IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS

ASHLEY COUNTY MEDICAL CENTER **1015 UNITY ROAD** **CROSSETT, AR 71635**	**)** **)** **)**
DELTA MEMORIAL HOSPITAL **300 EAST PICKENS ST.** **DUMAS, AR 71639**	**)** **)** **)**
ALAMEDA COUNTY MEDICAL CENTER **1411 EAST 31ST STREET** **OAKLAND, CA 94602**	**)** **)** **)**
ARKANSAS HOSPITAL ASSOCIATION **419 NATURAL RESOURCES DRIVE** **LITTLE ROCK, AR 72205**	**)** **)** **)**
AMERICAN HOSPITAL ASSOCIATION **325 SEVENTH STREET, N.W.** **WASHINGTON, DC 20004**	**)** **)** **)**
ASSOCIATION OF AMERICAN **MEDICAL COLLEGES** **2450 N STREET, N.W.** **WASHINGTON, DC 20037-1126**	**)** **)** **)** **)**
NATIONAL ASSOCIATION OF **CHILDREN'S HOSPITALS** **401 WYTHE STREET** **ALEXANDRIA, VA 22314**	**)** **)** **)** **)**
NATIONAL ASSOCIATION OF PUBLIC **HOSPITALS AND HEALTH SYSTEMS** **1301 PENNSYLVANIA AVENUE, N.W.** **SUITE 950** **WASHINGTON, DC 20004**	**)** **)** **)** **)** **)**
CALIFORNIA ASSOCIATION OF **PUBLIC HOSPTIALS AND HEALTH** **SYSTEMS**	**)** **)** **)**

2000 CENTER STREET,
SUITE 308
BERKELEY, CA 94704

CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION
1620 FIFTH AVE, SUITE 725
SAN DIEGO, CA 92101

CALIFORNIA HEALTHCARE ASSOCIATION
1215 K STREET, SUITE 800
SACRAMENTO, CA 95814

FLORIDA HOSPITAL ASSOCIATION
307 PARK LAKE CIRCLE
ORLANDO, FL 32803

GEORGIA HOSPITAL ASSOCIATION
1675 TERRELL MILL ROAD
MARIETTA, GA 30067

HEALTHCARE ASSOCIATION OF NEW YORK
1 EMPIRE DRIVE
RENSSELAER, NY 12144

Plaintiffs,

v.

THE HONORABLE TOMMY G. THOMPSON, in his official capacity as Secretary, United States Department of Health and Human Services
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, DC 20201

Defendant.

Civil Action No. _____

COMPLAINT FOR DECLARATORY, INJUNCTIVE AND OTHER RELIEF

Plaintiffs, Ashley County Medical Center ("Ashley"), Delta Memorial Hospital ("Delta"), Alameda County Medical Center ("Alameda"), Arkansas Hospital Association

("ArHA), American Hospital Association ("AHA"), Association of American Medical Colleges ("AAMC"), National Association of Children's Hospitals ("N.A.C.H."), National Association of Public Hospitals and Health Systems ("NAPH"), California Association of Public Hospitals and Health Systems ("CAPH"), California Children's Hospital Association ("CCHA"), California Healthcare Association ("CHA"), Florida Hospital Association ("FHA"), Georgia Hospital Association ("GHA"), and Healthcare Association of New York State ("HANYS") (collectively referred to as "Plaintiffs"), by their undersigned attorneys, sue Defendant, the Honorable Tommy G. Thompson, the Secretary of the United States Department of Health and Human Services in his official capacity ("the HHS Secretary" or the "Secretary") and allege as follows:

INTRODUCTION

1. This is an action for declaratory, injunctive and other relief brought by Plaintiffs, Ashley, Delta, Alameda, ArHA, AHA, AAMC, N.A.C.H., NAPH, CAPH, CCHA, CHA, FHA, GHA, and HANYS against the Secretary. Plaintiffs seek injunctive and declaratory relief barring the implementation and enforcement of a new Medicaid regulation issued by the Department of Health and Human Services ("HHS" or "Agency") and due to become effective on March 19, 2002 ("the 2002 Upper Payment Limit Rule" or the "2002 UPL Rule"), and declaring it unlawful.

2. UPL supplemental payments are a critical source of support for "safety net hospitals," i.e., those that serve the poor. Most of these hospitals are in severe financial distress because they provide significant amounts of unreimbursed (or under-reimbursed) health care to poor and uninsured patients; often they are the only source of health care for these patients. A rash federal regulation that drastically reduces UPL supplemental

payments to these hospitals will have a profound impact on poor and uninsured patients, threatening their access to life-saving and prolonging health care.

3. The 2002 UPL Rule purports to limit the amount of Medicaid supplemental payments states may make to safety net hospitals. These supplemental payments are a critical source of support for such hospitals, which are generally under severe financial distress due to the significant amount of care they provide to low income patients with little or no reimbursement. Yet for many of the nation's poor and uninsured, safety net hospitals are the sole source of health care; cuts in critical support for these hospitals directly reduce access to care for patients that rely on them.

4. The 2002 UPL Rule significantly lowered the limit on such payments for public hospitals that had been adopted by HHS in a regulation just nine months before (the "2001 UPL Rule"). As described in detail below, HHS offered no legally sufficient reason for this change of mind, and violated numerous administrative requirements in doing so.

5. As described in more detail in the Declarations included in the Exhibit Volume submitted in support of Plaintiffs' Motion for Preliminary and Permanent Injunctive Relief (the "Motion"), the 2002 UPL Rule will force many financially-strapped safety net hospitals to reduce or eliminate inpatient and outpatient services in some of the nation's poorest communities. Many such hospitals will also be forced to reduce community-wide emergency and public health services and will otherwise be unable to respond effectively to future emergencies. The cutbacks in services will directly affect their mostly poor patients, who will be forced to forego or postpone seeking care, travel great distances for treatment, or rely on already overburdened

emergency rooms for care that is more appropriately (and efficiently) provided in other settings. The impact on their health status will be direct and in some cases, tragic.

6. HHS's issuance of the 2002 UPL Rule was effected in an arbitrary, capricious and otherwise illegal fashion in four major respects:

(a) HHS has acted arbitrarily and capriciously by promulgating the 2002 UPL Rule on the basis of irrelevant data, failing to consider relevant evidence, failing to consider properly the harm to safety net hospitals, failing to articulate a rational connection between its policy decision and claimed mitigating factors and ignoring Congressional intent, in violation of the Administrative Procedure Act ("APA");

(b) The 2002 UPL Rule's statement of basis and purpose is legally insufficient;

(c) HHS has failed to perform the analyses required by the Regulatory Flexibility Act and the Social Security Act to assess the negative impact that the rule will have on small entities, such as Ashley, Delta, and Alameda (the "Hospital Plaintiffs") and other member hospitals of ArHA, AHA, AAMC, N.A.C.H., NAPH, CAPH, CCHA, CHA, FHA, GHA, and HANYS (the "Association Plaintiffs"); and

(d) HHS has violated the requirements of the Congressional Review Act by not complying with that Act's mandatory notice requirements.

PARTIES

7. Plaintiff, Ashley County Medical Center ("Ashley"), is a 46 bed general acute care hospital located in Crossett, Arkansas. The hospital was rebuilt in 1998 with

taxpayer funds, replacing an outdated facility. The hospital is county-owned, and operated by a local non-profit corporation. Ashley County Medical Center is the only hospital in this rural county, and its primary service area comprises a population of approximately 25,000 people.

8. Plaintiff, Delta Memorial Hospital ("Delta"), is a 50 bed general acute care hospital located in rural Desha County, Arkansas. The hospital is county-owned and operated by a local non-profit corporation. Delta is the only full service hospital in Desha County, and is the primary safety net hospital for approximately 10,000 people, including a significant number of low-income and uninsured persons.

9. Plaintiff, Alameda Medical Center ("Alameda"), located in Alameda County, California, provides a full range of basic and specialized health care services, excluding inpatient pediatrics, in several facilities, primarily to low-income and uninsured residents of surrounding areas. Alameda operates Highland Hospital, a general acute care hospital with a daily average patient load of 120 to 150 beds, an acute care psychiatric hospital that averages 80 beds per day, a 50 bed rehabilitation unit, a 109 bed Skilled Nursing Facility, and five free-standing community health centers. Alameda is the most important safety net health care provider in Alameda County, serving all individuals without regard to insurance status or ability to pay.

10. Plaintiff, Arkansas Hospital Association ("ArHA"), is a non-profit corporation organized and existing under the laws of the State of Arkansas. ArHA is headquartered in Little Rock, Arkansas. ArHA's members include the 41 public hospitals in Arkansas, and the membership organization assists its members through

integration and improvement in the delivery of healthcare services throughout Arkansas. ArHA brings this suit on behalf of its members.

11. Plaintiff, American Hospital Association ("AHA"), is a non-profit corporation organized and existing under the laws of the State of Illinois. The AHA is headquartered in Chicago, Illinois. AHA's members include approximately 5,000 hospitals, health systems, networks and other providers of medical care. AHA represents its members' interests in matters before Congress, the Executive Branch and the courts, as well as other public and private entities. AHA brings this suit on behalf of its members.

12. Plaintiff, Association of American Medical Colleges ("AAMC"), is a non-profit corporation organized and existing under the laws of the State of Illinois. AAMC is headquartered in Washington, D.C. AAMC represents approximately 300 major public and private general acute and specialty teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools, approximately 98 professional and academic societies; and the medical students and residents. The mission of AAMC is to bring this suit on behalf of its members and improve the health of the public by enhancing the effectiveness of academic medicine.

13. Plaintiff, National Association of Children's Hospitals ("N.A.C.H."), is a non-profit corporation organized and existing under the laws of the Commonwealth of Virginia. N.A.C.H. is headquartered in Alexandria, Virginia. N.A.C.H.'s membership includes more than 100 children's hospitals across the country, including freestanding acute care children's hospitals, children's hospitals organized within larger hospitals, and freestanding children's specialty and rehabilitation hospitals. N.A.C.H. represents its

members' interests in matters before Congress, the Executive Branch, and the courts, as well as with other public and private entities. N.A.C.H. brings this suit on behalf of its members.

14. Plaintiff, National Association of Public Hospitals & Health Systems ("NAPH") is a non-profit corporation, organized and existing under the laws of the District of Columbia. NAPH is headquartered in Washington, D.C. NAPH is a national association comprised of approximately 100 of the nation's largest urban and metropolitan area safety net hospitals and health systems, committed to providing health care services to all individuals without regard to ability to pay. NAPH has been a leading advocate for public safety net hospitals on all matters concerning the Medicaid program. Throughout this regulatory process, NAPH has expressed its strenuous objections to the 2002 UPL Rule, highlighting its predictable devastating impact on its member hospitals. NAPH brings this suit on behalf of its members.

15. Plaintiff, California Association of Public Hospitals and Health Systems ("CAPH"), is a non-profit corporation, organized and existing under the laws of the State of California. CAPH is headquartered in Berkeley, California. CAPH represents more than two dozen hospitals, health care systems and academic medical centers in 18 counties throughout California. The geographic areas served by these hospitals and health systems account for 86 percent of the State's population. The members of CAPH share a mission and mandate to provide care to all Californians, regardless of their insurance status or ability to pay. Among the members of CAPH are county-owned and operated facilities, University of California medical centers, and private, not-for-profit

facilities sharing a common commitment to serving all people. CAPH brings this suit on behalf of its members.

16. Plaintiff, California Children's Hospital Association ("CCHA"), is a non-profit trade association organized and existing under the laws of the State of California. CCHA is headquartered in San Diego, California. CCHA is a membership organization comprised of eight private, not-for-profit pediatric hospitals located in Oakland, Palo Alto, Madera, Los Angeles, Long Beach, Loma Linda, Orange and San Diego. CCHA strives to advance the health and well-being of children by protecting the financial stability of children's hospitals and taking a leadership role in advocacy, public policy, education and research in support of California children's health care delivery systems. CCHA brings this suit on behalf of its members.

17. Plaintiff, California Healthcare Association ("CHA"), is a non-profit organization organized and existing under the laws of the State of California. CHA is headquartered in Sacramento, California. CHA represents nearly 500 hospital and health system members and more than 200 affiliate and personal members in California. It provides its members with state and federal representation and advocacy in legislative and regulatory areas. CHA brings this suit on behalf of its members.

18. Plaintiff, Florida Hospital Association ("FHA"), is a non-profit corporation organized and existing under the laws of the State of Florida. FHA is headquartered in Orlando, Florida. FHA's membership includes approximately 230 hospitals, health systems, networks, and other providers or care. FHA's mission is to promote high quality health care and health services through leadership and assistance to hospitals in meeting the health care needs of their communities. FHA represents its

members' interests in matters before Congress, the state legislature, before state and federal executive branches, and in the courts, as well as before other public and private entities. FHA brings this suit on behalf of its members.

19. Plaintiff, Georgia Hospital Association ("GHA"), is a non-profit corporation organized and existing under the laws of the State of Georgia. GHA is headquartered in Marietta, Georgia. GHA's membership includes more than 150 hospitals in Georgia. GHA's purpose is to promote health and welfare of the public through the development of better hospital care for all Georgia's citizens. GHA represents its members before Congress, the state legislature and federal and state regulatory agencies. GHA's mission is to advocate for and assist its members in improving the delivery of accessible quality comprehensive and cost-effective hospital and health services and to improve the overall health status of the community. GHA brings this suit on behalf of its members.

20. Plaintiff, Healthcare Association of New York State ("HANYS"), is a non-profit corporation organized and existing under the laws of the State of New York. HANYS is headquartered in Rensselaer, New York. HANYS serves as a key advocate for more than 550 non-profit and public hospitals, health systems, nursing facilities, home care agencies, hospice and adult day care programs throughout New York State. HANYS's key functions are representation and advocacy, public policy development, and providing leadership in assisting its members in preparing for change in the healthcare environment. HANYS's goal is a stronger more stable healthcare system where its members can pursue their individual missions of providing quality, cost-effective, care. HANYS brings this suit on behalf of its members.

21. At least one of each of the Association Plaintiffs' members possesses standing to sue in its own right; Medicaid payments are of vital concern to the members of each of the Association Plaintiffs; and neither the claims asserted nor the relief demanded necessitates the participation of individual members.

22. Defendant the Honorable Tommy G. Thompson is the Secretary of the United States Department of Health and Human Services (the "HHS Secretary" or the "Secretary") whose responsibility is, *inter alia*, to implement the provisions of Title XIX of the Social Security Act, as amended, 42 U.S.C. § 1396 *et seq*. (the "Medicaid Statute"). In accordance with 42 U.S.C. §§ 1396(a)(30)(A), 1396(a)(4) and 1302 pursuant to an informal rule-making process, 5 U.S.C. § 553, HHS promulgated the 2002 UPL Rule in a regulation proposed on November 23, 2001, finalized on January 18, 2002 and scheduled to become effective March 19, 2002. To be lawful, this regulation must comply with the procedural requirements of the Congressional Review Act, 5 U.S.C. § 801 *et seq*. and the strictures of the APA, 5 U.S.C. § 551 *et seq*. The Secretary is sued in his official capacity only.

JURISDICTION

23. Subject matter jurisdiction is founded on 28 U.S.C. §§ 1331, 28 U.S.C. §§ 2201 and 2202, and 5 U.S.C. §§ 553, 604, 702, 706 and 801 and 42 U.S.C. § 1302(b)(1) because this case arises under the laws of the United States.

24. This Court has authority to grant declaratory relief pursuant to 28 U.S.C. §§ 2201 and 2202.

VENUE

25. Venue is proper in this Court under 28 U.S.C. § 1391(e) because at least one Plaintiff resides within this judicial district.

FACTUAL BACKGROUND

January 12, 2001 UPL Rule

26. The 2001 UPL Rule was proposed on October 10, 2000, finalized January 12, 2001 and effective March 13, 2001. It established specific limits on the aggregate amount that states could pay health care providers ("upper payment limits" or "UPLs") for delivering care to Medicaid recipients and receive matching federal funds. This action was taken in an attempt to prevent misuse of Medicaid funding that had been reported in some state nursing home programs. 66 Fed. Reg. 3148 (2001) (codified at 42 C.F.R. §§ 447.272, 447.321).

27. The 2001 UPL Rule established three different categories of facilities – private, state, and non-state government owned or operated facilities. The new UPL for the first two categories of these providers was set at 100 percent of the reasonable estimate of the aggregate amount that would have been paid under Medicare payment principles for inpatient and outpatient services. For hospitals that are owned or operated by governmental entities other than the state (local public hospitals), the limit was set at a 150 percent of the Medicare rate. This higher limit permitted significant supplemental payments to local public hospitals, recognizing the critical and uniquely challenging role of local public hospitals in providing access to health care services to low income Medicaid and uninsured individuals.

28. In reliance on this new regulation, several states began developing supplemental payment programs for public and private safety net providers. In 2001, Arkansas and Mississippi were the first two states to receive approval for amendments to their Medicaid State Plans ("State Plans") implementing such programs. By November 2001, 28 states had pending or approved State Plans relying on reimbursement at 150 percent.

November 23, 2001 Notice of Proposed Rule Making

29. Just eight months after implementation of the 2001 UPL Rule, HHS moved to rescind a significant part of it. On November 23, 2001, HHS published a Notice of Proposed Rule Making, Modification of Upper Payment Limit for Non-State Government-Owned or Operated Hospitals, 66 Fed. Reg. 58,694 (2001) ("NPRM"), proposing to eliminate the 150 percent UPL for public hospitals created in the 2001 UPL Rule.

30. HHS based this proposed rule on a September 11, 2001 HHS Office of the Inspector General ("OIG") Final Report ("the OIG Report"), which collected the results of a series of reviews of state supplemental payment programs by the OIG and claimed that a portion of the supplemental payments in those states were transferred back to the state. These OIG previously conducted reviews are the same reports upon which HHS had relied in implementing the 2001 UPL Rule.

Public Comments

31. HHS recognized that the 2002 UPL Rule could have a significant impact on hospitals and the low income patients they serve, and explicitly invited "public comments on the possible effects that this proposed rule would have on small entities in

general and on small rural hospitals in particular." 66 Fed. Reg. 58,696. The comment period it established, however, was as short as legally permissible, with comments due 30 days after publication of the proposed rule, or Christmas Eve, December 24, 2001.

32. At least 220 commenters submitted letters to HHS responding to the proposed rule, including the Plaintiffs and/or the hospital associations that represent the Hospital Plaintiffs. Of the letters in the record, *only two* expressed support for the proposed rule. *Over 200* letters opposed it. These letters clearly predict the drastic and severe impact on public hospitals from the proposed new rule. They criticized the validity of the only empirical evidence HHS supplied to support the rule change (the OIG Report), the fact that the proposed rule ran counter to Congressional intent, the failure to comply with the requirements of the APA, and many other aspects undermining the proposed elimination of the enhanced Medicaid supplemental payment. None of these criticisms was answered in the final rule.

33. At least three of the letters that were submitted to HHS in a timely manner were inexplicably excluded from the official rulemaking record. Each of these excluded letters objects to the proposed rule and highlights the harm it would cause if implemented.

Congressional Action

34. Both before and after HHS published the proposed regulation in November 2001 and before the final regulation was released in January 2002, Congress made its views clear. In appropriating FY 2002 program management funding to the Centers for Medicare and Medicaid Services ("CMS") to administer Medicaid, Congress

directed HHS to wait until it had fully assessed the implementation of the 2001 UPL Rule before modifying it. HHS ignored this directive.

Hospitals' Reliance on the Current Rule

35. The supplemental funding allowed by the UPL is essential to the stability of the Medicaid program and safety net health care providers in many states. States use the payments to support hospitals providing health care to the nation's Medicaid and low-income populations. These payments have provided carefully targeted supplemental payments to the highest volume providers of services to Medicaid patients and the uninsured, including public hospitals, major teaching hospitals, and children's hospitals.

January 18, 2002 Final Rule

36. On January 18, 2002, HHS published the final 2002 UPL Rule in the Federal Register. Thus, HHS took a mere 17 working days after the deadline for receipt of comments, and a period in which two major federal holidays fell, to "review" more than 200 comments. Final Rule, Modification of Upper Payment Limit for Non-State Government-Owned or Operated Hospitals, 67 Fed. Reg. 2,602 (2002) (to be codified at 42 C.F.R. pt. 447). The 2002 UPL Rule "modified the Medicaid upper payment limit (UPL) provisions to remove the 150 percent UPL for inpatient hospital services and outpatient hospital services furnished by non-State government-owned or operated hospitals." 67 Fed. Reg. 2,602. The regulation, which HHS designated to take effect on March 19, 2002, will reduce the higher 150 percent UPL for non-State government-owned or operated hospitals to 100 percent, thereby sharply reducing the supplemental funding for local public hospitals.

37. In eliminating the 150 percent UPL, HHS relied on its asserted belief that the 100 percent UPL is "more than sufficient" to provide "adequate access to services" for Medicaid recipients at public hospitals. 67 Fed. Reg. 2,603. This "belief" on the part of the Agency is not supported by any concrete relevant data or other facts and not by the overwhelming evidence to the contrary contained in the 220 timely submitted comments. HHS failed to analyze the experience of the two states (Arkansas and Mississippi) that had received approval for and implemented supplemental payment for safety net hospitals pursuant to the 150 percent limit, even though it received comments from hospital associations in both states documenting the benefits of their programs. Rather, HHS relies almost exclusively on the same OIG reports that had led to the establishment of the 150 percent limit in the first place.

Harm to Hospitals

38. The Hospital Plaintiffs and members of the Association Plaintiffs are safety net hospitals that participate in the Medicaid program and qualify for supplemental Medicaid funds available pursuant to the January 12, 2001 UPL Rule. These hospitals rely on these payments in order to ensure access to essential health care services for Medicaid and other low-income patient populations they serve.

39. As reflected in the Declarations in the Exhibit Volume, if the current 150 percent upper payment limit for non-state public hospitals is eliminated on March 19, 2002, the Hospital Plaintiffs and many members of the Association Plaintiffs will be required to make deep cuts in essential services on which their underserved patient populations rely. Predicted cuts could include elimination of entire departments and closure of certain on- and off-campus facilities. In many of these hospitals' communities,

there are simply no other providers able to step in and replace these lost services. As a result, many Medicaid and other low-income people will effectively lose their access to essential health care services, while entire communities will lose essential community-wide services and be less prepared for future emergencies.

40. Some of the outcomes of the implementation of the rule, as documented in the Declarations, include:

- elimination of community clinics, forcing people to use hospital emergency rooms for primary care services;
- overburdened emergency rooms leading hospitals to divert critical patients to distant hospitals;
- reduction in services requiring patients to travel long distances to the nearest alternative provider;
- significant reductions in linguistic services and outreach to non-English speaking patients;
- inability to retain physicians on staff who are qualified to provide specialized care (including critically-needed basic care such as obstetrical/gynecological services for women); and
- reduction in hospital programs to handle acute psychiatric patients.

41. The impact of the loss of the supplemental funding for non-state governmental hospitals, moreover, is not limited to public hospitals alone. Other safety net providers – including private children's and teaching hospitals and public and private clinics – also will be harmed. The importance of the 150 percent UPL rule to maintaining the delicate balance of safety net financing in many states cannot be overestimated.

42. The Hospital Plaintiffs and the Association Plaintiffs and their members have an interest in delivering quality health care to Medicaid and other low-income

recipients in an efficient manner and at payment rates sufficient to enable them to continue to meet their patients' needs. The Hospital Plaintiffs and the Association Plaintiffs and their members are interested in assuring that unlawfully forced reductions in payments do not jeopardize low-income patients' access to services, that decisions regarding Medicaid payment limits are based on reliable and verifiable data, and that these decisions are made in conformance with the APA and take into account concerns of Congress, providers, recipients and other interested parties.

The 2002 UPL Rule Should be Enjoined

43. The 2002 UPL Rule should be enjoined for numerous reasons. HHS's issuance of the 2002 UPL Rule was effected in an arbitrary, capricious and otherwise illegal fashion in four major respects.

44. First, HHS acted in an arbitrary and capricious manner in implementing the 2002 UPL Rule by relying on irrelevant and inaccurate data, failing to consider relevant evidence, failing to consider properly the harm to safety net hospitals, failing to articulate a rational connection between its policy decision and claimed mitigating factors and ignoring Congressional intent, in violation of the APA.

45. Second, HHS acted in an arbitrary and capricious manner, and the basis and purpose statement of the 2002 UPL Rule is legally deficient, by failing to consider and respond to significant public comments that HHS itself requested, such as comments on the impact of the rule on hospitals, also in violation of the APA.

46. Third, HHS issued the 2002 UPL Rule in violation of the Regulatory Flexibility Act and the Social Security Act by failing to assess the negative impact that

the rule will have on small entities, such as the Hospital Plaintiffs and member hospitals of the Association Plaintiffs.

47. Fourth, HHS has failed to comply with the most basic notice requirement in the Congressional Review Act. Pursuant to 5 U.S.C. § 801(a)(3)(A), a major regulation like this one cannot be effective until 60 days after the rule and a report on its impact has been delivered to Congress. Here, as discussed below, while the 2002 UPL Rule was published as a final rule in the Federal Register on January 18, 2002, it was not received by Congress until February 20, 2002. Thus, the rule's purported effective date of March 19, 2002 is legally defective.

48. Plaintiffs do not have an adequate remedy at law. If the 2002 UPL Rule is implemented, as designated by HHS, on March 19, 2002, Plaintiffs' ability to continue to provide necessary medical care to Medicaid and other low income and vulnerable patients will be seriously and irreparably compromised. As those individuals lose access to medical care, the sick will get sicker, minor injuries will become life-threatening, hospital emergency rooms will overflow with patients, causing lengthy and dangerous ambulance diversions, and the quality of health care will suffer immeasurably. These are all consequences of the 2002 UPL Rule, should it go into effect.

49. As detailed below, Plaintiffs have a substantial likelihood of success on the merits, Plaintiffs will suffer irreparable harm, any harm to HHS is outweighed by the harm to Plaintiffs, and the injunction sought is in the public interest. Accordingly, Plaintiffs respectfully request a preliminary injunction and a permanent injunction to prevent the UPL 2002 Rule from being implemented. Plaintiffs further request that the Court entertain their Motion for a Preliminary and Permanent Injunction on an expedited

basis so that this matter is determined before the rule's currently scheduled effective date of March 19, 2002.

50. Plaintiffs have complied with all necessary conditions to bring this action.

51. Plaintiffs have no effective administrative remedies.

Count One
(Arbitrary and Capricious Action)

52. Plaintiffs incorporate Paragraphs 1-51 above as if fully set forth herein.

53. This is a claim for declaratory and injunctive relief.

54. The APA, 5 U.S.C. § 551 *et seq.* and 5 U.S.C. § 702 *et seq.* provide for judicial review of federal agency actions.

55. The APA provides that a court may "hold unlawful and set aside" agency actions found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law " 5 U.S.C. § 706(2)(A).

56. In promulgating the 2002 UPL Rule, HHS violated the APA by the following actions:

(a) basing the new rule on inaccurate and irrelevant data;

(b) ignoring relevant evidence that was counter to its predetermined policy choice;

(c) failing to analyze or consider properly the harm to safety net hospitals (and their patients) that will result;

(d) failing to articulate a rational connection between the policy decision contained in the 2002 UPL Rule and claimed mitigating factors; and

(e) ignoring Congressional intent regarding the retention of the 150 percent January 2001 UPL Rule.

Count Two
(Unlawful Statement of Basis and Purpose)

57. Plaintiffs incorporate Paragraphs 1-51 and 54-55 above as if fully set forth herein.

58. This is a claim for declaratory and injunctive relief.

59. All final rules must include a "concise general statement of their basis and purpose," 5 U.S.C. § 553(c), including responses to the major comments received by the agency.

60. In promulgating the 2002 UPL Rule, HHS has violated the APA and/or acted in an arbitrary and capricious fashion by the following actions, reflected in the legally deficient statement of basis and purpose included in the 2002 UPL Rule**:**

(a) failing to respond to significant comments on the deficiencies in the OIG Report, or to explain how those comments affected the new regulation;

(b) failing to respond to significant comments predicting severe harm to hospitals;

(c) ignoring significant comments regarding Congress' intent that the 2001 UPL Rule remain in force until it has been properly assessed; and

(d) failing to review all of the timely comments, and failing to accurately characterize many significant comments.

61. The statement of basis and purpose in the 2002 UPL Rule demonstrates that all relevant factors have not been considered by HHS and major issues of policy were not addressed properly.

Count Three
(Violation of Regulatory Flexibility Act and the Social Security Act)

62. Plaintiffs incorporate Paragraphs 1-51 and 54-55 above as if fully set forth herein.

63. This is a claim for declaratory and injunctive relief.

64. The Regulatory Flexibility Act ("RFA"), 5 U.S.C. § 601, *et seq.* requires HHS to assess the negative impact that a proposed rule will have on small entities.

65. For purposes of the RFA, all hospitals are considered to be small entities.

66. The Social Security Act requires HHS to prepare a regulatory impact analysis when HHS publishes a proposed rule under the Medicaid statute that may have a significant impact on the operations of a substantial number of small rural hospitals. 42 U.S.C. § 1302(b)(1).

67. In the NPRM, HHS noted that the new rule eliminating the higher upper payment limit could have a significant impact on hospitals.

68. The 2002 UPL Rule included a final regulatory flexibility analysis ("FRFA") that concluded that nationwide, approximately 1,275 non-State government-owned or operated hospitals could potentially be affected by the rule.

69. The FRFA must include, among other information, a summary of significant issues raised by public comments in response to the initial regulatory flexibility analysis, a summary of the agency's assessment of these issues, a statement of any changes in the proposed rule based on the comments, and a description of the steps the agency has taken to minimize the "significant economic impact on small entities consistent with the stated objectives of applicable statutes" as well as legal reasons for selecting the alternative adopted and why each of the other "significant alternatives to the

rule considered by the agency which affect the impact on small entities was rejected." 5 U.S.C. § 604(a).

70. The FRFA contained in the 2002 UPL Rule was defective and insufficient in failing to substantively assess the impact on small entities and rural hospitals by, among other things, HHS's insufficient response to significant comments outlining the devastating harm to non-public government-owned or operated hospitals resulting from the implementation of the 2002 UPL Rule (including but not limited to comments that the funding under the 2002 UPL Rule will not cover costs), HHS's failure to respond to significant comments and HHS's failure to adequately consider the harm to small entities and/or rural hospitals.

71. As a result, HHS lacked rational support in implementing the 2002 UPL Rule.

Count Four
(Violation of Congressional Review Act)

72. Plaintiffs incorporate Paragraphs 1-51 above as if fully set forth herein.

73. This is a claim for declaratory and injunctive relief.

74. The Congressional Review Act ("CRA"), 5 U.S.C. § 801 *et seq.* requires a federal agency to submit a report including a copy of a proposed major rule and other information to each house of Congress and to the Comptroller General before the rule can be effective.

75. The CRA provides that major rules such as the 2002 UPL Rule shall take effect on the *later* of 60 days after Congress receives the required report or 60 days after the rule is published in the Federal Register, if so published. 5 U.S.C. § 801(a)(3).

76. The 2002 UPL Rule was published on January 18, 2002 with an effective date of March 19, 2002.

77. The House of Representatives received the 2002 UPL Rule from HHS on February 20, 2002. 148 Cong. Rec. H633 (daily ed. Feb. 27, 2002).

78. According to the CRA, the 2002 UPL Rule cannot be effective until April 20, 2002, at the earliest.

79. The Comptroller General informed HHS that the March 19, 2002 implementation date is impermissible.

80. HHS has not taken steps to correct the March 19th effective date.

RELIEF REQUESTED

WHEREFORE, Plaintiffs pray that this Honorable Court hold a hearing at an early date on their request for a preliminary injunction and permanent injunction, schedule this case for an early trial, and enter the following relief:

A. A preliminary injunction, issued before March 19, 2002, preventing the Secretary from implementing the 2002 UPL Rule on March 19, 2002 and requiring the Secretary to preserve the status quo, allowing the continuation of upper payment limits to non-state government-owned and operated hospitals pursuant to the 2001 UPL Rule, until this Court has the opportunity to determine the merits of this action;

B. A permanent injunction, issued before March 19, 2002, preventing the Secretary from implementing the 2002 UPL Rule on March 19, 2002 and requiring the Secretary to preserve the status quo, allowing the

continuation of upper payment limits to non-state government-owned and operated hospitals pursuant to the 2001 UPL Rule;

C. Alternatively, if HHS defers the effective date of the 2002 UPL Rule to anytime after March 19, 2002, a preliminary and/or permanent injunction, as described above, issued before the deferred effective date preventing the Secretary from implementing the 2002 UPL Rule on the deferred effective date;

D. A preliminary and permanent injunction vacating the 2002 UPL Rule and enjoining the Secretary from implementing the 2002 UPL Rule;

E. A declaratory judgment, pursuant to 28 U.S.C. § 2201, that the Secretary's issuance of the 2002 UPL Rule violates the Congressional Review Act;

F. A declaratory judgment, pursuant to 28 U.S.C. § 2201, that the Secretary's issuance of the 2002 UPL Rule was effected in an arbitrary and capricious fashion, and is unlawful under APA;

G. A declaratory judgment, pursuant to 28 U.S.C. § 2201, that the 2002 UPL Rule violates the Regulatory Flexibility Act and the Social Security Act; and

H. Such other and further relief as this Court deems appropriate.

Dated: March 7, 2002

Respectfully submitted,

WILLIAM C. CRENSHAW
POWELL, GOLDSTEIN, FRAZER & MURPHY, LLP
1001 Pennsylvania Avenue, N.W.
Sixth Floor
Washington, DC 20004

(202) 347-0066

DIANE MACKEY
FRIDAY, ELDREDGE & CLARK
2000 Regions Center
400 West Capitol Avenue
Little Rock, Arkansas 72201-3493
(501) 376-2011

Attorneys for Plaintiffs

BY:_____
DIANE MACKEY #_____

OF COUNSEL:
Larry S. Gage, Esq.
Barbara D.A. Eyman, Esq.
POWELL, GOLDSTEIN, FRAZER & MURPHY, LLP
1001 Pennsylvania Avenue, N.W.
Sixth Floor
Washington, DC 20004
(202) 347-0066

::ODMA\PCDOCS\WSH\257286\9