No. 20-

In the
Supreme Court of the United States

EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER,

Cross-Petitioner,

v.

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Cross-Respondent.

On Conditional Cross-Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

CONDITIONAL CROSS-PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Medicare statute provides that any hospital serving a "significantly disproportionate number of low-income patients" is entitled to additional payments for treating Medicare patients. 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). In a Notice of Proposed Rulemaking for Federal fiscal year ("FFY") 2004, the Secretary of the U.S. Department of Health & Human Services ("HHS") addressed the complex equations used to determine which hospitals are entitled to payment and how much they should get. *See* 68 Fed. Reg. 27,154 (May 19, 2003); 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

This notice had a problem, though. In it, HHS claimed that its current policy was something it was not and proposed to *change* its policy going forward to what was actually its current policy. Although HHS had been made aware of the error and formally addressed the public on two subsequent occasions regarding its proposal, it did not correct those misstatements. Instead, a few days before the final notice-and-comment period, HHS issued a correction on its website. Despite widespread confusion among commenters and requests for additional time to comment, HHS did not extend the time for comments. Instead, HHS issued a final rule that was radically different from its current policy, the opposite of what it had proposed, and that decreased the amount of DSH payments for most hospitals.

The questions presented, therefore, are:

1) Whether agencies must accurately include key facts and data in notices of proposed

rulemaking in order to satisfy the requirements of fair notice and the opportunity for the public to meaningfully comment; and

2) Whether, whenever a proposal presents a binary choice of policies, the adoption of one of those policies will always be a "logical outgrowth" of the proposal that can excuse any failure to comply with notice-and-comment obligations.

Because these questions are inherently intertwined with any assessment of the substantive validity of HHS's policy, if the Court grants review of HHS's petition of certiorari it should also grant this conditional cross-petition.

CORPORATE DISCLOSURE STATEMENT

Empire Health Foundation for Valley Hospital Medical Center is not a publicly traded company. It has no parent company and no company owns 10% or more its stock.

RELATED PROCEEDINGS

This case arises from the following proceedings in the United States District Court for the Eastern District of Washington and the United States Court of Appeals for the Ninth Circuit, listed here in reverse chronological order:

- *Empire Health Found., for Valley Hosp. Med. Ctr. v. Azar,* Nos. 18-35845 and 18-35872 (9th Cir. May 5, 2020), reported at 958 F.3d 873;
- *Empire Health Found., for Valley Hosp. Med. Ctr. v. Price,* No. 16-cv-209 (E.D. Wash. Aug. 13, 2018), reported at 334 F. Supp. 3d 1134.

TABLE OF CONTENTS

QUESTIONS PRESENTED.. i

CORPORATE DISCLOSURE STATEMENT.......... iii

RELATED PROCEEDINGS iv

TABLE OF AUTHORITIES.................................... vii

CONDITIONAL CROSS-PETITION FOR WRIT OF CERTIORARI 1

OPINIONS BELOW 1

JURISDICTION 1

STATUTORY AND REGULATORY PROVISIONS INVOLVED...................................... 2

INTRODUCTION... 2

STATEMENT OF THE CASE 4

A. Legal Background 4

B. The Rulemaking Process.............................. 6

C. The Proceedings Below 12

REASONS FOR GRANTING THE CONDITIONAL CROSS-PETITION 14

I. This Court Should Grant Certiorari Because the Validity of the Procedures Followed in Promulgating the Rule Is Intertwined With the Rule's Substantive Reasonableness 15

II. Whether an Agency's Notice Must Include the Facts and Data Needed for the Public to Meaningfully Comment Is an Important Question... 18

III. The Procedural Validity of the Rule Also Raises the Important Question Whether and When Misstating Key Information Deprives the Public of Notice and a Meaningful Opportunity to Comment 24

IV. A Grant of Certiorari Would Allow This Court to Clarify the Contours of the Logical Outgrowth Rule 27

CONCLUSION 29

TABLE OF AUTHORITIES

Cases

Agape Church, Inc. v. FCC,
738 F.3d 397 (D.C. Cir. 2013) 18

Am. Radio Relay League, Inc. v. FCC,
524 F.3d 227 (D.C. Cir. 2008) 21

Am. Trucking Ass'ns v. EPA,
175 F.3d 1027 (D.C. Cir. 1999) 20

Azar v. Allina Health Servs.,
139 S. Ct. 1804 (2019) 23, 24

Cabell Hunting Hosp., Inc. v. Shalala,
101 F.3d 984 (4th Cir. 1996) 5

Chamber of Commerce of U.S. v. SEC,
443 F.3d 890 (D.C. Cir. 2006) 22

Chesapeake Climate Action Network v. EPA,
952 F.3d 310 (D.C. Cir. 2020) 23, 26

Chevron U.S.A. Inc.
v. Nat. Res. Def. Council, Inc.,
467 U.S. 837 (1984) 17

Cincinnati Bell Tel. Co. v. FCC,
69 F.3d 752 (6th Cir. 1995) 18

Conn. Light & Power Co.
v. Nuclear Regulatory Comm'n,
673 F.2d 525 (D.C. Cir. 1982) 27

Consumer Fed'n of Am. & Pub. Citizen
v. U.S. Dep't of Health & Human Servs.,
83 F.3d 1497 (D.C. Cir. 1996) 18

Deaconess Health Servs. Corp. v. Shalala,
83 F.3d 1041 (8th Cir. 1996),
aff'g, 912 F. Supp 438 (E.D. Mo. 1995) 6

Detroit/Wayne Cty. Port Auth. v. Interstate Commerce Comm'n,
59 F.3d 1314 (D.C. Cir. 1995) 18

Encino Motorcars, LLC v. Navarro,
136 S. Ct. 2117 (2016) 18

Envtl. Integrity Project v. EPA,
425 F.3d 992 (D.C. Cir. 2005) 28

Jewish Hosp., Inc. v. Sec'y of Health & Human Servs.,
19 F.3d 270 (6th Cir. 1994) 6

Legacy Emanuel Hosp. & Health Ctr. v. Shalala,
97 F.3d 1261 (9th Cir. 1996) 5, 6

Long Island Care at Home, Ltd. v. Coke,
551 U.S. 158 (2007) 3

Mid Continent Nail Corp. v. United States,
846 F.3d 1364 (Fed. Cir. 2017) 28

Nat'l Black Media Coal. v. FCC,
791 F.2d 1016 (2d Cir. 1986) 22

Nat'l Cable & Telecomm'ns v. Brand X Internet Servs.,
545 U.S. 967 (2005) 17

Nat'l Lifeline Ass'n v. FCC,
921 F.3d 1102 (D.C. Cir. 2019) 23

Nat'l Mining Ass'n v. EPA,
59 F.3d 1351 (D.C. Cir. 1995) 18

Ne. Hosp. Corp. v. Sebelius,
657 F.3d 1 (D.C. Cir. 2011) 6

Owner-Operator Indep. Drivers Ass'n v. Fed. Motor Carrier Safety Admin.,
494 F.3d 188 (D.C. Cir. 2007) 22

Portland Cement Ass'n v. Ruckelshaus,
486 F.2d 375 (D.C. Cir. 1973) 20

Prometheus Radio Project v. FCC,
652 F.3d 431 (3d Cir. 2011) 23

Shell Oil Co. v. EPA,
950 F.2d 741 (D.C. Cir. 1991) 26

Solite Corp. v. EPA,
952 F.2d 473 (D.C. Cir. 1991) 22

Synthetic Organic Chem. Mfrs. Ass'n v. Brennan,
506 F.2d 385 (3d Cir. 1974) 20

Statutes

5 U.S.C. § 553 .... *passim*

5 U.S.C. § 706(2) 12

42 U.S.C. § 1395oo(f)(1) 12

42 U.S.C. § 1395ww(d)(5)(F) 4, 5, 13

Regulations

42 C.F.R § 412.106(b) 10, 12, 13

68 Fed. Reg. 27,154 (May 19, 2003) 7, 8

68 Fed. Reg. 45,346 (Aug. 1, 2003) 9

69 Fed. Reg. 28,196 (May 18, 2004) 9

69 Fed. Reg. 48,916 (Aug. 11, 2004) 10, 11, 26

75 Fed. Reg. 50,042 (Aug. 16, 2010) 11

Other Authorities

Dennis Barry et al.
Reimbursement Advisor, 2007 SSI Fraction Reduces Medicare DSH Payments for Many Hospitals (Nov. 1, 2009), *available in* WoltersKluwer.com 25

Jack M. Beermann & Gary Lawson,
Reprocessing Vermont Yankee,
75 Geo. Wash. L. Rev. 856 (2007) 21

Lewis Carroll,
Alice's Adventures in Wonderland &
Through the Looking-Glass (Barnes &
Noble, Inc. 2015) (1871)... 28

HHS, HCFA Ruling No. 97-2 (Feb. 27, 1997)............ 6

1 Kristin E. Hickman & Richard J. Pierce,
Administrative Law Treatise (6th ed. 2019) .. 17, 24

Richard J. Pierce, Jr.,
Waiting for Vermont Yankee *III, IV and V? A Response to Beermann and Lawson*, 75
Geo. Wash. L. Rev. 902 (2007) 22

CONDITIONAL CROSS-PETITION FOR WRIT OF CERTIORARI

Cross-petitioner Empire Health Foundation for Valley Hospital Medical Center[1] respectfully files this conditional cross-petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit. The Court should deny the petition for a writ of certiorari in No. 20-1312 and, if the Court does so, it should also deny this cross-petition. If the Court grants that petition, however, it should also grant this cross-petition.

OPINIONS BELOW

The opinion of the court of appeals is reported at 958 F.3d 873 and reproduced at App.1a-22a. The opinion of the district court is reported at 334 F. Supp. 3d 1134 and reproduced at App.23a-75a. The decision of the Provider Reimbursement Review Board is unreported and reproduced at App.76a-83a.

JURISDICTION

The court of appeals issued its opinion on May 5, 2020, and denied a petition for rehearing on October 20, 2020. The Acting Solicitor General filed a petition for writ of certiorari on behalf of HHS on March 19, 2021. This conditional cross-petition is timely filed within 30 days of that date, in accordance with Rule 12.5. This Court has jurisdiction under 28 U.S.C. § 1254(1).

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[1] Empire acquired the outstanding Medicare reimbursement owed to Valley Hospital Medical Center for periods prior to October 1, 2008, including the 2008 fiscal year at issue here.

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Pertinent statutory and regulatory provisions are reproduced in the appendix. App.86a-105a.

INTRODUCTION

HHS has petitioned for certiorari from the appellate court's decision striking down HHS's final rule as substantively invalid. As the district court correctly found, the final rule was also procedurally invalid because HHS had failed to provide the public an opportunity to meaningfully comment as required by the APA. The district court reached this conclusion because HHS had affirmatively misstated its existing policy when giving the requisite notice, miscategorized its proposal as a policy *change* rather than a *continuation* of current policy, failed to correct these misstatements until days before the final comment period closed, and then adopted the opposite of the policy it had proposed without providing further opportunity for comment. This conditional cross-petition is being filed to ensure that, if the Court decides to grant HHS's petition for certiorari, it is able to consider both the substantive and procedural defects in the final rule.

Neither HHS nor the Ninth Circuit disputed that HHS had misstated the agency's then-existing policy in the Notice of Proposed Rulemaking for FFY 2004. Neither disputed that what HHS had presented as its proposed policy change going forward was in fact its actual policy at the time. And neither disputed that while HHS had formally addressed the public regarding its proposed rule twice *after* being told of

those errors, it didn't acknowledge, let alone promptly correct them. Instead, HHS waited well over a year after being alerted to its mistake before issuing a website posting, just days before the close of the *second* comment period. That belated notice informed the public that despite what HHS had said over a year earlier, its then-current policy was actually the opposite of what HHS had claimed. Despite that belated correction, widespread confusion amongst commenters, and requests for additional time to consider the proposed rule in light of the correction, HHS provided no additional time for notice and comment. As a result, commenters were denied an opportunity to meaningfully comment because they were given the wrong information about what HHS's then-current policy was in order to assess HHS's proposal for purportedly changing that policy. Put differently, commenters could not understand what HHS was actually proposing: a change from what HHS *thought* was its policy or a change from its actual policy. This confusion applied even to the handful of commenters that realized HHS was misstating its current policy.

That's not good enough. The APA requires federal agencies engaged in rulemaking to comply with notice-and-comment procedures. *See* 5 U.S.C. § 553(b). Those procedures require *fair* notice. *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 174 (2007). But that fair notice requirement isn't satisfied where, as here, the interested parties do not have accurate notice of the then-existing policy and the potential change that the rule would effect, and are deprived of a meaningful opportunity to comment on the corrected statement. That problem was only compounded here

by the fact that the rule ultimately adopted by HHS was not a logical outgrowth of what HHS had proposed.

In sum, the problem wasn't just the rule, but also how it was promulgated. Because those procedural errors are relevant to (and intertwined with) the substantive ones, this Court should not consider the latter without also considering the former. Accordingly, while the Court should deny HHS's petition for certiorari, if it does not, it should also grant this conditional cross-petition for certiorari.

STATEMENT OF THE CASE

A. Legal Background

Because hospitals that treat a disproportionate share of indigent patients incur higher costs, Congress directed that hospitals that serve a "significantly disproportionate number of low-income patients" receive additional payment for treating Medicare patients. 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital receives a disproportionate-share-hospital ("DSH") adjustment, and how much a qualifying hospital receives, is determined by calculating the hospital's disproportionate patient percentage. 42 U.S.C. § 1395ww(d)(5)(F)(v), (vii).

The disproportionate patient percentage is the sum of two fractions, commonly referred to as the Medicare fraction and the Medicaid fraction. The Medicare fraction is the percentage of a hospital's patient days attributable to individuals who are "entitled" to both benefits under Medicare Part A and to supplemental-security-income benefits. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Medicaid fraction is the

percentage of all a hospital's patient days attributable to individuals "eligible" for Medicaid coverage but not entitled to Medicare Part A benefits. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The statute requires HHS to consider these two factors in calculating that percentage (and thus a hospital's DSH adjustment). The larger the percentage of either or both, the higher the payment.

The more broadly HHS construes individuals "entitled to benefits under [Medicare] part A," the more patients are categorically excluded from the *Medicaid* fraction. While the Medicare fraction has its own measure of indigency, (namely, entitlement to SSI benefits), HHS maintains an extremely narrow definition of what patients are "entitled to SSI benefits." The result is that fewer impoverished individuals count for purposes of the equation (and thus fewer hospitals qualify for relief).

HHS initially contended that only patients with an absolute right to have their services paid for by Medicare or Medicaid would be considered "entitled to [Medicare]" or "eligible for [Medicaid]." This reduced the number of patients that would be considered "eligible for [Medicaid]," and, as a result, the DSH reimbursement to which hospitals were entitled. But four different circuit courts rejected HHS's position that only those with an absolute right to Medicaid payment were "eligible for [Medicaid]." *See Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1266 (9th Cir. 1996); *Cabell Hunting Hosp., Inc. v. Shalala*, 101 F.3d 984, 987-88 (4th Cir. 1996); *Deaconess Health Servs. Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996) (per curiam), *aff'g*, 912 F. Supp

438, 447 (E.D. Mo. 1995); *Jewish Hosp., Inc. v. Sec'y of Health & Human Servs*., 19 F.3d 270, 275 (6th Cir. 1994). In reaching their conclusions, all four circuits contrasted Congress's use of "entitled" in the Medicare context with "eligible" in the Medicaid context and held that HHS should not treat different words in the same statutory provision as if they were the same. To the contrary, "the use of the broader word 'eligible' indicates a meaning different from 'entitlement,' which means 'the absolute right to … payment.'" *Legacy Emanuel*, 97 F.3d at 1265 (quoting *Jewish Hosp., Inc*., 19 F.3d at 275); *see also Ne. Hosp. Corp. v. Sebelius,* 657 F.3d 1, 20 & n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) (holding that "'entitlement' is not just an abstract ability to sign up for Part A ... [r]ather, it is entitlement to have payment made ... ." (emphasis omitted)).

After four losses, HHS agreed to recognize the obvious—namely, that under the plain language of the statute, patients who meet Medicaid eligibility criteria are "eligible for Medicaid." *See* HHS, HCFA Ruling No. 97-2, at 97-2-3 (Feb. 27, 1997).

B. The Rulemaking Process

Forced to adopt a more expansive reading of which patients are "eligible for Medicaid" in the Medicaid fraction, HHS proposed a different approach that would have the same result (limiting how many hospitals qualified and how much HHS had to pay them) through different means—this time, by changing how it applied the second part of the statutory equation, *i.e.*, the Medicare fraction. In May 2003 and May 2004, HHS published a notice of proposed rulemaking in anticipation of promulgating

a final rule for the upcoming federal fiscal year. An approximately two-month-long open comment period followed each notice of proposed rulemaking. In August 2003 and August 2004, HHS promulgated final rules for the upcoming federal fiscal year, the 2004 Final Rule and the 2005 Final Rule.

But there was a problem with the underlying 2003 notice. *See* 68 Fed. Reg. 27,154, 27,207-08-09 (May 19, 2003). That notice stated incorrectly that the agency's then-existing policy counted all days for patients who were eligible for both Medicare Part A and Medicaid benefits in the Medicare fraction even if the patient was not receiving Medicare Part A benefits. *See id.* at 27,207-08. In other words, HHS claimed that its current policy was to treat patients who were not entitled to payment under Medicare Part A as nonetheless being "entitled to benefits under [Medicare] part A." HHS proposed to change this alleged policy and begin excluding exhausted Medicare Part A patient-days from the Medicare fraction (and including them in the Medicaid fraction to the extent the patient was also eligible for Medicaid). *See id.* at 27,208-09.

HHS's statement of its current policy was wrong. It wasn't the current policy. In fact, it was the exact opposite of the current policy, which HHS incorrectly described as the proposed rule that it wanted to adopt. HHS also mischaracterized its proposal as a *change* in policy when it really was a *continuation* of current policy. In other words, HHS misstated both the existing policy and also the proposed changes to it.

An initial open comment period followed the 2003 notice of proposed rulemaking, with a July 18, 2003

deadline for the submission of comments. 68 Fed. Reg. at 27,154. Although two commenters pointed out that HHS had misrepresented the current policy, ER 150-151, AR 405R,[2], HHS did not correct it. As one of those commenters pointed out, though, "[t]hat begs the question—What was the 'policy'—what CMS professed [in the notice] or what it did?" AR 405R.

Without understanding what the existing policy was, it was impossible to comment meaningfully on whether or how it should be changed. Among the few data points hospitals had to assess HHS's proposal was whether they were satisfied with their current DSH payments. Because HHS misstated the policy on which current DSH payments were based, hospitals who did not want the current policy changed found themselves inadvertently supporting such a change. Moreover, their reasons for supporting what they thought the status quo was might have nothing to do with the actual content of the policy. Given the expense and administrative burdens associated with any change in those regulations, the commenters might understandably prefer the devil they thought they knew to the one they didn't.

On August 1, 2003, HHS issued a final rule for the 2004 federal fiscal year. Regarding the treatment of dual-eligible patient-days, HHS noted that "[w]e are still reviewing the large number of comments received on the proposed provision relating to dual-eligible patient days in [the] May 19, 2003 [proposed rule]." 68

[2] References to the record are defined as "ER" for the Excerpts of Record filed in the Ninth Circuit and "AR" for the Recordmaking Record (ECF No. 55) filed in the district court.

Fed. Reg. 45,346, 45,421 (Aug. 1, 2003). The 2004 Final Rule did not acknowledge or address the commenters' concerns that the agency had misstated its then-existing policy by confusing its current practice with its proposed practice, and HHS did not issue any other document or notice between August 1, 2003, and May 2004.

In May 2004, HHS issued a notice of proposed rulemaking for the 2005 fiscal year for general changes to the Medicare system, which stated that the comments relating to dual-eligible patient-days would be addressed in a forthcoming final rule. 69 Fed. Reg. 28,196, 28,286 (May 18, 2004). Again, however, it did not mention the misstatement in the 2003 notice's description of HHS's policy for handling dual-eligible days or address the confusion over what the agency's current policy and its proposed policy were. In fact, HHS did nothing to correct any hospitals' false understanding of what the current policy actually was. That mistaken understanding left hospitals incapable of properly assessing HHS's proposals to purportedly change that policy. Instead, HHS explained that "[d]ue to the number and nature of the public comments received, we did not respond to the public comments on these proposals in the [2004 Final Rule]." *Id.*

After the publication of the 2004 notice of proposed rulemaking, a second comment period followed. 69 Fed. Reg. at 28,196 (comment period closed on July 12, 2004). Just days before the closing of that second comment period, HHS finally issued a correction regarding the agency's misstatement of its then-existing policy through the CMS website,

acknowledging that: "It has come to our attention, however, that [our previous statement of our policy] is not accurate. Our policy has been that only covered patient days are included in the Medicare fraction (42 C.F.R § 412.106(b)(2)(i))." *See* ER 116; *see also* 69 Fed. Reg. 48,916, 49,098 (Aug. 11, 2004).

Some entities did comment on that correction before the close of the comment period, noting that they had taken "at face value CMS's" description of what its policy actually was, explaining that they had based their comments on that mistake, and asking that the notice and comment period be extended. ER 75-76, 102-104. HHS declined to do so.

Instead, in August 2004, HHS promulgated the 2005 Final Rule at issue in this case ("2005 Final Rule"). *See* 69 Fed. Red. at 49,098. In the publication of the 2005 Final Rule, HHS acknowledged for the first time in the Federal Register that the agency had "misstated [its] current policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003," *id.* at 49,098, and noted that "[a] notice to this effect was posted on CMS's Web site on July 9, 2004," *id.* (citation omitted). The agency clarified that "[i]n that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted.... This statement was not accurate. Our policy has been that only covered patient days are included in the Medicare fraction." *Id*.

While HHS acknowledged that it had received "numerous comments that commenters were disturbed and confused by our recent Web site posting

regarding our policy on dual-eligible patient days," and that many commenters "believed that this posting was a modification or change in our current policy" that required "formal notification by CMS" and an "opportunity for providers to comment," 69 Fed. Reg. at 49,098, HHS provided no further opportunity for comment.

Instead, HHS adopted a policy that substantially expanded the universe of patients deemed "entitled to benefits under part A"—which in turn limited which hospitals receive additional payment and what payment they get. This expansion was detrimental to the majority of DSH hospitals because patients that are "entitled to benefits under Part A" are categorically excluded from the Medicaid fraction. As noted above, while HHS has been compelled by four circuit courts to adopt a broad definition of what patients would be considered "*eligible* for Medicaid," HHS maintains an extremely narrow definition of which patients are "entitled to SSI benefits," which is the proxy for indigency within the Medicare fraction. Specifically, HHS's policy is that only patients that actually *receive* SSI benefits are "entitled to SSI benefits." 75 Fed. Reg. 50,042, 50,280-81 & n.19 (Aug. 16, 2010). That policy excludes individuals who have their SSI checks returned as undeliverable, refuse direct deposit, or have their SSI benefits offset by other outstanding debts.

As a result, that rule entirely excludes from a hospital's DSH calculation individuals who are *both* eligible for Medicaid *and* entitled to SSI—the poorest of the poor—if those individuals did not *receive* their

SSI benefits for whatever reason. This is true even if Medicaid paid for that patient's care.

C. The Proceedings Below

As part of the DSH reimbursement process, the Medicare contractor auditing Valley Hospital Medical Center's cost report applied the amended policy from the 2005 Final Rule to the Hospital's cost reporting period for the 2008 fiscal year. ECF No. 34 at 14. The Hospital timely filed an appeal with the Provider Reimbursement Review Board ("Board"). *Id.*

After filing its appeal, the Hospital sought expedited judicial review pursuant to 42 U.S.C. § 1395oo(f)(1). *See* ECF No. 11-1. Because it lacked authority to decide the legal issue in this case, the Board granted the Hospital's request for expedited judicial review regarding whether the regulation, 42 C.F.R. § 412.106(b)(2), was valid. ECF No. 11-2.

The district court held that the 2005 Rule was substantively valid, but that it should be vacated because the rulemaking process didn't comply with the APA's procedural requirements. It concluded that HHS's inadequate notice was not harmless under the APA because the notice misstated the then-existing policy, that misstatement was acknowledged only days before close of comment period and only through a website posting, not publication in the Federal Register, and HHS provided no additional opportunity for comment. This, the court concluded, substantially undermined the substance of the decision by depriving HHS of useful comments, and the hospital was directly injured as result because it wasn't being reimbursed. 5 U.S.C. §§ 553(b), 553(c), 706(2); Social

Security Act § 1886, 42 U.S.C. § 1395ww(d)(5)(F)(vi); 42 C.F.R. § 412.106(b).

On appeal, the Ninth Circuit acknowledged that "HHS undoubtedly misstated the then-applicable rule in the 2003 Notice," and conceded that the rulemaking process was "certainly not perfect." App.14a. It nonetheless found that the 2005 Rule's rulemaking process, while "not without flaws," satisfied the APA's notice-and-comment requirements. App.22a. It held that the adequacy of notice turned on whether changes in the final rule are a "logical outgrowth" of the notice and comments received. App.16a.

Because the Ninth Circuit found that interested parties were "apprised of a binary choice" and could reasonably have anticipated the final rulemaking from the proposed rule, it found that HHS's rulemaking was a "logical outgrowth" and therefore met the APA's requirements. App.15a-16a. The Ninth Circuit did not independently consider whether HHS's misstatement had deprived the public of fair notice or an opportunity to meaningfully comment on its final rule.

Though the Ninth Circuit upheld the adequacy of HHS's rulemaking process, it affirmed the grant of summary judgment in favor of Empire Health, holding that the 2005 Rule was substantively invalid because it was inconsistent with the unambiguous meaning of "entitled to [Medicare]" in 42 U.S.C. § 1395ww(d)(5)(F)(vi). HHS sought rehearing en banc, which was denied. It subsequently filed a petition for certiorari, which is pending before this Court.

REASONS FOR GRANTING THE CONDITIONAL CROSS-PETITION

While Empire Health could raise these reasons in opposition to HHS's petition for certiorari (and, if certiorari is granted, in merits briefing), Empire Health is submitting this conditional cross-petition because the issues raised are important ones that should be considered if the Court grants HHS's petition. If this Court decides to consider the substantive reasonableness of the rule, it should grant this conditional cross-petition so that it has before it the full set of arguments regarding the rule's legality, including its procedural reasonableness.

First, while the substantive inquiry should begin and end with the unambiguous language of the statute, if HHS were to invoke *Chevron* deference to defend the rule here, the reasonableness of that rule depends in part on the reasonableness of the process by which it was promulgated. Having an understanding of HHS's rulemaking process and its contemporaneous explanation of its interpretation of "entitled to benefits under Part A" is relevant to any assessment of the reasonableness of HHS's statutory interpretation.

The issue of the rule's procedural reasonableness in turn raises two questions warranting review: (1) whether the APA requires agencies to give fair notice and allow meaningful public comment by accurately providing the key facts and data needed to understand and assess the agency's proposed change; and (2) whether, when an agency proposal raises a binary choice between policies, the adoption of one of those policies will always be a logical outgrowth of the

proposal that can independently excuse any failure to comply with the requirements of fair notice and a meaningful opportunity to comment.

That first question is especially relevant in light of the unresolved question of whether requiring agencies to provide notice of key facts is consistent with *Vermont Yankee*, discussed below, where this Court held that courts may not impose requirements not found in the APA.

The second is important because the Ninth Circuit applied the logical outgrowth rule to effectively immunize HHS's earlier misstatements. In so doing, it held that a final rule that substantially changes the status quo can be a logical outgrowth of a proposed rule that: (1) falsely claimed the proposed rule was the current status quo; (2) characterized the *actual* status quo as a proposed *change* in policy going forward; and (3) adopted a brand new policy as the policy going forward.

These questions go to the heart of the integrity of notice and comment rulemaking and provide the Court with an opportunity to clarify that agencies must give fair notice and a meaningful opportunity to comment by providing accurate information on key points, and that the logical outgrowth rule does not excuse the failure to provide that information.

I. This Court Should Grant Certiorari Because the Validity of the Procedures Followed in Promulgating the Rule Is Intertwined With the Rule's Substantive Reasonableness

The Administrative Procedure Act gives agencies broad discretion, but subject to two general essential

constraints. First, the agency has to act within the confines of its proper delegated authority. And, second, it has to follow certain procedural requirements to ensure transparent, accountable government. Courts have long recognized that essential interconnection between the substantive and procedural requirements of reasoned decisionmaking. For these reasons, if this Court agrees to consider the substantive validity of the rule, it should also consider its procedural validity.

As Empire Health has consistently argued, the statute here unambiguously forecloses HHS's rule. HHS's petition disagrees, and contends that the rule is a proper interpretation of the statute. At a minimum, HHS contends, its "interpretation reflects a reasonable construction of the statute's text." Pet. 27. (emphasis added). In assessing HHS's argument that its policy is "reasonable," this Court must necessarily consider the rulemaking process that lead to it. *See Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 52 (1983). In *State Farm*, this Court held that an agency policy will be considered "arbitrary and capricious," and *not* "reasonable," if the agency failed to engage in "reasoned decisionmaking." As the Court explained:

> Normally, an agency [policy decision] would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not

> be ascribed to a difference in view or the product of agency expertise.

Id. at 43.

This makes good sense. While a procedural failure of reasoned decisionmaking is an APA violation in its own right, it can be related to (and the explanation for) a rule that's substantively arbitrary or unreasonable. If the agency mistakes what its own policy is and as a result commenters don't understand either the current policy or the impact of any proposed change, it's hardly surprising that the rule produced by such a flawed process is substantively invalid as well.

In addition, while HHS does not explicitly cite *Chevron* deference in support of its petition, it defended the rule below relying on that deference. If this Court were to grant certiorari, and the government were again to argue that *Chevron* applies, the procedural errors identified here are relevant to that analysis too. Specifically, *Chevron*'s second step asks whether the agency's answer is based on a permissible construction of the statute. *Chevron U.S.A. Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984). In considering that second step, courts can consider; "whether the agency adequately discussed the relationship between the interpretation and any data available with respect to the factual predicates for the interpretation." *See also* 1 Kristin E. Hickman & Richard J. Pierce, Administrative Law Treatise § 3 (6th ed. 2019). Indeed, this Court has implicitly recognized an overlap between *State Farm* and *Chevron*. *Nat'l Cable & Telecomm'ns v. Brand X Internet Servs.*, 545 U.S. 967, 981 (2005); *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117 (2016)

(*Chevron* deference was not warranted in light of procedural failure of agency to explain the change in its position adequately); *see also Agape Church, Inc. v. FCC*, 738 F.3d 397, 410 (D.C. Cir. 2013) (*Chevron* step two synonymous with *State Farm*'s arbitrary and capricious review). Other courts have followed this approach in evaluating *Chevron's* second step. *Nat'l Mining Ass'n v. EPA*, 59 F.3d 1351, 1362 (D.C. Cir. 1995) (per curiam); *see, e.g., Consumer Fed'n of Am. & Pub. Citizen v. U.S. Dep't of Health & Human Servs.,* 83 F.3d 1497, 1505-06 (D.C. Cir. 1996); *Cincinnati Bell Tel. Co. v. FCC,* 69 F.3d 752, 761 (6th Cir. 1995); *Detroit/Wayne Cty. Port Auth. v. Interstate Commerce Comm'n,* 59 F.3d 1314, 1316 (D.C. Cir. 1995).

Accordingly, because a review of the substantive validity of HHS's Rule entails consideration of the procedural reasonableness of the rulemaking process that yielded the Rule, the Court should not grant review of one without the other.

II. Whether an Agency's Notice Must Include the Facts and Data Needed for the Public to Meaningfully Comment Is an Important Question

The question of the Rule's procedural validity also raises a subsidiary question that is both important and unresolved about whether the APA's notice and comment requirements require an agency to disclose (accurately) the key facts or studies needed for the public to *meaningfully* comment on the agency's proposal. The district court held that it did, and that because the agency didn't do so, "interested parties could not have understood the essential attributes of

the proposed rule when the Secretary and the agency misunderstood and misstated them." App.66a.

The Ninth Circuit, however, never addressed whether HHS's "undoubted[] misstatement" had deprived parties of the information needed to meaningfully comment. Instead, it simply upheld HHS's final rule as a logical outgrowth of its proposed rule. App.16a ("Because we conclude that the 2005 Rule was a logical outgrowth of the notice and the comments received, we reverse the district court's contrary conclusion"). The court found that because commenters were aware of a "binary" choice, the rulemaking "was a logical outgrowth of the proposed rule change." App.15a-16a.

In failing to consider whether—logical outgrowth aside—HHS had otherwise failed to provide the public the information it needed to meaningfully comment, the Ninth Circuit departed from the holdings of multiple other courts that have invalidated agency rulemakings on just such considerations. In addition, the Ninth Circuit also stretched the logical outgrowth doctrine beyond its breaking point by using it to justify an inherently confused and illogical rulemaking process.

A. The APA requires agencies to publish notice of proposed rules that include "either the terms or substance of the proposed rule or a description of the subjects and issues involved." 5 U.S.C. § 553(b)(3). The agency must publish notice of a proposed rule more than thirty days before its effective date. *Id.* § 553(d). And, after providing notice, agencies must allow "interested persons an opportunity to participate in the rule making through submission of

written data, views, or arguments with or without opportunity for oral presentation." *Id.* § 553(c). Separate and apart from the APA, Section 1871(a)(2), (b)(1) of the Medicare Act requires notice-and-comment rulemaking for any "rule, requirement, or other statement of policy" that, like the one here, "establishes or changes a substantive legal standard governing … the payment for services." In particular, it requires a period of not less than 60 days for public comment before establishing or changing a substantive legal standard regarding the matters enumerated by the statute.

1. Many courts have held that these requirements invalidate agency rulemaking when the agency does not timely disclose the facts or studies necessary to provide the public a *meaningful* opportunity to comment on the agency's proposal. In the leading case on this question, the D.C. Circuit held that "[i]t is not consonant with the purpose of a rule-making proceeding to promulgate rules on the basis of inadequate data, or on data that, [to a] critical degree, is known only to the agency." *Portland Cement Ass'n v. Ruckelshaus*, 486 F.2d 375, 393 (D.C. Cir. 1973), *as amended on denial of r'hrg* (Oct. 1, 1973), *superseded by statute on other grounds as stated in Am. Trucking Ass'ns v. EPA*, 175 F.3d 1027, 1042 (D.C. Cir. 1999).

The Third Circuit has reached a similar conclusion, holding that an agency's notice was inadequate when it was published before an advisory committee submitted its report, leaving parties insufficient time to submit comments after they had that report. *Synthetic Organic Chem. Mfrs. Ass'n v. Brennan*, 506 F.2d 385 (3d Cir. 1974).

2. A few years after these decisions, however, this Court held in *Vermont Yankee* that courts may not impose procedures greater than those required by the APA. Because the APA does not *explicitly* state that an agency must disclose key facts or studies, some jurists and scholars have argued that requiring agencies to provide key data would violate *Vermont Yankee*. *See* Jack M. Beermann & Gary Lawson, *Reprocessing* Vermont Yankee, 75 Geo. Wash. L. Rev. 856, 894 (2007); *see also Am. Radio Relay League, Inc. v. FCC*, 524 F.3d 227, 246-47 (D.C. Cir. 2008) (Kavanaugh, J., concurring in part and dissenting in part) (suggesting that the "*Portland Cement* doctrine" requiring "agencies to disclose, in time to allow for meaningful comment, technical data or studies on which they relied in formulating proposed rules," "cannot be squared with the text of § 553 of the APA" but nonetheless upholding the application of the *Portland Cement* doctrine "as binding precedent" in the D.C. Circuit).

In the decision below, by focusing solely on the question of whether HHS's policy was a logical outgrowth of its proposal, the Ninth Circuit appears to have rejected the D.C. Circuit's and Third Circuit's approach requiring agencies to provide interested parties with the facts and data needed for meaningful comment. Indeed, the Ninth Circuit went even further by affirming the validity of a rule promulgated based on notice that affirmatively misrepresented those facts. And what it misrepresented was technical data, what its policy was, and what it proposed as a change. That type of information goes to the core of the APA's protections.

3. The district court concluded that HHS should have but didn't provide accurate information about either the actual or proposed policies. On appeal, the Ninth Circuit implicitly rejected that conclusion. While this Court has not addressed the question of whether the APA requires agencies to provide the public with the facts and data needed for the public to meaningfully comment, the majority of courts have held that it does require. As the D.C. Circuit explained, "[a]n agency commits serious procedural error when it fails to reveal portions of the technical basis for a proposed rule in time to allow for meaningful commentary." *Owner-Operator Indep. Drivers Ass'n v. Fed. Motor Carrier Safety Admin.*, 494 F.3d 188, 199 (D.C. Cir. 2007) (quoting *Solite Corp. v. EPA,* 952 F.2d 473, 484 (D.C. Cir. 1991) (per curiam)); Richard J. Pierce, Jr., *Waiting for* Vermont Yankee *III, IV and V? A Response to Beermann and Lawson*, 75 Geo. Wash. L. Rev. 902 (2007).

For the same reason, many federal appellate decisions have held agency notice inadequate, not because the final rule was not a logical outgrowth of the proposed rule, but because the agency failed to provide the public the information it needed to meaningfully comment on the agency's proposal. *See, e.g., Nat'l Black Media Coal. v. FCC*, 791 F.2d 1016, 1018 (2d Cir. 1986) (holding that the FCC "relied on inadequately disclosed data to reach its conclusions"); *Solite Corp.*, 952 F.2d at 484 (holding supplemental notice containing new data and analysis was inadequate when it was received one day before the rule was promulgated); *Chamber of Commerce of U.S. v. SEC*, 443 F.3d 890, 906 (D.C. Cir. 2006) (holding notice inadequate where the agency's basic

assumptions were based on sources outside of the rulemaking record); *Prometheus Radio Project v. FCC*, 652 F.3d 431, 450 (3d Cir. 2011) (invalidating a rule in part because it "was not clear from the [agency's notice] which characteristics the Commission was considering or why"); *Nat'l Lifeline Ass'n v. FCC*, 921 F.3d 1102, 116 (D.C. Cir. 2019) (holding notice inadequate to enable sufficient comment on the proposed rule, much less allow an understanding of the effect of the final rule" because, *inter alia*, the FCC did not make available the searchable maps needed to assess its policy); *Chesapeake Climate Action Network v. EPA*, 952 F.3d 310, 321 (D.C. Cir. 2020) (holding EPA failed to provide adequate notice because, in part, the agency had not identified in its proposed rule a list of "best performing" power plants it ultimately relied upon in the final rule).

If omitting key facts or data cannot be squared with the fundamental goals of notice-and-comment rulemaking, that is equally if not more true when the agency affirmatively misstates those key facts. The district court, therefore, was correct to hold that HHS's 2005 Rule was procedurally invalid under the APA because "[HHS's] misstatement undermined the validity of the notice, making it insufficient 'to provide the public with a meaningful opportunity to comment on [the proposed] provisions.'" App.66a.

B. This Court recently emphasized the fundamental importance of notice-and-comment requirement in rulemaking in the context of another Medicare DSH policy arising from the same flawed rulemaking at issue here. *Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019). As *Allina* explained,

notice and comment "gives affected parties fair warning of potential changes in the law and an opportunity to be heard on those changes" and "affords the agency a chance to avoid errors and make a more informed decision." *Allina*, 139 S. Ct. at 1816 (citing 1 K. Hickman & R. Pierce, *supra*, at § 4.8). As *Allina* also explained, the government had to take any complaints about notice-and-comment requirements to Congress, not the courts. And "[s]urely a rational Congress could have thought those benefits especially valuable when it comes to a program where even minor changes to the agency's approach can impact millions of people and billions of dollars in ways that are not always easy for regulators to anticipate." 139 S. Ct. at 1816.

III. The Procedural Validity of the Rule Also Raises the Important Question Whether and When Misstating Key Information Deprives the Public of Notice and a Meaningful Opportunity to Comment

This question matters because the requirements that agencies give fair notice and that the public have a meaningful opportunity to comment depend on the agencies not misstating the key factual premises on which their proposals are based.

That is particularly true here given the general complexity surrounding the DSH calculation. *See, e.g., Allina*, 139 S. Ct. at 1816 (acknowledging complexity of the Medicare/Medicaid system); App.65a ("Medicare is a particularly complex regulatory system, with many interrelated rules which may have significant impacts on both Medicare recipients and health care providers"). But the lack of fair notice is

exacerbated by HHS's "insiste[nce] on performing its own calculations of SSI fractions in a 'black box' process."[3] Because of that "black box" approach, the healthcare industry relies on HHS to understand what days are included in DSH calculations. This is why nearly all commenters, aside from two non-hospital commenters, took HHS's description of what it claimed was its current policy at "face value." ER 74-77, 102-104.

It is also why it was essential for HHS to accurately state its current policy. In the absence of any other data or analysis regarding the impact of HHS's proposals (and HHS provided none), one of the few data points available to a hospital was whether it was satisfied with its current DSH payments. Commenters that were satisfied with their current DSH payments (and who didn't want to incur the expense and administrative burden associated with a change in the rules) predictably wrote in favor of maintaining HHS's stated status quo.

Once that was corrected, however, there was widespread confusion. One large hospital association, the Federation of American Hospitals, explained that its prior comment supporting what the agency said was its current policy was premised on the accuracy of the agency's statements, which it had taken "at face value." ER 74-77, 102-04. Given HHS's subsequent correction, it requested more time to assess its position in light of the new information posted on CMS's

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[3] Dennis Barry et al. *Reimbursement Advisor, 2007 SSI Fraction Reduces Medicare DSH Payments for Many Hospitals* (Nov. 1, 2009), *available in* WoltersKluwer.com.

website. *Id.* Not only did HHS not allow any additional time, but HHS has cited the Federation's original comment as support for its newly adopted policy. *See, e.g.,* Sec'y's 9th Cir. Br. at 28 (arguing that the Federation "strongly" supported what the Secretary erroneously stated its policy to be without mentioning the Federation's subsequent repudiation); *see also* App.14a (referencing the support of large hospital associations for what HHS's claimed was its current policy of "placing dual eligible exhausted coverage patient days in the Medicare fraction").

Indeed, even those commenters that had recognized HHS's misstatement[4] remained confused as to what the agency was actually proposing. ER 125-126 (asking "What was the "policy"—what CMS professed or what it did?"). HHS itself acknowledged receipt of "*numerous* comments that commenters were disturbed and confused by our recent Web site posting regarding our policy on dual-eligible patient days." 69 Fed. Reg. at 49,098 (emphasis added).

As the D.C. Circuit admonished, "[t]he process of notice and comment rule-making is not to be an empty charade." *Conn. Light & Power Co. v. Nuclear Regulatory Comm'n*, 673 F.2d 525, 528 (D.C. Cir.

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[4] While two commenters recognized HHS's misstatement, neither of those commenters were hospitals or hospital associations and, in any event, notice must come from the agency, not from commenters. *See, e.g., Chesapeake Climate Action Network*, 952 F.3d at 314 (holding that notice must come from the notice of proposed rulemaking and not comments received in response to the notice); *Shell Oil Co. v. EPA*, 950 F.2d 741, 751 (D.C. Cir. 1991) (per curiam) ("comments by members of the public would not in themselves constitute adequate notice").

1982). And, as the D.C. Circuit further explained, "[o]ne particularly important component of the reasoning process is the opportunity for interested parties to participate in a meaningful way in the discussion and final formulation of rules." *Id.* Hospitals were deprived of that opportunity here by HHS's misrepresentations, failure to timely correct them, and failure once corrected to allow additional time for comment.

IV. A Grant of Certiorari Would Allow This Court to Clarify the Contours of the Logical Outgrowth Rule

Even the Ninth Circuit's exclusive focus on the logical outgrowth rule itself raises important questions about the scope and proper application of that rule. In particular, it raises the question whether, whenever there is a binary choice, the adoption of one of those choices will always be a logical outgrowth regardless of any other circumstance. This conditional cross-petition thus also provides the Court an opportunity to clarify the scope of the logical outgrowth test.

As explained above, HHS sowed such hopeless confusion that virtually nothing, aside from maintaining the actual status quo of excluding days that were not entitled to Part A payments from the Medicare fraction, could be considered a logical outgrowth. HHS said its policy was X, when really it was Y; it proposed to *change* its policy to Y, which was actually the status quo; it then adopted X as a new policy going forward, even though X was neither its current policy nor its proposed policy. Under these circumstances, one can certainly commiserate with

Alice's befuddlement when it was explained to her that "[c]ontrariwise ... if it was so, it might be; and if it were so, it would be; but as it isn't, it ain't. That's logic." Lewis Carroll, Alice's Adventures in Wonderland & Through the Looking-Glass 187 (Barnes & Noble, Inc. 2015) (1871).

But just as "something is not a logical outgrowth of nothing," *Mid Continent Nail Corp. v. United States,* 846 F.3d 1364, 1374 (Fed. Cir. 2017) (quoting *Envtl. Integrity Project v. EPA,* 425 F.3d 992, 996 (D.C. Cir. 2005)), a well-considered policy cannot be a logical outgrowth of misstatements, confusion, and guesswork. As the D.C. Circuit held, "[w]hatever a 'logical outgrowth' ... may include, it certainly does not include the Agency's decision to repudiate its proposed interpretation and adopt its inverse." *Envtl. Integrity Project*, 425 F.3d at 998.

HHS's *misstatement* is, ironically, the *only* thing that distinguishes HHS's rulemaking on this issue from its rulemaking in *Allina*, which violated the logical outgrowth requirement. In *Allina*, HHS's current policy was to exclude Part C days from the Medicare fraction. It proposed to clarify that policy of excluding Part C days from the Medicare fraction, but then adopted the opposite policy of *including* Part C days in the Medicare fraction. Under these circumstances, the D.C. Circuit held that HHS's final policy was not a logical outgrowth of its proposal. 425 F.3d at 998.

Yet, if everything about the rulemaking process here remained the same *except* for HHS's misstatement, the rulemaking would be on all fours with *Allina*. In that case, HHS would have said

(accurately this time) that its current policy was to exclude days that weren't entitled to Part A payment from the Medicare fraction, it would have proposed to clarify that policy of *excluding* unpaid Part A days from the Medicare fraction, but it then would have finalized the opposite policy of *including* these days in the Medicare fraction. Because HHS's final rule in *Allina* was not a logical outgrowth of it proposed rule, it would be perverse to allow HHS's own misstatement to change that outcome here.

CONCLUSION

For the foregoing reasons, this Court should grant this conditional cross-petition if it grants HHS's petition for certiorari.

Respectfully submitted,

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