the DSH payment.

111. One type of claim that Ruling 1498-R addresses is claims in jurisdictionally proper appeals to the Board challenging errors and omissions in the data and processes that CMS used to calculate the Medicare Part A/SSI fraction, the same claim that is addressed in the hospitals' appeals in this case. The Ruling purports to provide for recalculation of the Medicare Part A/SSI fraction, making the corrections required to comply with the Baystate decision on remand of pending appeals on that issue.

112. Ruling 1498-R instructs the Board that once it determines that a pending appeal challenging errors and omissions in the data and processes that CMS used to calculate the Medicare Part A/SSI fraction meets all "applicable jurisdictional and procedural requirements of section 1878 of the [Social Security] Act" - i.e., the statute governing appeals to the Board, codified at 42 U.S.C. § 1395oo - then the Board must remand the appeal to the Secretary's intermediary on the ground that the Board lacks jurisdiction over the appeal.
113. Ruling 1498-R directs the Secretary’s intermediary, upon remand by the Board, to recalculate and apply a revised Medicare Part A/SSI fraction, ostensibly to implement this Court’s decision in the *Baystate* case. However, the Ruling also requires that the recalculated Medicare Part A/SSI fractions include a hospital’s Medicare eligible days, for periods prior to October 1, 2004, regardless of whether the patient was entitled to have Medicare part A payments made on his behalf for those patient days. These provisions of Ruling 1498-R flatly contradict the Secretary’s express representations to this Court in *Baystate* and apply even if a hospital claims in its appeal to the Board that Medicare eligible days should be *excluded* from the Medicare Part A/SSI fraction and included in the numerator of the Medicaid fraction. As discussed in the following paragraphs of this Complaint, these provisions of the Ruling on Medicare eligible days would reduce DSH payments and result in recoupment of DSH payments previously made to hospitals for the cost reporting periods involved in these appeals to the Board.

114. In addition, the provisions of Ruling 1498-R indicate that on remand, the recalculated Medicare Part A/SSI fractions will include Medicare part C days, for periods on or after October 1, 2004, even though patients receiving benefits under Medicare part C were not entitled to have Medicare part A payments made on their behalf for those patient days. It is not clear how the Secretary intends to effectuate the inclusion of Medicare part C days in the Medicare Part A/SSI fraction, because she does not have the necessary data for years prior to 2007, other than for teaching hospitals and certain other hospitals that have submitted no-pay claims for Medicare Advantage patients pursuant to several agency transmittals. *See, e.g.*, Change Request 6329, Transmittal No. 1695 (Mar. 6, 2009), *available* at http://www.cms.gov/transmittals/downloads/R1695CP.pdf; *see also* Change Request 6821,
Transmittal 696 (May 5, 2010) (requiring hospitals to furnish data needed to include Medicare part C days for 2007 in the Medicare Part A/SSI fraction by August 31, 2010); see also Northeast Hosp., 657 F.3d at 15-16 (discussing Secretary’s failure to count Medicare part C days in the Medicare Part A/SSI fraction).

115. The inclusion of Medicare part C days in the Medicare Part A/SSI fraction is contrary to the Medicare statute because the patients at issue were eligible for Medicaid and they were not entitled to benefits under part A for such days because they had elected instead to receive benefits under the Medicare+Choice program under part C of the Medicare Act. See 42 U.S.C. § 1395w-21(a)(1)(B). As discussed in the following paragraphs of this Complaint, the inclusion of Medicare part C days in the Medicare Part A/SSI fractions would further reduce DSH payments and result in recoupment of DSH payments previously made to hospitals for the cost reporting periods involved in appeals to the Board.

116. Ruling 1498-R asserts that CMS’s “original policy” was to exclude all Medicare eligible days from the numerator of the Medicaid fraction. That statement in the Ruling conflicts with the Secretary’s original policy at the inception of the DSH payment in 1986 and for the next 14 years, as shown in preceding paragraphs of this Complaint.

117. Ruling 1498-R also conflicts with the Secretary’s narrower interpretation of the same term “entitled” as that term is used in the same provisions of the same DSH statute to define the numerator of the Medicare Part A/SSI fraction. The DSH statute defines the numerator of that fraction to include a hospital’s patient days “which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplemental security income benefits.” 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
118. The Secretary construes the numerator of the Medicare Part A/SSI fraction to include only those days for patients who were entitled to have supplemental security income ("SSI") benefits paid to them on those days. See 75 Fed. Reg. 50042, 50280-81 (Aug. 16, 2010). Thus, with respect to an individual’s entitlement to SSI benefits, the Secretary recognizes that "eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month." This narrower interpretation of "entitled" to SSI benefits restricts the number of days that are counted in the numerator of the Medicare Part A/SSI fraction and thus reduces DSH payments to hospitals. But, with respect to an individual’s entitlement to Medicare part A benefits, the Secretary maintains that anyone who is eligible for Medicare part A benefits is always "entitled" to those benefits. This broader interpretation of the same term "entitled" enlarges the denominator of the Medicare Part A/SSI fraction and likewise reduces DSH payments to hospitals. Here again, the Secretary’s inconsistent interpretations of the same term used in the same sentence of the same statute serve to consistently reduce payments to hospitals.

FACTS SPECIFIC TO THIS CASE

PROCEDURAL BACKGROUND

119. Each of the 163 plaintiff hospitals received a notice of program reimbursement including the intermediary’s DSH payment determination for each of the cost reporting periods at issue.

120. Each of the plaintiff hospitals is participating in one of sixty-eight “group” appeals to the PRRB contesting the Secretary’s calculation of the hospitals’ Medicare Part A/SSI fractions. Those group appeals, at issue here, were assigned PRRB case numbers 00-3404G, 00-3405G, 00-3406G, 01-0504G, 02-0943G, 02-0982G, 03-1046G, 03-1332G, 04-0181G, 04-0324G, 04-2092G, 04-2139G, 05-0109G, 05-0231G, 05-1332G, 05-1603G, 05-1786G, 05-
1825G, 06-0285G, 06-0294G, 06-0295G, 06-0296G, 06-0297G, 06-0298G, 06-0330G, 06-
0034GC, 09-2306GC, 11-0574GC, 11-0588GC, 12-0099GC, 12-0100GC, 12-0101GC, 12-
0102GC, 12-0103GC, 12-0104GC, 12-0105GC, 12-0106GC, 12-0107GC, 12-0108GC, 12-
0118G, 12-0120G, 12-0121G, 12-0124GC, and 12-0125GC. The plaintiff hospitals claim in
those sixty-eight group appeals that they were improperly underpaid for DSH for the periods at
issue because of certain errors and omissions, discussed at length in this Court’s decision in
Baystate Medical Center v. Leavitt, in the data and match process used by the Secretary to
calculate the Medicare Part A/SSI fraction.

121. The plaintiff hospitals contend that Medicare eligible days and Medicare part C
days must be included in the numerator of the Medicaid fraction, to the extent that the patient is
also eligible for Medicaid for such days.

122. The hospitals also contend that Medicare eligible patient days for patients who
were not entitled to have Medicare part A benefits paid on their behalf and Medicare part C
days must be excluded from the Medicare Part A/SSI fraction. For the cost reporting periods or
portions of cost reporting periods at issue occurring prior to October 1, 2004, Medicare eligible
days (for patients who were not entitled to have Medicare part A benefits paid on their behalf)
were not included in the Medicare Part A/SSI fraction. In addition, Medicare part C days were
not included in the Medicare Part A/SSI fraction prior to 2007, except by mistake, and the
Secretary does not have the data needed to include those days in the Medicare Part A/SSI
fraction, except for a select group of hospitals, including teaching hospitals and certain other
hospitals that have submitted claims for Medicare Advantage patients to the Secretary’s contractors.

123. Each of the plaintiff hospitals timely appealed the calculation of its Medicare Part A/SSI fraction to the PRRB within 180 days of the hospital’s receipt of the intermediary’s notice of program reimbursement for the cost reporting periods at issue.

124. In their group appeals to the PRRB, each of the plaintiff hospitals noted its dissatisfaction with the Secretary’s calculation of the Medicare Part A/SSI fraction.

125. The plaintiff hospitals in each group appeal estimated that the amount in controversy on their claim to have their Medicare Part A/SSI fraction calculated correctly exceeds the $50,000 amount in controversy requirement for a group appeal to the Board. The amount in controversy on the hospitals’ claims to have the Medicare Part A/SSI fraction calculated correctly is approximately $175 million. That figure only considers the estimated impact of the Secretary’s errors and omissions in the data and match process used to calculate the Medicare Part A/SSI fraction. It does not account for the negative payment impact that would result if Medicare eligible and Medicare part C days were added to the Medicare Part A/SSI fractions on remand, instead of to the Medicaid fractions (to the extent that the patients were eligible for Medicaid for such days) as the hospitals claim that they should be. Factoring in the negative impact on payment of adding Medicare eligible days (for periods prior to October 1, 2004) and Medicare part C days (for periods on or after October 1, 2004) to the Medicare Part A/SSI fraction would substantially increase the estimated amount in controversy.

126. The Ruling, as noted above, purports to acquiesce in this Court’s decision in Baystate Medical Center v. Leavitt, by declaring plaintiff hospitals’ appeals moot and remanding them to the Secretary’s contractors for recalculation of the Medicare Part A/SSI fractions in a
manner that is the opposite of the way the hospitals contend and the statute requires that they should be calculated.

127. CMS Ruling 1498-R did not, and could not, reopen the DSH payment determinations at issue in the plaintiff hospitals’ group appeals challenging the Secretary’s calculation of the Medicare Part A/SSI fraction. By its terms, the Ruling does not purport to reopen any determinations pursuant to 42 C.F.R. § 405.1885 and applies only to claims pending in appeals before the PRRB.

128. When CMS issued Ruling 1498-R, the hospitals’ group appeals challenging the Secretary’s calculation of the Medicare Part A/SSI fraction for the cost reporting periods at issue were pending before the PRRB. None of those appeals was pending before the Acting Administrator of CMS when she issued Ruling 1498-R.

129. On February 29, 2012, the plaintiff hospitals in the sixty-eight group appeals at issue here requested that the Board grant expedited judicial review of the provisions of Ruling 1498-R that declared their appeals moot and directed the Board to remand them to the Secretary’s intermediaries for recalculation of the hospitals’ Medicare Part A/SSI fractions to include the hospitals’ Medicare eligible days (for periods prior to October 1, 2004) and Medicare part C days (for periods on or after October 1, 2004) in that fraction.

**Prior Board Hearing on Same Provisions of Ruling**

130. Earlier, on August 31, 2010, the Board conducted a hearing on 84 hospitals’ request for expedited judicial review of the same provisions of the Ruling.

131. In support of their request for expedited judicial review, those 84 hospitals presented evidence showing that their DSH payments would be substantially reduced if the Medicare Part A/SSI fraction is revised to include Medicare eligible days and Medicare part C days for patients who were not entitled to have Medicare part A payments made on their behalf.
132. Those hospitals’ evidence showed that the addition of Medicare eligible and Medicare part C days to the Medicare Part A/SSI fraction would dilute the resulting percentage, and thus reduce DSH payments, in nearly all cases.

**IMPACT OF ADDING MEDICARE ELIGIBLE DAYS TO MEDICARE PART A/SSI FRACTION**

133. With respect to Medicare eligible days, the evidence presented at the August 2010 hearing showed that even in the small percentage of cases in which the addition of those days would increase the Medicare Part A/SSI fraction, the resulting increase in the DSH payment would be much less in all of those cases than the increase in the DSH payment that would result if the patient days for patients who were also eligible for Medicaid were included in the numerator of the Medicaid fraction.

134. In summary, the evidence presented at the hearing showed that the net effect of adding Medicare eligible days to the Medicare Part A/SSI fraction and excluding them from the numerator of the Medicaid fraction amounts to a loss of $155,000 on average, per hospital, per cost reporting period.

135. Projected nationally to 1,700 of approximately 2,000 hospitals that receive Medicare DSH payments, the evidence showed that aggregate DSH payments would be about $260 million less, per year, if Medicare eligible days were included in the Medicare Part A/SSI fraction instead of the Medicaid fraction.

136. At the August 2010 hearing, the hospitals also presented evidence showing that under CMS’s original policy and practice from 1986 until about 2003, the agency and its intermediaries knowingly and willingly allowed hospitals to count Medicare eligible patient days in the numerator of the Medicaid fraction for patients who were paid by Medicaid and were not entitled to have Medicare part A payment made on their behalf for those patient days.
137. The Secretary and her intermediary were given opportunities in a prior Board hearing in a related case challenging the Ruling as well as before and during the August 2010 hearing to present evidence rebutting the hospitals' showing on the impact of adding Medicare eligible days to the Medicare Part A/SSI fraction or the Secretary's original policy and practice of counting these days in the Medicaid fraction for patients who were eligible for Medicaid. The Secretary and intermediary declined to present any evidence rebutting this evidence.

138. The Secretary's agency has sole possession of and control over the information that would definitively measure the precise impact of adding Medicare eligible days to the Medicare Part A/SSI fraction for every hospital that participates in the Medicare program.

139. The Secretary had ample opportunity to submit that evidence in the proceedings before the Board in the August 2010 hearing, but, as the Secretary's counsel put it in another earlier hearing challenging a related provision of the Ruling, "that's not what the Secretary decided to do." Transcript of Proceedings Before the Provider Reimbursement Review Board, June 1, 2010, at 135-36. Instead, the Acting Administrator of CMS "essentially removed with the signing of a pen hundreds and hundreds" of hospital appeals on the DSH calculation with the issuance of Ruling 1498-R. Id. at 93.

**IMPACT OF ADDING MEDICARE PART C DAYS TO THE MEDICARE PART A/SSI FRACTION**

140. With respect to Medicare part C days, the evidence presented at the August 2010 hearing showed that the impact of adding Medicare part C days to the Medicare Part A/SSI fraction, and excluding those days from the Medicaid fraction (where the hospitals contend the days should properly be included) would reduce DSH payments to hospitals by an average of $450,000 per hospital per year.

141. Projected nationally to 1,700 of approximately 2,000 hospitals that receive Medicare DSH payments, the evidence showed that aggregate DSH payments would be about
$775 million less, per year, if Medicare part C days are included in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction.

142. The evidence presented at the August 2010 hearing also showed that the Secretary and her fiscal intermediaries did not include Medicare part C days in the Medicare Part A/SSI fraction for any periods prior to 2007, except by mistake.

143. The Secretary and her intermediary were given opportunities before and during the Board’s August 2010 hearing to present evidence rebutting the hospitals’ showing on the impact of adding Medicare part C days to the Medicare Part A/SSI fraction or the Secretary’s exclusion of these days from the Medicare Part A/SSI fraction for periods prior to 2007. However, the Secretary and intermediary declined to present any evidence rebutting that evidence.

144. The Secretary’s agency has sole possession of and control over the information that would definitively measure the precise impact of adding Medicare part C days to the Medicare Part A/SSI fraction for every hospital that participates in the Medicare program.

145. The Secretary and her fiscal intermediary had ample opportunity to submit that evidence in those earlier proceedings, but they declined to do so.

THE PROVIDER REIMBURSEMENT REVIEW BOARD’S DECISION

146. In a unanimous decision dated March 23, 2012, the Secretary’s Board granted the request for expedited judicial review with respect to the sixty-eight group appeals that are at issue in this case.

147. Consistent with case law from this Circuit as well as the Supreme Court, the Board concluded that its decision to grant expedited judicial review of the contested provisions of the Ruling is a proper exercise of its inherent jurisdiction to determine its own jurisdiction because expedited judicial review of the Ruling maintains the status quo in the appeals before the
Board while this Court reviews the validity of the contested provisions of the Ruling. See, e.g.,

148. In its final decision, the Board determined (at p.17), in pertinent part:

1) The plaintiff hospitals’ group appeals “are properly pending before the Board, because, as the Ruling requires us to determine, they satisfy ‘the applicable jurisdictional and procedural requirements of section 1878 of the Act’ [42 U.S.C. § 1395oo(a)] . . . ” (Footnote omitted).

2) “The Board lacks authority to make a determination whether the Ruling deprives it of continuing jurisdiction . . . . The Board has no authority to invalidate any provision of the Ruling. EJR is, therefore, appropriate for the Federal court to make the determination in that EJR preserves the status quo and aids the Board’s determining its own jurisdiction.”

3) “If the Federal court finds the terms of the Ruling invalid as to the Board’s continuing jurisdiction to grant EJR, then [CMS] does not dispute that the Board lacks authority to decide the other legal questions raised as to the validity of the Ruling and EJR is appropriate as to those questions as well without further action by the Board.”

4) “The Board lacks authority to make a determination, and concludes that EJR is also appropriate to determine the validity of the regulatory provisions at 42 C.F.R. §§ 405.1842(a)(3) and (g)(1)(i)-(iii) . . . .”

5) “If the Federal court finds the Ruling valid as to its provisions on the Board’s loss of jurisdiction, EJR is appropriate to determine whether the Board is required to dismiss under the regulation [42 C.F.R. § 405.1840] or remand under the Ruling.”
149. By letter dated April 6, 2012, the Office of the Attorney Advisor notified the plaintiff hospitals that the CMS Administrator intended to review the Board’s “jurisdictional decision” in its determination to grant expedited judicial review.

**COUNT I**

**(EXPEDITED JUDICIAL REVIEW)**

150. Plaintiffs repeat the allegations in paragraph 1-149 of this Complaint as is fully set forth herein.

151. The Medicare statute provides for expedited judicial review of the questions presented here “pursuant to the applicable provisions under chapter 7 of title 5,” *i.e.*, the Administrative Procedure Act. 42 U.S.C. § 1395oo(f)(1).

152. The applicable provisions of the APA provide that the “reviewing court shall . . . hold unlawful and set aside agency action . . . found to be . . . (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; . . . (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (D) without observance of procedure required by law; [or] (E) unsupported by substantial evidence[.]” 5 U.S.C. § 706(2).

153. The provisions of Ruling 1498-R declaring that the PRRB lacks jurisdiction over the plaintiff hospitals’ group appeals and requiring the Board to remand them for recalculation and revision of the hospitals’ Medicare Part A/SSI fractions, by including Medicare eligible days in the Medicare Part A/SSI fractions for periods prior to October 1, 2004, and excluding those days from the numerator of the Medicaid fraction, are unlawful and must be set aside pursuant to 5 U.S.C. § 706(2).

154. The provisions of Ruling 1498-R indicating that, on remand, the Secretary will also include Medicare part C days in the Medicare Part A/SSI fractions for periods on or after
October 1, 2004, and exclude those days from the numerator of the Medicaid fraction, are unlawful and must be set aside pursuant to 5 U.S.C. § 706(2).

155. The provisions of the Ruling declaring that the PRRB lacks jurisdiction over the plaintiff hospitals’ appeals and requiring the Board to remand them violate 42 U.S.C. § 1395oo and deny the hospitals due process. As the Board found, the hospitals met “the applicable jurisdictional and procedural requirements” of 42 U.S.C. § 1395oo(a). Nothing in section 1395oo or any other statute authorizes the Secretary or the Acting Administrator of CMS to divest the hospitals of the appeal rights granted to them, or the Board of the jurisdiction conferred to it, by section 1395oo. When the Acting Administrator issued Ruling 1498-R, the DSH payment determinations at issue in the hospitals’ appeals to the PRRB were pending before the PRRB, not the Acting Administrator. Additionally, those determinations were not, and could not have been, reopened through the Ruling in accordance with the limitations on reopening under the Secretary’s reopening regulation. See 42 C.F.R. § 405.1885. The reopening regulation prohibits CMS from directing an intermediary to reopen a determination where, as here, there has been a “change of legal interpretation or policy by CMS in a . . . CMS Ruling, . . . whether made in response to judicial precedent or otherwise.” See 42 C.F.R. §§ 405.1885(b)(1), (c)(1) and (c)(2). Therefore, as applicable here, the remand provisions of the Ruling are null and void. Cf. Monmouth Med. Ct. v. Thompson, 257 F.3d 807, 814-15 (D.C. Cir. 2001) (concluding that the provision of CMS’s 1997 Ruling prohibiting reopening of prior unlawful DSH payment determinations was “simply inapplicable” because it violated the plain language of the reopening regulation then in effect).

156. The provisions of the Ruling declaring moot the hospitals’ claims to have their Medicare Part A/SSI fractions calculated correctly are arbitrary, capricious, not based upon
substantial evidence, and otherwise contrary to law. The Ruling does not resolve the hospitals’
claims to have their Medicare Part A/SSI fractions calculated correctly, because under the
Ruling, Medicare eligible days and Medicare part C days would be added to the Medicare Part
A/SSI fraction on remand. The Secretary’s Board correctly noted (at page 16 of its decision) that
this “determination is precisely the opposite of what Providers claim is required,” namely that
Medicare eligible days and Medicare part C days should be counted in the numerator of the
Medicaid fraction and excluded from the Medicare Part A/SSI fraction, to the extent that the
patient is also eligible for Medicaid.

157. The addition of Medicare eligible days to the Medicare Part A/SSI fractions
would increase, not reduce, the amount in controversy on the Medicare eligible days issue for the
hospitals’ cost reporting periods at issue. The Acting Administrator’s declaration in the Ruling
that some of the plaintiff hospitals might be satisfied with that result conflicts with all of the
evidence in the record, is not based upon any evidence, let alone substantial evidence, is arbitrary
and capricious and conflicts with binding case precedents in this Circuit. See, e.g., Ramer v.
Saxbe, 522 F.2d 695, 704 (D.C. Cir. 1975). Additionally, even if the amounts in controversy for
some hospitals would be reduced if their Medicare Part A/SSI fractions were recalculated and
revised to include Medicare eligible days and Medicare part C days, the resulting change in the
amount in controversy in the hospitals’ appeals to the PRRB would not defeat the Board’s
jurisdiction over the appeals. 42 C.F.R. § 405.1839(c)(5).

158. The Secretary’s determination in the Ruling to add Medicare eligible days to the
Medicare Part A/SSI fraction and exclude them from the numerator of the Medicaid fraction
violates 42 U.S.C § 1395hh and 5 U.S.C. § 553. Both section 1395hh and section 553 require
advance notice and opportunity to comment on changes to the substantive legal standards
governing the payment for services furnished to Medicare providers. Both statutes also prohibit the Secretary from retroactively applying rules or policies adopting new substantive standards. See 42 U.S.C. § 1395hh(e)(1); *Northeast Hosp.*, 657 F.3d at 13-17 (prohibiting the Secretary from retroactively applying 2004 rule requiring inclusion of Medicare part C days in the Medicare Part A/SSI fraction to periods beginning prior to the October 1, 2004 effective date of that rule); *Catholic Health Initiatives*, 2012 WL 255275, at *7-12 (prohibiting the Secretary from retroactively applying 2004 rule requiring inclusion of part A exhausted and MSP days in the Medicare Part A/SSI fraction to periods prior to the Secretary’s policy change); *see also Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988). Ruling 1498-R impermissibly applies a new substantive payment standard - to add Medicare eligible days to the Medicare Part A/SSI fraction and exclude them from the numerator of the Medicaid fraction - for prior cost reporting periods that began before October 1, 2004. See 69 Fed. Reg. 48916, 49098-99 (Aug. 11, 2004) (discussing the October 1, 2004 effective date of the Secretary’s rule to begin counting Medicare part A exhausted benefit days in the Medicare Part A/SSI fraction for discharges after that date); *see also 70 Fed. Reg. 47278, 47441 (Aug. 12, 2005) (explaining that CMS’s “policy change” with respect to Medicare secondary payor days applies to “FY 2005 and subsequent years”).

159. The Secretary’s determination in the Ruling to add Medicare eligible days to the Medicare Part A/SSI fraction and exclude them from the numerator of the Medicaid fraction for periods prior to October 1, 2004, and the Secretary’s indication in the Ruling that she will add Medicare part C days to the Medicare Part A/SSI fraction and exclude them from the numerator of the Medicaid fraction for periods on or after October 1, 2004, violates the DSH statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi). The DSH statute defines the Medicare Part A/SSI fraction to exclude patient days for Medicare eligible patients who were not entitled to have Medicare part

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A payment made on their behalf, and it defines the Medicaid fraction to include those days for patients who were eligible for Medicaid. If Congress meant for the Secretary to perform the DSH payment calculation based on a patient’s status as an individual who is “entitled to, or enrolled for” benefits under part A, it would have said so in the DSH statute, just as it has said explicitly in other provisions of the Medicare statute. Congress did not use such expansive terminology to define the calculus of the DSH payment at issue here. The Secretary’s expansive interpretation of the term “entitled to benefits under part A” in the context of the DSH statute at issue impermissibly conflates “eligible” and “entitled.” See Jewish Hosp. Inc., 19 F.3d at 275; Cabell Huntington Hosp., 101 F.3d at 987-88; Legacy Emanuel Hosp. & Health Ctr., 97 F.3d at 1265; Deaconess Health Servs. Corp., 83 F.3d at 1041. In addition, the Secretary inconsistently interprets the same term “entitled” as it relates to Medicare part A and SSI benefits in order to consistently ratchet down DSH payments to hospitals.

160. The Secretary’s determination in the Ruling to add Medicare eligible days for periods prior to October 1, 2004, and Medicare part C days for periods on or after October 1, 2004, to the Medicare Part A/SSI fraction is also arbitrary and capricious because the Ruling offers no rational explanation for this departure from the Secretary’s earlier interpretation of “entitled to benefits under part A.” See Transactive Corp. v. United States, 91 F.3d 232, 237-38 (D.C. Cir. 1996).

161. The Secretary’s determination in the Ruling to add Medicare eligible days to the Medicare Part A/SSI fraction and exclude them from the numerator of the Medicaid fraction violates the DSH regulation, 42 C.F.R. § 412.106, and the Secretary’s original interpretation of the regulation, that was in effect until October 1, 2004. See 51 Fed. Reg. at 16788; 51 Fed. Reg. at 31460-61; 55 Fed. Reg. at 35996; Legacy Emanuel Hosp. & Health Ctr., 97 F.3d at 1265;
Prior to October 1, 2004, the Secretary did not interpret the DSH regulation to include Medicare eligible days in the SSI fraction. See id.; see also Northeast Hosp., 657 F.3d at 13-17 (discussing the Secretary's policy prior to October 1, 2004 with respect to Medicare part C days); Catholic Health Initiatives, 2012 WL 255275, at *7-12 (discussing Secretary’s policy prior to October 1, 2004 with respect to part A exhausted and MSP days). The Secretary cannot retroactively change her longstanding prior policy through the Ruling, which was not issued until years after the Secretary amended her policy prospectively to count Medicare eligible days in the Medicare Part A/SSI fraction. See Northeast Hosp., 657 F.3d at 13-17; Catholic Health Initiatives, 2012 WL 255275, at *7-12.

162. The Secretary's current regulations at 42 C.F.R. §§ 405.1842 and 405.1875 are invalid because they violate 42 U.S.C. § 1395oo(f)(1) insofar as the regulations provide for review by the CMS Administrator of “the jurisdictional component” of a Board decision granting expedited judicial review. Section 1395oo(f)(1) precludes review by the Secretary of a Board determination granting expedited judicial review.

163. The regulations at 42 C.F.R. §§ 405.1842 and 405.1875 are also invalid because the 2008 amendments to the Secretary’s regulations providing for review by the Administrator of the “jurisdictional component” of a Board determination to grant expedited judicial review are arbitrary and capricious. The Secretary originally construed section 1395oo(f)(1) to mean that a Board decision granting expedited review “will allow the provider to seek judicial review without any intervening Secretary’s review.” See 47 Fed. Reg. at 31690-91. In amending the regulations in 2008, the Secretary neither acknowledged nor explained the reason for the
Secretary’s change in her interpretation of the statute. See 73 Fed. Reg. at 30214-15, 30228-30, 30255, 30262.

**REQUEST FOR RELIEF**

164. WHEREFORE, the plaintiff hospital requests an Order:

A. declaring invalid and setting aside the provisions of Ruling 1498-R that declare that the Board lacks jurisdiction over, and require the Board to remand, the plaintiff hospitals’ claims in their appeals to the PRRB to have their Medicare Part A/SSI fraction calculated correctly, in accordance with this Court’s decision in *Baystate Medical Center v. Leavitt*;

B. declaring invalid and setting aside the CMS Administrator’s determination in Ruling 1498-R that Medicare eligible and Medicare part C days for patients who were not entitled to have Medicare part A payments made on their behalf for those days should be included in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction;

C. declaring invalid and setting aside the regulations of the Secretary providing for review by the CMS Administrator of “the jurisdictional component” of a Board decision granting expedited judicial review;

D. requiring the Secretary to recalculate the plaintiff hospitals’ DSH payments for the 1991-2004 cost reporting periods at issue by recalculating the hospitals’ Medicare Part A/SSI fractions in accordance with this Court’s decision in *Baystate Medical Center v. Leavitt*, ordering the Secretary to exclude Medicare eligible and Medicare part C days from her recalculation of the Medicare Part A/SSI fractions for all years at issue, and to include those days for patient who are also eligible for Medicaid in the numerator of the Medicaid fraction, and requiring the Secretary to promptly pay the plaintiff hospitals the additional DSH
payments due as a result of that correction, plus interest calculated in accordance with 42 U.S.C. § 1395oo(f)(2);

E. requiring the Secretary to pay legal fees and costs of suit incurred by the plaintiff; and

F. providing such other relief as the Court may consider appropriate.

Respectfully submitted,

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