UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SARASOTA MEMORIAL HOSPITAL
1700 S. Tamiami Trail
Sarasota, FL 34239

and

ALLINA HEALTH f/b/o ABBOTT NORTHWESTERN HOSPITAL
800 E. 28th St.
Minneapolis, MN 55407

and

ALLINA HEALTH f/b/o BUFFALO HOSPITAL
303 Catlin St.
Buffalo, MN 55313

and

ALLINA HEALTH f/b/o CAMBRIDGE MEDICAL CENTER
701 Dellwood St. S.
Cambridge, MN 55008

and

ALLINA HEALTH f/b/o MERCY HOSPITAL
4050 Coon Rapids Blvd. NW
Coon Rapids, MN 55433

and

ALLINA HEALTH f/b/o OWATONNA HOSPITAL
2250 NW 26th St.
Owatonna, MN 55060

and

Case No. ____

ALLINA HEALTH f/b/o REGINA HOSPITAL
1175 Nininger Rd.
Hastings, MN 55033

and

ALLINA HEALTH f/b/o ST. FRANCIS REGIONAL MEDICAL CENTER
1455 St. Francis Ave.
Shakopee, MN 55379

and

ALLINA HEALTH f/b/o UNITED HOSPITAL
333 Smith Ave N.
St. Paul, MN 55102

and

ALLINA HEALTH f/b/o UNITY HOSPITAL
550 Osborne Rd. NE
Fridley, MN 55432

and

FLOYD MEDICAL CENTER
304 Turner McCall Blvd.
Rome, GA 30165

and

MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER
4700 Waters Ave.
Savannah, GA 31404

and

GRADY MEMORIAL MEDICAL CENTER
80 Jesse Hill Jr. Dr. SE
Atlanta, GA 30303

and )
)
BANNER HEALTH f/b/o BANNER )
IRONWOOD MEDICAL CENTER )
37000 N. Gantzel Rd. )
Queen Creek, AZ 85140 )
)
and )
)
BANNER HEALTH f/b/o BANNER DESERT )
MEDICAL CENTER )
1400 South Dobson Rd. )
Mesa, AZ 85202 )
)
and )
)
BANNER HEALTH f/b/o BANNER DEL E. )
WEBB MEDICAL CENTER )
14502 West Meeker Blvd. )
Sun City West, AZ 85375 )
)
and )
)
BANNER HEALTH f/b/o BANNER )
THUNDERBIRD MEDICAL CENTER )
5555 West Thunderbird Rd. )
Glendale, AZ 85306 )
)
and )
)
BANNER HEALTH f/b/o BANNER )
BOSWELL MEDICAL CENTER )
10401 West Thunderbird Blvd. )
Sun City, AZ 85351 )
)
and )
)
DENVER HEALTH MEDICAL CENTER )
777 Bannock St. )
Denver, CO 80204 )
)
and )
)
WEST VIRGINIA UNIVERSITY HOSPITAL )
1 Medical Center Dr. )
Morgantown, WV 26506 )

and

BOULDER COMMUNITY HOSPITAL
1100 Balsam Ave.
Boulder, CO 80304

Plaintiffs,

v.

ALEX M. AZAR II, Secretary, U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES
200 Independence Avenue, SW
Washington, DC 20201

Defendant.

# COMPLAINT

## I. SUMMARY

1. Plaintiffs are twenty-one acute care hospitals (the "Hospital Plaintiffs") participating in the Medicare program. The Hospital Plaintiffs bring this complaint for judicial review of the final administrative decision of the Provider Reimbursement Review Board (the "Board") that it does not have jurisdiction to review the Hospital Plaintiffs' claims as to the amount of their Medicare "outlier" payments due for providing services under the Medicare program during Hospital Plaintiffs' respective fiscal year ending ("FYEs") in 2013, 2014, and 2015.

2. Congress has mandated that a provider "which has filed a required cost report" shall have the right to a hearing before the Board if it "(A)(i) is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement

due the provider . . . for the period covered by such report, [or] (B) has not received such final determination from such intermediary on a timely basis after filing such report. . . ." 42 U.S.C. § 1395oo(a). The Secretary (the "Secretary") of the United States Department of Health and Human Services ("HHS") promulgated a regulation permitting providers that have not received final determinations to file appeals with the Board where "[a] final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report…." 42 C.F.R. § 405.1835(c)(1) (the "Late NPR Regulation").

3. The Board's longstanding position has been that it is jurisdictionally proper for a provider to appeal issues based on the lack of a timely final determination (*i.e.*, a Notice of Program Reimbursement ("NPR")) even when the provider has submitted an amended cost report following the acceptance of the original perfected cost report.

4. That is what occurred here. The Hospital Plaintiffs each timely appealed from their contractor's failure to issue an NPR within the requisite 12-month period. Although each of the Hospital Plaintiffs had filed an amended cost report, they had a right to appeal from their original as-filed cost reports under the statute and the regulation.

5. Nevertheless, the Board suddenly and without notice changed how it would apply the Late NPR Regulation, and did so in a manner that violated the statute and the regulation. The Board found that it lacked jurisdiction and dismissed the Hospital Plaintiffs' appeals, concluding that "the amended cost report replaces and supersedes the originally filed cost report," and "the provider must file its untimely NPR appeal from the most recently accepted cost report's receipt date." *See* Board Decision, No. 16-2530G, at 4 (Exhibit A); *see also* Board Decision, No. 17-

2022GC, 15-3400GC, 16-0244GC, 17-1929G, 18-0081GC, 16-1459G, 17-1751G (Exhibit A) (collectively "Board Decisions").

6. Several of the Hospitals Plaintiffs relied on the Board's past interpretation of the Late NPR Regulation to their detriment. They did not file a separate appeal within 180 days of receipt of their NPRs because they already had pending jurisdictionally proper appeals under the statute, the Late NPR Regulation and the Board's prior interpretation of those sources of authority.

7. As a result of the Board Decisions, the Hospital Plaintiffs have been deprived of their statutory right to appeal their Medicare underpayments.

8. The Board Decisions are invalid because they: (1) are contrary to the statute; (2) are an unreasonable application of the Late NPR Regulation and contrary to record evidence; (3) are arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, and otherwise not in accordance with law; and (4) have deprived the Hospital Plaintiffs of due process.

9. Given the basis for the Board's decisions (*i.e.*, dismissal based on alleged lack of jurisdiction), the merits of the Hospital Plaintiffs' appeals are not presently at issue and the Hospital Plaintiffs have not pleaded their substantive claims. *See, e.g., Tucson Med. Ctr. v. Heckler*, 611 F. Supp. 823, 825 (D.D.C. 1985). Nevertheless, the Hospital Plaintiffs' substantive claims warrant brief discussion as they are ones that ultimately may only be heard in this Court.

10. In their appeals, the Hospital Plaintiffs assert that HHS underpaid them both in the number and in the amount of Medicare payments for treating extraordinarily expensive patient cases, known as "outlier" cases ("Outlier Case Payments"), and mandated by 42 U.S.C.

§ 1395ww(d)(3) (b) & (5)(A). The total amount of underpayments at issue cannot now be determined with precision, but is estimated to be in excess of $6.3 million.

11. Before the Board, the Hospital Plaintiffs sought expedited judicial review ("EJR") of their Outlier claims appeals, under 42 U.S.C. § 1395oo(f), because the Board lacks authority to decide the underlying challenges to HHS's regulations governing the Outlier Case Payments. In other Outlier claims cases, the Board has consistently granted EJR, finding that it lacks authority to decide such regulatory challenges. In the instant case, however, the Board made an unprecedented change in its application of the Late NPR Regulation, without notice to the regulated community in general or to the Hospital Plaintiffs in particular, which resulted in its denial of the Hospital Plaintiffs' requests for EJR.

12. Should the Hospital Plaintiffs prevail in their appeal of the Board's procedural decisions, remand would ordinarily be the remedy. However, in this instance, a remand would be futile as the Board lacks authority to hear the regulatory challenges set forth in the Hospital Plaintiffs' appeal and would simply grant EJR, thus returning the Hospital Plaintiffs' substantive appeals to this Court.

13. Therefore, the Hospital Plaintiffs respectfully seek the entry of an order that (1) the Board Decisions are arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, and not otherwise in accordance with law; (2) that Hospital Plaintiffs' appeals are jurisdictionally proper; (3) that the Court shall retain jurisdiction over this case as a remand to the Board would be futile; and (4) that the Hospital Plaintiffs shall be permitted to file an amended complaint pleading their substantive claims, together with the other members of their group appeal, within 20 days after the issuance of the Order.

## II. PARTIES

14. Hospital Plaintiffs are non-profit organizations that own and operate the acute care hospitals identified in the subparagraphs below. Each of the Hospital Plaintiffs has been certified to and has participated in the Medicare program as a "provider of services" during the time relevant to this Complaint, including, with respect to each hospital, during the fiscal year identified below.

a. Plaintiff, Sarasota Memorial Hospital, is a non-profit organization located in Sarasota, Florida. It is appealing its payment by HHS for its FYE September 30, 2015.

b. Plaintiff, Abbott Northwestern Hospital, is a non-profit organization located in Minneapolis, Minnesota and is under the common ownership and control of Allina Health. It is appealing its payment by HHS for its FYEs December 31, 2013, and December 31, 2015.

c. Plaintiff, Buffalo Hospital, is a non-profit organization located in Buffalo, Minnesota and is under the common ownership and control of Allina Health. It is appealing its payment by HHS for its FYE December 31, 2015.

d. Plaintiff, Cambridge Medical Center, is a non-profit organization located in Cambridge, Minnesota and is under the common ownership and control of Allina Health. It is appealing its payment by HHS for its FYEs December 31, 2013, and December 31, 2015.

e. Plaintiff, Mercy Hospital, is a non-profit organization located in Coon Rapid, Minnesota and is under the common ownership and control of

Allina Health. It is appealing its payment by HHS for its FYEs December 31, 2013, and December 31, 2015.

f. Plaintiff, Owatonna Hospital, is a non-profit organization located in Owatonna, Minnesota and is under the common ownership and control of Allina Health. It is appealing its payment by HHS for its FYEs December 31, 2013, and December 31, 2015.

g. Plaintiff, Regina Hospital, is a non-profit organization located in Hastings, Minnesota and is under the common ownership and control of Allina Health. It is appealing its payment by HHS for its FYE December 31, 2015.

h. Plaintiff, St. Francis Regional Medical Center, is a non-profit organization located in Shakopee, Minnesota and is under the common ownership and control of Allina Health. It is appealing its payment by HHS for its FYE December 31, 2015.

i. Plaintiff, United Hospital, is a non-profit organization located in St. Paul, Minnesota and is under the common ownership and control of Allina Health. It is appealing its payment by HHS for its FYEs December 31, 2013, and December 31, 2015.

j. Plaintiff, Unity Hospital, is a non-profit organization located in Fridley, Minnesota and is under the common ownership and control of Allina Health. It is appealing its payment by HHS for its FYEs December 31, 2013, and December 31, 2015.

k. Plaintiff, Floyd Medical Center, is a non-profit organization located in Rome, Georgia. It is appealing its payment by HHS for its FYEs June 30, 2014, and June 30, 2015.

l. Plaintiff, Memorial Health University Medical Center, is a non-profit organization located in Savannah, Georgia. It is appealing its payment by HHS for its FYEs December 31, 2014 and December 31, 2015.

m. Plaintiff, Grady Memorial Medical Center, is a non-profit organization located in Atlanta, Georgia. It is appealing its payment by HHS for its FYE December 31, 2014.

n. Plaintiff, Banner Desert Medical Center, is a non-profit organization located in Mesa, Arizona and under the common ownership and control of Banner Health. It is appealing its payment by HHS for its FYE December 31, 2015.

o. Plaintiff, Banner Del E. Webb Medical Center, is a non-profit organization located in Sun City West, Arizona and under the common ownership and control of Banner Health. It is appealing its payment by HHS for its FYE December 31, 2015.

p. Plaintiff, Banner Thunderbird Medical Center, is a non-profit organization located in Glendale, Arizona and under the common ownership and control of Banner Health. It is appealing its payment by HHS for its FYE December 31, 2015.

q. Plaintiff, Banner Boswell Medical Center, is a non-profit organization located in Sun City, Arizona and under the common ownership and

control of Banner Health. It is appealing its payment by HHS for its FYE December 31, 2015.

r. Plaintiff, Banner Ironwood Medical Center, is a non-profit organization located in Queen Creek, Arizona and under the common ownership and control of Banner Health. It is appealing its payment by HHS for its FYE December 31, 2013.

s. Plaintiff, Denver Health Medical Center, is a non-profit organization located in Denver, Colorado. It is appealing its payment by HHS for its FYE December 31, 2014.

t. Plaintiff, West Virginia University Hospital, is a non-profit organization located in Morgantown, West Virginia. It is appealing its payment by HHS for its FYEs December 31, 2014, and December 31, 2015.

u. Plaintiff, Boulder Community Hospital, is a non-profit organization located in Boulder, Colorado. It is appealing its payment by HHS for its FYE December 31, 2015.

15. Defendant Alex M. Azar II (the "Secretary") is Secretary of HHS and is sued in his official capacity.

## III. JURISDICTION AND VENUE

16. This Court has jurisdiction under: 42 U.S.C. § 1395oo(f), which provides jurisdiction for appeals of Medicare payment decisions.

17. Venue is proper in this Court under 42 U.S.C. § 1395oo(f) and 28 U.S.C. § 1391(c).

18. The Board's decision that it lacks jurisdiction over an appeal is HHS's final decision and is subject to judicial review. 42 U.S.C. § 1395oo(f).

19. This action is timely filed under 42 U.S.C. § 1395oo(f), in that it has been brought within 60 days of Hospital Plaintiffs' receipt of HHS's final decisions on their administrative appeals.

## IV. STATUTORY, REGULATORY AND FACTUAL BACKGROUND UNDERLYING THE HOSPITAL PLAINTIFFS' RIGHTS TO APPEAL THEIR OUTLIER CASE PAYMENTS

### a. Provider's Statutory Rights to Appeal Medicare Reimbursement Decisions of Their Fiscal Intermediaries (the "FIs") and the FI's Failure to Timely Make the Same

20. The Medicare program, established as title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (referred to throughout the rest of this Complaint as the "Medicare Act"), is the federal entitlement program that provides health care insurance to the nation's aged and disabled. Medicare, as originally enacted, was divided into two parts, each with its own trust fund. The Federal Insurance Hospital Trust Fund, known as the "Part A Trust Fund," established under the Medicare Act was and is used to pay claims for inpatient hospitalizations, stays in skilled nursing facilities, and other designated institutions.

21. HHS administers the Medicare program. The Centers for Medicare and Medicaid Services ("CMS") is a component of HHS. CMS is responsible for the daily operation and administration of the Medicare program.

22. CMS makes payments to providers through its fiscal intermediaries ("FIs").[1] FIs are private insurance companies that process Medicare claims as HHS's agents.

[1] In 2005, FIs were replaced by Medicare administrative contractors ("MACs"). *See* 42 U.S.C. 1395h; 42 C.F.R. §413.24(f). The Complaint will refer to FIs and MACs interchangeably as FIs.

23. In connection with receiving reimbursement from HHS for providing covered services to Medicare beneficiaries, each provider submits a cost report at the end of its fiscal year to its FI.

24. The FI audits the cost report and issues a Notice of Program Reimbursement ("NPR") specifying the amount of reimbursement due to the provider and explaining any adjustments.

25. In 1972, Congress enacted provisions governing provider appeal rights, which are codified at 42 U.S.C. § 1395oo (the "Provider Appeal Rights Statute").

26. The Provider Appeal Rights Statute gives a provider the right to obtain a hearing before the Board with respect to a timely-filed cost report if:

> (1) such provider --
>
> > (A) (i) is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report, [or]
> >
> > . . . .
> >
> > (B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or
> >
> > (C) has not received such final determination . . . .
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days . . .

42 U.S.C. § 1395oo(a).

27. The Provider Appeals Right Statute also states:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report

> (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

42 U.S.C. § 1395oo(d).

28. HHS, acting through the CMS Administrator, may review a Board decision either on its own motion or at a provider's request. Any provider that remains dissatisfied with a final decision of the Board or HHS may seek review in the United States District Courts. 42 U.S.C. §§1395oo(a), (d), and (f).

**b. <u>HHS Promulgated the Late NPR Regulation, Which Permits Providers That Have Not Received Final Determinations to File Appeals With The Board.</u>**

29. The Late NPR Regulation states in relevant part that:

> (c) a provider…has a right to a Board hearing…for specific items for a cost reporting period if –
>
> > (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report **<u>or</u>** amended cost report….

42 C.F.R. § 405.1835(c) (emphasis added).

30. With respect to appeals in the absence of a timely NPR, the Board has simply required a provider to have appealed within 180 days of the expiration of the 12 month period following the intermediary's acceptance of the original perfected cost report. The Board has not found jurisdiction lacking, or found the appeal untimely, simply because the provider has filed an amended cost prior to the expiration of the original 12 month period. This historical position by the Board was consistent with the express language of the regulation, as quoted above.

**c. Facts Specific to the Hospital Plaintiffs' Appeals**

31. The Hospital Plaintiffs are challenging their Medicare outlier payments for some or all of their respective FYEs 2013, 2014 and 2015.

32. With respect to each of their FYEs at issue, the Hospital Plaintiffs timely filed cost reports within five months after the end of their fiscal year, in accordance with HHS's applicable rules and regulations. The FI accepted these cost reports but failed to issue NPRs within twelve months of accepting such cost report.

33. The Hospital Plaintiffs each timely filed appeals pursuant to the Provider Appeal Rights Statute (42 U.S.C. § 1395oo(a)(1)(B)) and 42 C.F.R. § 405.1835(a)(3)(ii), as well as applicable Board Rules, which permit a provider to file an appeal within 180 days after the 12 month period for an FI to issue a final determination where the FI has failed to do so.

34. The Hospitals Plaintiffs submitted amended cost reports, and the FIs accepted these amended cost reports. However, many of the Hospital Plaintiffs did not submit an amended cost report until after the FI failed to issue final determinations within 12-month of accepting the initially filed cost report. Further, some of the Hospital Plaintiffs did not file an amended cost report until after their Board appeals were already properly pending. *See e.g.* PRRB Case No. 16-2530G (Memorial Health University Medical Center, 11-0036, appealed on September 20, 2016 but amended the cost report on November 3, 2017); PRRB Case No. 17-2022GC (Cambridge Medical Center, 24-0020, appealed on August 4, 2017 but amended the cost report on August 11, 2017; Owatonna Hospital, 24-0069, appealed on August 4, 2017 but amended the cost report on August 30, 2017); PRRB Case No. 17-1751G (Boulder Community Hospital, 06-0027, appealed on July 28, 2017 but amended the cost report on October 26, 2017). When these appeals were filed, they were jurisdictionally proper under the Provider Appeal

Rights Statute (42 U.S.C. § 1395oo(a)(1)(B)) and 42 C.F.R. § 405.1835(a)(3)(ii), as well as applicable Board Rules.

35. On March 2, 2018, which the Hospital Plaintiffs received on March 6. 2018, ruling on Hospital Plaintiffs' request for expedited judicial review, and contrary to its historical application of the Late NPR Regulation, the Board held that it lacked jurisdiction and dismissed the Hospital Plaintiffs' appeals here at issue because "the amended cost report replaces and supersedes the originally filed cost report." Thus, according to the Board, "the provider must file its untimely NPR appeal from the most recently accepted cost report's receipt date." *See* Exhibit A at 4.

36. The Board failed to note that numerous Hospital Plaintiffs filed amended cost reports long after the end of the relevant 12 months period for the FIs to issue NPRs.

37. Although the Board denied EJR for these Hospital Plaintiffs' appeals for the FYEs here at issue, it granted EJR for their other FYEs. The Board also either granted EJR or denied jurisdiction on other basis for the other hospitals in the group appeals. Exhibit A.

38. The Court should hold unlawful and set aside the Board's decisions to dismiss the Hospital Plaintiffs' appeals because that decision was (A) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right, (B) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law, (C) without observance of procedure required by law, and/or (D) unsupported by substantial evidence insofar as:

a. The Hospital Plaintiffs have satisfied all jurisdictional requirements of the Provider Appeal Rights Statute with respect to their appeals;

b. The Board's application of the Late NPR Regulation is contrary to the Board's historical application of the same, contrary to the unambiguous conclusion of the lead intermediary, and contrary to the statute;

c. The Board's decision deprived the Hospital Plaintiffs of due process because it dismissed their appeals after waiting until the time for them to take any further actions to cure any asserted defects had expired.[2]

## V. AFTER REVERSING THE BOARD'S JURISDICTIONAL RULING, THE COURT SHOULD RETAIN JURISDICTION AND ADJUDICATE THE MERITS OF THE HOSPITAL PLAINTIFFS' APPEALS BECAUSE THE BOARD LACKS AUTHORITY TO DECIDE THE CHALLENGES TO THE OUTLIER REGULATIONS

39. As noted, the Hospital Plaintiffs requested that the Board make a determination that it is without authority to decide the question of law or regulations relevant to their appeals and to grant EJR under 42 U.S.C. §1395oo(f)(1).

40. The Board did not rule on the EJR requests because it held that it did not have jurisdiction over the Hospital Plaintiffs' appeals.

41. Thus, although remand to the Board would ordinarily be the appropriate remedy following reversal of its jurisdictional determinations, a remand in the instant case would be a futile exercise as the Board already granted EJR to the other members of the Hospital Plaintiffs' group appeal.

42. Therefore, the Court should retain jurisdiction, permitting the Hospital Plaintiffs to file an amended complaint pleading their substantive claims, and then decide the merits of the Hospital Plaintiffs' appeals, together with the other members of the group appeal.

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[2] *See also* Board Rule 4.5, providing that a provider "may not appeal an issue from a final determination in more than one appeal."

## VI. REQUEST FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that the Court enter an order:

1. Finding that the Board's application of the Late NPR Regulation is unreasonable and contrary to the statute and the evidence before the Board;

2. Finding that the Hospital Plaintiffs' appeals are jurisdictionally proper;

3. Retaining jurisdiction over this appeal given that a remand to the Board to decide the EJR request would be futile because the Board has already granted EJR to the other members of the Hospital Plaintiffs' group appeal;

4. Permitting the Hospital Plaintiffs to file an amended complaint pleading their substantive claims within 20 days after the issuance of the Order;

5. Awarding the Hospital Plaintiffs their attorney fees and costs for prosecution of this appeal as permitted under any applicable law; and

6. Granting the Hospital Plaintiffs such further and additional relief as may be just and warranted.

Respectfully submitted this 1st day of May, 2018.

By:*/s/ Stephen P. Nash*
Stephen P. Nash (D.C. Bar #PA0037)
SQUIRE PATTON BOGGS (US) LLP
1801 California, Suite 4900
Denver, CO 80202
Tel.: (303) 830-1776
Fax: (303) 894-6173
E-mail: Stephen.Nash@squirepb.com

*Counsel for Plaintiffs*