No. 20-1113

IN THE

Supreme Court of the United States

AMERICAN HOSPITAL ASSOCIATION, *et al.*,
Petitioners,

v.

XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF OF DIGESTIVE HEALTH PHYSICIANS ASSOCIATION, LARGE UROLOGY GROUP PRACTICE ASSOCIATION, AND THE ORTHOFORUM AS *AMICI CURIAE* SUPPORTING RESPONDENT

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Interests of *Amici Curiae*[*]

Amici curiae are three trade associations representing independent physician practices: the Digestive Health Physicians Association (DHPA), the Large Urology Group Practice Association (LUGPA), and The OrthoForum. DHPA represents more than 2,300 gastroenterologists and other physician specialists in 97 independent gastroenterology practices in 38 States across the country who provide care for nearly three million patients annually. LUGPA represents 148 independent urology groups in the United States, with more than 2,100 physicians who, collectively, provide approximately 40% of the nation's urology services. And The OrthoForum represents approximately 100 independent orthopaedic practices with over 4,100 physicians in 41 States.

Amici's members provide many of the same services as hospital outpatient departments, just as safely and effectively, but the Medicare program has historically paid *amici*'s members a fraction of the amount paid to hospitals for identical services—even when the service provided by the hospital is furnished at an off-campus facility that looks like a physician's office. This payment disparity led to perverse financial incentives, causing increases in volume at hospitals—particularly for clinic visit services, which cover the evaluation and management of patients. The Secretary of Health and Human Services

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[*] Counsel for each party has consented in writing to the filing of this brief. No counsel for any party authored this brief in whole or in part. No person or entity—other than *amici*, their members, or their counsel—made a monetary contribution specifically for the preparation or submission of this brief.

deemed these increases in volume unnecessary because beneficiaries can receive the same services at physicians' freestanding medical offices, just as safely, but at a lower cost to the Medicare program and its beneficiaries. As a result, the Secretary promulgated a site-neutral payment rule, which effectively capped the rate paid to hospitals' off-campus outpatient departments for evaluation and management services at the same rate the Medicare program pays freestanding physician practices for these services. The American Hospital Association and various hospitals sued the Secretary, contending the rule is *ultra vires*.

Amici have a strong interest in ensuring the Secretary may exercise the authority Congress vested in him to control wasteful spending. Indeed, the unnecessary increases in the volume of evaluation and management services, which the Secretary sought to control through the promulgation of the challenged rule, came directly at the expense of independent medical practices such as *amici*'s members and the millions of Medicare beneficiaries those medical practices serve annually.

Introduction and Statement

This case does not present a *cert*-worthy question under *Chevron, U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). To be sure, the Petitioners seek review of the decision below by citing a supposed split among the circuits over whether *Chevron* deference applies to a statutory question that determines both the lawfulness of the agency's action and the court's jurisdiction. Pet. i.

But this case does not actually implicate the issue presented.

The court below concluded *as a matter of statutory interpretation* that the Secretary of Health and Human Services acted consistent with his authority when he promulgated the challenged rule. Petitioners and their *amici* have never offered a persuasive alternative construction of the relevant statutory provisions.

Simply put, *Chevron*'s second step plays no role in the outcome here, and as a result, the outcome would have been the same regardless of whether *Chevron* deference applied. Because the disposition of the case does not hinge on the question presented, this is not the vehicle to resolve that question.

Apparently recognizing this is the wrong case to resolve the question presented, Petitioners and their *amici* try to make it more appealing on the facts by framing their challenge to the rule as a parable about access to health care jeopardized by administrative overreach—and during a pandemic, no less. The real story is nothing of the sort.

The rule that Petitioners seek to nullify was narrowly tailored to address a specific, recent phenomenon in the health services market that was costing Medicare billions of dollars in unnecessary payments. It does not affect all services provided at the off-campus outpatient departments of hospitals—only evaluation and management services, where the Secretary expressly found an unnecessary increase in the volume of those services.

1. Physicians have traditionally cared for patients through independent medical practices, such as the ones *amici* represent. In the mid-2010s, however, hospitals accelerated their acquisitions of physician practices and converted them into so-called off-campus outpatient departments—typically without changing the location or care furnished. In 2012, hospitals owned 13.6% of American physician practices. By 2018, they owned 31.2%. Physicians Advocacy Institute, *Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment* 8 (Feb. 2019), *available at* http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf.

The reason hospitals went on this buying spree is no mystery. The Medicare program pays hospitals for services at their off-campus outpatient departments at the same rate the program pays when those services are performed in the hospitals' on-campus outpatient departments. This rate is set by Medicare's Outpatient Prospective Payment System (OPPS). 42 U.S.C. § 1395*l*(t). And OPPS rates are higher across-the-board than the rates paid to independent physician practices such as *amici*'s member practices, which are set by Medicare's Physician Fee Schedule. *Id.* § 1395w-4. This disparity gave hospitals the incentive to open more off-campus departments by acquiring freestanding physician practices and converting them to the OPPS. And so they did.

The discrepancy between what Medicare pays off-campus outpatient departments and freestanding physician practices created two problems for the Medicare program. First, by acquiring physician

practices, hospitals were shifting those practices to the OPPS's higher payment rates, which drove up program-wide reimbursement expenses. Second, even after hospitals acquired physician practices, they began ramping up the volume of services provided through the hospitals' off-campus outpatient departments.

In particular, the Medicare program saw tremendous growth in the number of "clinic visit services" for the evaluation and management of patients at hospitals' off-campus departments. These are services that could be—and traditionally have been—provided just as safely and effectively at a physician's office, and at a fraction of the cost to Medicare and its beneficiaries. And for these services, hospital off-campus facilities and independent physician offices are serving patients presenting issues of similar complexity. Dep't of Health & Human Servs., *Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs*, 83 Fed. Reg. 58,818, 59,007, 59,011-12 (Nov. 21, 2018) (explaining that patient acuity was not the main driver of the shift from freestanding physician offices to hospital outpatient departments).

In 2015, Congress stepped in to address the first problem by eliminating the financial incentive for hospitals to acquire new off-campus outpatient departments. Through Section 603 of the Bipartisan Budget Act of 2015, Pub. L. No. 114-74, 129 Stat. 584, 598, Congress decided that providers in off-campus outpatient departments acquired by hospitals after November 1, 2015—so-called non-excepted outpatient departments—would no longer be deemed

to be providing "covered [outpatient department] services" and, subject to certain exceptions, would have to be paid under a fee schedule other than the OPPS. At the same time, providers in off-campus outpatient departments that existed as of November 1, 2015—so-called excepted (or grandfathered) off-campus departments—could continue to bill under the OPPS.

But even after Congress fixed the first problem, the Secretary of Health and Human Services continued to see evidence of the second problem—an increase in the volume of services, and particularly "clinic visit services," that were being performed unnecessarily by grandfathered off-campus outpatient departments. The incentive to increase the volume of services was as powerful as ever. In 2019, the unadjusted Medicare payment under the OPPS for a clinic visit was roughly $116, with an average copayment of $23 from the beneficiary. 83 Fed. Reg. at 59,009. In contrast, the Physician Fee Schedule paid physicians in independent practice $46 for the same service, and the average beneficiary copayment was approximately $9. *Id.*

This second problem was costing Medicare and its beneficiaries billions of dollars in unnecessary expenses. The Medicare Payment Advisory Commission (MedPAC)—a nonpartisan legislative branch agency that advises Congress on issues affecting Medicare—estimated that, from 2011 to 2016, clinic visits to hospital outpatient departments increased by 43.8 percent, while "the volume of office visits in freestanding [physician] offices rose by only 0.4 percent." MedPAC, *Report to the Congress: Medicare Payment Policy* 73 (Mar. 2018), *available at*

https://go.usa.gov/xdCzu. According to MedPAC, Medicare spent $1.8 billion more in 2016 alone than it would have if it had paid for clinic visits at hospital outpatient departments at the same rate it paid freestanding physician offices. *Id.*

The second problem also was one the Secretary could not ignore—even if he had wanted to do so. Under the OPPS, Congress mandated that "the Secretary shall develop a method for controlling unnecessary increases in the volume of covered [outpatient department] services." 42 U.S.C. § 1395*l*(t)(2)(F). At the same time, Congress left to the Secretary's discretion the methods he may employ for controlling such unnecessary increases in volume. *See id.* And to underscore the breadth of the Secretary's authority, Congress provided that courts are without jurisdiction to review those methods. *Id.* § 1395*l*(t)(12)(A).

2. On November 21, 2018, the Secretary promulgated the challenged rule, which implemented a method for controlling the volume of unnecessary evaluation and management services at grandfathered off-campus outpatient departments by capping the payment for those services at a rate equivalent to that paid under the Physician Fee Schedule. 83 Fed. Reg. at 59,004-15. The Secretary opted to phase in the site-neutral payment rule over two years. *Id.* at 59,014. In 2019 alone, however, the Secretary estimated the method would result in roughly $300 million in savings for Medicare and an additional $80 million in savings for Medicare beneficiaries in reduced copayments. *Id.*

3. The American Hospital Association and a group of hospitals filed suit to vacate the site-neutral

payment rule, claiming the Secretary was without authority to cap the reimbursement rate for evaluation and management services as a method for controlling the unnecessary increase in the volume of those services. The challenging Hospitals argued separately that Section 603 of the Bipartisan Budget Act of 2015 stripped the Secretary of authority to control unnecessary increases in volume at grandfathered off-campus outpatient departments. The District Court for the District of Columbia agreed with the Hospitals on their first claim and vacated portions of the rule. *Am. Hosp. Ass'n* v. *Azar*, 410 F. Supp. 3d 142 (D.D.C. 2019) (*reprinted in* Pet. App. 33a-67a).

The Court of Appeals for the District of Columbia Circuit reversed, holding the courts were without jurisdiction to consider the Hospitals' challenge. *Am. Hosp. Ass'n* v. *Azar*, 964 F.3d 1230 (D.C. Cir. 2020) (*reprinted in* Pet. App. 1a-32a). Although the D.C. Circuit stated it could apply *Chevron* deference where, as here, "the agency's statutory authority merges with [the court's] consideration of the applicability of a preclusion provision," Pet. App. 18a, the court spent the bulk of its opinion discussing *Chevron*'s first step, Pet. App. 19a-28a. The D.C. Circuit ultimately found that every tool of statutory construction supported the Secretary's authority to promulgate the challenged rule, and the Hospitals' alternative construction was contrary to the text, structure, and purpose of the OPPS. *Id.* Although the court went on to hold that the rule was reasonable and entitled to deference at *Chevron*'s second step, Pet. App. 28a-30a, the Hospitals had already failed to show that the rule was not a valid "method" at

Chevron's first step, Pet. App. 19a-28a. The court then rejected the Hospitals' challenge under Section 603 without any discussion of deference. Pet. App. 30a-32a. Accordingly, because the Hospitals had failed to show the rule was not a valid "method[ ]" under the OPPS's jurisdiction-stripping provision, the D.C. Circuit ordered the Hospitals' suit dismissed. Pet. App. 32a.

Argument

This Court should deny the Hospitals' petition. The petition does not cast doubt on the Secretary's statutory authority to promulgate the challenged rule. Instead, it assumes that *Chevron* deference mattered to the outcome and then entreats this Court to decide whether it is proper for a court to defer to an agency's interpretation of a statute under *Chevron*'s second step where that issue bears on the court's duty to ascertain its jurisdiction. Pet. 2-5, 13-27. Even if that issue is worthy of this Court's review, this case is not a proper vehicle for considering it.

As explained below, the D.C. Circuit's decision concluded at *Chevron*'s first step that "a service-specific, non-budget-neutral rate reduction falls comfortably within the plain text of subparagraph (2)(F)," an interpretation "bolster[ed]" by "[t]he broader statutory context." Pet. App. 20a-21a. The Hospitals' competing interpretation was "difficult to square with the [statutory] language," Pet. App. 23a, and premised on arguments that were contrary to "[t]ext and precedent," Pet App. 26a. And the court explained earlier in its decision that, because of existing circuit precedent, the jurisdiction-stripping

provision barred it from determining at *Chevron*'s second step whether the site-neutral payment rule was "'arbitrary, capricious, or procedurally defective.'" Pet. App. 15a (quoting *Amgen, Inc.* v. *Smith*, 357 F.3d 103, 113 (D.C. Cir. 2004)).

Thus, the D.C. Circuit did not need to resort to *Chevron*'s second step to resolve the Hospitals' challenge. And because this case otherwise involves a straightforward analysis of the Secretary's statutory authority under the OPPS—an obscure issue that has not divided the lower courts—this case is unworthy of this Court's review. The petition should be denied.

I. The Hospitals' Challenge to the Site-Neutral Payment Rule for Evaluation and Management Services Fails Without Resort to *Chevron*'s Second Step.

The Hospitals' petition and the brief of their *amici* are premised on a fiction—that the D.C. Circuit needed to resort to *Chevron*'s second step to save the site-neutral payment rule from challenge. Pet. 4; Br. of *Amici Curiae* 33 State and Reg'l Hosp. Ass'ns in Support of Pet'rs 2, *Am. Hosp. Ass'n* v. *Becerra*, No. 20-1113 (U.S. Feb. 23, 2021) (Hosp. *Amici* Br.) (arguing that *Chevron* "deference changed the result in this case"). The opposite is true.

Here, Congress mandated that the Secretary develop "methods" for controlling unnecessary increases in the volume of services under Medicare, and it barred judicial review of "the establishment of . . . methods described in paragraph (2)(F)." 42 U.S.C. § 1395*l*(t)(12)(A). As a result of the jurisdiction-

stripping provision, the Hospitals bore the burden of showing the site-neutral payment rule was not a "method." Yet, that threshold issue is resolved without resort to *Chevron*'s second step.

Where, as here, Congress has provided an agency with explicit rulemaking authority, a court asks at *Chevron*'s first step whether a statute "unambiguously *forbids* the Agency's interpretation." *Barnhart* v. *Walton*, 535 U.S. 212, 218 (2002) (citing *Chevron*, 467 U.S. at 842-43) (emphasis added). The D.C. Circuit resolved that question in the Secretary's favor applying traditional tools of statutory interpretation.

The main issue before the D.C. Circuit was whether the Secretary was permitted to impose a rate cap on evaluation and management services in a non-budget-neutral manner. Because other provisions of the OPPS require the Secretary to regulate rates in a budget-neutral manner, the Hospitals had argued the Secretary was without statutory authority to impose a non-budget-neutral rate cap as a valid "method" for controlling unnecessary increases in the volume of specific services under 42 U.S.C. § 1395*l*(t)(2)(F).

The D.C. Circuit rejected the Hospitals' argument: "In our view, Congress did not 'unambiguously forbid' the [Secretary] from" reducing "the OPPS reimbursement for a specific service," and from implementing "that cut in a non-budget-neutral manner, as a 'method for controlling unnecessary increases in the volume of' that service." Pet. App. 19a (quoting *Barnhart*, 535 U.S. at 218, and 42 U.S.C. § 1395*l*(t)(2)(F)).

Because of the existence of the jurisdiction-stripping provision, the D.C. Circuit's conclusion—that the statute did not "unambiguously forbid" the Secretary's interpretation—resolved the Hospitals' challenge at *Chevron*'s first step. That's because Congress precluded judicial review of "the establishment of . . . methods described in paragraph (2)(F)." 42 U.S.C. § 1395*l*(t)(12)(A). In other words, to overcome the jurisdictional bar, the Hospitals bore the burden of showing that the challenged rule was not a "method[ ]"—an inquiry that the D.C. Circuit resolved without resort to *Chevron*'s second step.

Although the D.C. Circuit also discussed *Chevron*'s second step, observing that "the agency reasonably read subparagraph (2)(F) to allow a service-specific, non-budget-neutral reimbursement cut in the circumstances" before the court, Pet. App. 19a-20a, the court had not declared the statute "silent or ambiguous" at *Chevron*'s first step. Rather, it concluded at step one that the site-neutral payment rule "falls comfortably within the plain text of subparagraph (2)(F)" and was "bolster[ed]" by "[t]he broader statutory context." Pet App. 20a-21a. And the court declared the Hospitals' competing interpretation "difficult to square with the [statutory] language," Pet. App. 23a, and dependent on arguments that were contrary to "[t]ext and precedent," Pet App. 26a.

As explained below, the D.C. Circuit's foray into *Chevron*'s second step was unnecessary to the resolution of this particular case. And the Hospitals have offered no persuasive alternative construction of the statute that would require resort to *Chevron*'s second step.

A. Applying Traditional Rules of Statutory Interpretation, a Non-Budget-Neutral Rate Cap is a Valid Method for Controlling the Volume of Unnecessary Services.

When Congress enacted the OPPS in 1997, it granted the Secretary significant discretion to control unnecessary increases in utilization by hospital outpatient departments. As a first step, Congress provided that the Secretary "shall develop a method for controlling unnecessary increases in the volume of covered [outpatient department] services." 42 U.S.C. § 1395*l*(t)(2)(F). And as a contingent second step, "[i]f" the "volume of services . . . increased beyond" the amounts the Secretary intended after applying the "methodologies" of the first step, then the Secretary was granted discretion to further reduce volume by updating the conversion factor, a multiplier that applies to all outpatient services. *Id.* § 1395*l*(t)(9)(C).

This case concerns the first step of the Secretary's authority—specifically, whether capping rates in a non-budget-neutral manner is a valid "method for controlling unnecessary increases in the volume" of clinic visit services at hospitals' off-campus outpatient departments. As the D.C. Circuit recognized, every principle of "statutory construction" shows that capping rates in a non-budget-neutral manner is a permissible "method" under the OPPS. Pet. App. 20a.

The D.C. Circuit first found that "a service-specific, non-budget-neutral rate reduction falls comfortably within the plain text of subparagraph (2)(F)." Pet. App. 20a. As the D.C. Circuit put it, "[r]educing the payment rate for a particular OPPS

service readily qualifies, in common parlance, as a 'method for controlling unnecessary increases in the volume' of that service." Pet. App. 20a. "The lower the reimbursement rate for a service, the less the incentive to provide it, all else being equal." *Id.*

As for whether a rate reduction under subparagraph (2)(F) can be non-budget-neutral, the D.C. Circuit continued to find support for the agency's interpretation from the statute's plain text. Although subparagraph (2)(F) "says nothing about budget-neutrality," Pet. App. 20a, the D.C. Circuit noted that "the OPPS statute nearly always specifies, one way or the other, whether a rate-adjustment authority must be exercised budget-neutrally." Pet. App. 25a. As a result, the statute's silence—its failure to limit the agency's authority—"lends considerable support to the agency's reading of the statute at *Chevron* step one." Pet. App. 20a.

The D.C. Circuit then found that the "broader statutory context bolsters the agency's view that subparagraph (2)(F) authorizes service-specific rate cuts." Pet. App. 21a. As the court explained, "the agency can alter the reimbursement rate for a particular service under its subparagraph (2)(E) authority to make 'adjustments [it] determine[s] to be necessary to ensure equitable payments." *Id.* (quoting 42 U.S.C. § 1395*l*(t)(2)(E)). "If the agency can adjust payment rates in furtherance of the expansive purpose of achieving equitable payments, it stands to reason that the agency can also adjust rates to accomplish the more focused goal of controlling unnecessary volume growth." *Id.*

And the D.C. Circuit found that "statutory context also supports construing subparagraph (2)(F) to allow non-budget-neutral adjustments." Pet. App. 21a. "If the statute otherwise permits the agency to make a discretionary rate reduction as a method of volume control," the court explained, "it would be anomalous for the law to require the rate cut to be implemented budget-neutrally." *Id.* "That would require HHS to redistribute the costs traceable to the provision of unnecessary services throughout the OPPS, resulting in no net savings to Medicare and largely negating the point of reducing reimbursement in the first place." *Id.*

B. The Hospitals' Alternative Construction of the Statute is Contrary to the Text and Structure of the OPPS, and It is Certainly Not Enough to Avoid the Bar to Judicial Review.

The Hospitals and their *amici* have offered no viable, alternative construction at *Chevron*'s first step. And given that they otherwise bear the burden to overcome the jurisdictional bar by demonstrating that the site-neutral rule was not a "method[ ]" established under subparagraph (2)(F), their failure to prevail at *Chevron*'s first step dooms their challenge. Put simply, *Chevron*'s second step plays no role in the outcome here.

The Hospitals' main argument collapses the process Congress established for controlling unnecessary increases in volume. As explained above, paragraph (t) provides a two-step process for controlling unnecessary increases in volume. As a first step, subparagraph (t)(2)(F) directs the Secretary to devel-

op a method for "controlling" unnecessary increases in volume. 42 U.S.C. § 1395*l*(t)(2)(F). And as a contingent second step, "*[i]f* the Secretary determines under methodologies described in paragraph (2)(F) that the volume of services paid for under this subsection *increased beyond amounts established through those methodologies*, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year." *Id.* § 1395*l*(t)(9)(C) (emphasis added).

According to the Hospitals, "subparagraph (2)(F) does no more than enable the agency to develop an '*analytical mechanism* for *determining* whether there is an unnecessary increase in volume." Pet. App. 22a (quoting Resp. Br. for Appellees 31, *Am. Hosp. Ass'n* v. *Azar*, 964 F.3d 1230 (D.C. Cir. 2020) (No. 19-5352)) (emphasis added). The real work, the Hospitals claim, is done by subparagraph (t)(9)(C), which would allow the Secretary to adjust—and, according to the Hospitals, *only* adjust—the conversion factor. *See* Pet. App. 23a. Thus, as the D.C. Circuit summarized: "According to the Hospitals, subparagraph (9)(C) is the exclusive way for HHS to implement subparagraph (2)(F)." Pet. App. 23a.

But as the D.C. Circuit noted, the Hospitals' "interpretation of subparagraph (2)(F) is difficult to square with the provision's language." *Id.* "Subparagraph (2)(F) directs the agency to develop 'a method for *controlling* unnecessary increases' in volume, not just a method for *assessing* whether unnecessary increases exist." Pet. App. 23a-24a (emphasis in original). The Hospitals' interpretation not only fails to give meaning to the operative term "controlling," but it also ignores subparagraph (t)(9)(C)'s contingent

"if" clause. Indeed, "[s]ubparagraph (9)(C) appears to come into play only after the agency first attempts to address unnecessary volume increases through methodologies implemented under subparagraph (2)(F)." Pet. App. 24a.

As a fallback, the Hospitals claimed to find support for their interpretation from other provisions of paragraph (t), which establish the annual process for setting and adjusting the amount of payments under the OPPS. According to the Hospitals, because the standard course for setting and adjusting payments under the OPPS contemplates service-specific, budget-neutral adjustments, the "method" contemplated in subparagraph (t)(2)(F) cannot support a service-specific, non-budget-neutral rate cap. *See* Pet. App. 25a.

But this argument fails. The provisions the Hospitals highlighted involve the annual process for setting and adjusting payments in the ordinary course. And in each instance where Congress granted the Secretary authority in the ordinary course, it required budget neutrality. The same cannot be said for subparagraph (t)(2)(F). It lies outside the ordinary process for setting and adjusting payments in order to combat "unnecessary increases in the volume of covered [outpatient department] services." 42 U.S.C. § 1395*l*(t)(2)(F). And unlike the ordinary process, which requires budget neutrality, Congress omitted such a requirement when empowering the Secretary to curb unnecessary increases in volume. Thus, far from showing a limitation on the Secretary's authority under subparagraph (t)(2)(F), the remaining provisions of paragraph (t) show Congress knew how to constrain the Secretary's authority by

insisting upon budget-neutrality but did not do so when it came to addressing unnecessary increases in volume. *See* Pet. App. 20a.

The Hospitals imply that reading the statute as the D.C. Circuit did would allow a "sub-sub-sub provision" to grant the Secretary "nearly unfettered power" to set reimbursement outside the ordinary process. Pet. 4. But this ignores a substantive limitation inherent in the Secretary's authority under subparagraph (t)(2)(F): he is commanded to "develop a method," which may include a service-specific rate cap, only upon finding there has been an "unnecessary increase[ ] in the volume of covered [outpatient department] services." 42 U.S.C. § 1395*l*(t)(2)(F). And the Secretary's authority to adjust the conversion factor under Subsection (t)(9)(C) is unlocked only after the Secretary determines that the methodologies he employed under Subsection (t)(2)(F) were unsuccessful in controlling volume. *Id.* § 1395*l*(t)(9)(C). Far from being a tool for circumventing the ordinary process, subparagraphs (t)(2)(F) and (t)(9)(C) represent a response tailored for the extraordinary—combatting unnecessary increases in volume.

Finally, the Hospitals' constrained reading of subparagraph (t)(2)(F) ascribes to Congress an intent to create a blunt tool not tailored to the specific problem Congress directed the Secretary to address. According to the Hospitals, if the Secretary determines there has been an unnecessary increase in the volume of specific outpatient department services, then the Secretary's only recourse is to penalize all covered outpatient department services through an across-the-board cut by adjusting the conversion fac-

tor. The D.C. Circuit appropriately recognized it was "unlikely that Congress would have confined the agency's volume-control arsenal to the very blunt instrument of reducing the across-the-board conversion factor." Pet. App. 24a.

Based on all of this, the D.C. Circuit concluded that "the OPPS statute does not unambiguously foreclose [the Secretary]'s adoption of a service-specific, non-budget-neutral rate cut as a 'method for controlling unnecessary increases in' volume." Pet. App. 28a (quoting 42 U.S.C. § 1395*l*(t)(2)(F)). At the same time, the D.C. Circuit did not declare the statute "silent" or "ambiguous." It found no validity in the Hospitals' alternative construction of the statute. Pet. App. 22a-28a. And it explained earlier in its decision that, because of existing circuit precedent, the jurisdiction-stripping provision barred it from determining at *Chevron*'s second step whether the site-neutral payment rule was "'arbitrary, capricious, or procedurally defective.'" Pet. App. 15a (quoting *Amgen*, 357 F.3d at 113).

The D.C. Circuit's conclusion at *Chevron*'s first step was enough to resolve this case. Because of the jurisdictional bar, the Hospitals were required to show the site-neutral payment rule was not a valid "method[ ] described in paragraph (2)(F)." 42 U.S.C. § 1395*l*(t)(12)(A). The Hospitals' challenge failed. Indeed, the D.C. Circuit rejected every countervailing argument offered by the Hospitals as contrary to the text, structure, and overall purpose of the OPPS. Pet. App. 22a-28a.

C. The Challenged Rule is Consistent with the Bipartisan Budget Act of 2015.

In the proceedings below, the Hospitals invoked Section 603 of the Bipartisan Budget Act of 2015 as a separate constraint on the Secretary's authority. They argued that Section 603 had the effect of stripping the Secretary's distinct authority to control unnecessary increases in the volume of covered services at off-campus outpatient departments. *See* Pet. App. 30a.

No court has accepted this argument—not even the district court here—but the Hospitals' *amici* have attempted to revive it, claiming that "without *Chevron* deference," the Secretary had no answer for Section 603. Hosp. *Amici* Br. 20. The Hospitals' *amici* are mistaken.

Congress enacted Section 603 to end the proliferation of hospital off-campus outpatient departments by providing that departments that were not billing under the OPPS prior to November 2, 2015, are no longer permitted to bill for "covered [outpatient department] services" under the OPPS. 42 U.S.C. § 1395*l*(t)(1)(B)(v), (t)(21)(B). Thus, Section 603 had the effect of stripping certain off-campus departments of their ability to bill for "covered [outpatient department] services" under the OPPS.

But in the case of grandfathered off-campus outpatient departments (those that can still bill for "covered [outpatient department] services" under the OPPS), every other provision of paragraph (t) remains in force. Thus, for grandfathered outpatient departments, the Secretary retains the authority to

set annual rates and make adjustments for "covered [outpatient department] services." 42 U.S.C. § 1395*l*(t). More pertinent here, even after the enactment of Section 603, the Secretary retains the authority to "develop a method for controlling unnecessary increases in the volume of covered [outpatient department] services." *Id.* § 1395*l*(t)(2)(F).

Ignoring this, the Hospitals' *amici* claim that Section 603 conflicts with the site-neutral payment rule, and that, as the more specific provision, Section 603 must prevail over the general OPPS provisions. Hosp. *Amici* Br. 21. The Hospitals' *amici* are wrong.

There is no tension between the site-neutral payment rule and Section 603. First, as the D.C. Circuit recognized, the text of Section 603 exempts certain "providers from the change mandated by section 603 itself, leaving [grandfathered] providers subject to all the provisions of the OPPS statute, including subparagraph (2)(F)." Pet. App. 31a. As a result, grandfathered off-campus outpatient departments are still subject to the Secretary's authority to control unnecessary increases in volume at those departments. Second, Section 603's exemption still has force—even in the face of the site-neutral payment rule—because the rule is directed at only "one type of service (E&M services)." *Id.* Thus, grandfathered off-campus departments are still paid at the higher rate provided under the OPPS for all other services except evaluation and management services.

The Hospitals and their *amici* argue the site-neutral payment rule undid what Congress resolved through Section 603—referring to it as "the precise policy question at issue," Pet. 22—but they obscure

the fact that the rule is limited to evaluation and management services. Thus, grandfathered departments (those that are still permitted to bill under the OPPS) may bill under the OPPS for all services other than evaluation and management services. Evaluation and management services are the only type of services for which the Secretary exercised his independent authority under subparagraph (t)(2)(F) to control an unnecessary increase in the volume of those services.

The Hospitals' construction of Section 603 not only lacks textual support, but it also makes little sense. It would be strange if, in deciding to allow grandfathered off-campus departments to continue to provide "covered [outpatient department] services," Congress intended to strip the Secretary (albeit implicitly) of his pre-existing authority to control unnecessary increases in the volume of covered outpatient department services. This, in turn, would mean the Secretary would lack any authority to control runaway increases in the volume of unnecessary services at grandfathered off-campus departments, including the ability to invoke his fallback authority under subparagraph (t)(9)(C) to "adjust the update to the conversion factor," 42 U.S.C. § 1395*l*(t)(9)(C). If the Hospitals were right, the Secretary would be deprived of the ability to exercise authority the Hospitals otherwise concede he possesses under subparagraph (t)(9)(C). Pet App. 23a (noting the Hospitals' concession).

The D.C. Circuit correctly interpreted the interplay between Section 603 and subparagraph (t)(2)(F)—and without resort to *Chevron*'s second step. Pet. App. 30a-32a. The Hospital *amici*'s coun-

tervailing argument—that, "[w]ithout *Chevron* deference," "this case would be been decided in Petitioners' favor," Hosp. *Amici* Br. 21—is wrong.

II. Because the Outcome of this Case is the Same Regardless of Whether *Chevron* Deference Applies, this Case is the Wrong Vehicle to Resolve the Question Presented.

The question presented turns on whether agency deference is proper when a court is ascertaining its own jurisdiction, Pet. i, but this case is not a proper vehicle for resolving that issue. Deference to an agency did not decide the court's jurisdiction—the language of the statute did. Thus, even assuming a circuit split exists as described in the petition, review is unwarranted because the resolution of the "conflict is irrelevant to the ultimate outcome of the case before the Court." Eugene Gressman *et al.*, SUPREME COURT PRACTICE 248 (9th ed. 2007); *see, e.g.*, *Smith* v. *Butler*, 366 U.S. 161, 161 (1961) (per curiam) (dismissing a writ upon finding the decision below "did not turn on the issue on the basis of which certiorari was granted").

The core of the decision below is a rigorous but run-of-the-mill exercise of statutory interpretation. The D.C. Circuit concluded that "a service-specific, non-budget-neutral rate reduction falls comfortably within the plain text of subparagraph (2)(F)," an interpretation "bolster[ed]" by "[t]he broader statutory context." Pet App. 20a-21a. The Hospitals' competing interpretation was "difficult to square with the [statutory] language." Pet. App. 23a. And the text of Section 603 did not alter the result. Pet App. 30a-32a.

Those conclusions were enough to trigger the jurisdictional bar.

Deciding whether the Secretary's interpretation was also "reasonable" was unnecessary to the outcome. Indeed, the D.C. Circuit acknowledged that, under circuit precedent, the jurisdiction-stripping provision would bar it from considering at *Chevron*'s second step whether the site-neutral payment rule was "'arbitrary, capricious, or procedurally defective.'" Pet. App. 15a (quoting *Amgen*, 357 F.3d at 113). The Hospitals therefore ask this Court to resolve an issue of law that is unnecessary to the outcome.

The Hospitals wrongly assert that "[t]he court below nowhere suggested that it would have reached the same result if it had analyzed the jurisdictional statute *de novo*." Pet. 27. The court did not merely *suggest* that it would have reached the same result—it *did* reach the same result at *Chevron*'s first step. Pet. App. 20a-28a.

It is also telling that the Hospitals do not explain what an alternative, *de novo* analysis might look like. That is because, in a world without *Chevron* deference, the statutory analysis below would have been materially identical. Indeed, whether *Chevron* deference applies or not, the Hospitals cannot show the statute forbade the Secretary's chosen "method" for reducing the volume of evaluation and management services furnished at grandfathered off-campus outpatient departments.

It is not surprising, then, that the decision below does not fit into the Hospitals' purported circuit split.

For example, this is not a case like *Mugalli* v. *Ashcroft*, 258 F.3d 52 (2d Cir. 2001), where the jurisdiction-determining statute was profoundly ambiguous. In *Mugalli*, traditional tools of interpretation were not enough to decide whether the offense of statutory rape was encompassed by the undefined term "sexual abuse of a minor." *Id.* at 56. This, in turn, would determine whether the petitioner had committed an "aggravated felony." *Id.* If so, the court had no jurisdiction. *Id.* at 54. Faced with competing, plausible definitions borrowed from various places in the U.S. Code, the court deferred to the Board of Immigration Appeals on what "sexual abuse of a minor" meant. *Id.* at 56-60.

Unlike here, where the step-one analysis sufficed to decide the case, *Chevron* deference was dispositive in *Mugalli* because it was the court's decision to defer at step two that divested it of jurisdiction. *Id.* at 62. A case like that one would be the proper vehicle to resolve the question presented—and as the Hospitals point out, *Mugalli* is regularly reaffirmed in the Second Circuit. *See* Pet. 17 (citing *Rodriguez* v. *Barr*, 975 F.3d 188, 192 (2d Cir. 2020) (per curiam), *cert. denied sub nom. Rodriguez v. Garland*, --- S. Ct. ----, 2021 WL 1072410 (U.S. Mar. 22, 2021) (No. 20-6987)).

As a result, there is little doubt a vehicle cleanly presenting the question will arise from the immigration decisions that the Hospitals place on either side of the split. *See* Pet. 13-19. Indeed, the Hospitals are confident the question presented "will occur time and again." Pet. 24.

Here, however, the Hospitals seek *certiorari* to resolve a purported circuit split in a case where resolution of the question presented will not affect the outcome. Whatever the merits of the question presented, this is the wrong vehicle for answering it.

Conclusion

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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