IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CONWAY MEDICAL CENTER
300 Singleton Ridge Road
Conway, SC 29526;

Case No. 21-cv-1250

FLOYD MEDICAL CENTER
304 Turner McCall Boulevard
Rome, GA 30165;

EAST ALABAMA MEDICAL CENTER
2000 Pepperell Parkway
Opelika, AL 36801;

DCH REGIONAL MEDICAL CENTER
809 University Boulevard East
Tuscaloosa, AL 35401;

SCOTT & WHITE MEDICAL CENTER
2401 South Thirty First Street
Temple, TX 76508;

BAYLOR UNIVESRITY MEDICAL CENTER
3500 Gaston Street
Dallas, TX 75246;

WELLINGTON REGIONAL MEDICAL CENTER
10101 Forest Hill Boulevard
Wellington, FL 33414;

DOCTORS HOSPITAL OF LAREDO
10700 McPherson Road
Laredo, TX 78045;

CAPE FEAR VALLEY MEDICAL CENTER
1638 Owen Drive
Fayetteville, NC 28304;

BETSY JOHNSON REGIONAL HOSPITAL
aka Harnett Health System
800 Tilghman Drive
Dunn, NC 28335;

BAYLOR SCOTT & WHITE MEDICAL CENTER CARROLTON
4343 North Josey Lane
Carrollton, TX 75010;

BAYLOR ALL SAINTS MEDICAL CENTER
1400 Eighth Avenue
Fort Worth, TX 76104;

INTEGRIS BAPTIST MEDICAL CENTER, INC.
3300 Northwest Expressway
Oklahoma City, OK 73112;

INTEGRIS BASS BAPTIST HEALTH CENTER
600 South Monroe
Enid, OK 73701;

HOUSTON METHODIST SAN JACINTO HOSPITAL
aka Houston Methodist Baytown Hospital
4401 Garth Road
Baytown, TX 77521;

HOUSTON METHODIST SUGARLAND HOSPITAL
16655 Southwest Freeway
Sugar Land, TX 77479;

HOUSTON METHODIST HOSPITAL
6565 Fannin Street
Houston, TX 77030;

HOUSTON METHODIST WEST HOSPITAL
18500 Katy Freeway
Houston, TX 77094;

HOUSTON METHODIST ST JOHN HOSPITAL
aka Houston Methodist Clear Lake Hospital
18300 Houston Methodist Drive
Nassau Bay, TX 77058;

TEXOMA MEDICAL CENTER
5016 South US Highway 75
Denison, TX 75020;

AIKEN REGIONAL MEDICAL CENTER
302 University Parkway
Aiken, SC 29801;

NORTHWEST TEXAS HOSPITAL
aka Northwest Texas Healthcare System
1501 South Coulter
Amarillo, TX 79106;

SOUTH TEXAS HEALTH SYSTEM
aka South Texas Health System Edinburg
1102 West Trenton Road
Edinburg, TX 78539;

REGIONAL ONE HEALTH
877 Jefferson Street
Memphis, TN 38103;

COMANCHE COUNTY MEMORIAL HOSPITAL
3401 West Gore Boulevard
Lawton, OK 73505;

PARRISH MEDICAL CENTER
951 North Washington Avenue
Titusville, FL 32796;

BAPTIST MEDICAL CENTER – BEACHES
1350 13th Avenue South
Jacksonville Beach, FL 32250;

BAPTIST MEDICAL CENTER – NASSAU
1250 South 18th Street
Fernandina Beach, FL 32034;

BAPTIST MEDICAL CENTER – JACKSONVILLE
800 Prudential Drive
Jacksonville, FL 32207;

COX MEDICAL CENTER BRANSON
525 Branson Landing Boulevard
Branson, MO 65616;

COX MEDICAL CENTERS
1423 North Jefferson Avenue
Springfield, MO 65802

WESTCHESTER GENERAL HOSPITAL
2500 Southwest 75th Avenue
Miami, FL 33155

Plaintiffs,

v.

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

Defendant.

COMPLAINT FOR JUDICIAL REVIEW; WRIT OF MANDAMUS

The above-named Plaintiffs (Plaintiffs or Hospitals), by and through their undersigned counsel, state the following in the form of this Complaint against XAVIER BECERRA, Secretary of the United States Department of Health and Human Services (the Secretary) in his official capacity pursuant to 42 U.S.C. § 1395oo(f):

I. INTRODUCTION

1. Plaintiffs participate in Medicare and Medicaid. In the Affordable Care Act (ACA) (42 U.S.C. § 18001 *et seq*.), Congress "expanded" Medicaid eligibility by requiring all participating states to amend their state medical assistance plans, effective January 1, 2014, to cover persons under 65 years of age with incomes not exceeding 133% of the Federal Poverty Level (FPL) (138% with a statutory set-aside) who were not already eligible for Medicaid or Medicare.

2. For Plaintiffs, Medicaid expansion promised added coverage (and payments) under Title XIX of the Social Security Act (the act) for services previously furnished to uninsured patients. It also promised increases to their supplemental hospital payments under Medicare (Title XVIII of the act) for treating a disproportionate share of low-income patients

(DSH adjustments), which increase in proportion to the percentage of a hospital's low-income patients, which is relevantly determined based on the number of its patients who are "eligible for Medicaid" (which is a statutory proxy for low-income status).

3. Certain states advanced a broad array of constitutional challenges to the ACA in National Federation of Independent Businesses v. Sebelius, 567 U.S. 519 (2012) (NFIB). The Supreme Court broadly upheld the ACA, including both its expansion of Medicaid coverage and the "individual mandate" for people to enroll in a qualified health plan (QHP), but a plurality of the Court ruled that it would exceed the Secretary's authority under the Spending Clause of the Constitution to force states to expand their existing medical assistance plans as prescribed by the ACA through the withholding of federal funds under 42 U.S.C. § 1396c.

4. As a result of the elimination of financial penalties for noncompliance with the act's Medicaid expansion mandate in NFIB, a minority of states – including Alabama, Florida, Georgia, Texas, South Carolina, North Carolina, Oklahoma, Tennessee and Missouri, where Plaintiffs are located – refrained from submitting state plan amendments expanding their medical assistance programs to cover additional persons who became eligible for Medicaid coverage under the ACA, limiting Medicaid coverage in "non-expansion States" on a de facto basis to pre-ACA levels.

5. The injury from which Plaintiffs seek relief in this action, however, is not the absence of Medicaid reimbursements from their home states – which the Supreme Court permitted in NFIB – but the Secretary's independent and collateral refusal to recognize patients made "eligible for Medicaid" as a matter of law (based on their low incomes) under the ACA as "low-income patients" for purposes of determining their entitlement to Medicare DSH supplements. In taking this approach, the Secretary declined to recognize statutorily Medicaid-expansion populations as being "eligible for Medicaid" in states that chose not to amend their

state plans to extend Medicaid coverage based on a technicality, namely that the Medicare DSH provisions refer to Medicaid eligible patients as those made "eligible for medical assistance under a State plan approved under Title XIX."

6. The mundane reference to eligibility "under a State plan" is part of a broader statutory scheme under which states are *required* to amend their medical assistance plans on a pro forma to cover all eligibility categories that are mandated by Title XIX. To the extent the Supreme Court excused states in NFIB from submitting the state plan amendments (SPAs) presumptively required under the ACA, it was unreasonable for the Secretary to continue to condition the recognition of persons directly made eligible for Medicaid under federal law effective January 1, 2014 upon the submission of such SPAs.

7. Despite NFIB, the ACA still literally obligates all states *de jure* to amend their medical assistance plans to cover populations made newly eligible for Medicaid under the ACA. Congress framed the adoption of universal conforming SPAs that would add ACA coverage to all approved state plans as a pro forma and presumed occurrence. NFIB upheld the Medicaid coverage expansion as a whole, and never suggested that individuals who became eligible for Medicaid under the ACA should not be regarded as days of low-income patients (defined to include those eligible for Medicaid) for purposes of determining hospitals' entitlement to Medicare DSH adjustments. See NFIB at 586. It is arbitrary and capricious to continue to place continued reliance on whether expansion coverage has been memorialized under an approved SPA in view of the practical but unanticipated implications of NFIB's excusing the filing of mandated SPAs.

8. The Secretary's post-NFIB approach is arbitrary and capricious and contrary to law based on the simple and obvious fact that it results in patients who are "*eligible for Medicaid"* under mandate of Congress being treated by a federal agency as though they are *not*

patients eligible for Medicaid for Medicare DSH purposes. Allowing the inactions of states acting under the shield of NFIB to indirectly negate days of persons statutorily eligible for Medicaid in determining their low-income patient volumes under Medicare is counter-intuitive and produces a result that is diametrically opposite to what Congress expected and intended in enacting the ACA, and yields bizarre results in contravention of congressional intent and controlling principles of statutory construction.

9. The Secretary's approach not only understates the true volume of low-income patients to which Plaintiffs furnish care based on a technicality but denies Plaintiffs equal protection under the law by compensating them less under Medicare than similarly situated hospitals treating equivalent volumes of low-income patients in approximately 34 states that did not take advantage of the unexpected loophole created by the plurality decision in NFIB. It is implausible that Congress never would have wanted the Secretary to further extend NFIB's the unanticipated impairment of mandated SPAs into the realm of Medicare DSH subsidies. If anything, Congress would consider it even more imperative to recognize expansion-eligible days in the Medicare DSH calculations for those hospitals being deprived of underlying medical assistance payments for the same patients. The Secretary's contrary approach treats two wrongs as making a right!

10. Acting through BESLER Consulting of Florida (BESLER), Plaintiffs petitioned the Secretary to amend or clarify the regulations to confirm that inpatient days of *statutorily Medicaid eligible* expansion patients of hospitals located in non-expansion states may be counted in their Medicare low-income calculation, regardless of whether coverage was adopted through an approved SPA. After a long delay, the Secretary effectively denied BESLER's petition to amend the rules by inaction by issuing a letter dated December 10, 2020 stating that then-Secretary Azar was neither granting nor denying the Petition.

11. As a consequence of this Secretary's continued literal adherence to the plan amendment requirement that was rendered inoperable under NFIB, Plaintiffs' Medicare Administrative Contractors (MACs) and the Provider Reimbursement Review Board (PRRB) were themselves precluded by regulation from recognizing days of ACA expansion populations. Plaintiffs accordingly seek relief from this Court under the Administrative Procedure Act (APA) and the equal protection clause (as applicable to the Secretary under the Fifth Amendment) in the form of a remand order requiring the Secretary to recalculate Plaintiffs' Medicare DSH supplements for the cost years at issue to take these pivotal Medicaid-eligible days patient days into account.

II. JURISDICTION AND VENUE

12. This action arises under Title XVIII of the Social Security Act, 42 U.S.C. § 1395oo(f)(1), the APA, 5 U.S.C. §§ 551 et seq., and the equal protection clause of the United States Constitution as applied to the federal government through the Fifth Amendment.

13. This Court has jurisdiction under 42 U.S.C. § 1395oo(f)(1) to review a question of law or regulations relevant to the matters in controversy whenever the PRRB determines that it is without authority to decide the question.

14. The Plaintiffs initiated multiple group appeals to challenge their respective MACs' failure to issue timely determinations or Notices of Program Reimbursement for fiscal years 2014, 2015 and 2016.

15. In the appeals, the Plaintiffs alleged that a failure to permit participating hospitals located in non-expansion states to count days of expansion populations in the Medicaid fraction numerator while permitting similarly situated hospitals in states that did expand Medicaid, despite NFIB, to count the same category of patient days discriminates against non-expansion state hospitals in violation of their equal protection rights secured under the Fifth Amendment to

the United States Constitution. Further, the Plaintiffs argued that the exclusion of Medicaid expansion patient days from the numerator of the Medicare DSH Medicaid proxy/fraction fundamentally conflicts with the plain intent of the Social Security Act, as amended by the ACA, and therefore is invalid under the review standard imposed under the APA.

16. Relief in the appeals is precluded by current regulations, which have not been amended to account for the effects of the NFIB decision. Therefore, the Plaintiffs turned to expedited judicial review (EJR).

17. On November 25, 2020, the Plaintiffs filed a request for EJR. On March 10, 2021, the PRRB granted the Plaintiffs' request. This action is timely within the limitations periods in 42 U.S.C. § 1395oo(f)(1).

18. This Court also has federal jurisdiction pursuant to 28 U.S.C. § 1331 and mandamus jurisdiction under 28 U.S.C. § 1361 to mandate relief required by the terms of a federal statute.

19. Pursuant to 42 U.S.C. § 1395oo(f)(1), venue is proper in the United States District Court for the District of Columbia.

20. The Court is authorized to issue declaratory and other appropriate relief for Plaintiffs against Defendant under 28 U.S.C. §§ 2201, 2202.

III. PARTIES

21. Hospitals were at all relevant times serving as health care providers under agreements with the Secretary to participate in the Medicare program. Each has provided services to a disproportionate share of low-income patients (as those terms are defined under the act) for the fiscal years at issue.

22. Conway Medical Center, located in Conway, South Carolina, is a not-for-profit acute care hospital assigned Medicare Provider No. 42-0049, with this action covering its fiscal years 2014 and 2015.

23. Floyd Medical Center, located in Rome, Georgia and Memphis, Tennessee, is a not-for-profit acute care regional medical center assigned Medicare Provider No. 11-0054, with this action covering its fiscal years 2014 and 2015.

24. East Alabama Medical Center, located in Opelika, Alabama, is a not-for-profit acute care regional medical center assigned Medicare Provider No. 01-0029, with this action covering its fiscal year 2014.

25. DCH Regional Medical Center, located in Tuscaloosa, Alabama, is a not-for-profit community hospital assigned Medicare Provider No. 01-0092, with this action covering its fiscal years 2014 and 2015.

26. Scott & White Medical Center – Temple, located in Temple, Texas, is a not-for-profit acute care hospital assigned Medicare Provider No. 45-0054, with this action covering its fiscal years 2014 and 2015.

27. Baylor University Medical Center located in Dallas, Texas, is a not-for-profit acute care hospital assigned Medicare Provider No. 45-0021, with this action covering its fiscal year 2014.

28. Wellington Regional Medical Center located in Wellington, Florida, is an acute care regional medical center assigned Medicare Provider No. 10-0275, with this action covering its fiscal years 2014 and 2015.

29. Doctors Hospital of Laredo located in Laredo, Texas, is an acute care hospital assigned Medicare Provider No. 10-0275, with this action covering its fiscal year 2014.

30. Cape Fear Valley Medical Center, located in Fayetteville, North Carolina, is a not-for-profit acute care hospital assigned Medicare Provider No. 34-0028, with this action covering its fiscal year 2014.

31. Betsy Johnson Regional Hospital a/k/a Harnett Health System, located in Dunn, North Carolina, is a not-for-profit acute care hospital assigned Medicare Provider No. 34-0071, with this action covering its fiscal year 2014.

32. Baylor Scott & White Medical Center Carrolton, located in Carrolton, Texas, is a not-for-profit acute care hospital assigned Medicare Provider No. 45-0730, with this action covering its fiscal year 2015.

33. Baylor All Saints Medical Center, located in Fort Worth, Texas, is a not-for-profit acute care regional medical center assigned Medicare Provider No. 45-0137, with this action covering its fiscal year 2015.

34. Integris Baptist Medical Center, Inc., located in Oklahoma City, Oklahoma, is a not-for-profit acute care hospital assigned Medicare Provider No. 37-0028, with this action covering its fiscal year 2015.

35. Integris Bass Baptist Health Center, located in Enid, Oklahoma, is a not-for-profit acute care hospital assigned Medicare Provider No. 37-0016, with this action covering its fiscal year 2015.

36. Houston Methodist San Jacinto Hospital (now called Houston Methodist Baytown Hospital), located in Baytown, Texas, is a not-for-profit acute care hospital assigned Medicare Provider No. 45-0424, with this action covering its fiscal year 2015.

37. Houston Methodist Sugarland Hospital, located in Sugar Land, Texas, is a not-for profit acute care hospital assigned Medicare Provider No. 45-0820, with this action covering its fiscal year 2015.

38. Houston Methodist Hospital, located in Houston, Texas, is a not-for-profit acute care hospital assigned Medicare Provider No. 45-0358, with this action covering its fiscal year 2015.

39. Houston Methodist West Hospital, located in Houston, Texas, is a not-for-profit acute care hospital assigned Medicare Provider No. 07-077, with this action covering its fiscal year 2015.

40. Houston Methodist St. John Hospital (now called Houston Methodist Clear Lake Hospital), located in Nassau Bay, Texas, is a not-for-profit acute care hospital assigned Medicare Provider No. 45-0709, with this action covering its fiscal year 2015.

41. Texoma Medical Center, located in Denison, Texas, is an acute care hospital assigned Medicare Provider No. 45-0324, with this action covering its fiscal year 2015.

42. Aiken Regional Medical Center, located in Aiken, South Carolina, is an acute care hospital assigned Medicare Provider No. 42-0082, with this action covering its fiscal year 2015.

43. Northwest Texas Hospital (a/k/a Northwest Texas Healthcare System), located in Amarillo, Texas, is an acute care hospital and academic medical center assigned Medicare Provider No. 45-0209, with this action covering its fiscal year 2015.

44. South Texas Health System (a/k/a South Texas Health System Edinburg), located in Edinburg, Texas, is a community hospital assigned Medicare Provider No. 45-0119, with this action covering its fiscal year 2015.

45. Regional One Health, located in Memphis, Tennessee, is a not-for-profit acute care hospital assigned Medicare Provider No. 44-0152, with this action covering its fiscal year 2015.

46. Comanche County Memorial Hospital, located in Lawton, Oklahoma, is a not-for-profit, acute care hospital assigned Medicare Provider No. 37-0056, with this action covering its fiscal year 2015.

47. Parrish Medical Center, located in Titusville, Florida, is a not-for-profit community hospital assigned Medicare Provider No. 10-0028, with this action covering its fiscal year 2015.

48. Baptist Medical Center – Beaches, located in Jacksonville Beach, Florida, is a not-for-profit acute care hospital assigned Medicare Provider No. 10-0117, with this action covering its fiscal year 2016.

49. Baptist Medical Center – Nassau, located in Fernandina Beach, Florida, is a not-for-profit acute care hospital assigned Medicare Provider No. 10-0140, with this action covering its fiscal year 2016.

50. Baptist Medical Center – Jacksonville, located in Jacksonville Beach, Florida, is a not-for-profit acute care hospital assigned Medicare Provider No. 10-0088, with this action covering its fiscal year 2016.

51. Westchester General Hospital, located in Miami, Florida, is a physician-owned hospital and medical education facility assigned Medicare Provider No. 10-0284, with this action covering its fiscal year 2015.

52. Cox Medical Center Branson, located in Branson, Missouri, is a not-for-profit acute care hospital assigned Medicare Provider No. 26-0094, with this action covering its fiscal year 2016.

53. Cox Medical Centers, located in Springfield, Missouri, is a not-for-profit acute care hospital assigned Medicare Provider No. 26-0040, with this action covering its fiscal year 2016.

54. Defendant, Xavier Becerra, is the Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington D.C. 20201, the federal agency responsible for the administration of the Medicare and Medicaid Programs and the proper defendant under 42 U.S.C. § 1395oo(f)(1).

IV. THE MEDICARE PROGRAM

55. Congress enacted Medicare under the act in 1965 as a public health insurance program to provide health benefits to the aged, blind and disabled, and certain other persons, without regard to their incomes.

56. Inpatient hospital services are quintessential services covered under Part A of the Medicare provisions of the act.

57. For cost reporting years beginning prior to October 1, 1983, Medicare reimbursed inpatient hospitals for their services based on a retrospective audit of each hospital's actual reasonable costs. See 42 U.S.C. § 1395f(b).

58. Effective with cost reporting years beginning on or after October 1, 1983, Congress switched to a new prospective payment system (PPS) for reimbursing most acute care hospitals, under which payments were based on prospectively determined, fixed and federally determined per discharge DRG rates as a means of reigning in widely differing costs. See 42 U.S.C. § 1395ww(d).

59. Congress was, however, concerned that hospitals treating a large proportion of more costly low-income patients, (which also tend to be highly dependent on Medicare and Medicaid funding to make ends meet) might not survive on fixed DRG payments alone. Accordingly, Congress amended Title XVIII in 1986 to require the Secretary to make supplemental payments to the fixed DRG rates of hospitals that serve "a significantly disproportionate number of low-income patients . . . ." See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

60. The specifics of how the so-called Medicare disproportionate share hospital (DSH) adjustments are determined are discussed in Part VI below.

V. THE MEDICAID PROGRAM AND THE EXPANSION OF MEDICAID TO LOW-INCOME POPULATIONS UNDER THE ACA

61. In 1965, and along with Medicare, Congress enacted a "program to furnish medical assistance" under "Title XIX" of the act (commonly referred to as Medicaid) to fund state medical assistance for "individuals *who do not have* the income and resources to pay for medical services." See 42 U.S.C. § 1396, et seq.

62. Medicaid (or medical assistance) is a federally funded program that is administered at the state level under which state expenditure draw down federal matching funding. States generally possess flexibility in establishing their Medicaid programs, but all states that choose to participate in Medicaid are bound to comply with all federal requirements set under law and by HHS regulations and to operate their programs in compliance with Title XIX's mandates. These include, among other things, mandated coverage under each state's medical assistance plan for all groups for which eligibility is mandated rather than optional, and, coverage of all categories of medical services treated as mandatory under Title XIX of the act. See 42 U.S.C. § 1396d(a).

63. Mandatory categories of eligibility are set forth in 42 U.S.C. § 1396a(a)(10)(A)(i), and optional coverage categories are set forth in § 1396a(a)(10)(A)(ii).

64. Coverage of certain mandatory medical services (e.g., hospital and physician services), similarly, must be included in all federal state medical assistance plans as a condition of federal matching funding, while others (e.g., prescription drugs) are deemed optional under the act. See 42 U.S.C. § 1396a(a)(10)(A) (requiring states to provide at least the care and

services listed in 42 U.S.C. §§ 1396d(a)(1)-(5), (17), (21), (28) and (29), while the remainder of care and services under § 1396d(a) are considered optional).

65. Each state plan delineates which persons and services (including both mandatory and optional eligibility categories) and is submitted for approval by the Secretary. A state can modify its plan through submission of state plan amendments which are necessary for the state to receive matching federal financial participation (FFP). See 42 U.S.C. § 1396, 1396a, 1396d(a)-(b). SPAs are required to satisfy any new mandates that Congress adds to Title XIX.

66. Once the state plan or SPA is approved, FFP for furnishing items and services covered to persons covered under the state plan generally is paid quarterly using a matching percentage (from about 50% to 80% of the total costs) set by statute in relation to each state's respective average per capita income level. See 42 U.S.C. §§ 1396a, 1396b(a).

VI. THE ACA EXPANSION OF MEDICAID ELIGIBILITY AND COVERAGE

67. As part of the ACA, Congress "expanded" Medicaid eligibility effective January 1, 2014. Congress established a new Medicaid eligibility category for an expanded class of low-income persons by adding a new subpart (VIII) to 42 U.S.C. § 1396a(a)(10)(A)(i).

68. Simultaneously, Congress enacted an individual coverage mandate which requires most persons to procure health insurance coverage in a QHP. QHPs relevantly may include Medicaid coverage or enrollment in individual commercial coverage (subsidized through refundable tax credits for persons with incomes up to 400% of the FPL) purchased through a state or a federal marketplace "exchange."

69. Persons who qualify for Medicaid are not eligible for subsidies for commercial individual QHPs, as Congress presumed such persons would obtain comprehensive coverage for little or no cost through Medicaid.

70. This case involves so-called Medicaid "expansion" patients. This new Medicaid low-income eligibility category includes "individuals . . . who are under 65 years of age, not pregnant, not entitled to or enrolled for, benefits under Part A of Title XVIII [and not already eligible for Medicaid in their state] . . . and whose income does not exceed 133 percent of the poverty line [plus a 5% statutory disregard]," added as a mandatory benefits category at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). See ACA at sec. 2001(a)(1).47.

71. Medicaid expansion was enacted by Congress to make health insurance coverage available to a significant class of previously uninsured very low-income persons. As of 2014, the thresholds for expansion coverage (including the 5% set aside) was $16,105 for an individual and $32,913 for a family of four. These are persons who had no health insurance and, for the most part, have incomes at or below the 10th percentile of all Americans.

72. For the sake of simplicity and uniformity, Congress based expansion eligibility strictly on modified adjusted gross income (MAGI) data, which could be verified using available federal income tax-and related information.

73. The ACA prescribed the use of a single portal to apply for either Medicaid or QHP coverage.

74. The majority of states—including those where Plaintiffs do business—utilize federally established exchanges (FEEs) run by the Centers for Medicare and Medicaid Services (CMS) and through which CMS verifies eligibility for Medicaid and/or QHP subsidies based on MAGI through access to IRS, SSA and other electronic data sources. See 42 C.F.R. § 155.302. See also 42 C.F.R. § 603; Verification Procedures and Eligibility Rules in the Federally-facilitated Exchange, HHS-0938-2020-F-3442 (August 31, 2020)

75. Congress shielded states from most of the costs of medical assistance for newly eligible Medicaid populations, initially providing for 100% in FFP (for the first two years) and thereafter at least 90% in FFP to fund the ACA's Medicaid expansion mandate.

76. Congress legislatively presumed that expanded Medicaid coverage would be universally included under all state Medicaid plans and adopted through pro forma submission of SPAs required to achieve compliance with the ACA. This presumption was manifest from the fact that Congress made eligibility for the ACA expansion population *mandatory* rather than optional under the ACA amendments, leaving states (but for NFIB) no choice but to submit conforming SPAs to incorporate expansion coverage effective by January 1, 2014 as a condition of the continued receipt of federal Medicaid funding.

77. Consistent with these statutory presumptions, the Secretary issued a variety of published guidance which similarly presumed that all states participating in Medicaid would submit ministerial SPAs to expand coverage to cover the new class of low-income patients as mandated by the ACA by 2014.

78. The joint assumption that all states would be universally amending their approved Medicaid plans to extend coverage to the newly mandated expansion population was partially upended by the decision in NFIB. NFIB upheld the underlying Medicaid expansion, which remains a mandate under the terms of the act. At the same time a plurality ruling within NFIB empowered recalcitrant states on a de facto basis and without penalty to forego statutorily mandated expansions of their existing Medicaid programs.

79. As a result, a minority of (non-expansion) states, with many in the deep South, chose not to amend their state plans to comply with Section 1396a(a)(10)(A)(VIII). As a result they did not submit what should, under the terms of the ACA, have been pro forma SPAs

amendments adding the additional coverage terms required by the ACA for expansion populations.

80. The decisions of some states not to submit SPAs due to NFIB had the unintended consequence of unexpectedly reducing the Medicare DSH adjustments due hospitals located in non-expansion states, as discussed next.

81. Following the NFIB decision, legislation was proposed that would have changed "expansion population" coverage from mandatory to optional. That amendment was never enacted. See H.R. 1628, Sec. 112: Repeal of Medicaid Expansion (115th Cong. 1st Sess. 2017). Consequently, to this day, and as courts and the Secretary (in court filings) have recognized, Medicaid expansion is still considered mandatory as a matter of law under the terms of the act and notwithstanding NFIB.

VII. A DEEPER DIVE INTO THE MEDICARE DISPROPORTIONATE SHAREHOSPITAL ADJUSTMENT

82. As noted, Medicare DSH adjustments are designed to supplement the regular prospectively determined federal Medicare payments of hospitals serving high proportions of low-income patients in the form of a percentage add-on to their regular DRG rates. As the Secretary has observed, "the Congressional goals of the Medicare DSH adjustment [was] to recognize the higher costs to hospitals of treating low income patients covered by Medicare." 65 Fed. Reg. 3137 (Jan. 20, 2000).

83. A hospital's eligibility to receive DSH supplements and the amount of its supplemental Medicare DSH payments both turn on each hospital's "disproportionate share percentage" (DPP). See 42 U.S.C. §§ 1395ww(d)(5)(F)(v) and (vi). This DPP is meant to capture the share of a hospital's patients who are deemed to be of low-income and more expensive to treat (due to their indigency and corresponding inability to pay for medical services) as a matter of legislative fact.

84. To determine the DPP, Title XVIII – whose language is mirrored in the regulations – prescribes calculating and then combining two fractions that serve as low-income proxies: the so-called Medicare fraction and Medicaid fractions (low income proxies) are set forth in the statute and in the Secretary's implementing regulations.

85. While Medicare is not income-based, a subpopulation of Part A beneficiaries are low-incomes persons who also qualify for Supplemental Security Income (SSI) benefits. The Medicare low-income fraction is the ratio (for the relevant cost year) of the number of inpatient days of Medicare patients who are "entitled to receive" SSI benefits – the numerator – divided by the total number of patients who are "entitled to benefits under" Part A. See 42 C.F.R. § 412.106(b)(2).

86. This so-called Medicare fraction captures the low-income ratio of the hospitals "entitled to benefits" under Medicare Part A. Courts have regularly held that "entitlement" to Part A benefits refers to receipt of actual payments for services under Part A, as distinct from merely being "eligible" to apply for and receive such benefits.

87. The current action does not involve the Medicare fraction, but only the second, or so-called Medicaid low-income fraction. The Medicaid low-income fraction includes patients who are not entitled to receive healthcare benefits under Part A of Medicare and is based on the ratio of inpatient days of inpatients who are "eligible" for Medicaid (the numerator) divided by the hospital's total inpatient days (the denominator).

88. The Medicaid fraction clause states specifically as follows:

> (ii) The fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consists of patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX of this chapter, but who were not entitled to benefits under Part A of this Title, and the – denominator of which is the total number of the hospital patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi) (emphasis added).

89. The Secretary's regulation implementing the second fraction, which long pre-dates NFIB, similarly states:

> Second Computation
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

42 C.F.R. § 412.106(b)(4)(i) (emphasis added).

90. Courts have universally recognized that "eligibility" for Medicaid means the person is *capable under law of applying for and receiving coverage*, rather than actually having their benefits actually paid for by Medicaid (as would a person actually "entitled" to paid benefits under the program).

91. The first and second low-income fractions – i.e., the SSI percentage and the Medicaid days to total patient days percentage – are combined under the Medicare DSH provisions into a single low-income patient volume proxy representing the hospitals' so-called disproportionate patient percentage or DPP (in which persons eligible for Medicaid are deemed by statute to be low-income patients for DPP purposes).

92. As the Ninth Circuit Court of Appeals observed in Portland Adventist Medical Ctr. v. Thompson, 399 F.3d 1091, 1095 (9th Cir. 2005) (quoting Legacy Emanuel Hosp. & Health Ctr. v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996)):

> Congress's "overarching intent" in passing the [Medicare] disproportionate share provision was to supplement the prospective payment system payments of hospitals serving "low income" persons . . . Congress intended the Medicare and Medicaid fractions to serve as a proxy for *all low-income patients*. (Emphasis added).

VIII. THE HOSPITALS' CLAIMS AND ADMINISTRATIVE APPEALS

93. The Secretary has delegated responsibility for administering the Medicare Program to CMS, formerly known as the Health Care Financing Administration (and collectively referred to herein as CMS). CMS, in turn, delegates day-to-day audit and payment functions to organizations formerly known as fiscal intermediaries, and now called MACs. See 42 U.S.C. § 1395h.51.

94. Medicare DRG payments are processed using fixed rates and estimated add-on amounts (such as DSH supplements) are reconciled at the close of each fiscal year. After the fiscal year, each hospital submits to its MAC a cost report showing the allowable costs incurred and amounts due from Medicare for the fiscal year and the payments received from Medicare. The MAC audits the cost report, reconciles the amounts finally due with interim payments made during the course of the fiscal year, and informs the hospital of a final determination of the amount of Medicare reimbursement due through a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803.

95. A hospital "dissatisfied" with its MAC's program reimbursement determination may file an appeal to the PRRB within 180 days after receiving its NPR if its claim satisfies the amount-in-controversy threshold. See 42 U.S.C. § 1395oo(a). The Secretary's rules include provisions for the filing of "group appeals" by related or unrelated providers pursuing relief on commons issues. See 42 C.F.R. §405.1837.

96. The decision of the PRRB also is subject to review by the CMS Administrator upon motion or the Administrator's own motion. Upon review, the Administrator may reverse, affirm or modify the PRRB's decision. 42 U.S.C. § 1395oo(f). Unless the Administrator of CMS reverses or modifies the PRRB's decision (which was not the case in this appeal), the decision of the PRRB becomes the final administrative decision of the Secretary.

97. When the PRRB lacks the authority to grant relief because the relief sought is prohibited under the terms of one of the Secretary's regulation, the provider is entitled under 42 U.S.C. § 1395oo(f)(1) to file in federal district court for EJR without a full administrative review. This occurs upon a certification of EJR by the PRRB that the outcome is controlled by a regulation or CMS policy that the PRRB is powerless to disregard. See 42 C.F.R. § 405.1842

98. A provider may obtain judicial review of a final decision of the PRRB, including of the legal question the PRRB certified it lacked authority to decide in granting EJR by filing a civil action within 60 days of the date on which notice of any final decision by the PRRB, or of any reversal, affirmance, or modification of the PRRB's decision by the CMS Administrator, is received. See 42 U.S.C. § 1395oo(f)(1).

99. BESLER, in coordination with the undersigned counsel, has organized various Medicare group appeals for hospitals located in non-expansion states, including without limitation the Plaintiffs, who are seeking recognition in their Medicare DSH calculations of the low-income days attributable to patients who were statutory "eligible" for Medicaid since 2014 based on their qualifying income levels under the ACA eligibility expansion.

100. In all such cases, Plaintiffs seek credit only for the inpatient days of low-income patients who satisfied the financial and other mathematically determined eligibility levels established directly by the ACA's Medicaid eligibility expansion amendment, but which were excluded from the count of low-income days in the Hospitals' Medicare DSH calculations based on a mundane reference in the statute and regulations to persons "eligible" for Medicaid under a state plan approved by the Secretary.

101. The statute and regulations presume that persons within mandatory eligibility categories will be incorporated under the approved medical assistance plans of all participating states through the submission of required SPAs.

102. That statutory assumption was partially upended by NFIB, which created a prudential exception to the statutory mandate with which compliance is still presumed under the terms of the statute and the Secretary's regulations.

103. After a series of appellate decisions uniformly holding that the Secretary must count in the Medicaid low-income DSH fraction numerator, days for any and all persons "eligible" for Medicaid and not just those days for which hospitals received medical assistance reimbursement, the rule was modified to days for which are patient was merely "eligible" for Medicaid under a state plan rather than actually entitled to receive coverage of inpatient hospital days under a state plan.

104. Courts also have recognized that days of patients falling within mandatory eligibility category are included universally in the Medicare DSH calculation.

105. The statutory and regulatory reference to eligibility "under an approved State plan" pre-dated and never took into account the potential that days for which patients were eligible for mandatory benefits as a matter of federal law would not be covered automatically under an approved state plan, namely, the incongruous situation resulting from NFIB.

106. The underlying statutory and regulatory assumption that all days of patients within mandatory federal eligibility groups became inoperative in states declining to amend their medical assistance plans to include expansion populations under the loophole created by NFIB, prior to which services that might be excluded from approved state plans were limited to categories that were categorized as "optional" under Title XIX.

107. Despite the unanticipated decision in NFIB, excusing state that chose to not expand their medical assistance programs to add coverage for expansion populations, the Secretary's regulations at 42 C.F.R. § 412.106(b)(4) were never reconciled with NFIB and

continue to include without qualification the description of Medicaid eligible days as being days for which a person is eligible for medical assistance "under an approved State Medicaid plan."

108. The Secretary has woodenly and formulaically excluded Plaintiffs' expansion days from their Medicaid low-income proxies because they were not the subject of approved SPAs without taking the implications of the pivotal decision in NFIB into account.

109. As a result, days for patients entitled to mandatory Medicaid eligibility as a matter of federal law attached for patients based on their age and income levels were treated in the Medicare DSH calculation as days of patients who are not eligible for Medicaid.

110. This results in Plaintiffs being paid far less under Medicare than Congress intended or than similarly situated hospitals serving equivalent volumes of low-income patients receive in the majority of states (which amended their state plans to actually extend benefits to expansion populations despite the NFIB loophole.

111. Plaintiffs initiated timely appealed to the PRRB challenging the exclusion from the Medicare DSH calculations of Medicaid expansion days to recognize the right of hospitals located in non-expansion states to count inpatient days for persons who statutorily qualify for Medicaid.

112. In the various appeals organized by BESLER, the Plaintiffs have alleged: i) that the exclusion of Plaintiffs' Medicaid expansion patient days from the numerator of their Medicare DSH calculations fundamentally conflicts with the plain and obvious intent of the act, as amended by the ACA, and ii) that a failure to permit participating hospitals located in non-expansion states to count patient days of expansion populations in the Medicaid fraction numerator while permitting similarly situated hospitals in states that did expand Medicaid to count the same category of patient days both violates the APA and irrationally discriminates

against non-expansion state hospitals in violation of their right to equal under federal laws (as guaranteed through the Fifth Amendment to the Constitution).

113. After filing timely administrative appeals, on November 25, 2020, Plaintiffs filed a consolidated petition for EJR with the PRRB. (See Plaintiffs' petition for EJR). Plaintiffs requested a certification for EJR based on the fact that the PRRB remained bound by the literal terms of the Secretary's regulations, despite the inoperability of the approved state plan requirements in states using the NFIB loophole to forego submitting statutorily mandated SPAs.

114. The PRRB granted Plaintiffs' EJR petition on March 10, 2021, concluding that the MAC lacked authority or discretion to make payment in the manner sought, and that because it is bound by applicable existing Medicare law and regulation (42 C.F.R. § 405.1867) and that lacked authority to decide the legal question at issue, EJR is appropriate. (See Plaintiffs' PRRB EJR Decision, March 10, 2021)

115. Plaintiffs timely appealed from the PRRB's final decision of March 10, 2021.

COUNT I

THE SECRETARY'S APPLICATION OF THE "UNDER AN APPROVED STATE MEDICAID PLAN" REQUIREMENT TO NON-EXPANSION STATE HOSPITALS IN THE WAKE OF NFIB VIOLATES THE APA BECAUSE IT CONFLICTS WITH THE CLEAR INTENT OF THE MEDICARE DSH STATUTE

116. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 115 above as if fully set forth at length below.

117. The Secretary's final action is expressly made subject to judicial review pursuant to the applicable judicial review provisions of the APA in 42 U.S.C. § 1395oo(f)(1), under which provisions a reviewing court must set aside agency action if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

118. Agency action fails under the "otherwise not in accordance with law" prong of the APA when the agency has read and applied a statutory provision in a way that renders it nugatory, and that plainly fails to satisfy congressional intent.

119. The Secretary's refusal to recognize expansion population patients in the Medicare DSH low-income calculus of non-expansion state hospitals results from an unacceptable application of the statute and is contrary to law under these standards.

120. Because it universally mandated coverage of expansion populations in the ACA, Congress inextricably presumed that all states would submit amendments to their state plans to cover benefits for expansion populations. Because it mandated eligibility and concomitant state plan amendments, Congress inextricably presumed that those days be counted as low-income days in the DPP calculations for all hospitals that participate in Medicare.

121. To the extent that certain states refrained from submitting SPAs as a result of NFIB, the Court should regard the hospital days attributable to expansion patients in those states as presumptively covered under a "State plan approved under Title XIX" to reconcile the statute with inactions wrought by NFIB and still give force to congressional intent.

122. Insisting on strict compliance with the "State plan approved under Title XIX" clause of the Medicare DSH provision also conflicts with Congress' focus on *eligibility* to receive benefits under the Medicaid low-income proxy, rather than on *entitlement* to paid benefits (as it did in the SSI low-income fraction).

123. As the Fifth Circuit Court of Appeals observed:

> Put bluntly: Certain days just go into the Medicaid fraction's numerator. Which days? Days that a hospital treated Medicaid-eligible patients or—if the Secretary approves a demonstration project—patients regarded as Medicaid eligible because of a demonstration project. This is binary: Patient days are either in or out. If patients underlying a given day were Medicaid-eligible or "receive[d] benefits under a demonstration project," then that day goes into the numerator. Period.

> Just as the statute's mechanics are straightforward, so too are its words. The word "eligible" is generally construed to mean "capable of receiving."

Forrest Gen. Hosp. v. Azar, 926 F.3d 221, 228-29 (5th Cir. 2019); accord Legacy Emanuel Hosp. v. Shalala, 97 F.3d 1261, 1266 (9th Cir. 1996).

124. Congress presumed that expansion patients would be counted for Medicare DSH purposes by making them "eligible" for Medicaid under mandate of law, irrespective of whether the patients are "entitled to" actually receive benefits.

125. The primary effect of an SPA is for the state to generate federal funding for reimbursing states for medical assistance expenses. In contrast, a state's declination to submit a SPA does not alter the patients' underlying eligibility for Medicaid under the ACA.

126. The Medicaid eligibility of expansion populations is not a product of any state plan, but is mathematically determined based on age and adjusted income (MAGI) standards which were set directly by Congress in 42 U.S.C. § 1396a(a)(10)(i)(VIII) through the ACA amendments. This differs from the eligibility of persons falling under "optional" Medicaid eligibility categories in which both being eligible for coverage as well as entitled to actual medical assistance services depends on the existence of an approved state Medicaid plan.

127. An approved state plan is secondary and not central to an expansion patient's eligibility for expansion coverage, which is bestowed directly by federal statute to persons with qualifying incomes.

128. This further mitigates against treating the "under a State plan approved under Title XIX" reference in the Medicare DSH provisions as obligatory and militates in favor of construing the "under a State plan approved under Title XIX" clause as precatory in the wake of NFIB.

129. Statutes must be read to avoid bizarre results. Yet the Secretary's application of the law following NFIB yields a bizarre and untenable result: namely excluding an entire class

of patients who became eligible for Medicaid as a matter of law on a mandatory basis (due to their low-income status) from a calculation specifically intended to capture all of low-income patients eligible for Medicaid.

130. Nothing in the NFIB decision holds, states or suggests that excusing states from amending their existing medical assistance plans under Spending Clause principles should impact recognition of expansion populations as being statutorily eligible for Medicaid under Tittle XIX let alone in Title XVIII Medicare DSH calculations.

131. The controlling significance the Secretary attributes to the "under a State plan" clause also is not in accordance with law because it fails entirely to take into account that fact that the requirement to file Title XIX SPAs were excused by NFIB and should likewise be excused, and treated as merely a precatory clause by the Secretary under the inter-related Medicare DSH clause.

132. Requiring an approved SPA under the Medicare DSH provisions whose submission has been excused under related statutory provision in NFIB is not in accordance with law because it violates the principle that statutes must be read in pari material and as an integrated whole, rather than as isolated parts. By ignoring the inter-related statutory *presumption* that all state plans *would* be amended to include expansion populations and insisting on approved SPAs after they were excused at the request of individual states by NFIB, the Secretary also is applying the act in an inconsistent manner which only further frustrates pre-NFIB congressional expectations.

133. The Secretary's insistence on literal compliance with the state plan approved under Title XIX language also is not in accordance with law because it unnecessarily transforms one narrow and unanticipated legal loophole under NFIB into a broader exception that also

swallows the statutory presumption that expansion days would automatically and universally be counted towards every hospital's DPP, turning one collision with congressional intent into two.

134. Excusing satisfaction with the "under a State plan approved under Title XIX" clause in the DSH provision also is consistent with a fair reading of the Act under important principles of statutory interpretation followed by the U.S. Supreme Court in King v. Burwell, 516 U.S. 988 (2014), which involved another more recent challenge to the ACA.

135. The ACA authorized the establishment of both state and federally established insurance exchanges, but a section of the law at issue in King v. Burwell literally defined the tax credits designed to make ACA coverage "affordable" literally referred only to coverage purchased in an exchange established by a state. In a ruling that strongly supports Plaintiffs, the U.S. Supreme Court refused to strictly construe the ACA as limiting tax credits to purchases made through State Exchanges, despite that being "the most natural reading" of the statute because doing so would subvert or frustrate a primary statutory purpose set out in more substantive and obvious provisions of the ACA.

136. As an over-arching principle of statutory construction, the King v. Burwell majority forcefully warned against construing a statue, and specifically the ACA, in a manner where the literal application of more "ancillary provisions" of a law would overcome or "alter the [more] fundamental details of a regulatory scheme." The Court thus refused to adopt the most natural reading of the statutes, which facially qualified tax credits by reference only to coverage purchased through state exchanges where doing that would subvert the more primary and fundamental statutory purpose of making healthcare more broadly "affordable."

137. In the present action, the statutory creation of a new mandatory low-income Medicaid eligibility group was one of the primary purposes of the ACA, and recognition of

expansion patient days in Medicare low-income determinations was a related and necessary corollary of the Medicaid expansion.

138. The presumed submission of pro forma SPA amendments to memorialize the revised federal Medicaid eligibility standards was ancillary and secondary to Congress' establishment of expanded eligibility for millions of low-income persons based on their adjusted gross income levels itself, and to the corollary expectation of Congress that expansion patient days would automatically qualify as low-income days in inter-related Medicare DPP determinations.

139. Just as the failure of states to establish their own exchanges was a dubious basis for denying subsidies to persons purchasing QHPs through federally established exchanges, the unanticipated failures of certain states to submit mandated SPAs under the shield of NFIB is a dubious basis for ignoring the Medicaid eligibility of an entire class of low-income patients in the Medicare DSH calculations.

140. Indeed, the rule against allowing the literal language of more ancillary provisions of law applies with even greater force here than in King v. Burwell. In King v. Burwell, Congress at least had the opportunity to amend the problematic and (what the U.S. Supreme Court described as a) sloppily drafted clause to refer to both state and federally established exchanges. By contrast, Congress both mandated expansion coverage and anticipated routine SPAs to determine FFP to implement such coverage under the ACA amendments.

141. Acting under the settled presumption of regularity and constitutionality, Congress never assumed the mandated Medicaid expansion would run afoul of the Spending Clause limits, especially as Congress had routinely conditioned Medicaid funding in the past on the states' adoption of newly mandated categories of coverage.

142. Similarly, legal scholars widely regarded the Spending Clause challenge to mandated Medicaid expansion as unlikely to succeed because the Court had routinely upheld the right of Congress to impose conditions on the receipt of federal grants.

143. Consequently, there would have been no logical reason in enacting the ACA for Congress to amend the Medicare DSH provision to qualify the need to satisfy the "State plan approved under Title XIX" requirement in non-expansion states (which category did not even exist until after the NFIB decision).

144. It is implausible that Congress would have wanted the unanticipated, adverse decision in NFIB to further disrupt the regulatory scheme established in the ACA by additionally precluding hospitals from including Medicaid eligible expansion days in their Medicare DSH calculations.

145. The U.S. Supreme Court also underscored in King v. Burwell the need to construe the key ACA reforms as applying uniformly across state lines and without variation based on the vagaries of state actions or inactions concerning the establishment of their own insurance exchanges.

146. Accordingly, the Secretary must be required to recognize all expansion patient days for purposes of the Medicare low-income determinations in the Medicare DSH calculation to facilitate Plaintiffs' entitlement to have their Medicare DSH adjustments calculated in accordance with law. The failure to do so was arbitrary and capricious.

COUNT II

WRIT OF MANDAMUS

147. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 146 above as if fully set forth at length below.

148. The Secretary has a clear non-discretionary duty to credit all inpatient days of patients who became eligible for Medicaid under the ACA's Medicaid expansion in calculating Plaintiffs' entitlements to Medicare DSH payments.

149. Plaintiffs have exhausted all administrative remedies and relief was not available under the prescribed review procedures.

150. Plaintiffs are entitled to the entry of a Writ of Mandamus pursuant to 28 U.S.C. § 1361 requiring the Secretary to adjust Plaintiffs' Medicare DSH supplements to account for days of patients who became eligible for Medicaid under the ACA.

COUNT III

THE SECRETARY'S FAILURE TO RECOGNIZE MEDICAID EXPANSION PATIENT DAYS IN PLAINTIFFS' MEDICARE DSH PERCENTAGE CALCULATIONS IS ARBITRARY, CAPRICOUS AND OTHERWISE VIOLATES FEDERAL LAW

151. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 150 above as if fully set forth at length below.

152. Under the "arbitrary and capricious" review standard of the APA, agency rules or regulatory actions normally must be set aside if an agency has failed entirely to address important aspects of a problem, or failed to account for relevant factors.

153. Agency action also is arbitrary and capricious if it results in a clear error in the way controlling law is being applied in light of all relevant factors.

154. The Secretary's controlling reliance for DSH purposes of whether a state has submitted an SPA for approval after NFIB fails miserably to account for the fact that Congress had mandated the submission of universal conforming SPAs under statutory requirements that were prudentially waived under NFIB.

155. That states were excused by NFIB from having to file statutorily mandated SPAs is not merely an important factor impacting compliance with the under an approved state plan clause, but the "elephant in the room."

156. The Secretary's wooden insistence on compliance with this clause fails entirely to account for the unexpected implications of the NFIB loophole or to reconcile those unexpected implications with the intended operation of other related provisions of the act. Ignoring the central implications of NFIB on the administration of the inter-related Medicare DSH provisions entirely was arbitrary and capricious in itself.

157. The Secretary's approach also is arbitrary and capricious because it squarely frustrates Congress' expectation that the ACA amendments would result in a new class of Medicaid eligible days that would factor into Medicare DSH low-income calculations.

158. Even if the Secretary possessed discretion to condition the recognition of patient days of persons falling within the ACA's mandatory eligibility expansion following the NFIB decision, it still would be arbitrary and capricious and an abuse of discretion to do so, given the unexpected impact of NFIB on the need for states to submit mandated SPAs.

159. The Secretary's approach also is arbitrary and capricious because it undermines the uniform national application of a clear federal eligibility standard in determining Medicare DSH status under federal law based solely on the vagaries of state action.

160. That a given state may decline to expand medical assistance coverage under NFIB based on the Spending Clause rationale is not a logical or reasonable basis for treating the inpatient days of extremely indigent patients who are federally eligible for Medicaid as though they do not qualify for Medicaid under a fully federal program.

161. While disregarding such days might make sense if the Medicaid fraction relied on "entitlement" to Medicaid benefits, or if the case involved an optional coverage category for

which eligibility could not exist without a SPA, it makes no sense when the dispositive eligibility standard is income based and determined through mathematical calculations, and the data used for assessing eligibility is routinely verified by CMS-run federal exchanges which are operated in all states where Plaintiffs are located.

COUNT IV

THE FAILURE TO ALLOW NON-EXPANSION STATE HOSPITALS TO COUNT INPATIENT DAYS OF PATIENTS STATUTORILY ELIGIBLE FOR MEDICAID ACA EXPANSION COVERAGE IN DETERMINING THEIR MEDICARE DSH PERCENTAGES DENIES THEM EQUAL PROTECTION UNDER THE LAW

162. Plaintiffs hereby incorporate by reference paragraphs 1 through 161 above as though set forth herein.

163. Regulated parties are entitled under the Fifth Amendment to the Constitution to be treated similarly under the law to similarly situated parties.

164. Social and economic legislation may adopt discriminatory classifications, but such discrimination must be rationally related to achieving or furthering the law's articulated purpose.

165. The Secretary's disparate treatment of non-expansion state hospitals under Medicare financially discriminates against them under a federal program by excluding from their low-income DPP determinations the exact same category of patients that are routinely credited to all similarly situated providers doing business in so-called expansion states.

166. This discriminatory classification is without a rational basis because it frustrates rather than achieves the purposes of both the ACA amendments and the Medicare DSH statute.

167. The Secretary's action lacks a rational basis because Congress inherently regarded patients who are eligible for Medicaid under Title XIX as low-income patients for purposes of Medicare DSH adjustments, while the Secretary's approach undermines that expectation for all hospitals located in non-expansion states.

168. Congress implemented the Medicare DSH adjustments to financially buttress and buffer hospitals treating larger volumes of more costly uninsured low-income patients. Yet the Secretary's approach undermines this very purpose by artificially undercounting the volumes of such patients—who have incomes from well below to slightly above the federal poverty line—in non-expansion state hospitals.

169. The Secretary's action is doubly insidious—and all the more irrational—because it reduces Medicare low-income supplements to the very hospitals that require even more support because they are not paid anything for furnishing the underlying hospital care to expansion-eligible patients by their state Medicaid programs. While expansion state hospitals receive both direct Medicaid payments and enhanced Medicare payments for treating expansion populations, Plaintiffs receive neither by dint of NFIB combined with the Secretary in the Secretary's discriminatory policy.

170. ACA expansion-eligible patients do not present to hospitals with Medicaid cards, which makes them more challenging to identify than equivalent patients living in expansion states. But neither that factor nor anything else about the absence of an approved SPA covering expansion patients supplies a rational basis for excluding them from the Medicare DSH determinations.

171. The submission of an SPA is not critical to determining whether an uninsured individual patient qualifies under the 138% of FPL and age tests because the criteria are set forth in federal law. Conforming SPAs do not create and cannot alter or vary the federal eligibility standards, which are mathematically precise.

172. States do create and often have flexibility to determine eligibility for "optional" coverage groups through their approved state plans, which makes the existence of an SPA significant. That is not, however, the case with mandatory eligibility categories such as the

expansion population, where eligibility is based on a federal MAGI formula that is validated using federal data sources.

173. Finally, for other categories of coverage, eligibility determinations are made by state or county agencies. That is not the case here, however, since eligibility for Medicaid under the ACA expansion provisions is uniquely determined by the Secretary.

174. As noted, the ACA requires the use of a single eligibility portal to apply and determine a person's eligibility either for Medicaid or individual QHP coverage purchased through an exchanges.

175. While avoiding administrative inconvenience is in any case not considered a rational basis for agency discrimination, HHS in this instance already has a system in place to verify everyone's MAGI.

176. Moreover, federal ACA insurance exchanges, rather than exchanges established by the state, are utilized in every state in which Plaintiffs are located. Consequently, the Secretary already has a structure in place that would enable him to determine Medicaid eligibility under the statutory MAGI formula for all or any of Plaintiffs' uninsured patients using preexisting electronic federal data sources.

177. On information and belief, the Secretary also maintains statistics on the number of individuals who are being denied Medicaid coverage in non-expansion states.

178. Consequently, there is no impediment, either legal or practical, that supports the rationality of the Secretary's refusal to acknowledge expansion patients in the Plaintiffs' low-income DSH determinations that is tied to the need to file a SPA for the Secretary's approval.

179. The central focus of the numerator in the Medicare DSH calculation is whether the *individual patient* is a person of low-income. A given state's decision to freeze its medical assistance coverage under the shield of NFIB does not in any way shape or form change the

low-income status of those patients who qualify for Medicaid under the ACA expansion amendments based on their incomes (ranging from well below to just above the FPL) which are determined using federal and not state data.

180. It does not rationally advance the core purpose of the federal Medicare DSH program – which is to financially assist those hospitals that treat a disproportionate volume of low-income patients with special needs – to simply ignore the actual presence of significant numbers of low-income patients in non-expansion states. To the contrary, doing so deprives those hospitals of the Medicare subsidies Congress intended them to receive as a matter of law.

181. In sum, while the Supreme Court may have shielded states that chose not to expand medical assistance by filing SPAs in conformance with the ACA from financial penalties, the underpayment of Plaintiffs' Medicare DSH supplements deprives them of equal protection under the law without a rational basis, in derogation of the Fifth Amendment.

COUNT V – JURISDICTION

THE SECRETARY ERRED AS A MATTER OF LAW IN FAILING TO FIND PRRB JURISDICTION FOR PLAINTIFFS AIKEN REGIONAL MEDICAL CENTER AND WESTCHESTER GENERAL HOSPITAL

182. Plaintiffs hereby incorporate by reference paragraphs 1 through 181 above as though set forth herein.

183. The PRRB withheld EJR for Plaintiffs' Aiken Regional Medical Center and Westchester General Hospital on grounds that these two hospitals lacked PRRB jurisdiction.

184. Plaintiffs disagree with the PRRB's decision in that it erred as a matter of law in denying EJR to Aiken Regional Medical Center and Westchester General Hospital based on a lack of jurisdiction. Plaintiffs assert that Aiken Regional Medical Center and Westchester General Hospital meet the PRRB jurisdictional requirements and include these two hospitals in

this Complaint and its Prayer for Relief and that they should be entitled to any relief ordered under this Complaint the same as all other Plaintiffs.

PRAYER FOR RELIEF

WHEREFORE, All Plaintiffs listed in the caption above request relief under all Counts in the form of an ORDER invalidating the Secretary's failure to recognize patients made newly eligible for Medicaid under the ACA for purposes of determining Plaintiffs' Medicare DSH adjustment for Fiscal Years 2014-2016, and further

Ordering that the Secretary recognize that Plaintiffs Aiken Regional Medical Center and Westchester General Hospital have met the PRRB jurisdictional requirements and are entitled to full relief under this Complaint;

ORDERING the entry of a Writ of Mandamus pursuant to 28 U.S.C. § 1361 requiring the Secretary to adjust Plaintiffs' Medicare DSH supplements to account for days of patients who became eligible for Medicaid under the ACA. And further

ORDERING the matter remanded to the Secretary with instructions to cooperate with Plaintiffs to verify the eligibility of their uninsured inpatients for Medicaid under 42 U.S.C. § 1396a(a)(10)(I)(viii), and further

ORDERING the Secretary to instruct his Medicare administrative contractors to re-determine Plaintiffs' Medicare DPP and DSH entitlements for the cost years in question, and further,

ORDERING the payment of interest to Plaintiffs pursuant to 42 U.S.C. §1395oo(f)(2).

Dated this 6th day of May, 2021.

Respectfully submitted,

COZEN O'CONNOR, P.C.

/s/ Chad E. Kurtz

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