No. 19-68

In The
Supreme Court of the United States

UNITY HEALTHCARE,

Petitioner,

v.

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

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

REPLY BRIEF FOR PETITIONER

JONATHAN BIRAN
Counsel of Record
LESLIE DEMAREE GOLDSMITH
ROBERT E. MAZER
BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, PC
100 Light Street
Baltimore, Maryland 21202
Telephone: (410) 685-1120
Fax: (410) 547-0699
jbiran@bakerdonelson.com

Counsel for Petitioner Unity HealthCare

COCKLE LEGAL BRIEFS (800) 225-6964
WWW.COCKLELEGALBRIEFS.COM

TABLE OF CONTENTS

TABLE OF AUTHORITIES

REPLY BRIEF FOR PETITIONER

1. Alex M. Azar, II, Secretary of Health and Human Services ("Respondent" or "Secretary") asserts that review of the court of appeals' decision is unwarranted because it "does not conflict with the decision of any other court or present any issue of significant continuing importance." Brief of the Respondent in Opposition ("Brief of Respondent") at 14. As previously stated (Petition for Writ of Certiorari ("Petitioner's Writ") at 19), the Court has recognized that GVR may be appropriate "in cases whose precedential significance does not merit [the Court's] plenary review." *Lawrence v. Chater*, 516 U.S. 163, 168 (1996) (*per curiam*).

2. Respondent does not attempt to challenge the assertion of Unity HealthCare ("Petitioner") that, if given an opportunity to further consider the issue, the court of appeals would not afford deference to the agency's regulatory interpretation under *Auer v. Robbins*, 519 U.S. 452 (1997). *See* Petitioner's Writ at 22-25.

3. Respondent's main argument against GVR is that "Petitioner has failed to demonstrate . . . that there is a reasonable probability of a different result on remand." Brief of Respondent at 15, 17. As further discussed below, Petitioner has demonstrated that the agency's regulatory interpretation, as reflected in its final VDA calculation, was incorrect and, absent *Auer* deference, is unlikely to be upheld by the Eighth Circuit. *See* Petitioner's Writ at 25-26.

4. Respondent makes little, if any, attempt to explain how the CMS Administrator arrived at the final VDA determination and how such determination complied with applicable regulatory requirements, as would be required under the Administrative Procedure Act should a GVR be issued in this matter. *See* 5 U.S.C. § 706(2)(A) (requiring court to set aside agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"). In fact, Respondent has effectively acknowledged that the MAC's VDA computation, which computation was adopted by the CMS Administrator, did not comply with terms of the VDA Regulation.

a. Respondent recognized that the VDA Regulation, 42 C.F.R. § 412.92 (App. 102-103), requires the MAC to determine "a lump sum adjustment amount" reflecting the hospital's fixed and semi-fixed costs and other specified factors. This determination is subject to a ceiling ("not to exceed" amount) reflecting the difference between the hospital's Medicare inpatient operating costs and its total DRG payments. *See* Brief of Respondent at 19. This effectively requires a two-step determination, with the final VDA allowance equal to the lesser of the payment adjustment determination and the ceiling computation. In determining the VDA adjustment, the MAC did not follow this procedure, but instead, relied solely on a modified ceiling formula that did not comply with the VDA Regulation. As detailed in the PRRB's decision, the MAC computed the difference between FY 2006 Operating Costs Less Variable Costs of $5,033,835 (FY 2006 fixed costs) and FY 2006

DRG Payments of $4,957,521, resulting in a Net Volume Adjustment or VDA allowance of $76,314. App. 97. Although the CMS Administrator attempted to recharacterize the MAC's determination to be consistent with the VDA Regulation – suggesting that it made a separate calculation of payment adjustment and ceiling (App. 58) – the Respondent acknowledged that the CMS Administrator "reinstate[d] the [MAC's] payment calculation" that had been reversed in part by the Board. Brief for Respondent at 9.[1] As stated previously, Respondent has not shown how the MAC's VDA calculation described above complied with the VDA Regulation. In fact, it did not. The calculation did not include the determination of an adjustment amount and a ceiling determined based on the formula included in the VDA Regulation, as the regulation required.

Respondent recognized that the determination reflected "the difference between petitioner's *fixed* costs and its DRG payments . . . ," and that it would "fully compensate petitioner for any *fixed* costs associated with providing inpatient care to Medicare beneficiaries in excess of DRG payments petitioner received for providing that care." Respondent's Brief at 8 (emphasis added). While the lower court found this sufficient under the statute (Respondent's Brief at 3), neither statement reflects the requirements under the VDA Regulation, particularly, the method specified for

[1] In fact, the ceiling of $741,308 to which the CMS Administrator referred had been determined by the Board approximately five years after the MAC had made its VDA determination. App. 61, 69, 99.

determining the VDA ceiling because the MAC's computation was limited to a comparison of Petitioner's DRG payments and its fixed costs. The VDA Regulation provided for a comparison of DRG payments and total Medicare inpatient operating costs, including both variable and fixed costs. App. 102.[2]

Respondent asserts that Petitioner has argued that the VDA 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.'" Respondent Brief at 18. Similarly, Respondent asserts that the VDA Regulation "did not require the agency to treat the ceiling as the amount to which a hospital is invariably entitled" or "require that the adjustment *equal* the ceiling." Respondent's Brief at 18-19 (emphasis in original). Petitioner, however, has asserted only that the VDA Regulation does unambiguously require a computation of the VDA ceiling to be made as specified in the regulation, and does not permit use of a modified formula that would result in a reduction of the ceiling amount by limiting the costs to be compared against DRG

[2] Under Respondent's regulatory interpretation, an ice cream shop that lost money because of a rainy day would be considered to have been made whole by a $100 payment allowance reflecting the difference between the $300 received from customers and its fixed costs (rent and minimum staffing) of $400. The payment allowance would have totally disregarded the shop's variable costs, particularly ice cream which had cost $250 and which was a necessary part of the product for which the shop received $300 payments.

payments to fixed costs, contrary to the terms of the regulation.

5. Respondent asserts that Petitioner's VDA calculation methodology would result in "dollar-for-dollar reimbursement of [the hospital's] *variable* costs," which would permit Petitioner to recoup all of its excess costs, contrary to the intent of the prospective payment system ("PPS"). Brief of Respondent at 22. That assertion is incorrect.

a. Petitioner's methodology, which is the same as the methodology included in the Centers for Medicare and Medicaid Services, Provider Reimbursement Manual ("PRM" or "Manual") as in effect during the period at issue, does not necessarily result in dollar-for-dollar reimbursement of Petitioner's variable costs. During the relevant time period, there were at least three mechanisms built into the Manual methodology which limited variable costs included in the VDA determination.

b. First, hospitals otherwise eligible for a VDA adjustment that had operated at a Medicare profit are not permitted to receive such an adjustment. Specifically, in 1987, the Secretary stated that hospitals that experienced a decline in occupancy but that received DRG payments that exceeded their Medicare inpatient operating costs, were "not entitled to receive a [VDA] payment adjustment." 52 Fed. Reg. 33,034, 33,049 (Sept. 1, 1987). The Secretary amended 42 C.F.R. § 412.92(e)(3) accordingly to limit VDA amounts such that they were not to "exceed the

difference between the hospital's Medicare inpatient operating costs and the total payment made under the prospective payment system." 52 Fed. Reg. at 33,049, 33,057.

c. Second, the calculation methodology used by Petitioner and reflected in the Manual, includes a provision that removes the cost of excessive staff from a hospital's allowable costs, such that those costs are not included in the VDA calculation. In Petitioner's Writ, Petitioner discussed the VDA calculation methodology, including the example provided in the Manual at PRM § 2810.1.D (Example A). App. 106-107. *See* Petitioner's Writ at 9, 11-12. Specifically, the Manual provides a calculation that is to be made prior to the VDA calculation set forth at PRM § 2810.1.D (Example A), removing costs for excessive staff from a hospital's allowable costs. PRM § 2810.1.C.6.[3] "Once the excess salary costs are eliminated, the cost report is re-run, generating a new Program Inpatient Operating Cost that is the basis for the [VDA] payment

[3] PRM § 2810.1.C.6 in effect at the time in issue required a hospital requesting a VDA allowance to identify and provide justification of its core staff and services and their cost. The MAC was then required to determine necessary core staff and related costs, and to the extent a hospital exceeded necessary core staff and related cost, the starting cost eligible for consideration in the VDA calculation was reduced by the excess cost. *See* Administrative Record below, Docket No. 10 at District Court at pp. 220-223. (The Appendix does not include these provisions, because the issue to which they relate was not part of the decision of either the CMS Administrator or lower court.) In this case, the MAC found that Petitioner had no excessive staff costs. *Id.* at pp. 223, 257-258.

adjustment." PRM § 2810.1.C.6.a (Example B). Thus, the starting point in the VDA calculation is actual costs minus potentially excessive staff costs. Since labor is a significant cost for a hospital – potentially the most significant variable cost – this adjustment could significantly reduce or eliminate the VDA allowance.

d. Third, the starting point in the VDA calculation (after costs for excessive staff have been eliminated) also limits variable costs. That starting point is the lesser of either the hospital's costs in the prior year adjusted by an update factor or the hospital's actual costs in the year at issue. PRM § 2810.1.D (Example A). App. 107. The Manual explains that the VDA adjustment should be calculated under the assumption that a sole community hospital has "budgeted based on prior year utilization and had sufficient time in the year in which the volume decrease occurred to make significant reductions in cost." PRM § 2810.1.D. App. 106. Thus, a hospital that has had a substantial increase in costs in the relevant fiscal year – including variable costs – cannot benefit from that cost increase because the VDA calculation starting point is limited to the lower of the prior year's costs adjusted by an update factor or actual costs of the current year. *See* PRM § 2810.1.D (Example B). App. 108.

CONCLUSION

For the reasons set forth above, Petitioner Unity HealthCare respectfully submits that this Court should grant certiorari, vacate the opinion of the United States Court of Appeals for the Eighth Circuit, and remand the case to that court for further consideration in light of *Kisor v. Wilkie*, 139 S. Ct. 2400 (2019).

Dated: October 24, 2019

Respectfully submitted,

JONATHAN BIRAN
Counsel of Record
LESLIE DEMAREE GOLDSMITH
ROBERT E. MAZER
BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC
100 Light Street
Baltimore, Maryland 21202
Telephone: (410) 685-1120
Fax: (410) 547-0699
jbiran@bakerdonelson.com