UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

ARTHUR G. JAMES CANCER HOSPITAL
460 West 10th Avenue
Columbus, OH 43210

and

OHIO STATE UNIVERSITY HOSPITAL
410 10th Avenue
Columbus, OH 43210

and

MIAMI VALLEY HOSPITAL
1 Wyoming Street
Dayton, OH 45409

and

GOOD SAMARITAN
HOSPITAL & HEALTH CENTER
2222 Philadelphia Drive
Dayton, OH 45406

and

MAIMONIDES MEDICAL CENTER
4802 Tenth Avenue
Brooklyn, NY 11219

and

STRONG MEMORIAL HOSPITAL
601 Elmwood Avenue
Rochester, New York 14642

and

SAINT LUKE'S HOSPITAL
OF BETHLEHEM, PENNSYLVANIA
d/b/a St. Luke's Hospital
801 Ostrum Street
Bethlehem, PA 18015

and

Case No. 20-cv-460

HMH HOSPITALS CORPORATION
d/b/a Hackensack University Medical Center
30 Prospect Avenue
Hackensack, NJ 07601

and

HMH HOSPITALS CORPORATION
d/b/a Jersey Shore University Medical Center
1945 Corlies Avenue
Neptune, NJ 07753

and

HIGHLAND HOSPITAL OF ROCHESTER
1000 South Avenue
Rochester, NY 14620

and

TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA
d/b/a Hospital of the University of Pennsylvania
3400 Spruce Street
Philadelphia, PA 19104

and

PRESBYTERIAN MEDICAL CENTER OF THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
d/b/a Penn Presbyterian Medical Center
51 N. 39th Street
Philadelphia, PA 19104

and

THE PENNSYLVANIA HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
d/b/a Pennsylvania Hospital
800 Spruce Street
Philadelphia, PA 19107

Plaintiffs,

vs.

ALEX M. AZAR II,
in his official capacity as
Secretary of the United States Department of
Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Defendant.

COMPLAINT FOR JUDICIAL REVIEW AND DECLARATORY RELIEF AND SUMS DUE UNDER THE MEDICARE STATUTE

INTRODUCTION

1. This is a civil action brought to obtain judicial review of agency decisions regarding Medicare reimbursements rendered by Alex M. Azar II (the "Secretary" or "Defendant") in his official capacity as the Secretary of the United States Department of Health and Human Services. Plaintiffs are hospitals that participate in the Medicare program and qualify under the Medicare program for direct graduate medical education ("DGME") payments for training medical residents. Plaintiffs seek an order setting aside the Secretary's regulation at 42 C.F.R. § 413.79(c)(2)(iii), which unlawfully reduces Plaintiffs' DGME payments by decreasing the number of residents that Plaintiffs may claim during a fiscal year.

2. Plaintiffs operate approved medical training programs for physician residents and fellows (collectively "residents"). Plaintiffs receive Medicare DGME payments, which are calculated, in part, based on the number of full-time equivalent ("FTE") residents that train at each hospital. If a resident exceeds the number of years designated as the "initial residency period" ("IRP"), the resident's time is weighted at 0.5, which means that the hospital may only count one-half of the resident's time that exceeds the IRP. Also, the number of FTEs that a hospital may

claim for payment in any given year is generally capped at the number of *unweighted* FTEs that it trained in its 1996 fiscal year.

3. The regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the Medicare statute because it calculates a hospital's DGME payments using a weighted FTE cap rather than an unweighted FTE cap. 42 U.S.C. § 1395ww(h)(4)(F). The effect of the unlawful regulation is to impose on Plaintiffs a weighting factor on residents that are within their IRP or, viewed differently, results in a reduction of greater than 0.5 for many residents who are beyond the IRP, which prevents Plaintiffs from claiming their full FTE caps authorized by statute. Thus, the calculations of the current-year, prior-year, and penultimate-year weighted DGME FTEs (all three of which are elements of a hospital's DGME calculation in a given year) and the FTE caps are contrary to the statutory provision at 42 U.S.C. § 1395ww(h), and, as a result, Plaintiffs' DGME payments are unlawfully understated.

4. The Secretary's application of this regulation violates the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.* (2012) (the "APA"); is contrary to the Medicare statute; is arbitrary, capricious, and an abuse of discretion; and otherwise contrary to law. Accordingly, Plaintiffs ask this Court to reverse the Secretary's final agency decisions and to order the Secretary to recalculate Plaintiffs' DGME payments as required by statute.

JURISDICTION AND VENUE

5. This action arises under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (2012) (the "Medicare statute"), which establishes the Medicare program, and the APA.

6. This Court has jurisdiction under 42 U.S.C. § 1395oo(f)(1), which grants Medicare providers the right to obtain expedited judicial review ("EJR") of any action involving "a question of law or regulations relevant to the matters in controversy" when the Secretary's Provider

Reimbursement Review Board (the "Board") "determines . . . that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received." The Board granted EJR to Plaintiffs in decisions dated January 8, 2020 and January 14, 2020. Accordingly, this action is timely filed within the sixty-day limitations period established at 42 U.S.C. § 1395oo(f)(1). Plaintiffs have exhausted all administrative remedies prior to commencing this action.

7. Venue in this Court is proper under 42 U.S.C. § 1395oo(f)(1).

PARTIES

8. Plaintiff Arthur G. James Cancer Hospital is an academic medical center located in Columbus, Ohio. Arthur G. James Cancer Hospital participates in the Medicare program and has been assigned Medicare Provider Number 36-0242. Arthur G. James Cancer Hospital operates graduate medical education programs and receives Medicare DGME payments. Arthur G. James Cancer Hospital contests the Medicare reimbursement decisions for its fiscal years ending June 30, 2015 and June 30, 2016.

9. Plaintiff Ohio State University Hospital ("OSU Hospital") is an academic medical center located in Columbus, Ohio. OSU Hospital participates in the Medicare program and has been assigned Medicare Provider Number 36-0085. OSU Hospital operates graduate medical education programs and receives Medicare DGME payments. OSU Hospital contests the Medicare reimbursement decisions for its fiscal years ending June 30, 2015 and June 30, 2016.

10. Plaintiff Miami Valley Hospital is an academic medical center located in Dayton, Ohio. Miami Valley Hospital participates in the Medicare program and has been assigned Medicare Provider Number 36-0051. Miami Valley Hospital operates graduate medical education

programs and receives Medicare DGME payments. Miami Valley Hospital contests the Medicare reimbursement decision for its fiscal year ending December 31, 2015.

11. Plaintiff Good Samaritan Hospital & Health Center is an academic medical center located in Dayton, Ohio. Good Samaritan Hospital & Health Center participates in the Medicare program and has been assigned Medicare Provider Number 36-0052. Good Samaritan Hospital & Health Center operates graduate medical education programs and receives Medicare DGME payments. Good Samaritan Hospital & Health Center contests the Medicare reimbursement decision for its fiscal year ending December 31, 2015.

12. Plaintiff Maimonides Medical Center is an academic medical center located in Brooklyn, New York. Maimonides Medical Center participates in the Medicare program and has been assigned Medicare Provider Number 33-0194. Maimonides Medical Center operates graduate medical education programs and receives Medicare DGME payments. Maimonides Medical Center contests the Medicare reimbursement decisions for its fiscal years ending December 31, 2009 and December 31, 2014.

13. Plaintiff Strong Memorial Hospital is an academic medical center located in Rochester, New York. Strong Memorial Hospital participates in the Medicare program and has been assigned Medicare Provider Number 33-0285. Strong Memorial Hospital operates graduate medical education programs and receives Medicare DGME payments. Strong Memorial Hospital contests the Medicare reimbursement decisions for its fiscal years ending December 31, 2009 and December 31, 2014.

14. Plaintiff Saint Luke's Hospital of Bethlehem Pennsylvania d/b/a St. Luke's Hospital is an academic medical center located in Bethlehem, Pennsylvania. St. Luke's Hospital participates in the Medicare program and has been assigned Medicare Provider Number 39-0049.

St. Luke's Hospital operates graduate medical education programs and receives Medicare DGME payments. St. Luke's Hospital contests the Medicare reimbursement decision for its fiscal year ending in June 30, 2014.

15. Plaintiff HMH Hospitals Corporation d/b/a/ Hackensack University Medical Center is an academic medical center located in Hackensack, New Jersey. Hackensack University Medical Center participates in the Medicare program and has been assigned Medicare Provider Number 31-0001. Hackensack University Medical Center operates graduate medical education programs and receives Medicare DGME payments. Hackensack University Medical Center contests the Medicare reimbursement decision for its fiscal year ending December 31, 2014.

16. Plaintiff HMH Hospitals Corporation d/b/a Jersey Shore University Medical Center is an academic medical center located in Neptune, New Jersey. Jersey Shore University Medical Center participates in the Medicare program and has been assigned Medicare Provider Number 31-0073. Jersey Shore University Medical Center operates graduate medical education programs and receives Medicare DGME payments. Jersey Shore University Medical Center contests the Medicare reimbursement decision for its fiscal year ending December 31, 2014.

17. Plaintiff Highland Hospital of Rochester is an academic medical center located in Rochester, New York. Highland Hospital of Rochester participates in the Medicare program and has been assigned Medicare Provider Number 33-0164. Highland Hospital of Rochester operates graduate medical education programs and receives Medicare DGME payments. Highland Hospital of Rochester contests the Medicare reimbursement decision for its fiscal year ending December 31, 2014.

18. Plaintiff Trustees of the University of Pennsylvania d/b/a Hospital of the University of Pennsylvania is an academic medical center located in Philadelphia, Pennsylvania. Hospital of

the University of Pennsylvania participates in the Medicare program and has been assigned Medicare Provider Number 39-0111. Hospital of the University of Pennsylvania operates graduate medical education programs and receives Medicare DGME payments. Hospital of the University of Pennsylvania contests the Medicare reimbursement decision for its fiscal year ending June 30, 2013.

19. Plaintiff Presbyterian Medical Center of the University of Pennsylvania Health System d/b/a Penn Presbyterian Medical Center is an academic medical center located in Philadelphia, Pennsylvania. Penn Presbyterian Medical Center participates in the Medicare program and has been assigned Medicare Provider Number 39-0223. Penn Presbyterian Medical Center operates graduate medical education programs and receives Medicare DGME payments. Penn Presbyterian Medical Center contests the Medicare reimbursement decision for its fiscal year ending June 30, 2013.

20. Plaintiff The Pennsylvania Hospital of the University of Pennsylvania Health System d/b/a Pennsylvania Hospital is an academic medical center located in Philadelphia, Pennsylvania. Pennsylvania Hospital participates in the Medicare program and has been assigned Medicare Provider Number 39-0226. Pennsylvania Hospital operates graduate medical education programs and receives Medicare DGME payments. Pennsylvania Hospital contests the Medicare reimbursement decision for its fiscal year ending June 30, 2013.

21. Defendant Alex M. Azar II is the Secretary of the Department of Health and Human Services and is the federal officer responsible for administering the Medicare program pursuant to the Social Security Act. Defendant is sued in his official capacity. References to "Defendant" or "Secretary" herein are meant to refer to him, his subordinates, his official predecessors or successors, and the Department and its components that he oversees, as the context requires.

BACKGROUND

I. The Medicare Program and Payment for Hospital Services

22. Medicare is a public health insurance program that generally furnishes health benefits to participating individuals once they reach the age of 65. 42 U.S.C. § 1395c. The Secretary has delegated much of the responsibility for administering the Medicare program to the Centers for Medicare and Medicaid Services ("CMS"), which is a component of the Department of Health and Human Services.

23. Under the Medicare statute, an eligible Medicare beneficiary is entitled to have payment made by Medicare on his or her behalf for, *inter alia*, inpatient and outpatient hospital services provided by a hospital participating in the Medicare program as a provider of health care services. *Id.* The Medicare program consists of four Parts: A, B, C, and D. Inpatient hospital services are paid under Part A of the Medicare statute. *Id.* § 1395d(a). Physician, hospital outpatient, and certain other services are paid under Medicare Part B. *Id.* § 1395k(a). Medicare Part C is an optional managed care program that pays for services that would otherwise be covered under Medicare Parts A and B. *Id.* §§ 1395w-21–1395w-29. Medicare Part D is an optional insurance program for prescription drugs. *Id.* §§ 1395w-101–1395w-154. This action concerns Medicare Part A.

II. Direct Graduate Medical Education

24. The Medicare statute reimburses hospitals for the direct costs of graduate medical education. 42 U.S.C. § 1395ww(h). The DGME payment is calculated by multiplying a hospital's "patient load" times its "approved amount." 42 U.S.C. § 1395ww(h)(3)(A). The "patient load" is "the fraction of the total number of inpatient-bed-days . . . during the period which are attributable to patients with respect to whom payment may be made under [Medicare] part A." 42 U.S.C. §

1395ww(h)(3)(C). The "approved amount" is the product of a hospital's base-period per-resident amount ("PRA") and its weighted average number of FTE residents. *Id*. § 1395ww(h)(3)(B); 42 C.F.R. § 413.76(a). The weighted average number of FTEs is calculated using the average of "the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods." 42 U.S.C. § 1395ww(h)(4)(G). This action concerns the FTE component of the DGME payment calculation. The following is the basic formula for calculating a hospital's DGME payment:

PRA x (3-year FTE average) x (Medicare Patient Load) = DGME Payment

25. When determining the FTE count, residents who are beyond their IRP are weighted at 0.5, so that only half their time is counted. *Id.* § 1395ww(h)(4)(C). The IRP is defined as the period necessary for board eligibility in the resident's training program, not to exceed five years. *Id.* § 1395ww(h)(5)(F). Most, though not all, residents who are beyond the IRP are participating in post-residency fellowship programs.

26. For cost reporting periods beginning on or after October 1, 1997, Congress established a cap on the number of *unweighted* DGME FTEs that a hospital may count, which is set at each hospital's number of unweighted FTEs during its most recent fiscal year that ended on or before December 31, 1996. *Id.* § 1395ww(h)(4)(F).[1] Thus, a hospital's three-year FTE average in the DGME formula is limited by the number of unweighted FTEs that the hospital trained in its 1996 cost reporting period. The FTE cap is determined "before application of weighting factors" based on the IRP. *Id.* § 1395ww(h)(4)(F)(i).

27. In 1997, the Secretary promulgated a regulation to implement the 1996 cap that calculates a *weighted* FTE cap to be used in the payment calculation:

[1] This cap is subject to limited adjustment under certain other statutory provisions, however such adjustments do not impact the method of calculating DGME payment.

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, exceeds the limit described in this paragraph (g) [i.e., the 1996 unweighted cap], the hospital's weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

42 C.F.R. § 413.86(g)(4) (1997).

28. When issuing this regulation, the Secretary stated, "We believe this proportional reduction in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision." Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates, 62 Fed. Reg. 45,966, 46,005 (Aug. 29, 1997) (final rule with comment period); Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates, 63 Fed. Reg. 26,318, 26,330 (May 12, 1998) (final rule) (hereinafter "FY 1998 IPPS Rule").

29. On August 1, 2001, the Secretary amended the regulation to determine separate weighted FTE caps for primary care residents and non-primary care residents, effective for cost reporting periods beginning on or after October 1, 2001. 42 C.F.R. § 413.86(g)(4)(iii) (2001); Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Rates and Costs of Graduate Medical Education: Fiscal Year 2002 Rates, 66 Fed. Reg. 39,828, 39,893-96 (Aug. 1, 2001) (hereinafter the "FY 2002 IPPS Rule"). The Secretary did not change the formula for determining the weighted FTE cap. Rather, the Secretary used the same methodology as in the 1997 rule to calculate a primary care weighted FTE cap and a non-primary care weighted FTE cap, which are then added together. 42 C.F.R. § 413.86(g)(4)(iii); FY 2002 IPPS Rule, 66 Fed. Reg. at 39,894.

30. In 2004, CMS redesignated the regulation from 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii). Medicare Program; Changes to the Hospital Inpatient Prospective

Payment Systems and Fiscal Year 2005 Rates, 46 Fed. Reg. 48,916, 49,112, 49,258-64 (Aug. 11, 2004).

31. The regulation in effect during all fiscal years at issue in this action states as follows:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [i.e., the 1996 unweighted cap], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

42 C.F.R. § 413.79(c)(2)(iii) (2010-2017). This regulation is still in effect today.

32. The Secretary's regulation at 42 C.F.R. § 413.79(c)(2)(iii) calculates the ratio of a hospital's unweighted FTE cap to the hospital's current-year unweighted FTE count. 42 C.F.R. § 413.79(c)(2)(ii)-(iii) (the "proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996"). This ratio represents the percentage by which the hospital's 1996 cap is above or below the current-year unweighted FTE count. The ratio is then multiplied by the current-year weighted FTE count (both residents within and beyond their IRP) to reduce the weighted count. *Id.* The resulting number is the weighted FTE cap. The Secretary's methodology is expressed in the following equation:

(1996 FTE Cap)/(Unweighted FTEs) x Weighted FTEs = Weighted FTE Cap

The Secretary describes the result of this formula as "the hospital's reduced cap." FY 2002 IPPS Rule, 66 Fed. Reg. at 39,894.

33. The regulation calculates a hospital's DGME payment based on its weighted FTEs, which may not exceed its weighted cap. 42 C.F.R. §§ 413.76(a), 413.79(c)(2)(iii).

III. Medicare Cost Report Appeals

34. At the close of a hospital's fiscal year, it is required to submit to its designated Medicare Administrative Contractor ("MAC") a "cost report" showing both the costs incurred by the hospital during the fiscal year and the appropriate share of these costs to be apportioned to Medicare. 42 C.F.R. § 413.24(f) (2018). MACs are private companies under contract with the Secretary to pay Medicare claims and audit hospital cost reports, among other duties. 42 U.S.C. § 1395kk-1.

35. The MAC must analyze and audit the cost report and inform the hospital of a final determination of the amount of Medicare reimbursement through a Notice of Program Reimbursement ("NPR"). 42 C.F.R. § 405.1803(a). A hospital's DGME payment is among the components of the final payment determination reported in the NPR.

36. A hospital may appeal a final determination of its Medicare reimbursement to the Board. 42 U.S.C. § 1395oo(a).

37. The Board has jurisdiction over appeals from MAC determinations if the following requirements are met: (1) the hospital is dissatisfied with the final determination; (2) the amount in controversy is at least $10,000; and (3) the hospital requests a hearing within 180 days of receiving the final determination. *Id*.

38. A group of hospitals may appeal a common dispute to the Board if the following requirements are met: (1) the hospitals are dissatisfied with the Secretary's final determination; (2) the amount in controversy is, in the aggregate, at least $50,000; and (3) the hospitals request a hearing within 180 days of the Secretary's determinations. *Id*. § 1395oo(a)-(b). A group of hospitals may file a group appeal directly without first filing individual appeals. *Id.* § 1395oo(b); 42 C.F.R. § 405.1837(a), (b). A hospital may also transfer an issue from an individual appeal to a

group appeal. 42 C.F.R. § 405.1837(e)(4).

39. In addition, for group appeals, the matter at issue must involve "a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider in the group." 42 C.F.R. § 405.1837(a)(2).

40. The Board lacks the authority to decide the validity of a Medicare regulation. *Id*. § 405.1867. If a hospital (or group of hospitals) appeals an issue that involves a question that is beyond the Board's authority, the Board may authorize EJR of the case. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842.

41. The Board must grant EJR if it determines that (1) the Board does not have the authority to decide the legal question because the question is a challenge either to the constitutionality of a statute or to the substantive or procedural validity of a regulation or CMS Ruling; and (2) the Board has jurisdiction to hold a hearing on the specific matter at issue. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

42. If the Board issues an EJR decision, the CMS Administrator has the right to "review the Board's jurisdictional finding, but not the Board's authority determination." 42 C.F.R. § 405.1842(a)(3). The Board's decision to grant EJR "becomes final and binding on the parties unless the decision is reversed, affirmed, modified, or remanded by the Administrator." *Id*. § 405.1842(g)(1)(iii). A final Board decision constitutes the final agency action of the Secretary. 42 C.F.R. § 405.1877(a)(2).

43. If the Board grants a hospital's request for EJR, the hospital may seek judicial review of the action involving a question of law or regulations by commencing a civil action within sixty days of the date on which notification of the Board's EJR determination is received. 42 U.S.C. § 1395oo(f)(l); 42 C.F.R. § 405.1842(g)(2).

FACTS SPECIFIC TO THIS CASE

44. Plaintiffs are teaching hospitals that receive Medicare DGME payments. Plaintiffs all trained residents in their fiscal year 1996 ("FY 1996") cost reporting periods. Accordingly, the Secretary established a DGME FTE cap for each Plaintiff based on its FY 1996 resident FTE count.

45. During the fiscal years at issue in this action, Plaintiffs' FTE counts exceeded their 1996 FTE caps. Plaintiffs' FTE counts included residents who were both within and beyond the IRP.[2] The Secretary employed the methodology of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) when applying the FTE weighting factors to Plaintiffs' DGME FTE caps.

46. Each Plaintiff timely filed an appeal with the Secretary's Board following the receipt of its final determination from its MAC, pursuant to 42 U.S.C. § 1395oo.

47. Plaintiffs Arthur G. James Cancer Hospital and OSU Hospital joined a group appeal contesting the application of 42 C.F.R. § 413.79(c)(2)(iii) to their fiscal years ending in 2015, which the Board designated as case number 19-0398GC. By letter dated December 12, 2019, Plaintiffs in case number 19-0398GC requested that the Board grant EJR on the question of the validity of the Secretary's methodology for applying the FTE caps and weighting factors as specified in 42 C.F.R. § 413.79(c)(2)(iii). On January 8, 2020, the Board granted EJR in case number 19-0398GC. The Board's EJR decision is attached as Exhibit "A." The Board concluded that it had jurisdiction over the matter for the subject years and lacked the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid. *See* Exhibit A. As of the filing

[2] One of the Plaintiff hospitals, Highland Hospital, did not train any residents who were beyond the IRP in the fiscal year appealed, however the hospital did train residents beyond the IRP during the two years prior to the fiscal year appealed. Because the prior year and penultimate year are averaged with the current year when calculating the DGME payment, the FTE counts for those two years have a direct impact on the hospital's reimbursement for the appealed year.

of this complaint, the Board's decision has not been reversed, affirmed, modified, or remanded by the Administrator. The Board's January 8, 2020 EJR decision constitutes the Secretary's final agency action in Board case number 19-0398GC. By filing this Complaint, Arthur G. James Cancer Hospital and OSU Hospital have timely sought EJR under 42 U.S.C. § 1395oo(f)(1).

48. Plaintiffs Arthur G. James Cancer Hospital and OSU Hospital joined a group appeal contesting the application of 42 C.F.R. § 413.79(c)(2)(iii) to their fiscal years ending in 2016, which the Board designated as case number 19-0746GC. By letter dated December 17, 2019, Plaintiffs in case number 19-0746GC requested that the Board grant EJR on the question of the validity of the Secretary's methodology for applying the FTE caps and weighting factors as specified in 42 C.F.R. § 413.79(c)(2)(iii). On January 14, 2020, the Board granted EJR in case number 19-0746GC. The Board's EJR determination is attached as Exhibit "B." The Board concluded that it had jurisdiction over the matter for the subject years and lacked the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid. *Id.* As of the filing of this complaint, the Board's decision has not been reversed, affirmed, modified, or remanded by the Administrator. The Board's January 14, 2020 EJR decision constitutes the Secretary's final agency action in Board case number 19-0746GC. By filing this Complaint, Arthur G. James Cancer Hospital and OSU Hospital have timely sought EJR under 42 U.S.C. § 1395oo(f)(1).

49. Plaintiffs Miami Valley Hospital and Good Samaritan Hospital & Health System joined a group appeal contesting the application of 42 C.F.R. § 413.79(c)(2)(iii) to their fiscal years ending in 2015, which the Board designated as case number 18-1838GC. By letter dated December 12, 2019, Plaintiffs in case number 18-1838GC requested that the Board grant EJR on the question of the validity of the Secretary's methodology for applying the FTE caps and weighting factors as specified in 42 C.F.R. § 413.79(c)(2)(iii). On January 8, 2020, the Board

granted EJR in case number 18-1838GC. *See* Exhibit A. The Board concluded that it had jurisdiction over the matter for the subject years and lacked the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid. *Id.* As of the filing of this complaint, the Board's decision has not been reversed, affirmed, modified, or remanded by the Administrator. The Board's January 8, 2020, EJR decision constitutes the Secretary's final agency action in Board case number 18-1838GC. By filing this Complaint, Miami Valley Hospital and Good Samaritan Hospital & Health System have timely sought EJR under 42 U.S.C. § 1395oo(f)(1).

50. Plaintiffs Maimonides Medical Center and Strong Memorial Hospital joined a group appeal contesting the application of 42 C.F.R. § 413.79(c)(2)(iii) to their fiscal years ending in 2009, which the Board designated as case number 18-1875G. By letter dated December 12, 2019, Plaintiffs in case number 18-1875G requested that the Board grant EJR on the question of the validity of the Secretary's methodology for applying the FTE caps and weighting factors as specified in 42 C.F.R. § 413.79(c)(2)(iii). On January 8, 2020, the Board granted EJR in case number 18-1875G. *See* Exhibit A. The Board concluded that it had jurisdiction over the matter for the subject years and lacked the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid. *Id.* As of the filing of this complaint, the Board's decision has not been reversed, affirmed, modified, or remanded by the Administrator. The Board's January 8, 2020 EJR decision constitutes the Secretary's final agency action in Board case number 18-1875G. By filing this Complaint, Maimonides Medical Center and Strong Memorial Hospital have timely sought EJR under 42 U.S.C. § 1395oo(f)(1).

51. Plaintiffs Maimonides Medical Center, St. Luke's Hospital, Hackensack University Medical Center, and Jersey Shore University Medical Center joined a group appeal contesting the application of 42 C.F.R. § 413.79(c)(2)(iii) to their fiscal years ending in 2014, which the Board

designated as case number 19-0680G. By letter dated December 12, 2019, Plaintiffs in case number 19-0680G requested that the Board grant EJR on the question of the validity of the Secretary's methodology for applying the FTE caps and weighting factors as specified in 42 C.F.R. § 413.79(c)(2)(iii). On January 8, 2020, the Board granted EJR in case number 19-0680G. *See* Exhibit A. The Board concluded that it had jurisdiction over the matter for the subject years and lacked the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid. *Id.* As of the filing of this complaint, the Board's decision has not been reversed, affirmed, modified, or remanded by the Administrator. The Board's January 8, 2020 EJR decision constitutes the Secretary's final agency action in Board case number 19-0680G. By filing this Complaint, Maimonides Medical Center, St. Luke's Hospital, Hackensack University Medical Center, and Jersey Shore University Medical Center have timely sought EJR under 42 U.S.C. § 1395oo(f)(1).

52. Plaintiffs Highland Hospital of Rochester and Strong Memorial Hospital joined a group appeal contesting the application of 42 C.F.R. § 413.79(c)(2)(iii) to their fiscal years ending in 2014, which the Board designated as case number 19-0691GC. By letter dated December 12, 2019, Plaintiffs in case number 19-0691GC requested that the Board grant EJR on the question of the validity of the Secretary's methodology for applying the FTE caps and weighting factors as specified in 42 C.F.R. § 413.79(c)(2)(iii). On January 8, 2020, the Board granted EJR in case number 19-0691GC. *See* Exhibit A. The Board concluded that it had jurisdiction over the matter for the subject years and lacked the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid. *Id.* As of the filing of this complaint, the Board's decision has not been reversed, affirmed, modified, or remanded by the Administrator. The Board's January 8, 2020 EJR decision constitutes the Secretary's final agency action in Board case number 19-0691GC.

By filing this Complaint, Highland Hospital and Strong Memorial Hospital have timely sought EJR under 42 U.S.C. § 1395oo(f)(1).

53. Plaintiffs Pennsylvania Hospital, Penn Presbyterian Medical Center, and Hospital of the University of Pennsylvania joined a group appeal contesting the application of 42 C.F.R. § 413.79(c)(2)(iii) to their fiscal years ending in 2013, which the Board designated as case number 19-2185GC. By letter dated December 12, 2019, Plaintiffs in case number 19-2185GC requested that the Board grant EJR on the question of the validity of the Secretary's methodology for applying the FTE caps and weighting factors as specified in 42 C.F.R. § 413.79(c)(2)(iii). On January 8, 2020, the Board granted EJR in case number 19-2185GC. *See* Exhibit A. The Board concluded that it had jurisdiction over the matter for the subject years and lacked the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid. *Id.* As of the filing of this complaint, the Board's decision has not been reversed, affirmed, modified, or remanded by the Administrator. The Board's January 8, 2020 EJR decision constitutes the Secretary's final agency action in Board case number 19-2185GC. By filing this Complaint, Pennsylvania Hospital, Penn Presbyterian Medical Center, and Hospital of the University of Pennsylvania have timely sought EJR under 42 U.S.C. § 1395oo(f)(1).

COUNT I
Violations of the Medicare Statute—DGME Payments

54. Plaintiffs reallege and incorporate by reference paragraphs 1–53 as if fully set forth below.

55. The applicable provisions of the APA provide that the "reviewing court shall . . . hold unlawful and set aside agency action . . . found to be . . . not in accordance with law [or] in excess of statutory jurisdiction, authority, or limitations, or short of statutory right. 5 U.S.C. §

706(2).

56. The Secretary's regulation implementing the FTE cap and weighting factors is contrary to the Medicare statute because it determines the cap after applying the weighting factors. 42 U.S.C. § 1395ww(h)(4)(F)(i). The effect of the Secretary's unlawful regulation is to impose on Plaintiffs weighting factors that result in reductions greater than 0.5 for many residents who are beyond the IRP, and the regulation prevents Plaintiffs from claiming and receiving reimbursement for their full unweighted FTE caps. 42 C.F.R. § 413.79(c)(2)(iii). Thus, the Secretary's calculations of Plaintiffs' current-year, prior-year, and penultimate-year weighted DGME FTEs and the FTE caps are contrary to the statutory provision at 42 U.S.C. § 1395ww(h), and, as a result, Plaintiffs' DGME payments are unlawfully understated.

57. The Secretary's regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the Medicare statute. First, the regulation creates a weighted 1996 FTE cap. The statute plainly requires the Secretary to determine the 1996 FTE cap "before application of weighting factors," which is an unweighted cap. 42 U.S.C. § 1395ww(h)(4)(F)(i). Thus, the Secretary lacked the discretion to interpret the statute or deviate from its plain meaning. The Secretary's regulation, however, instead applies a weighted FTE cap for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The Secretary concedes that the regulation results in "the hospital's reduced cap," which is less than the 1996 FTE cap. FY 2002 IPPS Rule, 66 Fed. Reg. at 39,894. The Secretary applies this weighted FTE cap as an absolute limit on the number of FTEs that can be included in a hospital's DGME payment calculation. This weighted FTE cap is applied *after* applying the weighting factors to residents who are beyond the IRP in the current year, which violates Congress's directive to determine the cap *before* applying those weighting factors. 42 U.S.C. § 1395ww(h)(4)(F)(i).

58. Second, the Secretary's weighted FTE cap prevented Plaintiffs from ever reaching their 1996 unweighted FTE caps simply because they train fellows beyond their IRPs. In fact, the Secretary's regulation prevents any hospital that trains fellows beyond the IRP from reaching its 1996 FTE cap. The downward impact on the FTE count increases as a hospital trains more residents who are beyond the IRP.

59. The following example illustrates the unlawful impact of the Secretary's regulation. The example compares the application of 42 C.F.R. § 413.79(c)(2)(iii) to FTE statistics for OSU Hospital during its fiscal year ending June 30, 2016 ("FY 2016") and a hypothetical Hospital A that has the same 1996 FTE cap as OSU Hospital and the same count of residents within its IRPs as OSU Hospital. The only difference between the two hospitals is that OSU Hospital trained fellows beyond the IRPs:

	OSU FY 2016	Hospital A
1996 Unweighted FTE Cap (UCap)	310.10	310.10
Current Year Unweighted resident FTEs	373.26	373.26
Current Year Unweighted fellow FTEs	128	0.00
Current Year Total unweighted FTEs (UFTE)	501.26	373.26
Current Year Total weighted FTEs before application of cap (WFTE)	437.26	373.26
Current Year Total weighted FTEs after application of cap (WCap)	270.51	310.10

The Secretary's formula at 42 C.F.R § 413.79(c)(2)(iii) results in weighted FTE caps of 270.51 for OSU Hospital and 310.10 for Hospital A:

- 42 C.F.R. § 413.79(c)(2)(iii) formula:

  (1996 FTE Cap)/(Unweighted FTEs) x Weighted FTEs = Weighted FTE Cap

- 42 C.F.R. § 413.79(c)(2)(iii) applied to OSU Hospital:

  310.10/501.26 x 437.26 = **270.51**

- 42 C.F.R. § 413.79(c)(2)(iii) applied to Hospital A:

  310.10/373.26 x 373.26 = **310.10**

60. The Secretary's regulation at 42 C.F.R. § 413.79(c)(2)(iii) results in very different payments for OSU Hospital and Hospital A. Because Hospital A does not train fellows beyond their IRPs, it receives a DGME payment based on its full 1996 FTE cap of 310.10 FTEs, even though its weighted FTEs are *lower* than OSU Hospital's weighted FTEs. Hospital A would be paid for 39.59 FTEs *more* than OSU Hospital, even though their FTE caps are identical and Hospital A trained 64 *fewer* weighted FTEs (before application of weighted cap) than OSU Hospital.

61. The Secretary's regulation results in OSU Hospital receiving far less reimbursement than hypothetical Hospital A simply because OSU Hospital trained 128 fellows in FY 2016. OSU Hospital would receive far less reimbursement than Hospital A, even though it trained 128 more individuals than Hospital A trained. The Medicare statute requires that these fellows be weighted at 0.5, and the statute also requires that OSU Hospital is limited to its 1996 FTE cap of 310.10, but the Secretary has violated the statute by calculating an FTE count far below the 1996 FTE cap solely as a result of the Secretary's improper imposition of a weighted FTE cap.

62. All Plaintiffs are similarly situated to OSU Hospital. Each Plaintiff trained residents who were beyond their IRPs, and each Plaintiff trained a total number of residents that was higher than its unweighted 1996 FTE cap. Each Plaintiff is prevented from receiving DGME payments based on its unweighted 1996 FTE cap due to the Secretary's unlawful regulation.

63. All Plaintiffs suffered a downward payment adjustment that is greater than may be imposed by the statutory 0.5 weighting factor for training residents beyond the IRP.

64. By establishing the cap based on the hospital's unweighted FTE count for 1996, Congress entitled Plaintiffs to claim FTEs up to that cap. The Secretary's regulation renders this impossible because Plaintiffs trained residents who are beyond the IRP. The regulation at 42

C.F.R. § 413.79(c)(2)(iii) is contrary to the Medicare statute at 42 U.S.C. § 1395ww(h) and is, therefore, invalid and must be set aside under the APA.

COUNT II
Arbitrary and Capricious Agency Action—DGME Payments

65. Plaintiffs reallege and incorporate by reference paragraphs 1–64 as if fully set forth below.

66. The applicable provisions of the APA provide that the "reviewing court shall . . . hold unlawful and set aside agency action . . . found to be . . . arbitrary [and] capricious [or] an abuse of discretion." 5 U.S.C. § 706(2).

67. The regulation at 42 C.F.R. § 413.79(c)(2)(iii) is arbitrary and capricious and an abuse of discretion and is, therefore, invalid. 5 U.S.C. § 706(2). By establishing a cap on FTEs, Congress intended that hospitals be paid based on that cap. The Secretary's regulation prevents Plaintiffs from reaching their FTE caps and improperly treats similarly situated hospitals differently because hospitals with identical 1996 FTE caps and that have unweighted FTE counts equal to their caps, will receive very different payments. When promulgating the regulation at 42 C.F.R. § 413.79(c)(2)(ii)-(iii), the Secretary wholly failed to justify this differing treatment. *See Burlington N. and Santa Fe Ry. Co. v. Surface Transp. Bd.*, 403 F.3d 771, 776–77 (D.C. Cir. 2005). The Secretary did not even acknowledge that its regulation would have such an inequitable effect. FY 1998 IPPS Rule, 63 Fed. Reg. at 26,330. Because the Secretary relied on factors that Congress has not intended him to consider and "entirely failed to consider an important aspect of the problem," the regulation is "arbitrary and capricious," as well as an abuse of discretion, and must be set aside under the APA. *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

RELIEF REQUESTED

WHEREFORE, Plaintiffs respectfully request an Order:

1. Declaring that the Secretary's regulation at 42 C.F.R. § 413.79(c)(2)(iii) is arbitrary, capricious, an abuse of discretion, and contrary to statutory law, and is therefore invalid;

2. Declaring that 42 U.S.C. § 1395ww(h) forbids the Secretary from imposing a weighted FTE cap;

3. Declaring that the Secretary must apply FTE weighting factors after applying the unweighted FTE cap as required by 42 U.S.C. § 1395ww(h);

4. Requiring the Secretary to recalculate Plaintiffs' DGME payments consistent with the Medicare statute so that the Plaintiffs' FTE counts are weighted for residents beyond the IRP at 0.5 and are capped based on the number of residents trained in the most recent cost reporting periods ending on or before December 31, 1996;

5. Requiring the Secretary to pay Plaintiffs interest on the payments resulting from the Court's orders, pursuant to 42 U.S.C. § 1395oo(f)(2);

6. Awarding Plaintiffs their costs and fees incurred in this litigation to the extent permitted by law; and,

7. Granting such other relief in law and/or equity as this Court may deem just and proper.

Dated: February 18, 2020

Respectfully submitted,

/s/ Leslie Demaree Goldsmith

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