No. 20-1486

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

*ON CONDITIONAL CROSS-PETITION
FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT*

BRIEF FOR THE CROSS-RESPONDENT IN OPPOSITION

ELIZABETH B. PRELOGAR
Acting Solicitor General
Counsel of Record
BRIAN M. BOYNTON
Acting Assistant Attorney General
MARK B. STERN
STEPHANIE R. MARCUS
Attorneys

Department of Justice
Washington, D.C. 20530-0001
SupremeCtBriefs@usdoj.gov
(202) 514-2217

QUESTION PRESENTED

The Medicare statute provides that a hospital that serves a "significantly disproportionate number of low-income patients" may receive an additional payment for treating Medicare patients, known as the disproportionate-share-hospital adjustment. 42 U.S.C. 1395ww(d)(5)(F)(i)(I) and (ii). A hospital's disproportionate-share-hospital adjustment (if any) is calculated using a formula that is based principally on the sum of two separate figures. The first figure, known as the Medicare fraction, is the percentage of all patient days of individuals who were "entitled to benefits under [Medicare] part A" and who were also entitled to supplemental-security-income benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The second figure, known as the Medicaid fraction, is the percentage of all of a hospital's patient days that are attributable to individuals who were eligible for Medicaid coverage but who were not entitled to Medicare Part A benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II).

In the rulemaking at issue, the Department of Health and Human Services (HHS) invited comment on a proposed rule that would include in a hospital's Medicaid fraction patient days of individuals who were eligible for both Medicare and Medicaid and who had exhausted their Medicare coverage at the time services were provided. In the 2004 final rule, however, HHS declined to adopt that proposal and instead determined that such individuals' patient days should be included in the Medicare fraction. The question presented is as follows:

Whether the court of appeals correctly determined that HHS complied with applicable notice-and-comment requirements in adopting the 2004 regulation because the final rule that HHS adopted was a logical outgrowth of the agency's proposed rule.

ADDITIONAL RELATED PROCEEDING

Supreme Court of the United States:

Becerra v. *Empire Health Found.*, No. 20-1312
(petition for a writ of certiorari filed Mar. 19, 2021)

TABLE OF CONTENTS

Page

Opinions below ... 1
Jurisdiction ... 1
Statement:
A. Legal background ... 2
B. The present controversy ... 15
Argument ... 18
Conclusion ... 31

TABLE OF AUTHORITIES

Cases:

Allina Health Servs. v. *Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ... 21, 26
Arizona Pub. Serv. Co. v. *EPA*, 211 F.3d 1280 (D.C. Cir. 2000), cert. denied, 532 U.S. 970 (2001) ... 23
Azar v. *Allina Health Servs.*, 139 S. Ct. 1804 (2019) ... 20
Bowen v. *Galbreath*, 485 U.S. 74 (1988) ... 5
Catholic Health Initiatives Iowa Corp. v. *Sebelius*, 718 F.3d 914 (D.C. Cir. 2013) ... 3, 4, 5, 6, 8
Chevron U.S.A. Inc. v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) ... 29
Edgewater Med. Ctr. v. *Blue Cross & Blue Shield Ass'n*, HCFA Adm'r Dec. (PRRB Dec. Nos. 2000-D44 & 2000-D45), 2000 WL 1146601, June 19, 2000) ... 3, 8
Encino Motorcars LLC v. *Navarro*, 136 S. Ct. 2117 (2016) ... 29
Entergy Corp. v. *Riverkeeper, Inc.*, 556 U.S. 208 (2009) ... 28, 30, 31
FCC v. *Fox Television Stations, Inc.*, 556 U.S. 502 (2009) ... 25

Cases—Continued: Page

Good Samaritan Hosp. v. *Shalala*,
508 U.S. 402 (1993) 3
Holder v. *Martinez Gutierrez*, 566 U.S. 583 (2012) 28
Legacy Emanuel Hospital & Health Center. v. *Shalala*, 97 F.3d 1261 (9th Cir. 1996) 18
Little Sisters of the Poor Sts. Peter & Paul Home v. *Pennsylvania*, 140 S. Ct. 2367 (2020) 25
Long Island Care at Home, Ltd. v. *Coke*,
551 U.S. 158 (2007) .... *passim*
Maine Med. Ctr. v. *Burwell*,
841 F.3d 10 (1st Cir. 2016) 2
Metropolitan Hosp. v. *United States Dep't of Health & Human Servs.*, 712 F.3d 248 (6th Cir. 2013) 2, 3, 4
Monmouth Med. Ctr. v. *Thompson*,
257 F.3d 807 (D.C. Cir. 2001) 9
National Ass'n of Home Builders v. *Defenders of Wildlife*, 551 U.S. 644 (2007) 26
Natural Res. Def. Council, Inc. v. *EPA*,
279 F.3d 1180 (9th Cir. 2002) 20, 23
New York v. *EPA*, 413 F.3d 3 (D.C. Cir. 2005) 21
Northeast Hosp. Corp. v. *Sebelius*,
657 F.3d 1 (D.C. Cir. 2011) 3, 4
Northeast Md. Waste Disposal Auth. v. *EPA*,
358 F.3d 936 (D.C. Cir. 2004) 20, 23
Nuvio Corp. v. *FCC*, 473 F.3d 302 (D.C. Cir. 2006) 20
Portland Cement Ass'n v. *Ruckelshaus*,
486 F.2d 375 (D.C. Cir. 1973),
cert. denied, 417 U.S. 921 (1974) 27
Rybachek v. *EPA*, 904 F.2d 1276 (9th Cir. 1990) 23
Sebelius v. *Auburn Reg'l Med. Ctr.*,
568 U.S. 145 (2013) 3, 4, 5

Cases—Continued: Page

Stringfellow Mem. Hosp. v. *Azar*,
317 F. Supp. 3d 168 (D.D.C. 2018),
appeal dismissed, No. 18-5230,
2019 WL 668282 (D.C. Cir. 2019) 22, 24, 26, 27

Synthetic Organic Chem. Mfrs. Ass'n v. *Brennan*,
506 F.2d 385 (3d Cir. 1974),
cert. denied, 432 U.S. 830 (1975) 27

Your Home Visiting Nurse Servs., Inc. v. *Shalala*,
525 U.S. 449 (1999)... 23

Statutes and regulations:

Administrative Procedure Act, 5 U.S.C. 551 *et seq.*,
701 *et seq.* 16

5 U.S.C. 553(b)(3) 20

5 U.S.C. 706.. 25

5 U.S.C. 706(2)(D) 30

Clean Water Act, 33 U.S.C. 1326(b) 30

Social Security Act:

Tit. XVI, 42 U.S.C. 1381 *et seq.* 4

Tit. XVIII, 42 U.S.C. 1395 *et seq.* 2

42 U.S.C. 1395c *et seq.* 2

42 U.S.C. 1395d(b) 7

42 U.S.C. 1395hh.. 21

42 U.S.C. 1395hh(a)(2) 20

42 U.S.C. 1395hh(a)(4) 21, 30

42 U.S.C. 1395hh(b).. 20

42 U.S.C. 1395*oo*(f)(1) 16

42 U.S.C. 1395ww(d)(1)-(4) 3

42 U.S.C. 1395ww(d)(5)(F)... 3

42 U.S.C. 1395ww(d)(5)(F)(i)-(v) 4

42 U.S.C. 1395ww(d)(5)(F)(vii)-(xiv) 4

42 U.S.C. 1395ww(d)(5)(F)(v) 3

Statutes and regulations—Continued: Page

42 U.S.C. 1395ww(d)(5)(F)(vi) 3, 4, 6, 8
42 U.S.C. 1395ww(d)(5)(F)(vi)(I) 4, 5, 16, 28
42 U.S.C. 1395ww(d)(5)(F)(vi)(II) 5, 6, 8
42 U.S.C. 1395x(a) 7
42 U.S.C. 1396 *et seq.* 5

42 U.S.C. 426(a) 2, 7
42 U.S.C. 426(b) 2, 7
42 C.F.R.:
Section 400.202 7
Section 409.3 (2003) 8
Section 409.61(a)(1) 7
Section 409.61(a)(2) 7
Section 412.106(b)(2) (2003) 7
Section 412.106(b)(2)(i) 13, 14
Section 412.106(b)(2)(iii) 14

Miscellaneous:

Centers for Medicare and Medicaid Services, U.S. Dept. of Health and Human Services, *CMS Rulings: No. CMS-1498-R*, (Apr. 28, 2010) (*Ruling No. CMS-1498-R*), https://go.usa.gov/xsnnz...... 14
48 Fed. Reg. 12,526 (Mar. 25, 1983) 7
51 Fed. Reg. 31,454 (Sept. 3, 1986) 8
68 Fed. Reg. 27,154 (May 19, 2003) .... *passim*
68 Fed. Reg. 45,346 (Aug. 1, 2003) 11
69 Fed. Reg. 28,196 (May 18, 2004) 12
69 Fed. Reg. 48,916 (Aug. 11, 2004) .... *passim*
H.R. Rep. No. 141, 99th Cong., 1st Sess. Pt. 1 (1985) 4

In the Supreme Court of the United States

No. 20-1486

EMPIRE HEALTH FOUNDATION,
FOR VALLEY HOSPITAL MEDICAL CENTER,
CROSS-PETITIONER

v.

XAVIER BECERRA,
SECRETARY OF HEALTH AND HUMAN SERVICES

*ON CONDITIONAL CROSS-PETITION
FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT*

BRIEF FOR THE CROSS-RESPONDENT IN OPPOSITION

OPINIONS BELOW

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

JURISDICTION

The judgment of the court of appeals was entered on May 5, 2020. A petition for rehearing was denied on Oc-

[1] Unless otherwise indicated, the term "Pet. App." in this brief refers to the appendix to the petition for a writ of certiorari in No. 20-1312.

tober 20, 2020 (Pet. App. 84a-85a). The government's petition for a writ of certiorari in No. 20-1312 was filed on March 19, 2021. The conditional cross-petition was filed on April 19, 2021 (a Monday). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

A. Legal Background

1. The Medicare program, established in 1965 by Title XVIII of the Social Security Act (Medicare Act), 42 U.S.C. 1395 *et seq.*, provides health-insurance coverage to individuals who are at least 65 years old and are entitled to monthly Social Security benefits, and to disabled individuals who meet certain requirements. 42 U.S.C. 426(a) and (b). Such individuals are automatically "entitled to * * * benefits" under Medicare Part A, *ibid.*, which authorizes payments to providers for certain hospital and related services that they furnish to Medicare beneficiaries, see 42 U.S.C. 1395c *et seq.* The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) administers the Medicare program on behalf of the Secretary. See *Maine Med. Ctr.* v. *Burwell*, 841 F.3d 10, 13-14 (1st Cir. 2016).

Prior to 1983, "the federal government reimbursed hospitals for the 'reasonable cost' of treating Medicare patients." *Maine Med. Ctr.*, 841 F.3d at 14. In 1983, Congress replaced that reasonable-cost approach with "a prospective payment system through which hospitals are reimbursed predetermined amounts for certain services." *Ibid.* Under that prospective payment system, the government pays "a hospital a fixed dollar amount for each Medicare patient it discharges on the basis of the patient's diagnosis, regardless of the actual cost of the treatment provided." *Metropolitan Hosp.* v. *United States Dep't of Health & Human Servs.*, 712 F.3d 248, 250 (6th Cir. 2013)

(citing *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 406 n.3 (1993)); see 42 U.S.C. 1395ww(d)(1)-(4). Those fixed per-patient amounts are subject, however, to certain "adjustments" that Congress prescribed "based on various hospital-specific factors." *Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 3 (D.C. Cir. 2011); see *Edgewater Med. Ctr.* v. *Blue Cross & Blue Shield Ass'n*, HCFA Adm'r Dec. (PRRB Dec. Nos. 2000-D44 & 2000-D45), 2000 WL 1146601, at *2-*3 (June 19, 2000).

At issue here is one such adjustment that increases Medicare payments to "hospitals that serve a disproportionate share of low-income patients," *Sebelius* v. *Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 150 (2013), known as the "disproportionate share hospital" (or colloquially "DSH") adjustment, Pet. App. 3a; see 42 U.S.C. 1395ww(d)(5)(F). Congress recognized that "low-income patients are often in poorer health, and therefore costlier for hospitals to treat." *Catholic Health Initiatives Iowa Corp.* v. *Sebelius*, 718 F.3d 914, 916 (D.C. Cir. 2013). And "because hospitals with an unusually high percentage of low-income patients generally have higher per-patient costs," Congress determined that "such hospitals * * * should receive higher reimbursement rates." *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150.

Congress initially directed the Secretary to develop adjustments to account for those higher costs. But in 1985, after those efforts had not come to fruition, Congress "established its own measure for assessing whether a hospital 'serves a significantly disproportionate number of low income patients.'" *Metropolitan Hosp.*, 712 F.3d at 250 (quoting 42 U.S.C. 1395ww(d)(5)(F)(v)). The centerpiece of the measure that Congress enacted is the "disproportionate patient percentage," 42 U.S.C. 1395ww(d)(5)(F)(v) and (vi), which is a "'proxy measure'

for the number of low-income patients a hospital serves." *Northeast Hosp. Corp.*, 657 F.3d at 3 (quoting H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 17 (1985)). That percentage is used to determine whether a hospital will receive any disproportionate-share-hospital adjustment and, if so, to calculate the amount of that upward adjustment. See 42 U.S.C. 1395ww(d)(5)(F)(i)-(v), (vii)-(xiv); *Metropolitan Hosp.*, 712 F.3d at 250-251. In general, a "higher [disproportionate-patient percentage] means greater reimbursements" for a hospital, reflecting that "the hospital is serving more low-income patients." *Catholic Health Initiatives*, 718 F.3d at 916.

The disproportionate-patient percentage "is not the *actual* percentage of low-income patients served"; it is instead merely "an indirect, proxy measure for low income." *Catholic Health Initiatives*, 718 F.3d at 916. The disproportionate-patient percentage "is statutorily defined as the sum of two fractions, often called the 'Medicare fraction' and the 'Medicaid fraction,'" which "represent two distinct and separate measures of low income" that are focused on two different populations: low-income patients who are insured by Medicare Part A, and low-income patients who are not insured by Medicare Part A, respectively. *Ibid.*; see 42 U.S.C. 1395ww(d)(5)(F)(vi).

The first component of the disproportionate-patient percentage, the Medicare fraction, also "commonly called the SSI fraction," *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150, focuses on the Medicare beneficiaries—*i.e.*, persons who "were entitled to benefits under [Medicare] part A," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), and who were treated by a hospital during a reporting period. The Medicare fraction seeks to identify the percentage of those Medicare beneficiaries who were low-income patients. The Medicare fraction uses a patient's entitlement to supplemental-security-

income (SSI) benefits under Title XVI of the Social Security Act, 42 U.S.C. 1381 *et seq.*—which provides financial assistance to certain "financially needy individuals," *Bowen* v. *Galbreath*, 485 U.S. 74, 75 (1988)—to identify patients in that pool who also have low incomes. Specifically, the Medicare fraction is defined as a

> fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter [*i.e.*, Medicare Part A] and were entitled to supplementary security income benefits (excluding any State supplementation) under [Title XVI], and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under [Medicare] part A.

42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The Medicare fraction thus "effectively asks, out of all patient days *from Medicare beneficiaries*, what percentage of those days came from Medicare beneficiaries who *also*" were entitled to SSI benefits. *Catholic Health Initiatives*, 718 F.3d at 917; see *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150.

The second component of the disproportionate-patient percentage—the Medicaid fraction—focuses on low-income patients a hospital treated who were *not* Medicare beneficiaries, *i.e.*, "who were not entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). The Medicaid fraction uses a patient's eligibility for medical assistance under the Medicaid program, 42 U.S.C. 1396 *et seq.*, rather than entitlement to SSI benefits, to estimate the low-income non-Medicare patients a hospital served relative to its total patient population. Specifically, the Medicaid fraction is defined as a

> fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under [Title XIX], but who were not entitled to benefits under part A of this subchapter [*i.e.*, Medicare Part A], and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. 1395ww(d)(5)(F)(vi)(II). The Medicaid fraction thus calculates, as a percentage of a hospital's total patient days in a reporting period, how many days were attributable to patients who were *not* entitled to Medicare benefits but who *were* eligible for Medicaid benefits. See *Catholic Health Initiatives*, 718 F.3d at 917.

The Medicare and Medicaid fractions thus provide separate but complementary proxies for the percentage of low-income patients a hospital serves, each focused on a different subset of its patient pool: Medicare Part A patients, and all other patients, respectively. "[W]hen summed together," those two measures "provide a proxy for the [hospital's] total low-income patient percentage." *Catholic Health Initiatives*, 718 F.3d at 916.

2. The conditional cross-petition for a writ of certiorari concerns a procedural challenge to a notice-and-comment regulation promulgated by the Secretary in 2004 addressing the calculation of the disproportionate-share-hospital adjustment—and in particular the interpretation of the statutory phrase "entitled to benefits under [Medicare] part A" in the Medicare and Medicaid fractions." 42 U.S.C. 1395ww(d)(5)(F)(vi).

a. As relevant here, the rulemaking addressed the treatment of patient days of individuals who satisfied the statutory criteria to be "entitled" to Medicare Part A

benefits, 42 U.S.C. 426(a) and (b), at the time they received services from a hospital, but for which services Medicare ultimately did not (and was not required to) pay the hospital. The Secretary focused in particular on patient days of Medicare Part A beneficiaries who had exhausted their Medicare Part A coverage for hospital inpatient days for the relevant benefit period—such that the Medicare program was not required to pay the hospital for those particular days. 69 Fed. Reg. 48,916, 49,098-49,099, 49,246 (Aug. 11, 2004). In general, Medicare Part A will pay only for a limited number of successive hospital inpatient days (typically 90) in a single "spell of illness." 42 U.S.C. 1395d(b); see 42 U.S.C. 1395x(a); 42 C.F.R. 409.61(a)(1). With certain exceptions, if a patient's stay exceeds that limit, her Medicare coverage of hospital inpatient days for that period is "exhausted," and Medicare does not pay for the days in excess of the limit. Pet. App. 7a n.8; see 42 C.F.R. 409.61(a)(1) and (2). Such patient days are known as "exhausted coverage days." 69 Fed. Reg. at 49,098.

The Secretary has long interpreted the term "entitled" in the Medicare context to refer to an individual's status as a Medicare beneficiary, *i.e.*, that the individual satisfies the statutory requirements for entitlement to benefits under the program. See, *e.g.*, 48 Fed. Reg. 12,526, 12,535 (Mar. 25, 1983) (42 C.F.R. 400.202) ("As used in connection with the Medicare program, unless the context indicates otherwise," the term "*[e]ntitled* means that an individual meets all the requirements for Medicare benefits."). Prior to 2004, however, when HHS calculated a hospital's disproportionate-share-hospital adjustment, it nevertheless included in the Medicare fraction only "covered" Medicare patient days, 42 C.F.R. 412.106(b)(2) (2003)—*i.e.*, days for which payment from the Medicare program was

available to the hospital, thus excluding exhausted-coverage days. See 51 Fed. Reg. 31,454, 31,460 (Sept. 3, 1986) (discussing Medicaid fraction); *id.* at 31,460-31,461 (discussing Medicare fraction); cf. 42 C.F.R. 409.3 (2003) (providing that the term "*[c]overed*" in regulations addressing inpatient hospital services "refers to services for which the law and the regulations authorize Medicare payment"). HHS had interpreted the parenthetical phrase "(for such days)"—which appears in both the numerator and denominator of the Medicare fraction (referring to "patients who *(for such days)* were entitled to benefits under [Medicare] part A"), as well as the numerator of the Medicaid fraction (referring to "patients who *(for such days)* were eligible for [Medicaid]"), 42 U.S.C. 1395ww(d)(5)(F)(vi) (emphases added)—as directing it to focus on patient days for which a hospital was actually paid by Medicare or Medicaid, respectively.

At the same time, HHS had excluded from the Medicaid fraction's numerator *all* patient days of Medicare Part A beneficiaries, regardless of whether Medicare had paid the hospital for those days. See *Edgewater Med. Ctr.*, 2000 WL 1146601, at *4-*5. As the agency explained, "[t]he relevant language of the Medicaid proxy indicates that it is the status of the patients, as opposed to the payment of the day, which determines whether a patient day is included in the numerator of the Medicaid proxy." *Id.* at *4; see *Catholic Health Initiatives*, 718 F.3d at 918, 921 (discussing agency's explanation). In particular, in the definition of the Medicaid fraction's numerator in subclause (II), unlike in the definition of the Medicare fraction in subclause (I), the phrase "(for such days)" does not modify the phrase "entitled to benefits under [Medicare] part A"; it modifies only the phrase "eligible for medical assistance under [Medicaid]." 42 U.S.C.

1395ww(d)(5)(F)(vi)(II). Consequently, exhausted coverage days of Medicare Part A beneficiaries—including such days of individuals who were eligible for both Medicare and Medicaid (known as "dual eligible exhausted coverage patient days," Pet. App. 6a (citation omitted))—were not counted in either the Medicare or Medicaid fraction.

b. HHS subsequently revisited its approach to Medicaid following a series of judicial decisions rejecting its interpretation of the "(for such days)" qualifier in the context of the Medicaid fraction. See *Monmouth Med. Ctr.* v. *Thompson*, 257 F.3d 807, 810 (D.C. Cir. 2001) (citation omitted). By 1997, four courts of appeals had rejected HHS's position that only patient days actually paid by the Medicaid program should be counted in the numerator of the Medicaid fraction. See *ibid.* In 1997, CMS's predecessor issued a ruling that acquiesced nationwide in those courts' interpretation. *Ibid.*

In the rulemakings at issue here, HHS reconsidered its approach to exhausted *Medicare* patient days. In May 2003, HHS published a notice of proposed rulemaking for the 2004 year, in which it proposed to modify its regulations "to count in the Medicaid fraction"—in that fraction's numerator, which focuses on a hospital's Medicaid patient days—"the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage has expired." 68 Fed. Reg. 27,154, 27,207 (May 19, 2003). The preamble to the proposed rule stated correctly that, under HHS's then-existing approach, dual-eligible patient days were counted in the Medicare fraction but not counted in the Medicaid fraction. *Ibid.* Specifically, such days were counted in both the Medicare fraction's numerator and denominator, and they were not counted in the Medicaid fraction's numerator. The preamble noted that the statute provides that, in calculating the

Medicaid fraction's numerator, the patient days of Medicaid patients who were also "entitled to benefits under Medicare Part A" are not to be counted toward a hospital's total Medicaid patient days. *Ibid.* The preamble additionally stated, incorrectly, that "[t]his policy currently applies even after the patient's Medicare coverage is exhausted," and that, "if a dual-eligible patient is admitted without any Medicare Part A coverage remaining, or the patient exhausts Medicare Part A coverage while an inpatient, his or her patient days are counted in the Medicare fraction before and after Medicare coverage is exhausted." *Ibid.* The preamble to the proposed rule thus mistakenly described HHS's then-current approach as counting dual-eligible exhausted-coverage days in the Medicare fraction (in both the numerator and denominator), when in fact such days were not then counted in either the numerator or denominator of the Medicare fraction or the Medicaid fraction's numerator. Pet. App. 7a-8a.

The 2003 proposed rule would have counted dual-eligible exhausted-coverage days in the Medicaid fraction's numerator—*i.e.*, such days would no longer be excluded when calculating a hospital's total number of Medicaid patient days. See 68 Fed. Reg. at 27,208. In proposing that approach, HHS did not conclude that it was compelled by the statutory language. To the contrary, HHS stated that the inverse approach—counting such days in both parts of the Medicare fraction instead (and not counting them in the Medicaid fraction), which the proposed rule mistakenly described as HHS's then-current practice—was also consistent with the statutory language. *Ibid.* But HHS stated that "there are other plausible interpretations." *Ibid.* The agency addition-

ally reasoned that "it [wa]s often difficult for fiscal intermediaries to differentiate the days for dual-eligible patients whose Part A coverage has been exhausted," and it proposed counting dual-eligible exhausted-coverage days in the Medicaid fraction's numerator "to facilitate consistent handling of [dual-eligible exhausted-coverage] days across all hospitals." *Ibid.*

HHS received many comments on the 2003 proposed rule. See 68 Fed. Reg. 45,346, 45,350 (Aug. 1, 2003) (agency received more than 4000 comments on various aspects of the proposed rule). Among others, HHS received many comments from providers and organizations that opposed the proposed modification of HHS's regulations to include dual-eligible exhausted-coverage days in the Medicaid fraction, and that instead supported including exhausted-coverage days in the Medicare fraction. See, *e.g.*, C.A. E.R. 124, 131, 133, 137, 139-140, 142-143, 147-148. In contrast, only three commenters supported HHS's proposed rule. See *id.* at 126, 128, 151. Two of those three commenters suggested that the preamble to the proposed rule had misstated HHS's current policy, and that in fact the agency's then-current approach included only covered, *i.e.*, non-exhausted, Medicare patient days in the Medicare fraction. *Id.* at 128, 151.

In August 2003, HHS promulgated a final rule for the 2004 year that addressed various other issues. 68 Fed. Reg. 45,346. But the final rule issued in 2003 did not address dual-eligible exhausted-coverage days, explaining that the agency was "still reviewing the large number of comments received on the proposed provision relating to dual-eligible patient days," and that the agency would address that issue separately. *Id.* at 45,421.

c. In May 2004, HHS published a proposed rule to govern the 2005 year. 69 Fed. Reg. 28,196 (May 18, 2004). The proposed rule noted that HHS's final rule for the 2004 year had not responded to public comments on HHS's proposal to modify its treatment of dual-eligible exhausted-coverage days, and it explained that the agency "plan[ned] to address th[ose] comments" in its final rule (to be adopted later in 2004) for the 2005 year. *Id.* at 28,286. The period for public comments remained open until July 12, 2004. *Id.* at 28,196.

In early July 2004, several days before the comment period closed, HHS posted a notice on its website acknowledging (as several commenters had noted in 2003) that the proposed rule published in 2003 had misstated HHS's then-current policy with respect to dual-eligible exhausted-coverage days. C.A. E.R. 116.[2] The website notice explained that the proposed rule in 2003 had correctly "stated" that, "if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered a dual-eligible and the patient days are generally included in the Medicare fraction of the [disproportionate-share-hospital] patient percentage, but not the Medicaid fraction." *Ibid.* The website notice further explained, however, that the 2003 proposed rule had mistakenly "indicated, with respect to dual-eligibles, that [that] policy * * * currently applie[d] even after the patient's Medicare Part A coverage is exhausted." *Ibid.*

---

[2] The date on the website notice in the record is July 7, 2004 (C.A. E.R. 116), but the district court noted (Pet. App. 57a n.2) that the *Federal Register* states that the notice was published on July 9, 2004. Both the district court and the court of appeals concluded, however, that whether the website notice was published three or five days prior to the end of the comment period made no difference to the analysis. See *id.* at 9a n.11, 57a n.2.

The website notice clarified that, as a matter of HHS's existing practice, "th[at] statement [wa]s not accurate," and that up to that point HHS's "policy ha[d] been that only covered patient days are included in the Medicare fraction." *Ibid.* (citing 42 C.F.R. 412.106(b)(2)(i)).

HHS received many additional comments following the publication in 2004 of its proposed rule for the 2005 year. 69 Fed. Reg. at 48,925 (more than 30,000 comments on various aspects of the rule). Of the comments that addressed the treatment of dual-eligible exhausted-coverage days, virtually all of them opposed HHS's proposal to count such days in the numerator of the Medicaid fraction, and instead urged HHS to include such days in the numerator and denominator of the Medicare fraction. See, *e.g.*, C.A. E.R. 69-70, 71-73, 79, 81, 83, 85, 87-88, 90, 92-94, 96-97, 99-100, 106-108, 110-111, 113, 115, 118-119. Most of those comments were dated and submitted after HHS posted the notice on its website clarifying HHS's current approach.

d. In August 2004, HHS promulgated the final rule (commencing for the 2005 year) at issue here. 69 Fed. Reg. 48,916. In the final rule, the agency explained that it "ha[d] decided not to finalize [its] proposed rule to include dual-eligible beneficiaries who have exhausted their [Medicare] Part A hospital coverage in the Medicaid fraction." *Id.* at 49,099; see *id.* at 49,098-49,099. Instead, HHS adopted the inverse approach, which the 2003 proposed rule had discussed and mistakenly described as HHS's existing practice (an error that the 2004 website notice corrected), and which many commenters urged the agency to adopt. *Id.* at 49,099. Specifically, HHS stated that it was "adopting a policy to include the days associated with dual-eligible benefi-

ciaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage." *Ibid.* HHS explained that, under that approach, "[i]f [a] patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction." *Ibid.* Thus, all patient days attributable to Medicare Part A beneficiaries are counted in the Medicare fraction's denominator, and all patient days of such individuals who were also entitled to SSI benefits are counted in the Medicare fraction's numerator. See *ibid.*; 42 C.F.R. 412.106(b)(2)(i) and (iii).[3]

In adopting that approach in the 2004 final rule, the agency observed that "[n]umerous commenters" had "opposed [the agency's] proposal" and had "objected that the proposal would result in a reduction of DSH payments." 69 Fed. Reg. at 49,098. The Secretary additionally observed that a Medicare Part A beneficiary who exhausts her covered inpatient days for a benefit period does not thereby lose her entitlement to Medicare Part A benefits altogether. See *ibid.* To the contrary, the Secretary noted, Medicare "beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits." *Ibid.* For example, although a beneficiary's entitlement to inpatient care may be exhausted, "other items and services * * * still might be covered under Part A," such as "certain physician services and skilled nursing services." CMS, HHS, *CMS Rulings: No. CMS-1498-R*, at 10 (Apr. 28, 2010) (*Ruling No. CMS-1498-R)*, https://go.usa.gov/xsnnz. The

---

[3] The 2004 rule also continued to exclude all patient days of Medicare Part A beneficiaries from the numerator of the Medicaid fraction, regardless of whether those days were paid for by Medicare. See 69 Fed. Reg. at 49,098-49,099.

Secretary accordingly endorsed a commenter's observations "that a patient who exhausts coverage for inpatient hospital services still remains entitled to other Medicare Part A benefits," and that it is "difficult to reconcile" that fact with an interpretation of the statute that deems Medicare beneficiaries who have exhausted inpatient days to be "not entitled to Medicare Part A benefits" at all. 69 Fed. Reg. at 49,098. The Secretary recognized that counting Medicare beneficiaries' patient days in the numerator and denominator of the Medicare fraction and not counting them in the numerator of the Medicaid fraction could increase some hospitals' payments while decreasing those of others, depending on the makeup of their patient populations. See *ibid.*

The Secretary also addressed comments concerning the website notice that the agency posted in 2004 to correct the misstatement about HHS's then-current practice in the 2003 proposed rule. 69 Fed. Reg. at 49,098. HHS observed that some commenters had mistakenly interpreted the website notice as reflecting a change in the agency's policy on which the agency had not provided an adequate opportunity for public comment. *Ibid.* HHS clarified that the "[t]he Web site posting" was merely "a correction of an inadvertent misstatement made in the May 19, 2003 proposed rule" and that it "was not a new proposal or policy change," and HHS found it unnecessary to commence a further round of notice-and-comment rulemaking "in correcting a misstatement" of that kind in these circumstances. *Ibid.*

B. The Present Controversy

1. Valley Hospital Medical Center operated a short-term acute-care hospital that participated as a provider in the Medicare program. Compl. ¶ 5. Cross-petitioner Empire Health Foundation (respondent in No. 20-1312)

acquired Valley Hospital's right to payment from the Medicare program for (as relevant here) fiscal year 2008. Pet. App. 10a.

"Dissatisfied with its total reimbursement amount" for 2008 as determined by the Medicare contractor that calculated Valley Hospital's payment, cross-petitioner appealed to the Provider Reimbursement Review Board within HHS. Pet. App. 10a-11a. Cross-petitioner requested, and the Board granted, expedited judicial review under 42 U.S.C. 1395*oo*(f)(1). Pet. App. 11a n.13; see *id.* at 83a.

2. Cross-petitioner commenced this action in the district court challenging the 2004 rule as substantively and procedurally invalid. Pet. App. 24a-25a. As to the rule's substantive validity, cross-petitioner contended that "the Secretary's interpretation of the phrase 'entitled to benefits under [Medicare Part A]'" in Section 1395ww(d)(5)(F)(vi)(I) conflicted with the statutory language and Ninth Circuit precedent. *Id.* at 24a (brackets in original). As to the rule's procedural validity, cross-petitioner contended that the Secretary had failed to comply with notice-and-comment procedures prescribed in the Administrative Procedure Act (APA), 5 U.S.C. 551 *et seq.*, 701 *et seq.*, in promulgating the final rule. Pet. App. 51a, 62a.

The district court granted partial summary judgment to cross-petitioner. Pet. App. 23a-75a. The court rejected cross-petitioner's substantive challenge to the relevant portion of the 2004 rule. *Id.* at 31a-51a. The court concluded, however, that the rule was procedurally invalid because it was "not a logical outgrowth" of the agency's 2003 notice of proposed rulemaking. *Id.* at 70a; see *id.* at 51a-72a. The court enjoined HHS from applying the challenged portion of the 2004 rule to

cross-petitioner and directed the agency to recalculate cross-petitioner's disproportionate-share-hospital adjustment for fiscal year 2008 in accordance with the court's order. *Id.* at 74a-75a.

3. The court of appeals affirmed, but on different grounds. Pet. App. 1a-22a.

a. The court of appeals first determined that the final rule was a logical outgrowth of the agency's proposed rule and that the district court thus erred in vacating the rule on procedural grounds. Pet. App. 12a-16a. The court explained that that the agency's 2003 proposed rule had "describe[d] the content of the [2004 final] Rule, even if it incorrectly characterized it as the then-applicable rule," and that "HHS corrected its misstatement of the then-applicable rule before the end of the second comment period." *Id.* at 14a. In addition, the court noted that "many sophisticated commenters, including several large hospital associations, supported placing dual eligible exhausted coverage patient days in the Medicare fraction," as HHS did in the final 2004 regulation. *Ibid.* The court accordingly determined that the 2004 regulation was "a logical outgrowth of the proposed rule change, and HHS's 2003 Notice provided adequate notice to commenters of what the agency was considering." *Ibid.*

The court of appeals observed that this Court's decision in *Long Island Care at Home, Ltd.* v. *Coke*, 551 U.S. 158 (2007), supported the conclusion that the 2004 rule is procedurally valid. Pet. App. 15a. The court of appeals explained that, in both cases, the agency had presented commenters with a binary choice, and it ultimately did not adopt the original proposal. *Ibid.* The court noted that, as in *Long Island Care*, commenters

on the 2004 regulation "were similarly apprised of a binary choice—under the new rule, dual eligible exhausted coverage patient days would be included in either the Medicare or the Medicaid fraction." *Ibid.* The court concluded that either choice was "reasonably foreseeable," and that HHS satisfied the applicable notice-and-comment requirements. *Ibid.* (quoting *Long Island Care*, 551 U.S. at 175).

b. The court of appeals further concluded, however, that the 2004 regulation was "substantively invalid." Pet. App. 21a. The court reasoned that the Ninth Circuit's prior decision in *Legacy Emanuel Hospital & Health Center* v. *Shalala*, 97 F.3d 1261 (1996), foreclosed the 2004 regulation's interpretation of the statute. Pet. App. 16a-21a.

The court of appeals accordingly "affirm[ed], on different grounds, the district court's order * * * vacating the [2004] Rule." Pet. App. 22a (capitalization and emphasis omitted). The court stated that it was "reinstat[ing] the prior version of 42 C.F.R. § 412.106(b)(2)(i), which embraced only 'covered' patient days" in calculating the Medicare fraction. *Ibid.* That holding is the subject of the government's pending petition for a writ of certiorari in this case. 20-1312 Pet. at 15-33 (filed Mar. 19, 2021).

4. The court of appeals denied the government's petition for rehearing en banc. Pet. App. 84a-85a.

ARGUMENT

In the decision below, the Ninth Circuit concluded that the Secretary's longstanding interpretation, codified in a regulation in force since 2004, of a provision the Medicare Act is substantively invalid. Pet. App. 18a-21a. As we explain in our pending petition for a writ of certiorari, that conclusion is incorrect and warrants this Court's review. 20-1312 Pet. at 15-33.

In its conditional cross-petition for a writ of certiorari, cross-petitioner (respondent in No. 20-1312) contends (20-1486 Pet. (Cross-Pet.) 14-29) that, if this Court grants the government's petition presenting the question of the substantive validity of HHS's statutory interpretation reflected in the 2004 rule, then the Court should also grant review of cross-petitioner's separate argument that the 2004 rule was not promulgated in compliance with notice-and-comment procedures. That contention lacks merit. The court of appeals correctly rejected cross-petitioner's procedural challenge to the 2004 rule, and that context-specific application of administrative-procedure requirements does not conflict with any decision of this Court or of any other court of appeals. That ancillary issue does not warrant this Court's review.

Cross-petitioner errs in contending (Cross-Pet. 15-18) that the Court should nevertheless grant review of its procedural challenge on the theory that the 2004 rule's procedural validity is "[i]ntertwined" with the question presented in the government's petition, which concerns the proper interpretation of the Medicare Act. Cross-Pet. 15 (emphasis omitted). Whether the 2004 final rule was a logical outgrowth of the agency's 2003 proposed rule does not bear on the proper interpretation of the statutory provision establishing the disproportionate-share-hospital adjustment. And consideration of that distinct, orthogonal issue would not aid this Court's analysis of the statutory merits. The conditional cross-petition should be denied.

1. The court of appeals determined that HHS complied with applicable notice-and-comment requirements because the 2004 final rule's treatment of dual-eligible exhausted-coverage days in the disproportionate-share-hospital adjustment was a logical outgrowth of the

agency's proposed rule. Pet. App. 12a-16a. That determination is correct and does not warrant further review.

a. Under the APA, an agency promulgating a regulation ordinarily must provide "[g]eneral notice" in the *Federal Register* of "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). Such notice "must be sufficient to fairly apprise interested parties of the issues involved, but it need not specify every precise proposal which the agency may ultimately adopt as a rule." *Nuvio Corp.* v. *FCC*, 473 F.3d 302, 310 (D.C. Cir. 2006) (brackets, citation, and internal quotation marks omitted). The agency's final rule thus "need not be identical" to the proposed rule, as "[t]hat would be antithetical to the whole concept of notice and comment." *Natural Res. Def. Council, Inc.* v. *EPA*, 279 F.3d 1180, 1186 (9th Cir. 2002) (*NRDC*). Rather, "[a]gencies[] are free—indeed, they are encouraged—to modify proposed rules as a result of the comments they receive." *Northeast Md. Waste Disposal Auth.* v. *EPA*, 358 F.3d 936, 951 (D.C. Cir. 2004) (per curiam). An agency therefore satisfies the APA's notice requirements if its final rule is "a logical outgrowth of the rule proposed." *Long Island Care at Home, Ltd.* v. *Coke*, 551 U.S. 158, 174 (2007) (citation and internal quotation marks omitted).

The Medicare Act contains a provision requiring that certain policies and requirements adopted by HHS be promulgated through notice-and-comment rulemaking, see 42 U.S.C. 1395hh(a)(2) and (b), but that provision does not alter the analysis relevant in this case. Although this Court has held that the Medicare-specific provision differs in some respects from the APA's notice-and-comment requirements, see *Azar* v. *Allina Health Servs.*, 139 S. Ct. 1804, 1810-1814 (2019), that provision incorporates the

same logical-outgrowth principle that applies under the APA, see 42 U.S.C. 1395hh(a)(4). Specifically, it states that, "[i]f the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule," then that "provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation." *Ibid.* The court of appeals saw no salient difference between the notice required by the APA and by the Medicare Act, Pet. App. 12a n.15, and cross-petitioner does not invoke Section 1395hh in this Court or contend that it affects the analysis of its procedural challenge to the 2004 rule.

b. The court of appeals correctly determined that the 2004 final rule was a "logical outgrowth" of the 2003 proposed rule and thus complied with the notice-and-comment requirements on which cross-petitioner relies. Pet. App. 16a (citation omitted); see *id.* at 15a-16a. A "final rule is a logical outgrowth if affected parties should have anticipated that the relevant modification was possible." *Allina Health Services* v. *Sebelius*, 746 F.3d 1102, 1107 (D.C. Cir. 2014). For example, "[o]ne logical outgrowth of a proposal is * * * to refrain from taking the proposed step." *New York* v. *EPA*, 413 F.3d 3, 44 (D.C. Cir. 2005) (per curiam) (citation omitted).

As the court of appeals explained, although HHS did not ultimately adopt the proposal it described in the 2003 proposed rule, "the final rule was 'reasonably foreseeable' and the proposal had provided fair notice to commenters." Pet. App. 15a (quoting *Long Island Care*, 551 U.S. at 175). The relevant issue that the 2003 proposed rule and the 2004 final rule addressed was the treatment of dual-eligible exhausted-coverage days. 68 Fed. Reg. at

27,207-27,208; 69 Fed. Reg. at 49,098-49,099. At the time the proposed rule was published in 2003, HHS did not include such days in either the Medicare or Medicaid fraction. See pp. 9-10, 12-13, *supra*. The 2003 proposed rule discussed only two possibilities: counting such days in the numerator of the Medicaid fraction, the course that the notice of proposed rulemaking set forth for public comment; or counting such days in the Medicare fraction (in both the numerator and denominator of that fraction), as other dual-eligible patient days are, which the agency viewed as also consistent with the statute, and which the notice of proposed rulemaking mistakenly described as HHS's then-current practice. 68 Fed. Reg. at 27,207-27,208. After two rounds of public comments, in which commenters were predominantly critical of the first approach and advocated the second approach, HHS adopted the second. See 69 Fed. Reg. at 49,098-49,099.

As the court of appeals correctly found, that second approach "was a logical outgrowth of the proposed rule change." Pet. App. 14a. And commenters had "adequate notice * * * of what the agency was considering." *Ibid.* Commenters knew from the notice that an approach of including dual-eligible exhausted-coverage days in the Medicare (rather than Medicaid) fraction was a possible course the agency might adopt.

Indeed, as both the court of appeals and the district court in the only other case to address the issue explained, many commenters during both comment periods discussed that possibility and advocated that HHS adopt precisely that approach. Pet. App. 14a-15a (citing *Stringfellow Mem. Hosp.* v. *Azar*, 317 F. Supp. 3d 168, 187 (D.D.C. 2018), appeal dismissed, No. 18-5230, 2019 WL 668282 (D.C. Cir. 2019)). Those comments

demonstrate that "a new round of notice and comment" would not "provide the first opportunity for interested parties to offer comments that could persuade the agency to modify its rule," Pet. App. 14a (quoting *NRDC*, 279 F.3d at 1186)—but the third. And those comments reflect that "[c]ommenters clearly recognized" that the agency was considering the policy ultimately adopted (*i.e.*, the inclusion of dual eligible exhausted coverage days in the Medicare fraction rather than the Medicaid fraction). *Rybachek* v. *EPA*, 904 F.2d 1276, 1288 (9th Cir. 1990); see *Northeast Md. Waste Disposal*, 358 F.3d at 952. Following HHS's proposed rule, "any reasonable party" thus "should have understood that [the agency] might reach the opposite conclusion after considering public comments," and "the [a]gency's change of heart on this issue only demonstrates the value of the comments it received." *Arizona Pub. Serv. Co.* v. *EPA*, 211 F.3d 1280, 1300 (D.C. Cir. 2000), cert. denied, 532 U.S. 970 (2001). That is especially true in this context, where the commenters were "sophisticated Medicare[] provider[s]" that, through their comments, demonstrated an understanding of the key statutory interpretation issue underlying the Secretary's choice of whether or not to adopt the proposed rule. See *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 456 (1999).

As the court of appeals also correctly recognized, this Court's decision in *Long Island Care* further supports that conclusion. There, as here, "commenters could reasonably foresee that 'after . . . consideration of the proposal the [agency] might choose to adopt the proposal or to withdraw it.'" Pet. App. 15a (quoting *Long Island Care*, 551 U.S. at 175) (brackets omitted).

As the Court in *Long Island Care* observed, a "proposed rule [i]s simply a proposal" whose "presence mean[s] that [an agency] [i]s *considering* the matter." 551 U.S. at 175. And there, as here, the agency's ultimate determination not to adopt the approach it had been considering was "reasonably foreseeable" from the proposal itself. *Ibid.*

c. Cross-petitioner's contrary arguments lack merit. Cross-petitioner suggests (Cross-Pet. 19) that the inaccurate description in the preamble of the 2003 proposed rule of HHS's then-existing policy renders the 2004 final rule invalid. 68 Fed. Reg. at 27,207-27,208. But that "inadvertent misstatement," 69 Fed. Reg. at 49,098, did not deprive commenters of notice or opportunity to comment on the policy the agency ultimately adopted. As the court of appeals explained, the substance of that approach was set forth clearly in the 2003 proposed rule. Pet. App. 14a. The notice's mistaken description of that approach as already being in effect did not impede commenters from addressing it—as many commenters in each round of comment did. *Ibid.*; see pp. 11, 13, *supra*. "[T]he Administrative Record includes many comments opposing the proposed rule, indicating that commenters were on notice that the Secretary was deciding between two options: including dual-eligible exhausted days in either the Medicare fraction or the Medicaid fraction." *Stringfellow*, 317 F. Supp. 3d at 18. Whether the approach described in the 2003 proposed rule and adopted in the 2004 final rule represented the status quo or a departure from it, interested parties could and did address the merits of that approach.

Cross-petitioner asserts (Cross-Pet. 15) that the proposed rule's mischaracterization of counting dual-

eligible exhausted-coverage days in the Medicare fraction led the agency and commenters to confuse "the *actual* status quo" with "a proposed *change* in policy." That assertion is incorrect. The 2004 rulemaking was not an instance in which an agency failed to "display awareness that it *is* changing position." *FCC* v. *Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). The agency expressly recognized in promulgating its final rule that the approach it adopted marked a change from prior practice. 69 Fed. Reg. at 49,098. And the agency corrected its earlier misstatement before the comment period closed in 2004 to ensure that commenters were not under such a misimpression. *Ibid.*; C.A. E.R. 116.

Cross-petitioner faults HHS (Cross-Pet. 25-26) for posting the website notice correcting its misstatement. But as HHS explained, the website notice did not change what the agency was proposing or deprive commenters of the opportunity to comment on such a revised proposal. 69 Fed. Reg. at 49,098. The notice simply rectified the error in the proposed rule's description of one approach. Most of the comments addressing HHS's proposal in the second round postdated the website notice. See p. 13, *supra*.

The court of appeals thus correctly determined that the 2004 rule was a logical outgrowth of HHS's proposal of which commenters had adequate notice. At a minimum, as the many comments addressing the proposal that HHS ultimately adopted demonstrate, any error was not "prejudicial," 5 U.S.C. 706, and accordingly would not provide a valid basis for invalidating the 2004 rule. See *ibid.* (directing courts applying APA to take "due account * * * of the rule of prejudicial error"); *Little Sisters of the Poor Sts. Peter & Paul Home* v. *Pennsylvania*, 140 S. Ct. 2367, 2385 (2020) ("[T]he rule of prejudicial error is treated as

an 'administrative law . . . harmless error rule.'" (quoting *National Ass'n of Home Builders* v. *Defenders of Wildlife*, 551 U.S. 644, 659-660 (2007))). Cross-petitioner does not identify any benefit that reopening the comment period 17 years later would yield. The court of appeals correctly rejected cross-petitioner's procedural challenge.

2. Cross-petitioner offers no sound reason why the court of appeals' context-specific application of notice-and-comment requirements to a regulation promulgated in 2004 warrants plenary review in this Court.

a. The court of appeals' determination that the 2004 final rule comports with notice-and-comment requirements does not conflict with any decision of another court of appeals addressing that rule. Petitioner does not contend otherwise. And the only other court to address that issue reached the same conclusion as the court of appeals here. See *Stringfellow*, 317 F. Supp. 3d at 186-190.

Cross-petitioner argues (Cross-Pet. 28) that the Ninth Circuit's decision conflicts with the D.C. Circuit's holding in *Allina Health Services*, *supra*, that a different portion of the 2004 rule was not a logical outgrowth of the agency's proposed rule. As the court of appeals correctly recognized, however, *Allina* is distinguishable. See Pet. App. 15a-16a. In *Allina*, the D.C. Circuit held that the portion of HHS's 2004 regulation that addressed the treatment of Medicare Part C patient days for purposes of the disproportionate-share-hospital provision violated APA notice requirements. 746 F.3d at 1107-1109. That holding does not extend to the provision of the 2004 regulation at issue here. In addressing the issue before it, the *Allina* court considered a different rulemaking record with many fewer comments. And the decision "offer[s] little support" to cross-petitioner because it concluded that the agency's "proposal to clarify" existing policy did not

provide notice of a significant change it ultimately adopted. See *Stringfellow*, 317 F. Supp. 3d at 188-189 (brackets omitted). Here, in contrast, HHS's 2003 proposed rule made clear that it was contemplating a change, and the agency later clarified that an approach it had described as existing policy would in fact also reflect a change. See pp. 9-13, *supra*.

Cross-petitioner contends that the decision below is in tension with decisions of other courts of appeals addressing an agency's obligation during notice-and-comment rulemaking to "disclose the facts or studies" on which it has relied. Cross-Pet. 20 (citing *Portland Cement Ass'n* v. *Ruckelshaus*, 486 F.2d 375, 393 (D.C. Cir. 1973), cert. denied, 417 U.S. 921 (1974), and *Synthetic Organic Chem. Mfrs. Ass'n* v. *Brennan*, 506 F.2d 385 (3d Cir. 1974), cert. denied, 423 U.S. 830 (1975)). Those decisions are inapposite. Cross-petitioner has not contended in this litigation that HHS relied on data or technical studies that it failed to disclose. Instead, the procedural error that it alleges is that the substance of the final rule HHS adopted diverged too far from the proposed rule to be reasonably foreseeable—and in particular that the proposed rule inaccurately described one alternative approach as embodying HHS's then-current practice. That putative error does not rest on a failure to disclose underlying data. The court of appeals properly rejected that contention by comparing the proposed and final rules and reviewing the comments submitted. See Pet. App. 14a-15a. A fortiori, the doubt cross-petitioner seeks to raise (Cross-Pet. 21-22) of whether the decisions it cites are in tension with this Court's precedent does not warrant review in this case.

b. Unable to show that the context-specific notice-and-comment issue it raises independently warrants review, cross-petitioner contends (Cross-Pet. 15-18) that the

Court should nevertheless consider that issue if it grants the government's petition addressing the statutory merits because (according to petitioner) the procedural and substantive issues are "[i]ntertwined." Cross-Pet. 15 (emphasis omitted). That contention lacks merit.

The government's petition raises a question of statutory interpretation: whether HHS has permissibly included in a hospital's Medicare fraction all of the hospital's patient days of individuals who satisfy the requirements to be entitled to Medicare Part A benefits, regardless of whether Medicare paid the hospital for those particular days. 20-1312 Pet. at I, 15-33. As we explain in the government's pending petition (at 19-30), the Secretary's interpretation of "entitled to benefits under part A" set forth in the 2004 regulation embodies the best construction of the statutory text of 42 U.S.C. 1395ww(d)(5)(F)(vi)(I) in light of the context, structure, history, and purpose. At a minimum, HHS's interpretation represents a reasonable reading that the court of appeals was obligated to uphold. See *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 & n.4 (2009); see *Holder* v. *Martinez Gutierrez*, 566 U.S. 583, 591 (2012) (government's "position prevails if it is a reasonable construction of the statute, whether or not it is the only possible interpretation or even the one a court might think best").

In any event, that question of the statute's meaning does not turn on the particular procedural steps at issue here by which the agency articulated its position in a rule promulgated 17 years ago. And that substantive question warrants this Court's review for reasons that do not apply to the court of appeals' rejection of cross-petitioner's procedural challenge. The decision below created a circuit

conflict, entrenched by the court of appeals' denial of rehearing, regarding the validity of a federal regulation that applies to adjudications of Medicare payments nationwide. 20-1312 Pet. at 30-33. That conflict has significant practical consequences for the Medicare program. See *id.* at 32-33. The court's procedural holding, in contrast, creates no conflict and does not present similarly severe practical consequences. Indeed, the remedy that cross-petitioner apparently contemplates of "invalidat[ing]" the 2004 rule many years after its issuance (Cross-Pet. 20)—all to afford commenters yet another opportunity to express their views to the agency—would be highly disruptive and serve no evident purpose.

Moreover, cross-petitioner does not attempt to show that analysis of its procedural challenge to the 2004 rule overlaps with the analysis of the proper interpretation of the Medicare Act. Instead, cross-petitioner asserts (Cross-Pet. 17-18) that, if it were to succeed on its procedural challenge that the 2004 rule was not adopted in accordance with notice-and-comment requirements, then the deferential framework of *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), would not apply in this case. That contention provides no sound basis for this Court's review of the tangential procedural question cross-petitioner raises.

To be sure, this Court has stated that "*Chevron* deference is not warranted where the regulation is 'procedurally defective'—that is, where the agency errs by failing to follow the correct procedures in issuing the regulation." *Encino Motorcars LLC* v. *Navarro*, 136 S. Ct. 2117, 2125 (2016) (citation omitted). But cross-petitioner overstates the significance of that statement here. As we have shown, the agency's interpretation reflects the better reading of the statute, irrespective of deference.

20-1312 Pet. at 19-30. Moreover, if cross-petitioner's assertion of a non-harmless procedural error in the 2004 rule's promulgation were sound, the applicable form of judicial deference would be irrelevant in this case because such an error would render the rule inoperative under 42 U.S.C. 1395hh(a)(4); cf. 5 U.S.C. 706(2)(D).

In any event, even with respect to the application of the *Chevron* framework, it does not follow that this Court must first consider petitioner's procedural challenge in order to decide the statutory merits. Cross-petitioner's argument to the contrary disregards the case's posture. As the case comes to this Court, cross-petitioner's procedural challenge has been squarely rejected, and cross-petitioner has not shown that the court of appeals' context-specific application of settled administrative-law principles itself warrants review. Absent any independent justification for this Court to take up that ancillary issue, the appropriate course for this Court is to take the court of appeals' determination on that question as given.

This Court's decision in *Entergy* is illustrative. In that case, this Court granted review to resolve a substantive statutory question: whether a provision of the Clean Water Act, 33 U.S.C. 1326(b), authorized the Environmental Protection Agency (EPA) "to use cost-benefit analysis in determining the content of regulations promulgated under" that provision. 556 U.S. at 212. Writing for the Court, Justice Scalia upheld the agency's interpretation that use of cost-benefit analysis was authorized, determining that it embodied a "permissibl[e]" interpretation of the statute. *Id.* at 226; see *id.* at 218-226. In doing so, the Court stated that the Court "of course express[ed] no view on the remaining bases for the Second Circuit's remand which did not depend on the permissibility of cost-benefit analysis." *Id.* at 226. And the Court noted that it was unnecessary to

address a contention that the agency had provided an "inadequate explanation of [a] change in its" policy concerning the relative extent of costs and benefits. *Id.* at 226 n.8. The Court explained that the putative procedural deficiency in the agency's explanation of that policy concerning the relative extent of costs and benefits "c[ould] have no bearing upon whether the EPA can use cost-benefit analysis, which [wa]s the only question presented." *Ibid.*; see *ibid.* (finding the alleged deficiency unpersuasive in any event). So too here, there is neither any need nor any sound reason for this Court to address cross-petitioner's procedural challenge in order to resolve the statutory merits. Further review of that challenge to the 2004 rule is unwarranted.

CONCLUSION

The conditional cross-petition for a writ of certiorari should be denied.

Respectfully submitted.

ELIZABETH B. PRELOGAR
Acting Solicitor General
BRIAN M. BOYNTON
Acting Assistant Attorney General
MARK B. STERN
STEPHANIE R. MARCUS
Attorneys

MAY 2021