**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

| | | |
|---|---|---|
| COVENANT MEDICAL CENTER<br>1447 N. Harrison Street<br>Saginaw, MI 48602 | ) | |
| BAPTIST MEMORIAL HOSPITAL – BOONEVILLE<br>100 Hospital Drive<br>Booneville, MS 38829 | ) | |
| BAPTIST MEMORIAL HOSPITAL – DESOTO<br>7601 Southcrest Parkway<br>Southaven, MS 38671 | ) | |
| BAPTIST MEMORIAL HOSPITAL –<br>GOLDEN TRIANGLE<br>2520 5th Street North<br>Columbus, MS 39701 | ) | |
| BAPTIST MEMORIAL HOSPITAL-HUNTINGDON<br>631 R B Wilson Drive<br>Huntingdon, TN 38344 | ) | |
| BAPTIST MEMORIAL HOSPITAL – MEMPHIS<br>6019 Walnut Grove Road<br>Memphis TN 38120 | ) | |
| BAPTIST MEMORIAL HOSPITAL –<br>NORTH MISSISSIPPI<br>2301 South Lamar<br>Oxford, MS 38655 | ) | Civil Action No. |
| BAPTIST MEMORIAL HOSPITAL – TIPTON<br>1995 US-51<br>Covington, TN 38019 | ) | |
| BAPTIST MEMORIAL HOSPITAL – UNION CITY<br>1201 East Bishop Street<br>Union City, TN 38261 | ) | |
| BAPTIST MEMORIAL HOSPITAL UNION COUNTY<br>200 MS-30 W<br>New Albany, MS 38652 | ) | |

MISSISSIPPI BAPTIST MEDICAL CENTER
1225 N. State Street
Jackson, MS 39202

NEA BAPTIST MEMORIAL HOSPITAL
4802 East Johnson Avenue
Jonesboro, AR 72401

ST. AGNES MEDICAL CENTER
1303 E. Herndon Avenue
Fresno, CA 93720

ST. FRANCIS HOSPITAL AND MEDICAL CENTER
114 Woodland Street
Hartford, CT 06105

JOHNSON MEMORIAL HOSPITAL
201 Chestnut Road
Stafford Springs, CT 06076

ST. MARY'S HOSPITAL
56 Franklin Street
Waterbury, CT

ST. FRANCIS HOSPITAL
701 N. Clayton Street
Wilmington, DE 19805

HOLY CROSS HOSPITAL
4725 N. Federal Highway
Ft. Lauderdale, FL 33308

ST. MARY'S HEALTHCARE SYSTEM
1230 Baxter Street
Athens, GA 30606

ST. MARY'S SACRED HEART HOSPITAL, INC.
367 Clear Creek Drive
Lavonia, GA 30553

SAINT ALPHONSUS REGIONAL )
MEDICAL CENTER )
1055 North Curtis Road )
Boise, ID 83706 )
)
SAINT ALPHONSUS MEDICAL CENTER – NAMPA )
4300 East Flamingo Avenue )
Nampa, ID 83687 )
)
GOTTLIEB MEMORIAL HOSPITAL )
701 W. North Avenue )
Melrose Park, IL )
)
MACNEAL HOSPITAL )
3249 S. Oak Avenue )
Berwyn, IL 60402 )
)
MERCY HOSPITAL & MEDICAL CENTER )
2525 S. Michigan Avenue )
Chicago, IL 60616 )
)
LOYOLA UNIVERSITY MEDICAL CENTER )
2160 S. 1st Avenue )
Maywood, IL 60153 )
)
ST. JOSEPH REGIONAL MEDICAL CENTER )
5215 Holy Cross Parkway )
Mishawaka, IN 46545 )
)
SAINT JOSEPH REGIONAL MEDICAL CENTER- )
PLYMOUTH )
1915 Lake Avenue )
Plymouth, IN 46563 )
)
MERCY MEDICAL CENTER NORTH IOWA )
1000 4th Street SW )
Mason City, IA 50401 )
)
MERCY MEDICAL CENTER DUBUQUE )
250 Mercy Drive )
Dubuque, IA 52001 )
)
MERCY MEDICAL CENTER CLINTON )
1410 N. 4th Street )
Clinton, IA52732 )
)

MERCY MEDICAL CENTER SIOUX CITY )
801 5th Street )
Sioux City, IA 51101-1326 )
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MERCY MEDICAL CENTER )
1235 E. Cherokee Street )
Springfield, MO 65804 )
)
ST. MARY MERCY HOSPITAL )
36475 Five Mile Road )
Livonia, MI 48154 )
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ST. JOSEPH MERCY OAKLAND HOSPITAL )
44405 Woodward Avenue )
Pontiac, MI 48341-5023 )
)
ST. MARY'S HEALTH CARE SYSTEM )
200 Jefferson Avenue SE )
Grand Rapids, MI 49503 )
)
MERCY HEALTH HACKLEY CAMPUS )
1700 Clinton Avenue )
Muskegon, MI 49442-5502 )
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ST. JOSEPH MERCY HOSPITAL LIVINGSTON )
620 Byron Avenue )
Howell, MI 48843-1002 )
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ST. JOSEPH MERCY ANN ARBOR )
5301 McAuley Drive )
Ypsilanti, MI 48197 )
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ST. JOSEPH MERCY CHELSEA )
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Chelsea, MI 48118 )
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ST. FRANCIS MEDICAL CENTER )
601 Hamilton Avenue )
Trenton, NJ 08629 )
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ALBANY MEMORIAL HOSPITAL )
600 Northern Blvd. )
Albany, NY 12204 )
)
ST. PETER'S HOSPITAL )
315 S. Manning Blvd. )
Albany, NY 12208 )
)

ST. JOSEPH'S HOSPITAL HEALTH CENTER )
301 Prospect Avenue )
Syracuse, NY 13203 )
)
SAMARITAN HOSPITAL )
2215 Burdett Avenue )
Troy, NY 12180 )
)
SUNNYVIEW REHABILITATION HOSPITAL )
1270 Belmont Avenue )
Schenectady, NY 12308 )
)
MOUNT CARMEL ST. ANN'S HOSPITAL )
500 S. Cleveland Avenue )
Westerville, OH 43081 )
)
MOUNT CARMEL WEST )
6150 East Broad Street )
Columbus, OH 43213 )
)
MT. CARMEL NEW ALBANY SURGICAL HOSPITAL )
7333 Smith's Mill Road )
New Albany, OH 43054 )
)
SAINT ALPHONSUS MEDICAL CENTER )
ONTARIO, INC. HOLY ROSARY )
351 SW 9th Street )
Ontario, OR 97914 )
)
MERCY FITZGERALD HOSPITAL )
1500 Lansdowne Avenue )
Darby, PA 19023 )
)

NAZARETH HOSPITAL )
2601 Holme Avenue )
Philadelphia, PA 19152 )
)
ST. MARY MEDICAL CENTER )
1201 Langhorne Newton Road )
Langhorne, PA 19047 )

Plaintiffs, )
v. )
)
ALEX M. AZAR II, SECRETARY )
UNITED STATES DEPARTMENT OF )
HEALTH AND HUMAN SERVICES )
200 Independence Avenue, S.W. )
Washington, DC 20201 )
)
Defendant. )
)

**COMPLAINT FOR JUDICIAL REVIEW AND DECLARATORY AND INJUNCTIVE RELIEF UNDER THE MEDICARE ACT**

**NATURE OF ACTION**

1. The Plaintiff Hospitals (the "Hospitals") challenge the final determination of the Secretary of the Department of Health and Human Services (the "Secretary") and the Centers for Medicare & Medicaid Services ("CMS") for unlawfully failing make an increase of 0.7 percent to the Inpatient Prospective Payment System ("IPPS") rates in Federal fiscal year ("FFY") 2020 at issue to reverse the effect of a negative adjustment of 0.7 percent through 2017.

2. By continuing the 0.7 percent negative adjustment after FFY 2017, the Secretary has effectively extended an adjustment that Congress required be temporary, limited recoupments confined to statutorily specified FFYs. These limited changes were meant to address an administrative coding change to the IPPS that began in FFY 2008 and, anticipating an increase in aggregate payments, Congress authorized the Secretary to recoup the resulting overpayments. The first recoupment was to occur in FFYs 2010, 2011 and 2012, authorized

under the TMA [Transitional Medical Assistance], Abstinence Education and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA"), Pub. L. No. 110-90, § 7(b)(1)(B), 121 Stat. 984, 986-87 (2007). Then, Congress authorized additional adjustments to recover approximately $11 billion in overpayments, limiting the recoupments to FFYs 2014 through 2017. *Id.*, *as amended by* the American Taxpayer Relief Act of 2012 ("ATRA"), Pub. L. No. 112-240, § 631(b), 126 Stat. 2313 (2013).

3. Congress barred the Secretary from continuing any recoupment beyond FFY 2017 by stating that recoupment adjustments "shall not be included in the determination of standardized amounts for discharges occurring in a subsequent year." *Id.* § 7(b)(2). Despite several other amendments to the TMA over the subsequent years, that language remains.

4. To offset the recoupment adjustments from prior years, the Secretary should have adopted an increase in IPPS payments starting in FFY 2018. This increase was not fully made, and the Secretary did not reverse 0.7 percent of the total reduction. Because Congress did not authorize this permanent negative reduction to inpatient hospital payments, the Secretary's failure to reverse the 0.7 percent reduction in FFY 2018 (and onward) is in excess of the Secretary's statutory authority and otherwise not in accordance with law.

5. This action has reduced the Hospitals' Medicare reimbursement for inpatient services in FFY 2020 and will continue to do so in perpetuity.

6. Accordingly, the Hospitals seek an order requiring the Secretary to recalculate FFY 2020 inpatient payment rates to apply an additional 0.7 percent positive adjustment and make associated payments to the Hospitals.

## PARTIES

7. The Plaintiffs are the following Hospitals, all of which participated in the Medicare program during the relevant period:

- Baptist Memorial Hospital – Booneville, Medicare Provider No. 25-0044;
- Baptist Memorial Hospital – Desoto, Medicare Provider No. 25-0141;
- Baptist Memorial Hospital – Golden Triangle, Medicare Provider No. 25-0100;
- Baptist Memorial Hospital – Huntingdon, Medicare Provider No. 44-0016;
- Baptist Memorial Hospital – Memphis, Medicare Provider No. 44-0048;
- Baptist Memorial Hospital – North Mississippi, Medicare Provider No. 25-0034;
- Baptist Memorial Hospital – Tipton, Medicare Provider No. 44-0131;
- Baptist Memorial Hospital – Union City, Medicare Provider No. 44-0130;
- Baptist Memorial Hospital – Union County, Medicare Provider No. 25-0006;
- Mississippi Baptist Medical Center, Medicare Provider No. 25-0102;
- NEA Baptist Memorial Hospital, Medicare Provider No. 04-0118;
- Covenant Medical Center, Medicare Provider No. 23-0070;
- St. Agnes Medical Center, Medicare Provider No. 05-0093;
- St. Francis Hospital and Medical Center, Medicare Provider No.07-0002;
- Johnson Memorial Hospital, Medicare Provider No. 07-0008;
- St. Mary's Hospital, Medicare Provider No. 07-0016;
- St. Francis Hospital, Medicare Provider No. 08-0003;
- Holy Cross Hospital, Medicare Provider No. 10-0073;
- St. Mary's Healthcare System, Medicare Provider No. 11-0006;
- St. Mary's Sacred Heart Hospital, Inc., Medicare Provider No. 11-0027;
- Saint Alphonsus Regional Medical Center, Medicare Provider No. 13-0007;
- Saint Alphonsus Medical Center - Nampa, Medicare Provider No. 13-0013;
- Gottlieb Memorial Hospital, Medicare Provider No. 14-0008;
- MacNeal Hospital, Medicare Provider No. 14-0054;

- Mercy Hospital & Medical Center, Medicare Provider No. 14-0158;
- Loyola University Medical Center, Medicare Provider No. 14-0276;
- St. Joseph Regional Medical Center, Medicare Provider No. 15-0012;
- Saint Joseph Regional Medical Center – Plymouth, Medicare Provider No. 15-0076;
- Mercy Medical Center North Iowa, Medicare Provider No. 16-0064;
- Mercy Medical Center Dubuque, Medicare Provider No. 16-0069;
- Mercy Medical Center Clinton, Medicare Provider No. 16-0080;
- Mercy Medical Center Sioux City, Medicare Provider No. 16-0153;
- Mercy Medical Center, Medicare Provider No. 22-0066;
- St. Mary Mercy Hospital, Medicare Provider No. 23-0002;
- St. Joseph Mercy Oakland Hospital, Medicare Provider No. 23-0029;
- St. Mary's Health Care System, Medicare Provider No. 23-0059;
- Mercy Health Hackley Campus, Medicare Provider No. 23-0066;
- St. Joseph Mercy Hospital Livingston, Medicare Provider No. 23-0069;
- St. Joseph Mercy Ann Arbor, Medicare Provider No. 23-0156;
- St. Joseph Mercy Chelsea, Medicare Provider No. 23-0259;
- St. Francis Medical Center, Medicare Provider No. 31-0021;
- Albany Memorial Hospital, Medicare Provider No.35-0003;
- St. Peter's Hospital, Medicare Provider No. 33-0057;
- St. Joseph's Hospital Health Center, Medicare Provider No. 33-0140;
- Samaritan Hospital, Medicare Provider No.33-0180;
- Sunnyview Rehabilitation Hospital, Medicare Provider No. 33-0406;
- Mount Carmel St. Ann's Hospital, Medicare Provider No. 36-0012;
- Mount Carmel West, Medicare Provider No. 36-0035;

- Mt. Carmel New Albany Surgical Hospital, Medicare Provider No. 36-0266;
- Saint Alphnosus Medical Center Ontario, Inc. Holy Rosary, Medicare Provider No. 38-0052;
- Mercy Fitzgerald Hospital, Medicare Provider No. 36-0156;
- Nazareth Hospital, Medicare Provider No. 39-0204; and
- St. Mary Medical Center, Medicare Provider No. 39-0258.

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

9. The Centers for Medicare & Medicaid Services ("CMS") is the component of the Secretary's agency with responsibility for day-to-day operation and administration of the Medicare program. CMS was formerly known as the Health Care Financing Administration. References to CMS herein are meant to refer to the agency and its predecessors

**JURISDICTION AND VENUE**

10. This action arises under the Medicare statute, title XVIII of the Social Security Act, 42 U.S.C § 1395, the APA, 5 U.S.C. § 551, and 28 U.S.C. § 1361 (mandamus).

11. Jurisdiction is proper under 42 U.S.C. §§ 1395oo(a)(1)(A)(ii) and 1395oo(f)(1).

12. Venue is proper in this judicial district under 42 U.S.C. § 1395oo(f)(1).

## BACKGROUND

### A. MEDICARE PAYMENT FOR INPATIENT HOSPITAL SERVICES

13. The Medicare program provides federally funded health insurance for certain elderly and disabled persons under title XVIII of the Social Security Act. 42 U.S.C. § 1395. Part A of the Medicare program covers inpatient hospital services. 42 U.S.C. § 1395d(a)(1).

14. Medicare Part A pays hospitals for inpatient hospital services on a per discharge basis under the IPPS. 42 U.S.C. § 1395ww(d); 42 C.F.R. § 412.2(a). Hospitals receive payment under the IPPS for operating costs associated with covered inpatient discharges. 42 U.S.C. § 1395ww(d)(3); 42 C.F.R. § 412.2(c).

15. The amount paid for a covered discharge is the product of a base rate per discharge—the standardized amount as updated annually by the Secretary for inflation, 42 U.S.C. § 1395ww(d)(2)(C); 42 C.F.R. §412.64(c)—and the weighted rate for the patient's condition at the time of the admission—the diagnosis-related groups, 42 U.S.C. § 1395ww(d)(4); 42 C.F.R. § 412.60—relative to the average cost for treating Medicare beneficiaries in the same DRG.

16. The Secretary can make several types of adjustments to inpatient payment rates. The Secretary is required to adjust the weighted rates for each condition at least annually to account for changes in resource consumption, 42 U.S.C. § 1395ww(d)(4)(C)(i), made to reflect changes in treatment patterns, technology, and any other facts that may change the relative use of hospital resources. The Secretary may prospectively adjust the standardized amount when he determines that a change to the DRG classification and weighting factors are likely to result in a change in aggregate IPPS payments due to changes in coding and classification instead of changes in the mix of patients served. 42 U.S.C. § 1395ww(d)(3)(A)(vi). Lastly, the Secretary may also adjust the standardized amount by "provid[ing] by regulation for such other exceptions

and adjustments to such payment amounts under [section 1395ww(d)] as the Secretary deems appropriate." 42 U.S.C. §1395ww(d)(5)(I).

**B. CHRONOLOGY REGARDING THE ATRA ADJUSTMENT**

***1. Initial Documentation and Coding Adjustments***

17. In the FFY 2008 IPPS Final Rule, the Secretary implemented the Medicare severity diagnosis-related groups ("MS-DRG") classification system "to better recognize increased resource use due to severity of illness." 72 Fed. Reg. 47130, 47155 (Aug. 22, 2007). This change increased the number of payment groups from 538 to 745. *Id.* at 47170. Each MS-DRG is assigned a relative weight to reflect the average relative resources required to treat cases in the MS-DRG, and that amount is multiplied by the standardized amount to calculate IPPS payment. During the FFY 2008 rulemaking, the Secretary predicted that the MS-DRG rollout would incentivize providers to more accurately document and code their inpatient encounters, which was expected to result in an artificial increase in program payments "not respresent[ing] real increases in underlying resource demands." *Id.* at 47175.

18. The Secretary therefore estimated that a permanent documentation and coding adjustment of 4.8 percent to the standardized amount was necessary to maintain budget neutrality and eliminate the aggregate increase in payments that might flow from the more accurate coding of patient diagnoses. *Id.* at 47186. Purportedly acting on his authority under 42 U.S.C. § 1395ww(d)(3)(A)(vi), the Secretary reduced the standardized amount by 1.2 percent in FFY 2008, and proposed two sequential reductions in FFYs 2009 and 2010 in the amount of 1.8 percent. *Id.*

### *2. TMA and Prospective Adjustments and Limited Recoupment Through FFY 2012*

19. Shortly after the publication of the FFY 2008 IPPS Final Rule, Congress passed TMA. Section 7(a) of the TMA required the Secretary to reduce the negative 1.2 percent adjustment adopted for FFY 2008 to a negative 0.6 percent adjustment, and reduce the negative 1.8 percent adjustment proposed for FFY 2009 to negative 0.9 percent. TMA, § 7(a). Section 7(b)(1)(A) also required the Secretary to make further prospective and permanent adjustments as needed to budget-neutralize the MS-DRG rollout under 42 U.S.C. § 1395ww(d)(3)(A)(vi), but only after performing a retrospective evaluation of the discharge data for FFYs 2008 and 2009. *Id.* § 7(b)(1)(A). These latter adjustments would eliminate the effect of the coding and classification changes that do not reflect actual case mix changes in subsequent years, not recoup or repay overpayments or underpayments. TMA § 7(b)(1)(A); 42 U.S.C. §1395ww(d)(3)(A)(vi) (permitting the Secretary to "adjust the average standardized amounts . . . for subsequent fiscal years so as to eliminate the effect of such coding or classification changes").

20. Congress *also* directed the Secretary to determine whether additional adjustments were necessary to recoup or repay any change (positive or negative) in aggregate FFY 2008 and 2009 payments and to implement an appropriate adjustment for discharges in FFYs 2010 through 2012. TMA §7(b)(1)(B). However, Congress expressly prohibited the Secretary from making these adjustments permanent, stating that such adjustment "shall not be included in the determination of standardized amounts for discharges occurring in a subsequent year." TMA §7(b)(2).

### *3. ATRA and Additional Recoupment Through FFY 2016*

21. The Secretary did not fully phase in the prospective adjustments under section 7(b)(1)(A) until FFY 2013, and therefore alleged that payments in FFY 2010 through 2012 were

overstated. *See, e.g.*, 78 Fed. Reg. 27486, 27504 (May 10, 2013) ("delaying full implementation of the prospective portion of the adjustment . . . until FY 2013 resulted in payments in FY 2010 through FY 2012 being overstated"). As then drafted, TMA did not allow for recovery of those overpayments, as section 7(b)(1)(B) was limited to recoupments of overpayments from FFY 2008 and 2009 only.

22. Section 361 of ATRA, which added section 7(b)(1)(B)(ii) to TMA, addressed this issue and directed the Secretary to adjust the standardized rates for FFYs 2014 through 2017 to recoup $11 billion, representing the estimate of overpayments hospitals received due to the delay in implementing the adjustments necessary to budget neutralize the MS-DRG rollout. Importantly, ATRA explicitly limited recoupment to discharges "occurring only during fiscal years 2014, 2015, 2016 and 2017 . . . ." TMA § 7(b)(1)(B)(ii), *as amended by* ATRA § 631(b). This recoupment adjustment also remained subject to TMA's prohibition against recoupment adjustments continuing for discharges in subsequent years. TMA § 7(b)(2).

23. The Secretary applied the first ATRA-related cut in the FFY 2014 IPPS rule. At that time, the Secretary projected that it could recoup the $11 billion by applying four consecutive rate cuts of 0.8 percent each year between FFYs 2014 and 2017, for a cumulative reduction of 3.2 percent by FFY 2017. *See* 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013). Based on that initial projection, CMS adopted a 0.8 percent rate cut to the standardized amount in FFY 2014, and again in FFYs 2015 and 2016. *Id.*; 79 Fed. Reg. 49853, 49873 (Aug. 22, 2014); 80 Fed. Reg. 49325, 49345 (Aug. 17, 2015).

24. The Secretary indicated that the ATRA cuts were not to be a permanent reduction to inpatient payments, and that any negative adjustment would "eventually be offset by an equivalent positive adjustment once the full $11 billion recoupment requirement has been

realized." 78 Fed. Reg. at 50515. At no point during these three rulemakings did the Secretary propose a specific adjustment for FFY 2017 because "estimates of any future adjustments are subject to slight variations in total savings." 78 Fed. Reg. at 50515. However, the Secretary did reiterate his plan to implement an adjustment of "approximately" negative 0.8 percent in FFY 2017 for a total adjustment of negative 3.2 percent (accounting for adjustments in FFY 2014 through 2017). *See* 80 Fed. Reg. at 49345.

25. The Secretary also repeatedly reaffirmed that "the adjustment required under section 631 of ATRA is a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, any adjustment made to reduce rates in one year would eventually be offset by a positive adjustment, once the necessary amount of overpayment is recovered." *See*, *e.g.*, 79 Fed. Reg. at 49873, 78 Fed. Reg. at 50515, and 80 Fed. Reg. at 49345. This is consistent with the clear requirement under TMA section 7(b)(2) that any adjustment under section 7(b)(1)(B), including ATRA recoupment adjustments, "shall not be included in the determination of standardized amounts for discharges occurring in a subsequent year."

***4. MACRA and Additional Recoupment In FFY 2017***

26. In section 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), passed April 16, 2015, Congress instructed CMS *delay* (though not eliminate) the upward adjustment in FFY 2018, which Congress acknowledged the Secretary "estimated to be an increase of 3.2 percent," thus implying that Congress understood the negative adjustment through FFY 2017 to approximate 3.2 percent. Pub. L. No. 114-10, § 414, 129 Stat. 87, 162-63 (2015). Instead, MACRA instructed CMS to make six consecutive upward adjustments of 0.5 percent each year between FFYs 2018 and 2023, for a cumulative upward adjustment of 3.0 percent, rather than 3.2 percent, leaving the Secretary to implement any final restorative adjustment to fully offset the remaining ATRA adjustments in FFY 2024. *See* TMA § 7(b)(1)(B),

as amended. The Congressional Budget Office ("CBO") estimated that the reduction from 3.2 to 3.0 percent "would reduce direct spending by $15.1 billion over the 20182025 period." *See* CBO Cost Estimate and Supplemental Analyses for H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, dated March 25, 2015 at 7; *see also id.* at 12.

27. However, in a substantial departure from its previous estimates, the Secretary finalized a significantly higher negative adjustment to the standardized rate for FFY 2017: 1.5 percent instead of the 0.8 percent as originally planned "due to lower than previously estimated inpatient spending." 81 Fed. Reg. 56762, 56783 (Aug. 22, 2016). When coupled with the ATRA reductions from 2014 to 2016, this resulted in a cumulative reduction of 3.9 percent—0.7 percent higher than the 3.2 percent initially projected and 0.9 percent higher than the 3.0 percent cumulative positive adjustment mandated by MACRA. Such a large change is not the "slight" variation that the Secretary contemplated at 78 Fed. Reg. at 50515.

28. During the rulemaking process, commenters objected to this significant increase in the negative adjustment, and stated that MACRA ratified a negative 0.8 (not 1.5) percent reduction in FFY 2017 by expressly referencing the 3.2 percent adjustment in the statute. The Secretary disagreed, and argued that MACRA rendered the ATRA adjustments in excess of 3.0 percent permanent because the MACRA adjustments only totaled 3.0 percent—less than the expected 3.2 percent adjustment or the final 3.9 percent adjustment for FFY 2017. *See* 81 Fed. Reg. at 56783-84 ("[E]ven if we did not adopt an adjustment of -0.8 percent for FY 2017, the cumulative effect of our ATRA adjustment would be -3.2 percent, leaving a -0.2 percent gap between our ATRA adjustments and the MACRA adjustments. It is not clear to us that the MACRA provision was intended to augment or limit CMS' separate obligation, pursuant to the ATRA, to fully offset the $11 billion by FY 2017 under section 7(b)(1)(A)(ii) of the TMA, when

that language was not changed by the MACRA and, as noted, the MACRA would not fully restore even an estimated -3.2 percent adjustment."). The Secretary stated that he would "address the [MACRA] adjustments for FY 2018 and later in future rulemakings." *Id.* at 56784.

***5. 21st Century Cures and Failures in the FFY 2018 Rulemaking***

29. On December 13, 2016, Congress passed the 21st Century Cures Act, which replaced the 0.5 percent increase scheduled for 2018 (as implemented by MACRA) with a 0.4588 percent increase. Pub. L. No. 114-225, § 15005, 130 Stat. 1033, 1320 (2016). The remaining adjustments for years 2019 through 2023 were left at 0.5 percent. The CBO estimated that this would result in a negative $760 million in direct Medicare spending from 2017 through 2026. *See* CBO Direct Spending and Revenue Effects for H.R. 34, dated November 28, 2016.

*30.* In the 21st Century Cures Act, Congress *did not* amend the language in section 7(b)(1)(B)(iii) estimating the ATRA adjustments at issue to be 3.2 percent. Congress therefore also *did not* delay restoration of the additional 0.7 percent ATRA recoupment adjustment applied in FFY 2017 by amending this 3.2 percent language. Instead, Congress delayed restoration of a *mere* 0.0412 percent, but left intact the requirement that the "adjustment made under [section 7(B)(1)(B)] for discharges occurring in a year . . . not be included in the determination of standardized amounts for discharges occurring in a subsequent year."

31. Accordingly, in the FFY 2018 IPPS final rule, CMS increased the standardized amount by only 0.4588 percent. 82 Fed. Reg. 37991, 38009 (Aug. 14, 2017). The agency further proposed to make positive adjustments of 0.5 percent for FFYs 2019 through 2023. *Id.*

32. Commenters to the rulemaking noted that, if the Secretary were to adopt only a positive 0.4588 percent adjustment for FFY 2018, but continue the addition 0.7 percent ATRA reduction, hospitals would be left with a larger permanent cut that contemplated by Congress in MACRA. *See* 82 Fed. Reg. at 38009. Commenters also asserted that the Secretary's proposal to

apply just a 0.4588 positive adjustment misinterpreted the relevant statutory authority and thus urged the Secretary to restore the additional, positive 0.7 adjustment in FFY 2018. *Id.* This positive 0.7 percent adjustment is the difference between the *actual* ATRA adjustment of 3.9 percent and the initial CMS estimate of 3.2 percent. Commenters also requested that the Secretary use his "exceptions and adjustments" authority under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FFY 2018 adjustment by 0.7 percent. *Id.*

33. Notwithstanding these comments, CMS failed to restore the 0.7 percent additional ATRA reduction of IPPS payments imposed in FFY 2017, in violation of section 7(b)(2) of the TMA. *Id.* According to the Secretary, "the directive regarding the applicable adjustment for FY 2018 is clear" that it was required to finalize only a positive 0.4588 percent adjustment for FFY 2018, essentially continuing the negative 0.7 percent ATRA reduction permanently. *Id.*

34. The Secretary has therefore ignored the clear prohibition against continuing adjustments in subsequent years under TMA section 7(b)(2). Consequently, the Secretary unlawfully finalized a positive 0.4588 percent adjustment to the standardized amount for FFY 2018 instead of a 1.1588 percent adjustment (0.4588 + 0.7). The Secretary also erroneously stated that he was bound to this outcome without addressing commenters' request that he utilize his "exceptions and adjustments" authority under 42 U.S.C. § 1395ww(d)(5)(I).

35. Comments regarding the FY 2020 IPPS/LTCH PPS final rule confirm that this 0.7% reduction continued for FY 2020:

> Commenters asserted that the additional −0.7 percentage point adjustment made in FY 2017 has been improperly continued in FY 2018 and FY 2019, and failure to restore the additional 0.7 percentage point adjustment will make this reduction in hospital payments a permanent part of the baseline calculation of the IPPS rates, which, they contend, was not Congress's legislative intent in implementing the series of adjustments required under section 414 of the MACRA. Commenters urged CMS to use its exceptions and adjustments authority under

section 1886(d)(5)(I) to restore an additional 0.7 percentage point payment adjustment in FY2020 to restore payment equity to hospitals and comply. 84 Fed. Reg. 42057.

In response to the commenters, CMS stated:

> We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to adjust payments in FY 2020 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act. *Id.*

## C. THE MEDICARE APPEALS PROCESS

36. The Medicare Act, 42 U.S.C. 1395oo(a) entitles a provider of services under the Medicare program to a hearing before the Provider Reimbursement Review Board ("PRRB") if three prerequisites are met: (i) the provider is dissatisfied with a final determination of the Secretary as to the amount of the payment under the Medicare Act; (ii) the provider files a request for hearing within 180 days of the final determination; and (iii) the amount in controversy is at least $10,000 for an individual appeal or $50,000 for a group appeal. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835. If an appeal satisfies these requirements, the PRRB possesses jurisdiction to hear the appeal. *Id.*

37. Although Congress has limited the scope of judicial review of "determinations and adjustments" under section 7(b)(5) of the TMA ("There shall be no administrative or judicial review under section 1878 of the Social Security Act . . . or otherwise of any determination or adjustments made under this subsection"), Hospitals here do <u>not</u> challenge a "determination or adjustment" made under section 7. Rather, Hospitals challenge the Secretary's *ultra vires* failure to reverse a 0.7 percent <u>reduction</u>, which was required by Congress. The Hospitals also challenge

the Secretary's arbitrary and capricious failure to address comments urging him to use his exceptions and adjustments authority to offset the 0.7 percent reduction.

38. When the PRRB has jurisdiction to hear an appeal, but the appeal involves a statute, regulation, or policy that the PRRB is without authority to overturn, the PRRB may, through its own motion or upon request of the provider, grant expedited judicial review ("EJR") of the appeal. 42 U.S.C. § 1395oo(f)(1). If EJR is granted, the provider can seek judicial review in federal court without first having a hearing before the PRRB. *Id.* The provider must file its complaint no later than 60 days after receiving notice of the PRRB's decision to grant EJR. *Id.*

39. The Medicare statute allows providers to bring a civil action pursuant to the Administrative Procedure Act ("APA") through EJR. *See* 42 U.S.C. § 1395oo(f)(l).

40. The APA provides 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).

**D. PROCEDURAL HISTORY**

41. Pursuant to the procedures set forth at 42 U.S.C. § 1395oo, the Hospitals have challenged and are dissatisfied with the Secretary's failure to make a positive 0.7 percent adjustment to the FFY 2020 inpatient rates. The Hospitals filed appeals with the PRRB. The Hospitals' appeals satisfied all jurisdictional requirements for an appeal set forth at 42 U.S.C. § 1395oo(a)-(b).

42. In decisions dated March 27, 2020, the PRRB determined that it had jurisdiction to hear the Hospitals' appeals, but lacked authority to decide the legal questions at issue in this

case. The PRRB granted expedited judicial review ("EJR") for all of the Hospitals' appeals (Exhibits 1 and 2):

a. Covenant Medical Center, Case No. 02-0550 (Exhibit 1)

b. Baptist Memorial FFY 2020 0.7% ATRA Reduction CIRP Group
Case No. 20-0506GC (Exhibit 2

c. Trinity Health ATRA 2020 0.7% Reduction CIRP Group
Case No. 20-0535GC (Exhibit 2)

43. The Hospitals now file this civil action within 60 days of their receipt of the PRRB's EJR decisions, and claim that the Secretary's FY 2020 rulemaking, which failed to reverse 0.7 percent of the ATRA reductions, is unlawful for at least the substantive and procedural reasons set forth below.

**ERRORS IN THE SECRETARY'S RULEMAKING**

44. The Secretary's actions are 1) in excess of statutory authority, 2) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law, 3) without observance of procedure as required by law, and 4) otherwise defective both procedurally and substantively.

**A. The Secretary's Failure to Restore the 0.7 Percent ATRA Reduction Is Contrary to the Plain Meaning of TMA**

45. TMA explicitly requires that adjustments in one year may not apply in subsequent years. Although Congress made numerous revisions to section 7(b) of TMA, as discussed above, Congress never changed the requirement that each "adjustment made under [section 7(b)(1)(B)] for discharges occurring in a year . . . not be included in the determination of standardized amounts for discharges occurring in a subsequent year." *See* TMA § 7(b)(2). Congress has therefore consistently barred continued recoupment adjustments.

46. The ATRA adjustments were recoupment adjustments authorized under section 7(b)(1)(B), *including* the additional negative 0.7 percent adjustment applied in FFY 2017. Each ATRA recoupment adjustment must be reversed under section 7(b)(2) unless Congress explicitly authorizes CMS to continue such recoupment adjustment.

47. Congress did not intend to create an on-going negative adjustment to IPPS payments, and in MACRA and the 21st Century Cures Act, retained the language referencing the 3.2 percent estimate of ATRA adjustments to be reversed. Although Congress authorized the Secretary to continue *portions* of the ATRA recoupment adjustments into FFY 2023, MACRA § 414, it was silent as to the disposition of the additional, negative 0.7 percent recoupment adjustment applied in FFY 2017, and thus never authorized CMS to continue this additional negative recoupment adjustment of 0.7 percent. This is particularly true, given Congress's

passage of the 21st Century Cures Act, which could have authorized CMS's 0.7 percent adjustment (then published in final rulemaking), but did not; instead, it merely delayed 0.0412 of the original 3.2 percent recoupment. In absence of express authorization, the negative 0.7 percent recoupment must be reversed under section 7(b)(2).

48. The Secretary is aware of section 7(b)(2)'s requirement, and has even noted multiple times that "the adjustment required under section 631 of the ATRA is a one-time recoupment of a prior overpayment, not a reduction to payment rates. Therefore, … any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment, once the necessary amount of overpayment is recovered." 80 Fed. Reg. at 49345, 79 Fed. Reg. at 49873, 78 Fed. Reg. at 50515.

49. However, TMA section 7(b)(2) makes unlawful the Secretary's decision to only adjust the standardized amount by 0.4588 percent in FFY 2018, and its plan to increase the adjustment to the standardized amount by just 0.5 percent in FFYs 2019 through 2023 makes this reduction permanent. The Secretary has no discretion under 7(b)(2) to act otherwise.

50. This permanent negative reduction is therefore contrary to the plain language of TMA section 7(b)(2) and the Secretary is obligated to fully restore the ATRA adjustment by 1) restoring the residual ATRA adjustment of 0.7 percent in FFY 2018, 2) applying positive adjustments for FFY 2018 through 2023 as specified in MACRA section 414, *as amended by* 21$^{st}$ Century Cures section 15005, and, 3) in FFY 2024, make a final positive adjustment of 0.24 percent to complete the required restoration of the ATRA adjustments.

51. To the extent the Secretary suggests that MACRA § 414, *as amended by* 21$^{st}$ Century Cures § 15005, rescinded the TMA's command to restore the 0.7 percent payment cut, he is wrong. *See* 82 Fed. Reg. at 38009 (Secretary noting that 21$^{st}$ Century Cures was

enacted *after* it proposed and finalized the negative 1.5 percent reduction in FFY 2017). The House of Representative originally contemplated reducing the 0.5 percent MACRA increase with a lower increase in the Helping Hospitals Improve Patient Care Act of 2016. *See* H.R. 5273, 114th Cong. (2016), § 105 (introduced on May 18, 2016 and proposing to amend the TMA by reducing the 0.5 percent to 0.4599 percent). The House Ways and Means Committee report on the proposed legislation changed the reduction to 0.459 and stated that "[u]nder current law, hospitals are receiving a 0.8 percent reduction in payments, as mandated by [ATRA]." *See* H. Comm. on Ways and Means, Helping Hospitals Improve Patient Care Act of 2016, H.R. Rep. 114-604, at 12 (2016); *see also id.* at 5 (slightly revising proposed language).

52. Although the Helping Hospitals Improve Patient Care Act of 2016 was never passed, the draft language contained in the Committee's report was used nearly verbatim in 21st Century Cures, save for the slight reduction moving from 0.459 to 0.4588. Thus, at the time the relevant language was drafted (the same language that was eventually incorporated into 21st Century Cures), CMS had not finalized a policy to reduce FFY 2017 payments by 1.5 percent instead of 0.8 percent. Therefore, that language cannot be construed as authorizing the additional 0.7 percent payment cut.

53. Furthermore, the CBO scoring of 21st Century Cures indicates that the legislation was not meant to adopt the 0.7 percent reduction. The CBO scored a reduction in direct Medicare spending of just $760 **million** over a 10-year period. It stands to reason that this reduction is solely related to the reduction of the 0.5 percent increase to 0.4588 percent (*i.e.*, a change of 0.0412. Had Congress intended to apply (and had CBO scored) a larger reduction of 0.7412 percent (0.0412 + 0.7), the change in direct spending would be much more significant. By

point of contrast, the CBO scored the MACRA change of just 0.2 percent (from 3.2 to 3.0) at $15.1 **billion** over 8 years.

### B. The Secretary's Failure to Exercise or Even Recognized His Discretion Under 42 U.S.C. § 1395ww(d)(5)(I) Is Arbitrary and Capricious

54. Even if the Secretary were not *mandated* to restore the 0.7 percent payment cut, at a minimum, he has the discretion to do so under his power to implement "exceptions and adjustments to such payment amounts . . . as the Secretary deems appropriate." 42 U.S.C. § 1395ww(d)(5)(I). The Secretary has committed reversible error, therefore, in suggesting in the FFY 2018 IPPS Final Rule that he did not have the authority to make this curative adjustment. 82 Fed. Reg. at 38009.

55. In addition, the APA requires the Secretary to sufficiently and rationally explain his reasoning for his actions, findings or conclusions; to do otherwise is prohibitively arbitrary and capricious. *See* 5 U.S.C. § 706(2)(A). The Secretary is also barred under the APA from implementing the Medicare statute through actions, findings, or conclusions without observance of required procedure. 5 U.S.C. §706(2)(D). For example, the Secretary is required to provide notice of proposed rulemaking, afford interested parties an opportunity to comment, and consider the relevant matters presented. *See* 5 U.S.C. § 533. The Medicare statute itself also prohibits the application of any rule or policy that establishes or changes a substantive legal standard governing payment for services unless promulgated via regulation. 42 U.S.C. § 1395hh(a).

56. As highlighted above, numerous commenters during the FFY 2018 rulemaking requested that the Secretary exercise his "exceptions and adjustments" authority under 42 U.S.C. § 1395ww(d)(5)(I) to apply a positive adjustment of 0.7 percent in FFY 2018, in addition to the 0.4588 percent adjustment required under 21st Century Cures. *See* 82 Fed. Reg. at 38009. Since the final rulemaking did not engage with the commenters' requests, at a minimum, the Secretary

failed to provide a rational or sufficient explanation for his refusal to exercise his discretion rendering that refusal since the only purpose of the ATRA reductions was to recoup $11 billion, and because that purpose was fulfilled in 2017, it was an abuse of discretion for the Secretary not to reverse these reductions once the entire rational for their existence had been removed.

**COUNT I**
**Violation of the Administrative Procedure Act, Medicare Statute, and Other Statutes: The Secretary's Failure to Restore the ATRA Reduction Is Contrary to Law**

57. The allegations set forth in paragraphs 1 through 56 are incorporated by reference as if fully set forth herein.

58. Under the APA, the Secretary may not act in a way that is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law, 5 U.S.C. § 706(2)(A), or that is in excess of statutory jurisdiction, authority, or limitations, or short of statutory right. 5 U.S.C. § 706(2)(C).

59. The multi-year and possibly permanent 0.7 percent ATRA reduction in inpatient hospital payment rates is unlawful and should be set aside. Section 7(b)(2) of the TMA, as amended, requires that any adjustment under section 7(b)(1)(B)—including the ATRA recoupment adjustments—"shall not be included in the determination of standardized amounts for discharges occurring in a subsequent year." The Secretary has no authority to continue recoupment adjustments into subsequent years except as specifically direct by Congress in the TMA.

60. Further, Congress only authorized the Secretary to continue an ATRA recoupment adjustment of approximately 3.2 percent in section 7(b)(1)(B)(iii). Despite amending the TMA in 2016 (after CMS had finalized the additional negative 0.7 percent ATRA adjustment), Congress did not amend the TMA to replace the reference to a 3.2 percent

adjustment with a reference to a 3.9 percent adjustment or to otherwise authorize the Secretary to continue the additional 0.7 percent recoupment adjustment. Absent such statutory authorization for continuing the 0.7 percent payment reduction, the Secretary's action is unlawful.

61. In sum, the Secretary's failure to restore the 0.7 percent ATRA reduction in FFY 2018 is inconsistent with the TMA, as amended, and thus "not in accordance with law."

**COUNT II**
**Violation of the Administrative Procedure Act, Medicare Statute, and Other Statutes: The Secretary's Refusal to Exercise Discretion Under 42 U.S.C. § 1395ww(d)(5)(I) is Arbitrary and Capricious, Contrary to Law and an Abuse of Discretion**

62. The allegations set forth in paragraphs 1 through 61 are incorporated by reference as if fully set forth herein.

63. Conduct by an agency is considered arbitrary and capricious when it is not explained, or when it is not rationally explained. *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43 (*quoting Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962)).

64. The Secretary's suggestion in the FFY 2018 IPPS Final Rule that he did not have the authority to restore the 0.7 percent payment cut is contrary to law because 42 U.S.C. § 1395ww(d)95)(I) gives him the discretion to implement "exceptions and adjustments to such payment amounts . . . as the Secretary deems appropriate."

65. At a minimum, the Secretary's failure to adequately explain the rationale or fully address his decision for not applying his "exceptions and adjustments" discretion under 42 U.S.C. §1395ww(d)(5)(I) is thus arbitrary and capricious and violates the APA.

66. In addition, the Secretary's refusal to exercise his discretion under 42 U.S.C. § 1395ww(d)(5)(I) is an abuse of discretion since the sole purpose of the cuts at issue were to recoup the $11 billion contemplated by ATRA and that purpose was accomplished by FFY 2017. Therefore, there was no rational basis or justification for the Secretary to leave a portion of those

reductions in place when the Secretary certainly had at least the discretion (if not the mandate) to restore them.

**COUNT III**
**Violation of the Administrative Procedure Act, Medicare Statute, and Other Statutes: The Secretary's Refusal to Exercise Discretion Under 42 U.S.C. § 1395ww(d)(5)(I) is Arbitrary and Capricious Because the Secretary Failed to Observe the Procedure Required by Law**

67. The allegations set forth in paragraphs 1 through 66 are incorporated by reference as if fully set forth herein.

68. The APA proscribes agency action that is "without observance of procedure required by law." 5 U.S.C. § 706(2)(D); *see also* § 706(2)(A). The APA's procedural requirements include that the Secretary (a) provide a notice of proposed rulemaking, (b) afford interested parties the opportunity to provide comments, and (c) consider those comments before finalizing the rule. 5 U.S.C. § 553(b)-(c).

69. The Social Security Act, 42 U.S.C. § 1395hh(a), also requires the Secretary to utilize public notice-and-comment rulemaking procedures when establishing substantive changes in payment for services covered under the Medicare statute.

70. The Medicare statute provides that "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation." 42 U.S.C. § 1395hh(a)(2).

71. The Secretary wholly failed in the FFY 2018 IPPS Final Rule to address commenters' questions and requests regarding the exercise of his "exceptions and adjustments" authority under 42 U.S.C. § 1395ww(d)(5)(I), and it is thus not clear that the Secretary

considered the commenters' relevant questions and requests concerning FFY 2018 reductions to the IPPS base payment rate.

**COUNT IV**
**Mandamus (28 U.S.C. § 1361)**

72. The allegations set forth in paragraphs 1 through 70 are incorporated by reference as if fully set forth herein.

73. The Secretary has the non-discretionary duty to reimburse Hospitals fully at the amounts to which they are entitled under the law. The Secretary's failure to restore the additional 0.7 percent ATRA reduction violates the APA and the TMA. Under the Court's authority pursuant to 28 U.S.C. § 1361, the Hospitals are entitled to issuance of a writ of mandamus, directing the Secretary to reverse the unlawful 0.7 percent payment reduction and apply a positive adjustment of 0.7 percent for FFY 2020.

**COUNT V**
**Violation of the Administrative Procedure Act and Medicare Statute:**
**The Secretary's Dismissal of the Appeal of Saint Michael's Medical Center Is In Excess of Statutory Authority**

74. The allegations set forth in paragraphs 1 through 72 are incorporated by reference as if fully set forth herein.

75. Review of final PRRB decisions is conducted under the applicable provisions of the APA. 42 U.S.C. § 1395oo(f)(1).

76. Under the APA, 5 U.S.C. § 706(2)(A) & (C), this Court is required to hold unlawful and set aside final agency action that is "arbitrary, capricious [or] an abuse of discretion," or "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right."

77. The PRRB's decision to dismiss Saint Michaels' Medical Center from the group appeal is arbitrary and capricious because the PRRB has been known to exercise greater leniency to providers for omitting jurisdictional documentation from their appeals, as Saint Michael's Medical Center did here. In many cases, the PRRB will give providers an opportunity to resubmit their jurisdictional documentation rather than outright dismissing the provider's appeal. The PRRB's inconsistent enforcement of the rule for which Saint Michael's Medical Center's appeal was dismissed constitutes arbitrary and capricious action.

78. Furthermore, the PRRB's decision to dismiss the provider absent an opportunity to cure the purported deficiencies with its appeal was an abuse of discretion.

79. The PRRB also erred in dismissing Saint Michael's Medical Center from the HRS Prime Healthcare FFY 2018 ATRA IPPS 0.7% Rate Reduction Group (PRRB Case No. 18-0497GC) because the appeal *did* satisfy the three requirements for PRRB jurisdiction. Specifically, the provider (1) was dissatisfied with the final determination as to the amount of program reimbursement due to the provider for the period covered by such cost report, (2) the amount in controversy was at least $50,000; and (3) Saint Michael's Medical Center filed its request for hearing within 180 days after notice of the final determination. *See* 42 U.S.C. § 1395oo(a). Therefore, the PRRB's dismissal of Saint Michael's Medical Center from the group appeal was contrary to statute.

## II. RELIEF REQUESTED

The Hospitals request an Order:

(a) Declaring that the Secretary's failure to restore the 0.7 percent ATRA reduction in the FFY 2020 IPPS final rules (or otherwise) is arbitrary, capricious, an abuse of discretion, and otherwise not in accordance with law;

(b) Directing the Secretary to apply a positive adjustment of 1.1588 percent for FFY 2020, reflecting the sum of the 0.4588 percent adjustment

mandated under section 414 of MACRA, as amended by section 15005 of 21st Century Cures, and the 0.7 percent adjustment required to offset the additional negative adjustment applied in FFY 2017 under section 631 of ATRA; and make the payments due to the Hospitals with interest determined in accordance with 42 U.S.C. § 1395oo(f)(2);

(c) Requiring the Secretary to pay legal fees and cost of suit incurred by the Hospitals; and

(d) Providing such other relief as the Court may consider appropriate.

Respectfully Submitted,

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