No. 17-1484

In the Supreme Court of the United States

ALEX M. AZAR II, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

ALLINA HEALTH SERVICES, ET AL., RESPONDENTS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF OF *AMICI CURIAE* CATHOLIC HEALTH, ROCHESTER REGIONAL HEALTH, and SANFORD HEALTH IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether the Department of Health and Human Services was required to conduct notice-and-comment rulemaking before changing a substantive legal standard governing payment to hospitals under Medicare, a change that will cost hospitals as much as $4 billion for care they have already provided to low-income patients without private health insurance.

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INTEREST OF *AMICI CURIAE*[1]

Catholic Health is a non-profit healthcare system that provides care to Western New Yorkers across a network of hospitals, primary care centers, imaging centers, and other community ministries. The system includes Kenmore Mercy Hospital, Mercy Hospital of Buffalo, Mount St. Mary's Hospital, Sisters of Charity Hospital, and St. Joseph Campus.

Rochester Regional Health provides comprehensive care for Western New York and the Finger Lakes region through a broad spectrum of resources, an ability to advocate for better care, a commitment to innovation, and an abiding dedication to caring for the community. The system includes Rochester General Hospital, Unity Hospital, Newark-Wayne Community Hospital, Clifton Springs Hospital & Clinic, and United Memorial Medical Center.

Sanford Health is headquartered in the Dakotas and is the largest, rural, nonprofit health care system in the nation, with 45 hospitals and 289 clinics in nine states and five counties. With 28,000+ employees, including 1,300+ physicians in more than 80 specialty areas of medicine, Sanford Health is the largest employer in the Dakotas.

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that this brief was not authored in whole or in part by counsel for any party, and that no such counsel or party made a monetary contribution to fund the preparation or submission of the brief. A monetary contribution was made by McKay Consulting, Inc., an entity which is not a party to the case. In accordance with this Court's Rule 37.2, all counsel consented to the filing of the brief.

Amici have a strong interest in the outcome of this case, as they will suffer significant and direct financial loss if the government can change without notice the way that hospitals are reimbursed for services already provided to patients pursuant to the Medicare system. The government estimates that loss to be in the range of $3-$4 billion solely for the change at issue here. Pet. 14, 23.

Equally concerning to *Amici*, the Department's theory will justify similar changes to payment standards in the future, all without providing *Amici* or other hospitals the opportunity for the public notice and comment that Congress intended. *Amici* respectfully request that this Court affirm the well-reasoned decision of the D.C. Circuit.

STATUTORY PROVISIONS INVOLVED

42 U.S.C. § 1395hh(a)(2) states, in relevant part:

> No [1] rule, requirement, or other statement of policy . . . that [2] establishes or changes [3] a substantive legal standard [4] governing . . . the payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation [through notice-and-comment rule-making].

42 U.S.C. § 1395hh(a)(4) states:

> If the Secretary publishes a final regulation that includes a provision *that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule*, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation. [Emphasis added.]

INTRODUCTION

Every business in the country understands that the cost of goods and services it provides must have a close nexus to the amount of revenue the business expects to collect. Businesses that lack the ability to align costs and revenues go bankrupt.

The situation is no different for our nation's hospitals. This is particularly true when hospitals serve patients who depend on the government to pay the medical bills. Hospitals are happy to serve such patients. But the services they provide must be calibrated to the amount of revenue the hospitals can expect. Otherwise, hospitals, too, will go bankrupt.

Congress understood this reality when it enacted the notice-and-comment requirements that apply to Department of Health and Human Services changes in hospital reimbursement payment standards. Rather than incorporate the Administrative Procedures Act, Congress enacted two unique provisions. The first is 42 U.S.C. § 1395hh(a)(2), the "payment for services" provision. The second is 42 U.S.C. § 1395hh(a)(4), the "not a logical outgrowth" provision. In tandem, §§ (a)(2) and (a)(4) ensure that no hospital is stuck with the bill when the Department changes without advance notice how it reimburses hospitals.

Yet surprise is exactly what the Department sprung here. With the issuance of its 2012 Medicare "fractions" in 2014, the Department told hospitals that their reimbursements would be calculated at a lower rate. And the Department implemented this change with no notice or opportunity for hospitals to comment, contrary to §§ (a)(2) and (a)(4).

This change, if affirmed, will have a devastating impact on hospitals, especially those that have been most generous in serving low-income patients. In its petition, the government estimates the impact between $3 and $4 *billion* for fiscal years 2005 through 2013. Pet. 14, 23.

These amounts show why Congress dictated in § (a)(2) that the Department provide notice and an opportunity to comment when it alters standards governing the "payment for services" that hospitals receive. The requirement does not prohibit the Department from making changes; it merely prohibits the Department from pulling the rug out from under hospitals by unfairly changing the reimbursement payment standard without advance notice and an opportunity to comment.

Moreover, the burden on the Department is modest. The typical notice-and-comment period in this arena takes about 102 days. Br. in Opp'n App. 1a–3a. Yet those 15 weeks make all the difference in the world to hospitals. That is why the Department routinely provided notice and an opportunity to comment in more than a dozen previous attempts to revise the same payment standard at issue in this litigation. Br. in Opp'n App. 4a–6a.

As the D.C. Circuit concluded, § (a)(2)'s language is "fairly straightforward" (especially for Medicare) and its provisions are "readily met" here. Pet. App. 12a (Kavanaugh, J.). This Court should affirm the D.C. Circuit and hold the Department's 2012 reimbursement payment standard invalid.

STATEMENT

Medicare reimbursement in plain English

Medicare provides health insurance to elderly and disabled Americans. Pet. App. 2a. Patients can obtain insurance under different Medicare "Parts" specifying varying hospital-reimbursement methods. Pet. App. 2a–3a. What's important here is that monies paid to hospitals under Part A are adjusted when hospitals provide disproportionate services to low-income patients. Pet. App. 3a. This adjustment is based on the sum of two fractions. *Ibid.* The first fraction measures the percentage of Part A patients who are eligible for supplementary security income benefits. The second measures the percentage of all patients who were Medicaid-eligible but not Part A-eligible.

The dispute arises out of the Department's decision to change how it calculates the fractions used to determine a hospital's disproportionate share hospital reimbursement. As noted, the new standard will short the nation's hospitals between $3 and $4 billion. Pet. 14, 23. (Curiously, after relying in its petition on this massive change in the "payment for services" that hospitals receive, the Department's merits brief now suggests there might be no impact, Gov't Br. 4–5, highlighting the need for notice and public comment.)

Such a change in reimbursement dollars has a serious impact on an individual hospital's solvency and ability to provide future services. The question presented is whether the government was obligated to give hospitals advance notice and an opportunity to comment before the Department unilaterally implemented this change.

Medicare notice-and-comment requirements

Congress could have easily incorporated the APA when it established the notice-and-comment requirements for Department proposals to change Medicare reimbursement methods. It did not. Under the APA, only proposed "rules" require notice and an opportunity to comment. And even then, the APA excepts "interpretative rules, general statements of policy, [and] agency organization, procedure, [and] practice," plus circumstances where the regulating agency for "good cause" finds that notice and comment are "impracticable, unnecessary, or contrary to the public interest. 5 U.S.C. § 553(b)(A), (B).

For Medicare, Congress broadened the types of covered agency actions to include not only "rules," but "requirements," and "statements of policy" as well. 42 U.S.C. § 1395hh(a)(2). So, whereas the APA *excludes* statements of policy from notice-and-comment procedures, § (a)(2) expressly *includes* them.

Congress then specified the subject matter to which § (a)(2) applies. Notice and comment are required when a rule, requirement, or statement of policy involves "the scope of benefits, the payment for services, or the eligibility . . . to furnish or receive services." *Ibid.*

As the D.C. Circuit explained, the above requirements constitute steps one and four of a four-factor inquiry under § (a)(2) for determining when notice and comment are necessary: (1) a rule/requirement/statement of policy that (2) "establishes or changes" (3) a "substantive legal standard" (4) governing the scope of benefits/ payment for services/eligibility. Pet. App. 12a.

In 2003, Congress created an extra layer of notice-and-comment protection for hospitals. This layer cannot be found in the APA. And it prohibits a Department regulatory provision from going into effect until after notice and adequate opportunity to comment. The requirement is triggered whenever a provision of the original (invalidated) final rule "is *not a logical outgrowth* of a previously published notice of proposed rulemaking or interim final rule." 42 U.S.C. § 1395hh(a)(4) (emphasis added).

A brief history of the Department's position on the disproportionate-services adjustment

The parties' dispute is over how the Department calculates the fractions used to calculate the disproportionate services adjustment. The nitty-gritty of the Department's thinking on the issue is of no moment. What does matter is the chronology for the Department's reimbursement payment standard:

- 2003 & before: hospital-friendly standard under the 1986 regulation
- 2003: the beginning of the faulty notice and comment; proposed rule clarifies that hospital-friendly standard does apply
- 2004: faulty notice and comment; final rule adopts Department-friendly standard
- 2007: with no notice or comment, amended regulation "confirms" 2004 final rule
- 2011: D.C. Circuit voids 2004 final rule's retroactive application

- 2013: after notice and comment, prospective new rule adopts Department-friendly payment standard

- 2014: D.C. Circuit vacates 2004 final rule altogether; not a "logical outgrowth" of the proposed rule

- 2014: 16 days after D.C. Circuit decision, Department issues fractions for 2012 adjustments, using Department-friendly rule and without notice and comment

- 2017: D.C. Circuit reverses Department's 2012 fractions because notice and comment was required

In its 2017 decision, the D.C. Circuit concluded that the Department's issuance of the adjustment fractions for 2012 violated both of Medicare's notice-and-comment provisions. The Department violated the "payment for services" standard in § (a)(2) because the new payment standard was (1) a "requirement" that (2) "changed" (3) a "substantive legal standard" (4) "used to calculate the payment that providers will receive." Pet. App. 12a–14a. And the Department violated the "not a logical outgrowth" standard in § (a)(4) because the Department's action in promulgating the new standard was "not a logical outgrowth of a previously published notice of proposed rulemaking." Pet. App. 17a–18a (citation omitted).

The D.C. Circuit denied the Department's request for rehearing en banc without a single member of the court calling for a vote. Pet. App. 77a–78a, 79a–80a. The Court then granted the Department's petition.

SUMMARY OF ARGUMENT

It is perverse for the government to tell hospitals that they will be reimbursed for services one way and then change the payment standard without formal notice. Congress so recognized when it enacted two separate statutes requiring the government to give notice and an opportunity for hospitals to comment before such changes are implemented. And while the Department is always free to change a reimbursement standard if it so chooses, the Department must give fair notice first. That never happened here when, in 2014, the Department started applying a Department-friendly payment standard with no notice or opportunity to comment. The D.C. Circuit was right to enforce Congress's intent and invalidate the Department's actions.

The Department advances a garbled reading of §§ (a)(2) and (a)(4). The Department urges the Court to allow the Government to skim some $3 to $4 billion that the Department would have been obligated to pay under the previous reimbursement payment standard. And that request necessarily requires the Court to greatly expand the Department's opportunity to make changes in payment-for-services standards in the future without first notifying hospitals of the modification. The Department's position flouts the plain, statutory language and any notion of fairness. This Court should summarily reject it.

ARGUMENT

It is undisputed that the Department did not use the notice-and-comment process to promulgate the revised reimbursement standard when it published the new fractions for 2012 in 2014. If §§ (a)(2) or (a)(4) required that process, then the Department's actions are void. Because the D.C. Circuit correctly concluded that notice and comment was required under both provisions, this Court should affirm.

I. The Government's application of its new, Department-friendly payment standard—without notice or comment—violates the payment-for-services provision in § (a)(2).

Once all the Medicare and administrative-law argle-bargle is cleared away, this case is not difficult. With an admitted $3 to $4 billion at stake, this is precisely the scenario Congress envisioned when it enacted § (a)(2) and directed the Department not to modify the payment standard for calculating payments for hospital services absent notice and comment.

Respondents' *prima facie* case for showing § (a)(2)'s applicability is straightforward, just as the D.C. Circuit concluded. First, the Department's new payment standard is, at the very least, a "requirement" or "statement of policy" guiding payment calculations. The Department does not contest the latter, Govt. Br. 39–41, even though Respondents raised it below, Resp't C.A. Br. 25; Resp't C.A. Reply 11, and again in this Court, Resp't Br. 27–29. And the Department's own description of its 2014 action shows it was, in fact, a "statement of policy." Resp't Br. 27–28.

Second, it is not possible to say that a payment-standard modification resulting in reimbursement checks that collectively shortchange hospitals somewhere between $3 to $4 billion is not a "change." The Government does not contest this point, nor could it.

Third and fourth, the standard for calculating a hospital's reimbursement is "a substantive legal standard governing . . . the payment for services." As the D.C. Circuit explained, "substantive law" is law that "creates, defines, and regulates the rights, duties, and powers of parties." Pet. App. 13a–14a (citing Black's Law Dictionary (10th Ed. 2014). When the Department revises a payment standard that determines a hospital's reimbursement amount, that revision "defines" the rights of parties.

The Department ignores this plain application of § (a)(2)'s language and urges this Court to import the APA's distinction between legislative and interpretative rules. Gov't Br. 21–29. But as noted above, Congress did not incorporate the APA by reference in § (a)(2); it rejected the APA's standards. For example, § (a)(2) requires notice-and-comment procedures for statements of policy, while the APA expressly excludes them. 5 U.S.C. § 553(b)(A). Section (a)(2) also requires notice-and-comment for "requirements," a term the APA does not even use. Section (a)(2) has a minimum 60-day minimum comment period, 42 U.S.C. § 1395hh(b)(1), whereas the APA's period is only a minimum of 30 days, 5 U.S.C. § 553(d). So, it is nonsensical to argue that the APA's standards have any force in the context of a § (a)(2) inquiry.

In addition, the phrase "substantive legal standard" is unique to § (a)(2). The APA does not use those words in combination, even one time. Instead, the APA refers to a "substantive rule." 5 U.S.C. § 553(d). So, this is not even a case where the Department is attempting to use words in one statute to discern the meaning of the same words in an unrelated statute, an analysis that is itself disfavored. *Chamber of Commerce* v. *Whiting*, 563 U.S. 582, 612 (2011) (Breyer, J., dissenting) (use of the same word in an unrelated statute does not "demonstrate what scope Congress intended the word" to have in the statute being scrutinized). The Department is using *different* words in an *unrelated* statute to discern the meaning of § (a)(2). That exercise is as illogical as it sounds.

The Department tries to argue that legislative history shows conclusively that § (a)(2) incorporates the APA's standards by silence. Gov't Br. 30—37. But "courts have no authority to enforce a principle gleaned solely from legislative history that has no statutory reference point." *Shannon* v. *U.S.*, 512 U.S. 573, 583 (1994) (cleaned up). "Congress's 'authoritative statement is the statutory text, not the legislative history.' " *Whiting*, 563 U.S. at 599 (quoting *Exxon Mobil Corp.* v. *Allapattah Servs., Inc.*, 545 U.S. 546, 568 (2005)).

There is no statutory reference point for the Department's position here. That the Department would spend eight precious pages of briefing to make an incorporation-by-legislative-history argument says everything this Court needs to know about the merits of the Department's textual arguments.

II. The Government's change to its Department-friendly payment standard—without notice or comment—violates the not-a-logical-outgrowth provision in § (a)(4) as well.

Independent of § (a)(2), § (a)(4) similarly requires notice and an opportunity to comment when the Department promulgates a regulatory provision that is not a "logical outgrowth" of the proposed regulation. 42 U.S.C. § 1395hh(a)(4). A provision may not become legally operative until going through the notice-and-comment process. *Id.*

Here, the D.C. Circuit vacated the Department's 2004 rule adopting the Department-friendly reimbursement standard because the 2004 rule "was not a logical outgrowth of the proposed rule," which was the hospital-friendly standard. *Allina Health Servs.* v. *Sebelius* (*Allina I*), 746 F.3d 1102, 1109 (D.C. Cir. 2014). To re-impose the voided rule, § (a)(4) required the Department to give the public notice and an opportunity to comment. But the Department did not do so with respect to its 2014 promulgation of the 2012 fractions based on the same, vacated payment standard.

The Department's response to this second notice-and-comment requirement is to say that it was acting by way of adjudication, rather than rulemaking. Gov't Br. 46–49. But adjudication is not an exception that appears in § (a)(4)'s text. And the Department's nationwide policy was not an adjudication in any event. Resp't Br. 51–52. Section (a)(4) required notice and comment before the Department could impose its new reimbursement payment standard.

CONCLUSION

The judgment of the D.C. Circuit Court of Appeals should be affirmed.

Respectfully submitted,

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