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,

Cross-Respondent.

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

REPLY BRIEF FOR CROSS-PETITIONER

Anne M. Voigts
KING & SPALDING LLP
601 S. California Ave.
Suite 100
Palo Alto, CA 94304
(650) 422-6700
avoigts@kslaw.com

Daniel J. Hettich
Counsel of Record
KING & SPALDING LLP
1700 Pennsylvania Ave. NW
Washington, DC 20006
(202) 626-9128
dhettich@kslaw.com

Counsel for Cross-Petitioner

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REPLY BRIEF

HHS wants this Court to decide whether its final rule was "permissibl[e]" (HHS-Pet.*i*) without considering the fundamental procedural flaws that gave rise to it. But the reasonableness of HHS's choice cannot be divorced from the underlying process by which HHS made that choice. For the reasons set forth in Empire Health's brief in opposition, the Court should deny HHS's petition. But if the Court agrees to decide the validity of the rule, it should consider all the relevant arguments and not artificially limit that inquiry at the outset.

HHS's argument that its procedural missteps are not independently certworthy is a red herring. Empire Health's cross-petition is conditional. HHS's petition asks the Court to decide not whether the statute compels HHS's reading—a position that not even HHS itself took during the rulemaking—but whether HHS's reading is "permissibl[e]." HHS's problematic rulemaking is part and parcel of how HHS came to make the choice reflected in its final rule, so the questions conditionally presented by Empire Health would help the Court decide the question presented by HHS.

HHS does not dispute it affirmatively and repeatedly claimed its existing policy was the opposite of what it actually was, falsely said its proposal changed its policy rather than continued the status quo, and failed to correct these misstatements until mere days before the final comment period closed. As a result, commenters content with the status quo were misled into supporting a change to a complex regulatory system that apparently not even HHS

understood. Nearly all the comments HHS received were based on HHS's erroneous explanation of how DSH payments were calculated at the time, and HHS explicitly relied upon those flawed comments in "decid[ing]" to adopt its policy here. 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004).

The reasonableness of a rule depends in part on the reasonableness of the process by which it was promulgated. Because there was no meaningful opportunity to comment on HHS's actual proposal, HHS was deprived of the informed input rulemaking is supposed to provide. As programmers put it: garbage in, garbage out. This Court should not consider whether HHS's choice was permissible while ignoring the flawed process that led to it.

In sum, none of the reasons HHS advances warrant granting HHS's petition and denying Empire Health's cross-petition. The petitions should rise—or, more accurately, fall—together.

ARGUMENT

Empire Health's and HHS's Petitions Are Intertwined

1. HHS acknowledges, as it must, that it incorrectly described what its existing practice was and how it proposed to change it. But HHS contends those procedural flaws are irrelevant to the rule's substantive reasonableness. That might be true if the statute dictated HHS's rule, but it doesn't. (In fact, it compels the contrary conclusion, as the Ninth Circuit correctly held.) HHS explicitly acknowledged during rulemaking that its policy was *not* required by statute, 68 Fed. Reg. 27,154, 27,208 (May 19, 2003)

(recognizing "other plausible interpretations" besides including exhausted days in the Medicare fraction); 69 Fed. Reg. at 49,099 (stating "we have decided" to adopt the current policy), and HHS does not contend otherwise in its petition. HHS Pet.16, 27 (contending only that HHS's policy is "the best construction of the statutory text"); HHS-BIO 28 (same). Instead, HHS asks this Court to determine whether the rule represents a "permissibl[e]" or "reasonable" interpretation of the statute. HHS-Pet.*i*, 27. In other words, although HHS thought it had a choice in promulgating the rule, it wants to foreclose any consideration of how it made that choice.

At this stage, the Court shouldn't assume the statute compels HHS's chosen policy. And in considering whether the rule is reasonable, it would be important to consider how HHS arrived at it. *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 52 (1983).

HHS's position that the substantive reasonableness of the rule is divorced from the procedural mess that led to it is tantamount to saying that HHS would have reached the same result no matter what commenters said. That position is wrong as a matter of law: the law requires agencies to carefully consider comments and presumes that they in fact do so. *See infra* at 8-9. It is also contrary to HHS's own statements here, which explicitly acknowledged its policy choice was based on the comments it had received. *E.g.,* 69 Fed. Reg. at 49,098-99 (crediting two points made opposing HHS's alleged "change" in policy and concluding that "*[f]or these reasons*, we have decided not to finalize our

proposal … to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction" (emphasis added)). Because the comments submitted were based on HHS's error and HHS made its choice based on those comments, the reasonableness of *how* HHS arrived at its rule cannot be separated from its substantive reasonableness.

2. Virtually all the comments HHS received were flawed because they were based on the false premise HHS advanced that DSH calculations at the time included exhausted benefit days in the Medicare fraction. *All* twenty-three comment letters cited by HHS in its brief in opposition believed this misstatement. HHS-BIO 11 *e.g.,* ER 142-143 (Federation of American Hospitals noting its understanding that "CMS has included Exhausted Days in the Medicare fraction for years"). Contrary to HHS's suggestion, HHS-BIO 13, that mistake infected even the comments dated after HHS corrected its error on its website. Eleven of the sixteen comment letters HHS cites could not have taken into account HHS's belated correction because they were near-copies of the American Hospital Association's comment letter submitted before the correction. *Compare* ER 122 (AHA's letter) *with* ER 69-70, 79, 81, 87-88, 90, 96-97, 99-100, 110-111, 113, 115, 118-119.)[1]

[1] The fact that all twenty-three comments cited by HHS labored under that same false premise shows that HHS's last-minute website posting failed to "ensure that commenters were not under … a misimpression [regarding HHS's current policy]." HHS-BIO 25. That's clearly relevant in assessing HHS's determination that it was "unnecessary to commence a further

HHS's mistake warped the resulting comments. All twenty-three comments cited by HHS expressed, in one way or another, a desire to maintain the status quo. The Healthcare Association of New York State, for example, "urge[d] … CMS *not* [to] change the rules for counting dual-eligible days." ER 131 (emphasis added). All commenters also raised a concern that HHS's alleged policy "change" could lead to decreased DSH payments. 69 Fed. Reg. at 49,098 (acknowledging "[n]umerous commenters" "objected that [HHS's] proposal would result in a reduction of DSH payments").

None of the commenters realized, however, that HHS's proposal *was* the status quo, not a change to it as HHS repeatedly contended.[2] These commenters, therefore, wrote in favor of *including* exhausted benefit days in the Medicare fraction because HHS had told them that was the status quo. In short, hospitals that wrote in favor of the status quo ended up inadvertently supporting a radical change to it. *See* App.66a (district court noting it wasn't clear "[w]hich policy [the commenters were] advocating, the policy that the Secretary actually maintained at the

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round of notice-and-comment rulemaking … in these circumstances." HHS-BIO 15; *Envtl. Integrity Project v. EPA*, 425 F.3d 992, 998 (D.C. Cir. 2005) ("If the APA's notice requirements mean anything, they require that a reasonable commenter must be able to trust an agency's representations….").

[2] Because HHS's proposal was, in reality, a proposal to *continue* the status quo, it simply isn't true that "HHS's 2003 proposed rule made clear that it was contemplating a change." HHS-BIO 27.

time or the policy that the Secretary inaccurately stated that it maintained").

3. HHS suggests its error was not a "failure to disclose underlying data" and thus was inconsequential. HHS-BIO 27. Not so. HHS affirmatively misstated one of the only data points hospitals had to assess HHS's proposal—namely, the policy current DSH payments were based upon. As a result, hospitals couldn't accurately assess the financial impact of the proposed change. ER 133 (commenter cited by HHS stating that "[s]ince we are not aware of the extent of Part A exhausted days included in the SSI fraction, we cannot accurately assess the financial impact"); ER 83 (commenter cited by HHS expressing concern about lack of "estimate[s] as to the financial impact of this change on aggregate Medicare payments"); *see also* Merriam-Webster.com (2021) (defining "data" as "factual information (such as measurements or statistics) used as a basis for reasoning, discussion, or calculation").

If HHS had correctly stated the policy upon which DSH payments were calculated, the comments would have been quite different. ER 75 (commenter stating its original comments took HHS's misstatement at "face value"). For example, all the commenters that were happy with the status quo and their current DSH payments would have supported *excluding* exhausted benefit days from the Medicare fraction, not including them. Some commenters likely would have raised the very arguments Empire Health made that because many more patients are Medicaid-eligible than SSI-entitled (in part because of HHS's extraordinarily narrow definition of SSI entitlement, Cross-Pet.5, 11),

any change could decrease DSH payments for the significant majority of hospitals—the opposite of what Congress intended and what those hospitals would want.

HHS's failure to provide such an opportunity to meaningfully comment is itself sufficient grounds to find HHS's rule impermissible. *Auto. Parts & Accessories Ass'n v. Boyd,* 407 F.2d 330, 343 (D.C. Cir. 1968) (noting agency's obligation to ensure "that the disappointed have had the opportunity … to try to make their views prevail"); *see also Nat. Res. Def. Council v. EPA*, 279 F.3d 1180, 1188 (9th Cir. 2002) (holding issues raised were "precisely the type of comments that should have been directed in the first instance to the EPA, but which understandably were not because of the inadequate notice").

4. The fact that comments would have differed significantly had HHS provided accurate information goes to the heart of the substantive reasonableness of HHS's rule because HHS explicitly linked its rejection of its proposal to exclude exhausted benefit days from the Medicare fraction to the comments it received. 69 Fed. Reg. at 49,099. Since the agency relied on comments it solicited based on a false premise, HHS could very well have been swayed by comments based on the truth.

By arguing that the rule's reasonableness is *not* intertwined with how it was adopted, HHS is essentially arguing that it wouldn't have mattered what comments it received. But "[a]n agency *must consider* ... significant comments received during the period for public comment." *Perez v. Mortg. Bankers Ass'n,* 575 U.S. 92, 96 (2015) (emphasis added); *Pikes*

Peak Broad. Co. v. FCC, 422 F.2d 671, 682 (D.C. Cir. 1969) (ensuring agency gave comments a "hard look").

There's good reason for that requirement. As this Court recently explained in another DSH case arising from the same final rule, *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1816 (2019), notice-and-comment rulemaking provides "affected parties fair warning of potential changes in the law and an opportunity to be heard on those changes," thus giving "the agency a chance to avoid errors and make a more informed decision." *Id.* That is "especially valuable when it comes to a program [like Medicare] 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." *Id.* The foundational procedural errors here thwarted these important benefits. *Mobile Comm'ns Corp. of Am. v. FCC,* 77 F.3d 1399, 1407 (D.C. Cir. 1996) (agency had not engaged in "reasoned decision-making" when it "lulled [commenters] into a false sense of security" before it "reversed itself at the eleventh hour" and thereby failed to give an interested party the opportunity to provide—or the agency to consider—certain arguments).

In determining whether a policy is the result of reasoned decision-making process, courts consider whether the agency publicly responded to major criticisms in comments, *e.g., Prometheus Radio Project v. FCC*, 373 F.3d 372, 412 (3d Cir. 2004), *as amended* (June 3, 2016), seriously considered policy alternatives, *State Farm*, 463 U.S. at 48, and gave "consideration of the relevant factors," *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416

(1971). But, without a proper understanding of the policy underlying current payments, commenters could not do any of those things. If HHS did not understand what it was doing in administering a complex and arcane system, how could commenters be expected to figure it out? This is "[w]hat happens [when] we reach the point where even these legislating agencies don't know what their own 'law' is." *Caring Hearts Pers. Home Servs., Inc. v. Burwell*, 824 F.3d 968, 969-70 (10th Cir. 2016) (Gorsuch, J.).[3]

The rulemaking process is also relevant to whether HHS considered the factors Congress intended it to. *State Farm*, 463 U.S. at 42-43. HHS acknowledges Congress meant the DSH adjustment to provide "higher reimbursement" to "hospitals with an unusually high percentage of low-income patients." HHS-Pet.3-4 (quoting *Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 150 (2013)). Yet in its rulemaking, HHS made no attempt to discern what effect its new policy would have on payments for hospitals that treat a disproportionate share of low-income patients (other than stating the truism that an individual hospital may be better or worse off depending on its circumstances). 69 Fed. Reg. at 49,099; *see* ER 133 (commenter expressing concern about lack of any economic impact assessment); ER 83 (same).

5. The problems with HHS's rulemaking are also relevant to whether HHS's rule is a valid "logical

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[3] For this reason, HHS's reliance on *Entergy Corp. v. Riverkeeper, Inc.*, 556 U.S. 208, 218 & n.4 (2009), is misplaced. There, unlike here, "EPA's explanation was ample," *id.* at 226 n.8, and there was no argument that any inadequate notice reflected the agency's misunderstanding of its own current policy.

outgrowth" of its proposal. HHS, like the Ninth Circuit, relies on *Long Island Care at Home, Ltd. v. Coke,* 551 U.S. 158 (2007), in contending that it is. HHS-BIO 23-24. *Long Island* might be apropos if Empire Health were merely complaining that, faced with a binary choice, HHS adopted the opposite of its proposal. But that doesn't begin to capture this rulemaking's problems. HHS advanced a false premise in its proposed rule that commenters then relied on, resulting in comments that treated down as up and up as down. No change in policy could be a logical outgrowth of such a fundamentally illogical process.[4]

Additionally, unlike *Long Island*, HHS's proposed change was (unbeknownst to HHS) actually a proposal to continue its current policy, which HHS then

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[4] Even if *Long Island* were dispositive on the logical outgrowth question, it would still say nothing about whether an agency's solicitation of comments based on an affirmative misstatement may violate the APA by independently depriving parties of a meaningful opportunity to comment. The argument that if a rule satisfies the logical-outgrowth doctrine, all manner of other procedural sins are pardoned also conflicts with Congress's rejection in the Medicare context of the "harmless error" rule that applies to APA rulemaking violations generally. *Compare* 42 U.S.C. § 1395hh(4) *with* 5 U.S.C. § 706.

Separately, HHS argues that any finding of procedural error would shortcut review for substantive reasonableness because 42 U.S.C. § 1395hh(4) would simply make any procedurally flawed rule inoperative. *Id.* But § 1395hh(4) focuses on logical outgrowth violations while review under *State Farm* is far broader. (HHS erroneously claims that "cross-petitioner does not invoke Section 1395hh." HHS-BIO 21. In fact, Empire Health cited this provision, albeit in its uncodified form. Cross-Pet.20 (citing "Section 1871(a)(2), (b)(1) of the Medicare Act").

repudiated in its final rule. That puts this case on all fours with *Allina Health Servs. v. Sebelius,* 746 F.3d 1102, 1111 (D.C. Cir. 2014), which invalidated another DSH policy arising out of the same 2005 final rule because it was not a logical outgrowth of HHS's proposed rule.

HHS claims this case is different from *Allina,* HHS-BIO 26, but doesn't respond to Empire Health's showing that, *but for HHS's misstatement*, this case would be exactly the same. Cross-Pet.28-29. As in *Allina*, HHS's proposal was (albeit unbeknownst to HHS) a proposal to *continue* its current policy. And as in *Allina*, HHS ultimately did the opposite, radically changing the status quo. Allowing HHS's misstatement of its own policy to insulate HHS from the same result as *Allina* would create perverse rulemaking incentives indeed.

CONCLUSION

If, as the Ninth Circuit held, the statute at issue here compels Empire Health's reading, then how HHS arrived at its contrary reading does not matter. As Empire Health explained in its brief in opposition to HHS's petition, the Ninth Circuit was correct and its decision does not warrant this Court's review. But if the Court grants review to decide, as HHS requests, whether HHS made a "permissibl[e]" choice, then the Court should grant Empire Health's cross-petition so it can decide the procedural questions that are intertwined with whether HHS's choice was in fact permissible. To do otherwise would be to decide the rule's reasonableness in a vacuum, ignoring why and how HHS made the choice it seeks to defend.

This Court, therefore, should grant this conditional cross-petition if it grants HHS's petition for certiorari.

Respectfully submitted,

Anne M. Voigts
KING & SPALDING LLP
601 S. California Ave.
Suite 100
Palo Alto, CA 94304
(650) 422-6700
avoigts@kslaw.com

Daniel J. Hettich
Counsel of Record
KING & SPALDING LLP
1700 Pennsylvania Ave. NW
Washington, DC 20006
(202) 626-9128
dhettich@kslaw.com

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