No. 19-68

In the Supreme Court of the United States

UNITY HEALTHCARE, PETITIONER

v.

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

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

NOEL J. FRANCISCO
Solicitor General
Counsel of Record
JOSEPH H. HUNT
Assistant Attorney General
MICHAEL S. RAAB
KAREN SCHOEN
Attorneys
Department of Justice
Washington, D.C. 20530-0001
SupremeCtBriefs@usdoj.gov
(202) 514-2217

ROBERT P. CHARROW
General Counsel
RANDY BUTLER
SUSAN MAXSON LYONS
JONATHAN C. BRUMER
NANCY K. ACHORD
Attorneys
Department of Health and Human Services
Washington, D.C. 20201

QUESTION PRESENTED

The court of appeals sustained a determination by the Administrator of the Centers for Medicare & Medicaid Services of the amount of a special Medicare reimbursement to petitioner under a since-amended regulation applicable to sole community hospitals that experience a sudden decline in patient stays. See 42 U.S.C. 1395ww(d)(5)(D)(ii); 42 C.F.R. 412.92(e)(3) (2016). The question presented is whether the Court should grant the petition for a writ of certiorari, vacate the judgment below, and remand for reconsideration in light of *Kisor* v. *Wilkie*, 139 S. Ct. 2400 (2019).

TABLE OF CONTENTS

Page

Opinions below 1
Jurisdiction 1
Statement 2
Argument 14
Conclusion 23

TABLE OF AUTHORITIES

Cases:

Adirondack Med. Ctr. v. *Burwell*, 782 F.3d 707 (D.C. Cir. 2015) 3
Auer v. *Robbins*, 519 U.S. 452 (1997) 15
Baptist Health v. *Thompson*, 458 F.3d 768 (8th Cir. 2006), abrogated in part on other grounds by *Azar* v. *Allina Health Servs.*, 139 S. Ct. 1804 (2019) 2
Bowles v. *Seminole Rock & Sand Co.*, 325 U.S. 410 (1945) 15, 17
Chevron U.S.A. Inc. v. *Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984) 15
Christopher v. *SmithKline Beecham Corp.*, 567 U.S. 142 (2012) 16
Community Hosp. of Chandler, Inc. v. *Sullivan*, 963 F.2d 1206 (9th Cir. 1992) 2, 3
County of L.A. v. *Shalala*, 192 F.3d 1005 (D.C. Cir. 1999), cert. denied, 530 U.S. 1204 (2000) 2
Good Samaritan Hosp. v. *Shalala*, 508 U.S. 402 (1993) 2
Heckler v. *Community Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51 (1984) 21
Kisor v. *Wilkie*, 139 S. Ct. 2400 (2019) 15, 16, 17, 18

Cases—Continued: Page

Lawrence ex rel. Lawrence v. *Chater*, 516 U.S. 163 (1996) 16
Methodist Hosp. v. *Shalala*, 38 F.3d 1225 (D.C. Cir. 1994) 2
Sacred Heart Med. Ctr. v. *Sullivan*, 958 F.2d 537 (3d Cir. 1992) 22
St. Luke's Methodist Hosp. v. *Thompson*, 315 F.3d 984 (8th Cir. 2003) 13

Statutes and regulations:

42 U.S.C. 1395x(v)(1)(A)(i) 6
42 U.S.C. 1395*oo*(a) 9
42 U.S.C. 1395*oo*(f)(1) 9
42 U.S.C. 1395ww(d) (2012 & Supp. V 2017) 2
42 U.S.C. 1395ww(d)(1)(A)(iii) 3
42 U.S.C. 1395ww(d)(4)(A) 3
42 U.S.C. 1395ww(d)(5)(D) 3
42 U.S.C. 1395ww(d)(5)(D)(i) 3
42 U.S.C. 1395ww(d)(5)(D)(ii) 4, 13
42 U.S.C. 1395ww(d)(5)(D)(iii) 3
42 C.F.R.:
Pt. 405:
Section 405.476(d) (1984) 5
Section 405.1877(g)(1) 9
Pt. 412:
Section 412.92(a) 3
Section 412.92(d)(1) 3
Section 412.92(e) 5
Section 412.92(e)(3) 9
Section 412.92(e)(3) (1988) 6
Section 412.92(e)(3) (2016) 7, 13, 18, 19, 20

Regulations—Continued: Page

Section 412.92(e)(3)(i) (2016) 7
Pt. 413 19

Miscellaneous:

48 Fed. Reg. 39,752 (Sept. 1, 1983) 4, 5
50 Fed. Reg. 12,740 (Mar. 29, 1985) 5
52 Fed. Reg.:
p. 22,080 (June 10, 1987) 6, 20
p. 33,034 (Sept. 1, 1987) 6, 20
55 Fed. Reg. 15,150 (Apr. 20, 1990) 7
71 Fed. Reg. 47,870 (Aug. 18, 2006) 14
82 Fed. Reg.:
p. 19,796 (Apr. 28, 2017) 10, 11
p. 37,990 (Aug. 14, 2017) 11

In the Supreme Court of the United States

No. 19-68

UNITY HEALTHCARE, PETITIONER

v.

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

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-16) is reported at 918 F.3d 571. The opinion and order of the district court (Pet. App. 17-46) are reported at 289 F. Supp. 3d 985. The decision of the Administrator of the Centers for Medicare & Medicaid Services (Pet. App. 47-60) is unreported but is available at 2014 WL 5450066. The decision of the Provider Reimbursement Review Board (Pet. App. 61-99) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 12, 2019. On June 4, 2019, Justice Gorsuch extended the time within which to file a petition for a writ of certiorari to and including July 10, 2019, and the petition was filed on that date. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. Medicare is a federally funded health insurance program for the elderly and disabled. Under a "complex statutory and regulatory regime" known as Medicare Part A, *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 404 (1993), the government pays participating hospitals for inpatient care they provide to Medicare beneficiaries. At one time, the government reimbursed hospitals for the "reasonable costs" they incurred in providing such care. *Methodist Hosp.* v. *Shalala*, 38 F.3d 1225, 1227 (D.C. Cir. 1994) (citation omitted). "[E]ssentially, each hospital's actual costs incurred were reimbursed dollar-for-dollar so long as the Secretary found the costs reasonable." *Baptist Health* v. *Thompson*, 458 F.3d 768, 771 (8th Cir. 2006), abrogated in part on other grounds by *Azar* v. *Allina Health Servs.*, 139 S. Ct. 1804 (2019). That "cost-based system" was criticized for giving hospitals "no incentive to provide services at lower costs," *Community Hosp. of Chandler, Inc.* v. *Sullivan*, 963 F.2d 1206, 1207 (9th Cir. 1992), because "the more they spent, the more they were reimbursed," *County of L.A.* v. *Shalala*, 192 F.3d 1005, 1008 (D.C. Cir. 1999) (brackets and citation omitted), cert. denied, 530 U.S. 1204 (2000).

In 1983, to provide "an incentive for hospitals to reduce costs and operate more efficiently," Congress created a prospective payment system to compensate hospitals for providing inpatient services to Medicare beneficiaries. *Baptist Health*, 458 F.3d at 771. Under this system, set forth as amended in 42 U.S.C. 1395ww(d), hospitals generally receive a predetermined fixed payment per patient, "regardless of costs actually incurred." *Methodist Hosp.*, 38 F.3d at 1227. The amount of the payment is calculated according to "diagnosis-

related groups" (DRGs) that reflect the kinds of treatment provided to a particular patient, see 42 U.S.C. 1395ww(d)(1)(A)(iii) and (d)(4)(A)—so that, for example, a hospital is paid more for treating a patient with heart failure than for treating a patient with a broken arm. Because "[h]ospitals receive the per patient DRG amount no matter how much [they] spend[] on a given patient," hospitals that "treat patients for less than the DRG amount get 'rewarded,' while hospitals that spend more than the DRG amount must absorb the excess costs." *Community Hosp. of Chandler*, 963 F.2d at 1208.

b. The Medicare statute provides for alternative payment calculations for "sole community hospital[s]." 42 U.S.C. 1395ww(d)(5)(D).[1] Like other inpatient hospitals, sole community hospitals receive DRG payments—*i.e.*, a fixed amount on a per-patient basis that depends on each patient's diagnosis-related group. But the amount of the payment is based on either the standard DRG rate or a hospital-specific rate derived from the hospital's actual costs in a specified base year—whichever results in a greater payment in a particular cost year. See 42 U.S.C. 1395ww(d)(5)(D)(i); 42 C.F.R. 412.92(d)(1); *Adirondack Med. Ctr.* v. *Burwell*, 782 F.3d 707, 709 (D.C. Cir. 2015) (per curiam).

---

[1] The statute defines a "'sole community hospital'" to include any hospital that "the Secretary determines is located more than 35 road miles from another hospital" or that, "by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to [Medicare beneficiaries] in a geographic area." 42 U.S.C. 1395ww(d)(5)(D)(iii); see also 42 C.F.R. 412.92(a) (setting forth classification criteria).

To support sole community hospitals during periods of sudden declines in patient volume, the Medicare statute also provides for what is known as a volume-decrease adjustment to DRG payments. A sole community hospital is eligible for such an adjustment in a cost-reporting period in which the hospital experiences "a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control." 42 U.S.C. 1395ww(d)(5)(D)(ii). In those circumstances, the statute directs the Department of Health and Human Services to "provide for such adjustment to the [DRG payments] * * * as may be necessary to fully compensate the hospital for the *fixed costs* it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services." *Ibid.* (emphasis added).

The statute does not define the relevant "fixed costs," or what it means to "fully compensate" the hospital for those fixed costs. 42 U.S.C. 1395ww(d)(5)(D)(ii). In 1983, the agency promulgated a rule to implement this provision. 48 Fed. Reg. 39,752, 39,828 (Sept. 1, 1983). In the preamble to the rule, the agency explained that "fixed costs" are "those over which management has no control" in the short term, such as "rent, interest, and depreciation." *Id.* at 39,781. The agency distinguished those fixed costs from "[v]ariable costs," which are "costs for items and services that vary directly with utilization," such as "food and laundry services." *Id.* at 39,781-39,782. The agency also identified an intermediate category of "semifixed costs" in the "hospital setting," which are costs that "are neither perfectly fixed nor perfectly variable." *Ibid.* "Semifixed costs," the agency explained, "are those costs for items and ser-

vices that are essential for the hospital to maintain operation but [that] will also vary with volume," such as "personnel" costs. *Ibid.*

The preamble stated that the agency would, "on a case by case basis," consider semifixed costs "as fixed" costs, at least "[f]or a short period of time" following a sudden decrease in patient volume outside the hospital's control. 48 Fed. Reg. at 39,782. The agency anticipated, however, that "a cost-effective hospital would take some action to reduce unnecessary expenses" over time, and that "if a hospital did not take such action," the agency "would not include such costs in determining the amount of the adjustment." *Ibid.* Thus, the implementing regulation provided that the volume-decrease adjustment would be "based on * * * [t]he hospital's fixed (and semifixed) costs," as well as "[t]he length of time the hospital has experienced a decrease in utilization." *Id.* at 39,828.[2]

---

[2] The 1983 regulation provided in pertinent part:

> (3) [The Health Care Financing Administration] will determine a per discharge payment adjustment amount, including at least an amount reflecting the reasonable cost of maintaining the hospital's necessary core staff and services, based on—
>
> (i) The individual hospital's needs and circumstances, including minimum staffing requirements imposed by State agencies;
>
> (ii) The hospital's fixed (and semifixed) costs, other than those costs reimbursed on a reasonable cost basis under this subpart; and
>
> (iii) The length of time the hospital has experienced a decrease in utilization.

48 Fed. Reg. at 39,828; see 42 C.F.R. 405.476(d) (1984). That provision was later renumbered as Section 412.92(e) as part of a broader reorganization. See 50 Fed. Reg. 12,740, 12,741 (Mar. 29, 1985).

In 1987, the agency proposed to "clarify the regulations." 52 Fed. Reg. 22,080, 22,091 (June 10, 1987). The agency explained that some sole community hospitals that had received DRG payments in excess of their inpatient operating costs had been requesting a volume-decrease adjustment on top of those DRG payments, notwithstanding that the hospitals had made "a profit under the prospective payment system" even when faced with "a decline in occupancy." *Ibid.* The agency stated that hospitals are "not entitled to receive a payment adjustment" in those circumstances. *Ibid.* Paying a volume-decrease adjustment in those circumstances would mean that Medicare is "shar[ing] in the costs attributable to non-Medicare beneficiaries," which the agency concluded was "clearly inappropriate." *Ibid.*; cf. 42 U.S.C. 1395x(v)(1)(A)(i) (directing that "reasonable costs" for the Medicare program be calculated so as to exclude "costs with respect to individuals not * * * covered" by Medicare).

Accordingly, the agency revised its regulations "to make it clear that any adjustment amounts granted to [sole community hospitals] for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and [the] total payments made under the prospective payment system." 52 Fed. Reg. 33,034, 33,049 (Sept. 1, 1987); see 42 C.F.R. 412.92(e)(3) (1988) (providing that the agency will "determine[] a lump sum [volume-decrease] adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue based on DRG-adjusted prospective payment rates").[3]

---

[3] The agency also later transferred responsibility for processing requests for volume-decrease adjustments from its central office to

The substance of the regulations remained largely unchanged over the next 30 years. While the regulations established a ceiling that the volume-decrease adjustment may not exceed, they did not prescribe a formula for calculating the amount of the adjustment. During the time relevant to this case, the regulations directed the Medicare contractor responsible for processing requests for volume-decrease adjustments to "determine[] a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG [payments] for inpatient operating costs." 42 C.F.R. 412.92(e)(3) (2016). The regulations further directed the contractor to "consider[]," in determining the lump-sum amount: "[t]he individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies"; "[t]he hospital's fixed (and semifixed) costs, other than those costs paid on a reasonable cost basis under [other provisions]"; and "[t]he length of time the hospital has experienced a decrease in utilization." 42 C.F.R. 412.92(e)(3)(i) (2016).

2. This appeal arises out of the administrative determination of a volume-decrease adjustment petitioner requested for its 2006 fiscal year. "At all relevant times, [petitioner] qualified and was reimbursed as" a sole community hospital. Pet. App. 50.

---

fiscal intermediaries (now known as Medicare administrative contractors or MACs), private entities with which the Secretary contracts to make initial payment determinations under Medicare Part A. See 55 Fed. Reg. 15,150, 15,155 (Apr. 20, 1990).

a. In its 2006 fiscal year, petitioner's inpatient discharges decreased by more than 5%. Pet. App. 50. Petitioner submitted a request to its Medicare contractor for a volume-decrease adjustment of $741,308, which represented the difference between its Medicare inpatient operating costs for the relevant period and its DRG payments for that period. See *ibid.*; C.A. App. 91. The Medicare contractor determined that the decrease in patient volume was due to circumstances beyond petitioner's control and that petitioner was therefore eligible for a volume-decrease adjustment. See Pet. App. 50. The contractor disagreed, however, with petitioner's requested amount; the contractor calculated the appropriate adjustment to be $76,314. *Ibid.*

In calculating that volume-decrease adjustment, the contractor first excluded certain costs that the contractor determined to be variable (rather than fixed or semifixed). Pet. App. 50; see C.A. App. 86, 89. The contractor then determined that the appropriate volume-decrease adjustment was an amount equal to the difference between petitioner's fixed costs and its DRG payments, as set forth below. See Pet. App. 58; C.A. App. 86. The adjustment would thus fully compensate petitioner for any fixed costs associated with providing inpatient care to Medicare beneficiaries in excess of the DRG payments petitioner received for providing that care.

Inpatient Operating Costs	$5,698,829
Less: Variable Costs	– $664,994
Fixed Costs	$5,033,835
Less: DRG Payments	– $4,957,521
Volume-Decrease Adjustment	$76,314

b. Providers dissatisfied with a Medicare contractor's reimbursement decision may in some circumstances seek review by the Provider Reimbursement Review Board, an adjudicative body within the Department of Health and Human Services. See 42 U.S.C. 1395*oo*(a). Petitioner sought such review here.

The Board reversed the contractor's decision in part. Pet. App. 61-99. Although the Board accepted the contractor's classification of variable and fixed costs, *id.* at 87-89, the Board disagreed with the contractor's method for calculating the volume-decrease adjustment, *id.* at 95-96. After reviewing several examples in agency guidance, the Board concluded that the volume-decrease adjustment should be calculated as "simply the provider's fixed costs" (with an exception not relevant here), subject to the not-to-exceed "ceiling" specified in 42 C.F.R. 412.92(e)(3)—namely, the difference between the hospital's total Medicare inpatient operating costs and its DRG payments. Pet. App. 93-95. Here, because petitioner's fixed costs exceeded the ceiling, the Board determined that petitioner was entitled to an adjustment equal to the ceiling—or $741,308, as petitioner had requested. See *id.* at 96.

c. The Medicare contractor sought review by the Administrator of the Centers for Medicare & Medicaid Services, to whom the Secretary of Health and Human Services has delegated his authority to review Board decisions and to render final decisions on behalf of the agency. See 42 U.S.C. 1395*oo*(f)(1); 42 C.F.R. 405.1877(g)(1).

The Administrator modified the Board's decision to reinstate the contractor's payment calculation. Pet. App. 47-60. Like the Board, the Administrator agreed with the contractor's classification of fixed and variable costs. *Id.* at 56-57. Unlike the Board, the Administrator

also agreed with the contractor's method for calculating the volume-decrease adjustment. *Id.* at 57-58. Based on "the controlling statute," the regulation, and a prior Board decision in another proceeding (which had become a final agency action after the Administrator declined to review it, see *id.* at 14), the Administrator determined that the volume-decrease adjustment should be calculated as "the difference between [a hospital's] fixed and semi-fixed costs and its DRG payment, which in this case equates to $76,314, subject to the ceiling of $741,308." *Id.* at 58. The Administrator explained that the Board's method—equating the volume-decrease adjustment with fixed costs (subject to the ceiling)—would "overcompensate[]" hospitals for their fixed costs, because DRG payments already "contain partial compensation for [such] fixed costs." *Id.* at 59. The practical difference between the agency's method and petitioner's method was that approximately $664,994 in variable costs were excluded from the volume-decrease adjustment to DRG payments.

d. In April 2017, the agency issued a notice of proposed rulemaking to, among other things, make prospective changes to the method used by Medicare contractors to calculate the volume-decrease adjustment. 82 Fed. Reg. 19,796, 19,933-19,935 (Apr. 28, 2017).

The agency noted some hospitals' concerns with the then-current method, under which a hospital would receive no volume-decrease adjustment to its DRG payments when those payments exceeded the hospital's fixed costs. 82 Fed. Reg. at 19,933-19,934. The agency also observed that, "in some recent decisions," the Board "ha[d] indicated that it believes it would be more appropriate * * * to adjust the hospital's total [DRG payments] from Medicare by looking at the ratio of a

hospital's fixed costs to its total costs * * * and applying that ratio as a proxy for the share of the hospital's [DRG payments] that it assumes are attributable (or allocable) to fixed costs, and then comparing that estimate of the fixed portion of [DRG payments] to the hospital's fixed costs." *Id.* at 19,934.

The agency "continue[d] to believe that [its] current approach in calculating volume decrease adjustments is reasonable and consistent with the statute." 82 Fed. Reg. at 19,934. Nonetheless, after considering the views of the hospitals and the Board, the agency proposed to revise its regulations prospectively to require Medicare contractors to calculate the volume-decrease adjustment as the difference between a hospital's fixed costs and the estimated portion of its DRG payments allocable to fixed costs (calculated using a ratio of fixed costs to total costs). See *ibid.*

The agency issued final rules adopting this new method in August 2017. See 82 Fed. Reg. 37,990, 38,511 (Aug. 14, 2017). The agency adhered to its proposal to apply the new method only on a prospective basis, for cost-reporting periods beginning on or after October 1, 2017. See *id.* at 38,181-38,182. The new rule thus does not apply to the present dispute. The agency also reiterated its view that its "current approach," applicable to earlier cost-reporting periods, is "reasonable and consistent with the statute," regulations, and agency guidance. *Id.* at 38,180.

3. The district court affirmed the Administrator's determination of petitioner's volume-decrease adjustment in this case. Pet. App. 17-46. As relevant here, petitioner argued that the Medicare contractor had previously included variable costs when calculating volume-decrease adjustments and that the agency's

method of excluding variable costs from the adjustment undercompensates hospitals. D. Ct. Doc. 19-1, at 17-21 (Mar. 27, 2015). The court concluded, however, that the agency's decision to exclude variable costs from the calculation was neither arbitrary nor capricious. Pet. App. 46. The court explained that Congress's purpose in moving to the prospective payment system was to "restrain[] the growth of hospital expenditures and pass[] some of the burden (and risk) of cost management on to the hospitals," and that "the Secretary's interpretation of the statute and the regulation as requiring [that] qualifying hospitals be compensated only for fixed (or semifixed) costs is not inconsistent with the plain language of the statute or with the legislative intent." *Id.* at 37. The court also concluded that the agency's issuance of regulations during the litigation adopting a new method for calculating volume-decrease adjustments—applicable only to cost-reporting periods beginning on or after October 1, 2017, see p. 11, *supra*—did not "demonstrate that the prior regulations were invalid." Pet. App. 45 (citation omitted).

4. The court of appeals affirmed. Pet. App. 1-16.[4] As relevant here, the court observed that the Medicare statute "does not give the Secretary a formula or method for determining" the volume-decrease adjustment, and it concluded that the method the Secretary used here was a reasonable interpretation of the statutory requirement to "'fully compensate'" providers for their "'fixed costs'" in a period of sudden decreases in patient volume. *Id.* at

[4] The court of appeals issued a single opinion addressing both petitioner's appeal and two other pending, similar appeals by other providers. See Pet. App. 6-8, 10. The other providers have not sought this Court's review.

11 (quoting 42 U.S.C. 1395ww(d)(5)(D)(ii)). "The Secretary's interpretation," the court explained, "ensures that the total amount of a hospital's fixed costs in a given cost year are paid out through a combination of DRG payments" and the volume-decrease adjustment, which is consistent with the "plain language of the statute." *Id.* at 11-12.

The court of appeals rejected petitioner's argument that the Secretary's decision was inconsistent with the applicable regulation, 42 C.F.R. 412.92(e)(3) (2016). Pet. App. 13-15. The court observed that, "[w]here a regulation's plain language does not control the issue, [a court] must uphold an agency's interpretation of its own regulation unless that interpretation is plainly erroneous or inconsistent with the regulation." *Id.* at 13 (quoting *St. Luke's Methodist Hosp.* v. *Thompson*, 315 F.3d 984, 987 (8th Cir. 2003)). It then stated that, "[a]t first glance, the Secretary's interpretation of the relevant regulations in these cases is clearly consistent with their text." *Ibid.* The regulation, the court explained, specifies that the volume-decrease adjustment may not "exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG [payments] for inpatient operating costs." 42 C.F.R. 412.92(e)(3) (2016). The court further explained that the Secretary's approach "ensures" compliance with that mandate, and that the Secretary had properly considered the "characteristics of each hospital alongside the fixed or non-fixed nature of their costs," as required by the regulation. Pet. App. 13.

The court of appeals also rejected petitioner's argument that the Secretary's interpretation of the regulation was inconsistent with the agency's prior guidance. Pet. App. 13-15. Petitioner relied on several exemplary

calculations in the agency's Provider Reimbursement Manual, as well as the agency's statement in the preamble to a 2006 rulemaking describing "the process for determining the amount of the volume decrease adjustment." See *id.* at 13-14 (quoting 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006)). The court noted that the Board had previously concluded, in a decision that was issued shortly after the 2006 rulemaking and that became a final agency decision after the Administrator declined review, that the Manual examples "are meant to display the *ceiling* for a [volume-decrease adjustment], rather than its total amount." *Id.* at 14 (emphasis added).

Finally, the court of appeals determined that some Medicare contractors' use of "a more generous formula in previous years does not alter [the court's] conclusion that the Secretary's interpretation in these cases was not arbitrary or capricious." Pet. App. 14 n.3. The court explained that, although "a fiscal intermediary is the Secretary's agent for purposes of reviewing cost reports and making final determinations with respect to the total reimbursement due to a provider absent an appeal to the Board, intermediary interpretations are not binding on the Secretary, who alone makes policy." *Id.* at 14-15 n.3 (brackets and citation omitted).

ARGUMENT

The court of appeals' decision sustaining the Administrator's determination of the amount of petitioner's volume-decrease adjustment for one cost year under a since-amended regulation does not conflict with the decision of any other court or present any issue of significant continuing importance. Review by this Court therefore is unwarranted. Petitioner nevertheless requests (Pet. 18-27) that this Court grant the petition for

a writ of certiorari, vacate the judgment below, and remand to the court of appeals in light of *Kisor* v. *Wilkie*, 139 S. Ct. 2400 (2019), which postdated the decision below. Petitioner has failed to demonstrate, however, that there is a reasonable probability of a different result on remand. Granting, vacating, and remanding in light of *Kisor* is thus unwarranted. Accordingly, the petition should be denied.

1. The question presented in *Kisor* was whether to overrule the agency-deference doctrine established in *Bowles* v. *Seminole Rock & Sand Co.*, 325 U.S. 410 (1945), and applied in *Auer* v. *Robbins*, 519 U.S. 452 (1997), which has come to be known as *Auer* deference. *Kisor*, 139 S. Ct. at 2408. In *Kisor*, the Court explained in detail numerous limits on *Auer* deference, but on *stare decisis* grounds declined to overrule it. See *id.* at 2422-2423; see also *id.* at 2424 (Roberts, C.J., concurring in part). The Court explained that, "[f]irst and foremost, a court should not afford *Auer* deference" to an agency's interpretation of its own regulation "unless the regulation is genuinely ambiguous." *Id.* at 2415 (majority opinion). Moreover, before "concluding that a rule is genuinely ambiguous," a court "must exhaust all the 'traditional tools' of construction," giving careful consideration to "the text, structure, history, and purpose of a regulation, in all the ways it would if it had no agency to fall back on." *Ibid.* (quoting *Chevron U.S.A. Inc.* v. *Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843 n.9 (1984)). And "[i]f genuine ambiguity remains" after applying the traditional tools of construction, a court should defer to the agency's interpretation only if the interpretation falls "within the zone of ambiguity the court has identified." *Id.* at 2415-2416.

The Court also emphasized in *Kisor* that even a "reasonable agency reading of a genuinely ambiguous rule" should not receive *Auer* deference in some circumstances, and that a court "must make an independent inquiry into whether the character and context of the agency interpretation entitles it to controlling weight." 139 S. Ct. at 2416. Although the Court disclaimed any "exhaustive test" for that inquiry, *ibid.*, it identified several relevant considerations. First, the agency's interpretation "must be one actually made by the agency" and must represent the agency's "'authoritative' or 'official position.'" *Ibid.* (citation omitted). Second, to be entitled to deference, the agency's interpretation also "must in some way implicate its substantive expertise," such that Congress presumably would have wanted the agency, rather than a court, to resolve the regulatory ambiguity. *Id.* at 2417. Third, the Court indicated that deference would "rarely" be appropriate if an agency's interpretation has been inconsistent over time. *Id.* at 2418. Finally, the agency's "reading of a rule must reflect 'fair and considered judgment' to receive *Auer* deference." *Id.* at 2417 (quoting *Christopher* v. *SmithKline Beecham Corp.*, 567 U.S. 142, 155 (2012)).

2. The Court's decision in *Kisor* does not warrant granting, vacating, and remanding in this case. Such a "GVR order" is "potentially appropriate" when, in light of "intervening developments," there is a "reasonable probability" that the ultimate outcome of the litigation would change because "the decision below rests upon a premise that the lower court would reject if given the opportunity for further consideration." *Lawrence ex rel. Lawrence* v. *Chater*, 516 U.S. 163, 167 (1996) (per curiam). Those circumstances are not present here.

Petitioner fails to show a reasonable probability that the court would reach a different result on remand.

a. Petitioner argues (Pet. 18) that the court of appeals "limited its examination of the agency's regulatory interpretation to whether it was plainly erroneous or inconsistent with the regulation." Petitioner is correct (Pet. 20-21) that the court recited the standard for *Auer* deference as articulated in circuit precedent, which this Court effectively abrogated in *Kisor*. See 139 S. Ct. at 2416; Pet. App. 13.[5] But immediately after reciting that formulation, the court determined, "[a]t first glance," that "the Secretary's interpretation of the relevant regulations in these cases is clearly consistent with their text." Pet. App. 13; see also *id.* at 14-15 (concluding that the Secretary's interpretation "was consistent with the regulation").

The court of appeals' statement that the Secretary's interpretation of the regulation is "clearly consistent" with its text, see Pet. App. 13, indicates that the court agreed with the agency that the regulation expressly provided only a ceiling, with the actual amount of the adjustment to be based on various factors. Moreover, as the court correctly perceived, petitioner's "main argument" (*ibid.*)—that the regulation required equating the volume-decrease adjustment with the difference between inpatient operating costs and DRG payments—rested not on the regulation's text or context, but rather on petitioner's flawed reading of several examples in the

[5] The district court similarly observed that "an interpretation which is 'plainly erroneous or inconsistent with the regulation' must be reversed." Pet. App. 32-33 (quoting, indirectly, *Seminole Rock*, 325 U.S. at 414).

Provider Reimbursement Manual (a guidance document). At a minimum, it is not clear to what extent *Auer* deference ultimately played a role in the decision below.

b. In any event, granting, vacating, and remanding is unwarranted because petitioner has failed to demonstrate that the result below would be any different even if the court of appeals were to reconsider this case in light of *Kisor*. As set forth below, the "text, structure, history, and purpose" of the regulation applicable to the 2006 cost year, *Kisor*, 139 S. Ct. at 2415, demonstrate that the regulation prescribed a formula for calculating a not-to-exceed ceiling for volume-decrease adjustments to DRG payments, but that the regulation did not require the agency to treat the ceiling as the amount to which a hospital is invariably entitled.

Petitioner argues that there is a reasonable probability that the court of appeals would conclude on remand that the regulation "unambiguously require[d]" that the volume-decrease adjustment always equal the "'difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs.'" Pet. 21-22 (quoting 42 C.F.R. 412.92(e)(3) (2016)). As an initial matter, petitioner did not contend below that the regulation unambiguously required that result. Cf. Pet. C.A. Reply Br. 7 (relying on the Medicare statute and agency guidance, not the regulation). And the regulation plainly did not. Indeed, as the court of appeals observed, "[d]uring the time period in question, no regulation provided for a specific method of calculating a [volume-decrease adjustment] payment." Pet. App. 6. Notably, the court made that observation—which is sufficient to reject petitioner's contention that the regulation unambiguously

required the method petitioner prefers—without any mention of *Auer* deference.

The regulatory language that petitioner invokes (Pet. 22) instead specified that a Medicare contractor would determine "a lump sum adjustment amount *not to exceed* the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG [payments] for inpatient operating costs." 42 C.F.R. 412.92(e)(3) (2016) (emphasis added). The regulation did not require that the adjustment *equal* the ceiling. To the contrary, the regulation went on to say that in determining the actual "adjustment amount," the Medicare contractor was to "consider[]" three factors: "(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies"; "(B) The hospital's fixed (and semifixed) costs, other than those costs paid on a reasonable cost basis under [42 C.F.R. Pt. 413]"; and "(C) The length of time the hospital has experienced a decrease in utilization." *Ibid.* And as the court of appeals noted, consistent with these regulatory provisions, "the Secretary considered individual characteristics of [petitioner] alongside the fixed or non-fixed nature of [its] costs." Pet. App. 13.

The history and purpose of the regulation, as set forth by the court of appeals, also make clear that it did not prescribe a formula for calculating the adjustment, but merely a ceiling. See Pet. App. 4-6 (reviewing regulatory history); pp. 4-6, *supra* (same). When the agency amended its regulations in 1987 to adopt the language at issue here, it explained that hospitals that had experienced a decrease in patients were requesting volume-decrease adjustments even though their DRG

payments exceeded their inpatient operating costs. Pet. App. 5. "Recognizing that granting a [volume-decrease adjustment] in those circumstances would conflict with the general purpose behind adopting the prospective payment system, the agency made clear 'that any adjustment amounts granted to [sole community hospitals] for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and total payments made under the prospective payment system.'" *Ibid.* (quoting 52 Fed. Reg. at 33,049) (second set of brackets in original). In so doing, the agency "hope[d] to spare those hospitals [whose DRG payments exceeded their inpatient operating costs] the administrative burden of preparing a detailed request for an adjustment." 52 Fed. Reg. at 22,091.

Petitioner additionally contends (Pet. 23-24) that the agency's interpretation of 42 C.F.R. 412.92(e)(3) (2016) is "contrary to the prior longstanding agency interpretation." But petitioner identifies no reason to think the court of appeals would accept that assertion on remand. Petitioner merely reasserts (Pet. 23-24) the same arguments it already made to that court, which determined that petitioner's "main argument" rested on a misreading of the agency's guidance. Pet. App. 13.[6]

---

[6] Petitioner's other claims of inconsistency are equally unavailing. Petitioner made the same points below (compare Pet. 23-24, with Pet. C.A. Br. 26-27), and the court of appeals was not persuaded. For example, petitioner reprises its argument that the agency had agreed with petitioner's proposed method of calculating the volume-decrease adjustment in a 2004 letter to another provider (Pet. 23-24; Pet. C.A. Br. 31-32), but the cited correspondence was issued by an "accountant in a regional office" and did not reflect the *agency's* considered view (Gov't C.A. Br. 41). Likewise, the rulemaking preambles that petitioner cites (Pet. 23; Pet. C.A. Br. 33-34), when read

Petitioner suggests (Pet. 24-25) that the district court found that the agency had changed its interpretation of its regulations. That is incorrect. The agency's interpretation has been consistent. In stating that the Secretary "did not change the regulations, only the interpretation of the existing regulations," Pet. App. 41, the district court appears to have been referring to an error that some Medicare contractors had been making, which the Secretary corrected because it departed from the agency's consistent position. In particular, at a hearing before the Board, an auditor with the Medicare contractor testified "that in the past the [contractor] had not removed variable costs in processing [volume-decrease adjustment] requests," but that he determined, after reviewing the relevant authorities, that the contractor "had not been handling variable costs properly and that the only costs the [contractor] was to consider were fixed and semi-fixed costs." *Id.* at 39-40; see *id.* at 30. After recounting that testimony, the court found that "the Secretary discovered the Department had made a mistake in how it had been calculating" volume-decrease adjustments, and that the "Secretary took steps to correct the Department's error but did not change the regulations, only the interpretation of the existing regulations." *Id.* at 41. Although the district court referred to the error as "the Department's," *ibid.*, the court of appeals correctly recognized that a Medicare contractor's interpretation of the regulations is not *the agency's* interpretation, *id.* at 14 n.3.[7] Thus, it would

---

in the context of the regulation itself, do not support petitioner's proposed construction (Gov't C.A. Br. 42).

[7] See also *Heckler* v. *Community Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 64 (1984) (noting that a Medicare "fiscal intermediary * * * only acted as a conduit" and "could not resolve

be more accurate to say that the Secretary did not change the agency's interpretation of the regulations, but merely corrected some contractors' failure to conform to the agency's interpretation.

Finally, petitioner's reading of the regulation would produce anomalous results that would be contrary to the statutory design of the prospective payment system. Petitioner's proposed interpretation—in which the volume-decrease adjustment would have equaled the amount by which petitioner's total Medicare operating costs exceeded its DRG payments—would not only have fully compensated petitioner for its *fixed* costs but would also have resulted in dollar-for-dollar reimbursement of its *variable* costs. Through a combination of its regular DRG payments and the volume-decrease adjustment, the hospital would have been fully reimbursed for *all* of its operating costs—regardless of how cost-inefficient it was.

That is precisely the result that Congress sought to avoid when it adopted the prospective payment system. See pp. 2-3, *supra*. Under the prospective payment system, "[w]hen a hospital's actual operating costs exceed its federally prescribed limit for the given DRG, the hospital must absorb the difference." *Sacred Heart Med. Ctr.* v. *Sullivan*, 958 F.2d 537, 541 (3d Cir. 1992). Recognizing the unique needs and circumstances of sole community hospitals, Congress provided for the use of a hospital-specific rate in the payment formula for such hospitals. But Congress still required sole community hospitals to bear the risk that their costs would exceed

---

policy questions," and that a "participant in the Medicare program" is expected to be "acquainted with the nature of and limitations on the role of a fiscal intermediary").

their DRG payments. And nothing in the statute suggests that Congress intended the volume-decrease adjustment to eliminate that risk entirely. While the statute provides for full compensation of *fixed* costs to partially mitigate the impact of the prospective payment system when a hospital is unable to reduce its fixed costs to adjust to a significant decrease in patients, the statute does not suggest that all of a hospital's *variable* costs should be compensated in those circumstances.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

NOEL J. FRANCISCO
Solicitor General
JOSEPH H. HUNT
Assistant Attorney General
MICHAEL S. RAAB
KAREN SCHOEN
Attorneys

ROBERT P. CHARROW
General Counsel
RANDY BUTLER
SUSAN MAXSON LYONS
JONATHAN C. BRUMER
NANCY K. ACHORD
Attorneys
Department of Health and Human Services

OCTOBER 2019