No. ________

In The
Supreme Court of the United States

UNITY HEALTHCARE,

Petitioner,

v.

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

Respondent.

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

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PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

This case presents the following question: whether federal courts must defer to an agency's reasonable interpretation of its own regulations (commonly referred to as "*Auer* deference"[1]), as the Court of Appeals did here with respect to a claim by Unity HealthCare, a rural, non-profit acute care hospital, for a "volume decrease adjustment" provided for under the Medicare statute, 42 U.S.C. § 1395ww(d)(5)(D)(ii), and regulations promulgated by the Secretary of Health & Human Services, 42 C.F.R. § 412.92(e)(3).

In *Kisor v. Wilkie*, No. 18-15, 588 U.S. ___ (June 26, 2019), the Court declined to overrule *Auer* and *Seminole Rock*, but effectively limited their application by specifying the circumstances under which *Auer* deference continues to be applicable. As discussed below, under the Court's prior rulings and longstanding practices, the Court should grant Petitioner's writ of certiorari, vacate the decision of the United States Court of Appeals for the Eighth Circuit, and remand the matter to that court for consideration in light of *Kisor.*

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[1] *Auer v. Robbins*, 519 U.S. 452, 461 (1997). *See also Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 413-14 (1945).

PARTIES TO THE PROCEEDING

The parties to the proceeding in the United States Court of Appeals for the Eighth Circuit, whose judgment is sought to be reviewed, were:

Unity HealthCare;

St. Anthony Regional Hospital;

Lakes Regional Healthcare; and

Alex M. Azar, II, Secretary, U.S. Department of Health and Human Services.

Although the Medicare payment claims of each of the three non-government entities referenced above were addressed by the Eighth Circuit as part of a single decision, each entity was a party to a separately docketed case that was consolidated with the other two cases for purposes of argument and issuance of a single decision.[2] St. Anthony Regional Hospital and Lakes Regional Healthcare have not petitioned this Court for a writ of certiorari.

[2] *Unity HealthCare v. Alex M. Azar, II, Sec'y, U.S. Dept. of Health & Human Servs.*, No. 18-1316; *St. Anthony Reg'l Hosp. v. Alex M. Azar, II, Sec'y, U.S. Dept. of Health & Human Servs.*, No. 18-1703*; Lakes Reg'l Healthcare v. Alex M. Azar, II, Sec'y, U.S. Dept. of Health & Human Servs.*, No. 18-1704.

RULE 29.6 DISCLOSURE STATEMENT

Unity HealthCare, the Petitioner in this matter, is an Iowa nonprofit corporation.

The parent corporation of Unity HealthCare is Trinity Regional Health System.

Trinity Regional Health System is a subsidiary of Iowa Health System, d/b/a UnityPoint Health.

There is no publicly held company owning 10% or more of any stock in Unity HealthCare.

PROCEEDINGS DIRECTLY RELATED TO THIS CASE

- *Unity HealthCare v. BlueCross BlueShield Ass'n/Wis. Physician Servs.*, No. 2014-D15, Provider Reimbursement Review Board. Decision and order on July 10, 2014.
- *Unity HealthCare v. BlueCross BlueShield Ass'n/Wis. Physician Servs.*, No. 2014-D15, CMS Administrator. Decision and order on Sept. 4, 2014.
- *Unity HealthCare v. Hargan*, No. 3:14-cv-00121-HCA, U.S. District Court for the Southern District of Iowa. Judgment entered Jan. 31, 2018.
- *Unity HealthCare v. Azar*, No. 18-1316, U.S. Court of Appeals for the Eighth Circuit. Judgment entered Mar. 12, 2019.

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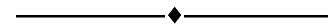
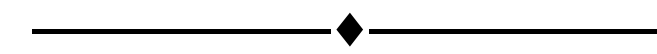
PETITION FOR WRIT OF CERTIORARI

The undersigned counsel, on behalf of Unity HealthCare ("Hospital"), respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.



OPINIONS BELOW

The opinion of the court of appeals (Petitioner's Appendix ("App.") 1-16) is reported at 918 F.3d 571. The opinion of the district court (App. 17-46) is reported at 289 F. Supp. 3d 985. The decision of the Administrator of the Centers for Medicare & Medicaid Services (App. 47-60) is reported at 2014 WL 5450066 (H.C.F.A. Sept. 4, 2014). The decision of the Provider Reimbursement Review Board (App. 61-99) is reported at 2014 WL 11127861 (PRRB July 10, 2014).



JURISDICTION

The judgment of the court of appeals was entered on March 12, 2019. On June 4, 2019, Petitioner's application to extend the time to file a Writ of Petition for Certiorari was granted by Justice Gorsuch, who extended the time to file such a petition until July 10, 2019. *See Unity HealthCare v. Azar*, No. 18A1260 (May 31, 2019). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant statutory and regulatory provisions involved in the case are:

42 U.S.C. § 1395ww(a)(4);

42 U.S.C. § 1395ww(d)(1)(A);

42 U.S.C. § 1395ww(d)(5)(D)(ii);

42 C.F.R. § 412.92(e); and

Center for Medicare and Medicaid Services, Provider Reimbursement Manual § 2810.1.

The pertinent text of these provisions are reproduced in the appendix to this petition. App. 100-108.

STATEMENT

1. This case concerns the deference to which an interpretation of a regulation by the Secretary of the Department of Health and Human Services ("Secretary") is entitled. The issue arises in the context of the Secretary's interpretation of regulations promulgated to implement the volume decrease adjustment ("VDA") provided for in the Medicare statute.

a. Title XVIII of the Social Security Act established the Medicare program as a system of health insurance for the aged and disabled (the "Medicare Program"). 42 U.S.C. § 1395 et seq. The Secretary has delegated authority to administer the Medicare

Program to the Centers for Medicare & Medicaid Services ("CMS"), which reimburses qualifying health care providers for the costs of services incurred in furnishing health care to Medicare patients. 42 U.S.C. § 1395g. CMS contracts with Medicare Administrative Contractors ("MACs") to administer Medicare payment functions. 42 U.S.C. § 1395h(a). Wisconsin Physician Services was the MAC assigned to Hospital during the relevant time period.

b. As originally established, the Medicare Program reimbursed hospital providers for services furnished to Medicare beneficiaries based on the "reasonable costs" that the hospital actually incurred treating such individuals. 42 U.S.C. §§ 1395f(b)(1), 1395x(v). In 1983, in an effort to create incentives for more efficient delivery of health care, Congress amended the Medicare statutory provisions to reimburse operating costs of inpatient hospital services on a prospective basis rather than on the basis of reasonable costs that had been incurred. Social Security Amendments of 1983, Pub. L. No. 98-21 tit. VI, 97 Stat. 65, 149-72.

c. Under the resulting inpatient prospective payment system ("PPS"), hospitals are paid a predetermined, fixed amount based on the particular diagnosis-related group ("DRG") assigned to each inpatient treated by the hospital. 42 U.S.C. § 1395ww(d)(1)(A). App. 100. DRG payment amounts are set to approximate the average inpatient operating cost of caring for a patient with a given diagnosis in a cost-effective hospital, including costs that are fixed, semi-fixed, and

variable in nature. 42 U.S.C. § 1395ww(a)(4), (d)(1)(A) (App. 100); Hospital Inpatient Prospective Payment Systems ("PPS") for Acute Care Hospitals, Fiscal Year 2018, 82 Fed. Reg. 37,990, 38,180 (Aug. 14, 2017). Thus, a hospital caring for Medicare beneficiaries receives a predetermined reimbursement amount for each inpatient, regardless of the hospital's actual costs of caring for that patient. However, payments under the Medicare prospective payment system are subject to certain adjustments, including the VDA, that may result in additional payments to qualifying hospitals.

d. When Congress created PPS, it required the Secretary to accommodate the special needs of certain rural, low-volume providers that experience periods of significant and uncontrollable declines in inpatient volume through a VDA. *See* 42 U.S.C. § 1395ww(d)(5)(D)(ii). App. 101. In doing so, Congress sought to account for the harsh financial consequences faced in such circumstances by rural hospitals that are highly dependent on Medicare patient populations and are, in many cases, the sole sources of health care services in their communities. Congress provided that such hospitals that satisfied specified conditions would receive a VDA payment in addition to the PPS payment during a period of unexpected inpatient decline. *See* H.R. REP. 98-25(I), 141, H.R. REP. 98-25, 141 (1983) *reprinted in* 1983 U.S.C.C.A.N. 141, 360. The statute provided for a VDA payment because such a hospital that received a DRG payment for each Medicare beneficiary who received inpatient care would not recover its fixed costs if the number of inpatient cases was less than

anticipated. Hospitals eligible for a VDA include "sole community hospitals," such as Hospital. *See* 42 U.S.C. § 1395ww(d)(5)(D)(ii). App. 101.

i. The VDA statutory provision states as follows:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the [PPS] payment amounts . . . as may be necessary to *fully compensate the hospital for the fixed costs* it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

Id. (emphasis added). *See generally*, Hospital Inpatient PPS, FY 2018, 82 Fed. Reg. at 38,179.

ii. To implement the statute, the Secretary adopted a regulation ("VDA Regulation") applicable to certain sole community hospitals, which regulation, during the Medicare fiscal year in issue, stated in relevant part:

> (e) *Additional payments to sole community hospitals experiencing a significant volume decrease. . . .*
>
> (3) The [MAC] determines a lump sum adjustment amount not to exceed the difference

> between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs. . . .
>
> (i) In determining the adjustment amount, the [MAC] considers –
>
> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and. . . .

42 C.F.R. § 412.92(e) (2004, 2005). App. 102-103.

iii. The VDA Regulation provides for a two-part determination of the VDA. The first part – which may be referred to as the "payment adjustment" – is a determination of a lump sum amount that reflects (1) the "individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies" and (2) "[t]he hospital's fixed (and semi-fixed) costs," other than any costs that continue to be paid on a reasonable cost basis. The second part – which may be referred to as the "ceiling" – is a computation of "the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient

operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs. . . .” The VDA Regulation provides that the VDA payment adjustment is “not to exceed” the results of application of the ceiling formula. *Id.*

iv. CMS has interpreted the VDA Regulation in chapter 28 of the Medicare Provider Reimbursement Manual (the “PRM” or “Manual”). The Manual is the Secretary’s primary source of sub-regulatory guidance on Medicare costs and payments directed to providers. *See Shalala v. Guernsey Mem’l Hosp.*, 514 U.S. 87, 101 (1995) (PRM provision was interpretive rule issued by agency to advise public of agency’s construction of statute and regulations). The Manual requires that the decrease in volume must be “due to circumstances beyond [the hospital’s] control.” PRM § 2810.1. App. 104. The Manual further instructs the MAC to apply the following guidelines and definitions to evaluate the factors specified in the VDA Regulation:

> Additional payment is made to an eligible [sole community hospital] for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital’s Medicare inpatient operating cost and the hospital’s total DRG revenue.
>
> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a

> reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.
>
> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semifixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.
>
> In evaluating semifixed costs, the [MAC] considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment.
>
> The [VDA] adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The [MAC] reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

PRM § 2810.1.B. App. 104-105.

v. The Manual requires the VDA to be calculated under the assumption that a sole community hospital has "budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." PRM § 2810.1.D. App. 106. Accordingly, the VDA adjustment allows additional reimbursement up to the "prior year's total Program Inpatient Operating Cost" multiplied by the PPS update factor. *Id.* The Manual includes the following example of the proper way to calculate a VDA payment, reflecting the excess of Medicare program operating costs over DRG payments:

> Hospital C has justified an adjustment to its DRG payment for FYE September 30, 1987. The adjustment is calculated as follows: . . .
>
> | | | |
> |---|---|---|
> | FY 1986 Program Operating Cost | | $2,900,000 |
> | PPS Update Factor | x | 1.0115 |
> | FY 1987 Maximum Allowable Cost | | $2,933,350 |
>
> | | | |
> |---|---|---|
> | . . . FY 1987 Program Inpatient Operating Cost | | $2,800,000 |
> | FY 1987 DRG Payment | – | $2,500,000 |
> | FY 1987 Payment Adjustment | | $ 300,000 |
>
> Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost and FY 1987 DRG payments.

PRM § 2810.1.D. (Example A) (footnotes omitted). App. 107.

2. The Medicare statute and regulations specify the manner in which Medicare payment determinations are made and procedures for challenging such determinations. Each hospital participating in the Medicare Program must file a cost report with its MAC at the conclusion of its fiscal year, detailing costs incurred, reporting relevant statistics, and calculating its Medicare Program payment and any applicable adjustments. *See* 42 C.F.R. §§ 413.20(b), 413.24(f). The MAC audits the cost report and determines the total Medicare reimbursement due to the hospital for that fiscal year, including any VDA allowed. *See* 42 U.S.C. § 1395oo(a)(1)(A)(i); 42 C.F.R. § 405.1803(a). If a hospital is dissatisfied with the MAC's determination of total payments due the hospital, it may appeal the MAC's determination to the Provider Reimbursement Review Board ("PRRB"). 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835. The PRRB is an expert panel of Medicare reimbursement adjudicators, which functions as an administrative tribunal appointed by the Secretary to adjudicate Medicare payment disputes between hospitals (and other health care providers) and their MACs. 42 U.S.C. § 1395oo(h). The PRRB conducts hearings and issues written decisions based on the evidence presented. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1871. A PRRB decision is final unless the Secretary, acting through the Administrator of CMS ("CMS Administrator"), timely reverses, affirms, or modifies the PRRB decision. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1875. Hospitals are entitled to judicial review of any final agency decision, including that of the CMS

Administrator. 42 U.S.C. § 1395oo(f); 42 C.F.R. § 405.1877.

3. In this matter, Hospital is a rural non-profit acute care hospital located in Muscatine, Iowa. App. 50, 68-69. At all times relevant to this case, Hospital has qualified and been reimbursed by CMS as a sole community hospital. App. 50, 68-69. In fiscal year ("FY") 2006, as a result of external circumstances beyond its control, Hospital suffered a decline in inpatient cases that exceeded 16 percent from the prior fiscal year. App. 50, 68-69.

a. Hospital requested a VDA adjustment in the amount of $741,308 for its FY 2006, which amount had been computed in accordance with the Manual instructions and sample calculations. App. 96. *See* PRM § 2810.1.D. App. 107-108. Hospital computed the requested adjustment as follows:

FY 2005 Program Operating Cost	$ 6,74,575
PPS Update Factor	x 103.7%
FY 2006 Maximum Allowable Cost	$ 6,963,014
FY 2006 Program Inpatient Operating Costs	$ 5,698,829
FY 2006 DRG Payments	- $ 4,957,521
FY 2006 Payment Adjustment	$ 741,308

App. 26, 96. Hospital: (a) determined the *lesser* of its updated FY 2005 operating costs ($6,963,014) and its FY 2006 operating costs ($5,698,829), which was $5,698,829; and (b) from that amount subtracted its Medicare DRG payments for inpatient hospital care ($4,957,521), which resulted in a VDA allowance of

$741,308. *See* App. 26, 96. The amount claimed reflected the shortfall in Medicare payments received compared to actual costs incurred in providing inpatient hospital care to Medicare beneficiaries.

b. As reflected in a notice to Hospital dated July 22, 2009, the MAC reduced Hospital's VDA claim significantly. App. 69. The MAC determined that certain costs were neither fixed nor semi-fixed, but were "variable" costs that should be eliminated from the VDA calculation. App. 26-27, 50, 69, 89. These costs included Hospital's expenses for (i) billable medical supplies; (ii) billable drugs and intravenous solutions; (iii) professional services and supplies obtained from outside providers for physical therapy, reference laboratory, blood bank and radiology; and (iv) dietary and linen. App. 26-27, 50, 69, 89. The MAC subtracted these costs from the FY 2006 Program Inpatient Operating Costs, as follows:

FY 2006 Program Inpatient Operating Costs	$ 5,698,829
Less Variable Costs for FY 2006	- $ 664,994
FY 2006 Fixed/Semifixed Costs	$ 5,033,835

App. 27, 58, 60, 97-98. In doing so, the MAC employed a VDA calculation methodology that was contrary to that set forth in the Medicare regulations and Manual, comparing the DRG payments that Hospital received for all of its inpatient operating costs with only the amount of such operating costs that were fixed or semi-fixed costs. Specifically, rather than basing the calculation on all Medicare inpatient operating costs (which

were $5,698,829), the MAC's calculation reflected only those costs that it had determined were fixed or semi-fixed costs ($5,033,835). App. 58, 97-98. The MAC's comparison of DRG payments received for all inpatient operating costs (fixed, semi-fixed and variable) to only fixed and semi-fixed costs created a mismatch of costs and revenues skewing the computation. The MAC calculated the VDA adjustment based on the difference between Hospital's fixed and semi-fixed costs and the total DRG payments that Hospital received as follows:

FY 2006 Fixed/Semi-fixed Costs		$ 5,033,835
Less FY 2006 DRG Payments	-	$ 4,957,521
VDA Payment		$ 76,314

App. 58, 97-98. Thus, the MAC's calculation of the VDA was:

VDA = Fixed/Semi-Fixed Costs – Total DRG payments.

c. Hospital timely filed an appeal with the PRRB on January 14, 2010, which was within 180 days of receipt of the relevant determination made by the MAC, pursuant to 42 C.F.R. § 405.1835. App. 69. Hospital asserted that the MAC's reclassification of certain costs as "variable," which costs were eliminated from the VDA calculation, was erroneous because these costs were either fixed or semi-fixed. App. 70-76. Hospital also asserted that in reducing FY 2006 operating costs by those costs which the MAC considered variable costs, the MAC had incorrectly calculated the VDA allowance. App. 73-74. The PRRB convened a

hearing, heard the testimony of witnesses, and received other evidence submitted by each party, after which it entered a decision. In a decision dated July 10, 2014, the PRRB found that the MAC had properly classified certain disputed costs as variable costs. App. 82-89, 98. It determined, however, that the MAC had incorrectly calculated the VDA (App. 97-98) and "should have applied the formula in the [Manual] that the low volume adjustment payment is fixed costs not to exceed the ceiling stated in 42 C.F.R. § 412.92(e)(3), *i.e.*, 'the difference between the hospital's inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs.'" App. 98. This calculation would be:

A. Fixed Costs = $5,033,835

B. Ceiling = Lower of FY 2005 Total Costs with update factor or FY 2006 Total Costs ($5,698,829) – DRG Revenues ($4,957,521) = $741,308

C. VDA = Lower of Fixed Costs (A) or Ceiling (B) = $741,308

App. 96. The PRRB ruled that, notwithstanding elimination of variable costs, Hospital should have received a VDA of $741,308, as it had claimed, because Hospital's fixed costs, as determined by the MAC, exceeded the $741,308 ceiling. App. 59, 96, 98.

d. In a decision dated September 4, 2014, the CMS Administrator upheld the PRRB's determination that the MAC had properly identified variable cost. App. 51, 56-57. The CMS Administrator did not

provide any substantive analysis of specific costs that the MAC had determined were variable. Evidence that certain costs were semi-fixed costs was disregarded without discussion. The CMS Administrator also ruled that the MAC had properly calculated the VDA allowance and that the PRRB should not have modified that determination. App. 51, 57-60. In doing so, the CMS Administrator failed to give effect to the plain meaning of the regulations that required DRG payments to be subtracted from total inpatient operating costs and instead subtracted DRG payments (reflecting all of Hospital's inpatient operating costs) only from its fixed costs. The CMS Administrator's decision reduced Hospital's VDA claim from $741,308 to $76,314. App. 50, 58.

e. Pursuant to 42 U.S.C. § 1395oo(f), Hospital sought review of the Secretary's determination in the United States District Court for the Southern District of Iowa, by filing a complaint with that court on October 30, 2014. In a decision dated January 30, 2018, the court (Chief U.S. Magistrate Judge Helen C. Adams) upheld the CMS Administrator's determination, finding that the MAC's methodology of computing the VDA, which method had been adopted by the CMS Administrator, was not arbitrary, capricious or contrary to applicable law, and that her classification of certain costs as variable costs, and the resulting exclusion of those costs from the calculation, was also not arbitrary, capricious or contrary to applicable law, or unsupported by substantial evidence. App. 17-46. Hospital sought appellate review of the district court's decision

pursuant to 28 U.S.C. § 1291 by filing a notice of appeal with the district court on February 9, 2018.

f. In a decision dated March 12, 2019 (judgment entered that same day), the United States Court of Appeals for the Eighth Circuit affirmed the decision of the district court. App. 1-16. In doing so, the court, without express discussion, rejected Hospital's contention that the agency's statutory and regulatory interpretations were not entitled to deference.

i. In reviewing the CMS Administrator's statutory interpretation, the appellate court stated that the statutory requirement that a hospital be "fully compensated" for its fixed costs did not provide the agency with a formula or method for determining what amounted to full compensation. App. 11. The court concluded that given the lack of statutory guidance and the substantial deference that it afforded to the agency, the CMS Administrator's decision reasonably complied with the requirement to provide full compensation. App. 12. According to the court, the CMS Administrator's statutory interpretation under which Hospital was fully compensated for its fixed costs through a combination of DRG payments and the VDA was reasonable. App. 11. The court found that the agency's prospective adoption of a new interpretation subsequent to the fiscal year in issue was not a sufficient basis to conclude that the prior interpretation was arbitrary or capricious or unreasonable. App. 12.

ii. In reviewing the agency's interpretation of the VDA Regulation, the court stated that it was

required to uphold such an interpretation unless it was plainly erroneous or inconsistent with the regulation. App. 13. According to the court, "at first glance," the interpretation, which ensured that the VDA "will not 'exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs,'" was "clearly consistent" with the regulation's text. App. 13 (citations omitted). The court rejected Hospital's reliance on calculations included in the Manual, stating they were meant to display the VDA ceiling rather than its total amount. App. 13-14. The court concluded that the CMS Administrator's interpretation was not arbitrary or capricious and was consistent with the regulation. App. 14-15. In doing so, the court noted that the Manual contained interpretative rules, and that an agency could change its interpretation of a regulation "if the revised interpretation is consistent with the underlying regulations," as in this case. App. 15, n.4. (quotations omitted).

iii. Finally, the court found reasonable the agency's decision to classify certain costs as variable costs, which costs were excluded from the VDA calculation, and that the variable cost determination was neither arbitrary nor capricious. App. 15-16. Accordingly, the appellate court affirmed the decision of the district court which had upheld the agency's administrative decision.

REASONS FOR GRANTING THE WRIT

1. As reflected above, in reviewing the agency's determination in this matter, the appellate court limited its examination of the agency's regulatory interpretation to whether it was plainly erroneous or inconsistent with the regulation. It did so based on this Court's decisions in *Auer v. Robbins*, 519 U.S. 452 (1997) and *Bowles v. Seminole Rock and Sand Co.*, 325 U.S. 410 (1945). There has been, however, a significant intervening development since that time. Application of *Auer* deference to an agency's interpretation of its own regulations was addressed recently by the Court in *Kisor v. Wilkie*, No. 18-15, 588 U.S. ___ (June 26, 2019), which specifies the circumstances under which an administrative agency's regulatory interpretation is entitled to *Auer* deference. This Court stated that *Auer* deference to an agency's regulatory interpretation applies only when the regulation is genuinely ambiguous. Slip op. at 13. The Court further stated that even then, *Auer* deference is not applicable unless the interpretation is "reasonable," reflects the agency's "authoritative" or "official position," implicates the agency's substantive expertise, and reflects the agency's "fair and considered judgment." Slip op. at 13-17 (quotations omitted). According to the Court, *Auer* deference would not apply when these requirements were not satisfied or when "a new interpretation . . . creates 'unfair surprise' to regulated parties,"

which "may occur when an agency substitutes one view of a rule for another." *Id.* at 18 (quotation omitted).[1]

2. For the reasons discussed below, it would be appropriate for this Court to grant certiorari in this case, vacate the opinion of the Eighth Circuit, and remand ("GVR") the case to the Eighth Circuit for further consideration in light of *Kisor*. This Court has stated that a GVR order is potentially appropriate "[w]here intervening developments . . . reveal a reasonable probability that the decision below rests upon a premise that the lower court would reject if given the opportunity for further consideration, and where it appears that such a redetermination may determine the ultimate outcome of the litigation." *Lawrence v. Chater*, 516 U.S. 163, 167 (1996) (per curiam). The Court has recognized that, under this approach, a GVR "can improve the fairness and accuracy of judicial outcomes while at the same time serving as a cautious and deferential alternative to summary reversal in cases whose precedential significance does not merit [the Court's] plenary review." *Id*. at 168; *see also Thomas v. Am. Home Prods., Inc.*, 519 U.S. 913, 915 (1996) (Scalia,

[1] Prior to *Kisor*, Hospital's position, as reflected in its application to extend the time to file a Writ of Petition for Certiorari, was that *Auer* and *Seminole Rock* should be overruled because they permit the agency to issue regulatory interpretations which under *Auer* deference are effectively binding without compliance with Administrative Procedure Act ("APA") notice and comment requirements, 5 U.S.C. § 553; they undermine judicial review provided under the APA, 5 U.S.C. § 706; and they do not reflect any provision of a statute or the Constitution.

J., concurring) (Court has never applied considerations governing review on certiorari to GVR practice, including routine issuance of GVR orders for cases not of general importance beyond the interest of the particular parties). This Court may issue a GVR order when subsequent authority is "sufficiently analogous and, perhaps, decisive to compel re-examination of the case," *Henry v. City of Rock Hill*, 376 U.S. 776, 777 (1964), or where that authority creates a "'reasonable probability' that the Court of Appeals would reject a legal premise on which it relied and which may affect the outcome of the litigation." *Tyler v. Cain*, 533 U.S. 656, 666 n.6 (2001) (quoting *Lawrence*, 516 U.S. at 167). In *Lawrence*, the Court indicated that "we may GVR" a case in light of a change in an agency's interpretation of a statute which "is reasonably probably entitled to deference and potentially determinative." 516 U.S. at 172. In this matter, while the agency's regulatory interpretation has not changed, as part of an intervening legal authority, *Kisor*, the Court has changed the standard of deference under which such an interpretation is judicially reviewed.

3. The standards that have been identified by the Court for a GVR order are satisfied in this case. There is a "reasonable probability" that the decision below rests on a premise that the appellate court would reject in light of *Kisor*. Although the Eighth Circuit did not cite *Auer* in its opinion, when it ruled it referred to *St. Luke's Methodist Hospital v. Thompson*, 315 F.3d 984 (8th Cir. 2003). *St. Luke's Methodist Hospital* relied on *Seminole Rock* and *Auer* in requiring an agency's

regulatory interpretation to be upheld unless it was "plainly erroneous or inconsistent with the regulation." 315 F.3d at 987 (quoting *Seminole Rock*, 325 U.S. at 414, and citing *Auer*, 519 U.S. at 461). In accordance with *Auer*, the Eighth Circuit limited its examination of the agency's regulatory interpretation to whether it was plainly erroneous or inconsistent with the regulation. App. 13-15. The court stated that when an issue was not controlled by the plain language of a regulation, "we must uphold an agency's interpretation of its own regulation unless that interpretation is plainly erroneous or inconsistent with the regulation." App. 13 (quoting *St. Luke's Methodist Hospital*, 315 F.3d at 987). The court concluded that the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation." App. 14-15. Therefore, it is beyond a reasonable probability that the Eighth Circuit's decision reflected application of *Auer* deference.

4. Given this Court's decision in *Kisor*, there is a reasonable probability that the Eighth Circuit would abandon *Auer* deference to the agency's regulatory interpretation in this case if it was provided with an opportunity to reconsider the issue because (a) the regulation at issue is unambiguous and (b) the CMS Administrator's regulatory interpretation reflects a new policy that was an abrupt reversal from longstanding agency policy.

a. The CMS Administrator's regulatory interpretation to which the Eighth Circuit deferred was contrary to the plain terms of the VDA Regulation. The VDA Regulation unambiguously requires a

computation of the "difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs." 42 C.F.R. § 412.92(e)(3). App. 102. The MAC computed the VDA payments to which Hospital was entitled on a different basis. The MAC subtracted Hospital's total DRG payments from only those hospital Medicare inpatient operating costs that were fixed or semi-fixed costs, a formula characterized by the PRRB as a "modified ceiling calculation." App. 97; *see also* App. 58. Thus, it computed the difference between the Hospital's fixed and semi-fixed costs and its total DRG revenue. The CMS Administrator adopted this computation as part of the agency's final administrative decision.[2] App. 58.

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[2] It appears that in subtracting fixed and semi-fixed Medicare inpatient operating costs from Hospital's DRG payments, the CMS Administrator revised the regulatory formula included in the ceiling provision of the VDA Regulation and then adopted the new formula as part of the regulation's payment adjustment provision. The result, however, was use of a formula that had not been used previously by the agency. Additionally, as discussed below, the CMS Administrator's revised formula did not give consideration to Hospital's needs and circumstances, including the cost of maintaining necessary core staff and services and other factors required to be considered by the payment adjustment provision of the VDA Regulation.

As the result of a subsequent regulatory amendment, for fiscal years beginning on or after October 1, 2017, the VDA adjustment is based on the difference between the hospital's fixed Medicare inpatient operating costs and an amount reflecting an estimate of Medicare DRG payments related to fixed costs. *See* Hospital Inpatient PPS, FY 2018, 82 Fed. Reg. at 38,180-181, 38,511. Application of the formula will determine the VDA adjustment. There will not be a separate ceiling. *Id.* at 38,182, 38,511.

b. Additionally, the CMS Administrator's regulatory interpretation would not receive *Auer* deference because it was a new interpretation that was contrary to the prior longstanding agency interpretation. *See Kisor*, slip op. at 18. The new regulatory interpretation – providing for use of a formula in which DRG payments were compared to fixed and semi-fixed costs – had not been previously included in the Federal Register, Manual, or other interpretive guidance of the agency. Indeed, the MAC, whose computation was adopted by the CMS Administrator, acknowledged that it had never previously removed variable costs from the VDA calculation, and that there was no change in regulations, Manual provisions, or other CMS instructions that permitted it to do so. App. 30, 39. Prior to that, the agency, acting through CMS or Medicare contractors, consistently required the VDA to be calculated based on total inpatient operating costs. In several notices included in the Federal Register, the agency reiterated that, subject to adjustments for excess staff, VDA adjustments were based on the hospital's "costs," making no distinction between fixed and variable costs. Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates, 71 Fed. Reg. 47,870, 48,056 (Aug. 18, 2006); Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, 73 Fed. Reg. 48,433, 48,631 (Aug. 19, 2008). In correspondence dated 2004, two years before the relevant fiscal year, CMS agreed with a hospital that its Medicare contractor had acted improperly when it removed variable costs from total

program inpatient operating cost before calculating the VDA. App. 37, 39.

Similarly, the Manual in place during the time in question stated that the VDA payment "is made to an eligible [sole community hospital] for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue." PRM § 2810.1.B. App. 104. The Manual made it clear that a hospital requesting a VDA "must demonstrate that the *Total Program Inpatient Operating Cost*, excluding pass-through costs, exceeds DRG payments, including outlier payments." (emphasis added). PRM § 2810.C.4. App. 106. According to the Manual, "[n]o adjustment is allowed if DRG payments exceeded *program inpatient operating cost*," which include fixed costs, semi-fixed costs, and variable costs (emphasis added). *Id.* As part of examples it indicated that so long as the current year's operating costs are less than the prior year's costs adjusted by the PPS update factor, the VDA adjustment was the difference between the current fiscal year's operating costs and the current year's DRG payments. PRM § 2810.1.D. App. 107-108. There is no suggestion in any of these agency regulatory interpretations that the relationship of DRG payments to those particular Medicare program inpatient operating costs that are fixed or semi-fixed has ever been considered a valid basis for determining a VDA allowance. As stated by the district court, the agency

"did not change the regulations, but only the interpretation of the existing regulations." App. 41. Accordingly, it is plain that the VDA computation methodology used by the CMS Administrator in this matter reflected a new interpretation of the VDA Regulation that was contrary to the agency's previous regulatory interpretations.[3]

5. There is a reasonable probability that review of the agency's regulatory interpretation in this matter, without the limitation of *Auer* deference, would require a result that is different from that previously reached by the Eighth Circuit.

a. As demonstrated previously, the CMS Administrator's regulatory interpretation is contrary to the plain terms of the regulation and the agency's longstanding interpretation and application of the regulation. Absent *Auer* deference, the appellate court would not have upheld an interpretation of a regulation that clearly states that the calculation is to be based on a comparison of DRG payments with "Medicare inpatient operating costs" to be based on a comparison of DRG payments with "fixed and semifixed costs" only.

b. Likewise, the CMS Administrator incorrectly reduced the Hospital VDA claim based on its determination regarding Hospital's variable costs. Even

[3] As part of a 2017 rulemaking (*see* n.2), the Secretary indicated that the approach used by the CMS Administrator in this case reflected its "current" policy. Hospital Inpatient PPS, FY 2018, 82 Fed Reg. at 38,180.

if she were correct that the costs at issue were variable costs, she should not have reduced the Hospital's VDR claim because, as reflected in the decision of the PRRB, the Hospital's fixed costs were in excess of the VDA ceiling which reflected the amount that had been claimed by Hospital. App. 96, 98. Variable costs should not be excluded from the formula in the VDR Regulation contrary to its express terms, which is precisely what the MAC and CMS Administrator did. Additionally, the CMS Administrator's decision includes no suggestion that either the MAC or CMS Administrator considered the Hospital's particular needs and circumstances, including its "reasonable cost of maintaining necessary core staff and services," and "minimum staffing requirements imposed by State agencies," as required under agency regulations. *See* 42 C.F.R. § 412.92(e)(3)(i)(A). App. 102-103. Similarly, the CMS Administrator failed to consider particular semi-fixed costs on a case-by-case basis, as required. *See* Updating Factors for Transition Prospective Payment Rates, 48 Fed. Reg. 39,746, 39,781-82 (Sept. 1, 1983); PRM § 2180.1.B. App. 105. The MAC's reliance on "commonsense assumption[s]" (App. 31) did not satisfy these regulatory requirements.

c. For the reasons discussed above, in the absence of *Auer* deference, the CMS Administrator's determination requires reversal.

CONCLUSION

As discussed above, there is a reasonable probability that the Eighth Circuit's decision in this case reflected application of *Auer* deference to the agency's interpretation of the VDA Regulation; that, as a result of this Court's recent decision in *Kisor*, the appellate court would not apply such deference to the agency's regulatory interpretation if it had the opportunity to reconsider the case; and, absent *Auer* deference, the court would find that the agency interpreted its regulation incorrectly. This would result in a different determination than that which the court reached previously.

Therefore, Unity HealthCare respectfully submits that this Court should grant certiorari, vacate the opinion of the United States Court of Appeals for the Eighth Circuit, and remand the case to that court for further consideration in light of *Kisor*.

Dated: July 10, 2019 Respectfully submitted,

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