No. 20-1312

In the
Supreme Court of the United States

Xavier Becerra, Secretary of
Health and Human Services,
Petitioner,
v.
Empire Health Foundation,
for Valley Hospital Medical Center,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF CERTAIN HOSPITALS AND HOSPITAL SYSTEMS AS *AMICUS CURIAE* IN SUPPORT OF THE RESPONDENT, EMPIRE HEALTH FOUNDATION

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INTEREST OF *AMICI CURIAE* [1]

Amicus Curiae are hospitals and hospital systems consisting of the following: Baptist Memorial Health Care Corporation, which offers care for patients at 22 hospitals in the Mid-South; Community Health Systems, which affiliates own, operate or lease 84 hospitals in 16 states with approximately 13,000 licensed beds; Lakeland Regional Health System, which provides care at more than 10 locations in over 30 specialties in Central Florida; Med Center Health, a not-for-profit health system with hospitals and facilities throughout Kentucky, and a combined 454 acute care beds and 110 extended care beds; Medical University of South Carolina, South Carolina's only comprehensive academic health science center; Penn State Health, a multi-hospital health system serving patients and communities across central Pennsylvania; Piedmont Healthcare Piedmont, a not-for-profit, community health system comprised of 16 hospitals, over 2,700 medical staff personnel and more than 22,000 employees; Prime Healthcare, which operates 45 acute care hospitals in 14 states and over 300 outpatient locations; and Saint Luke's

[1] Counsel for all parties have consented to the filing of this brief. In accordance with Rule 37.6, *Amici* confirm that no party or counsel for any party authored this brief in whole or in part, and that no person other than *amici* or their counsel made any monetary contribution intended to fund the preparation or submission of this brief.

Health System, which includes 16 hospitals and campuses across the Kansas City region, home care and hospice, behavioral health care, dozens of physician practices, a life care senior living community, and more. They respectfully submit this brief as *amici curiae* in support of Respondent Empire Health Foundation.

Amici hospitals and hospital systems ("*Amici*") are directly and adversely affected by the HHS policy change to the Medicare's "Disproportionate Share Hospital" ("DSH") program that is at issue in this case. *Amici* submit this brief because hospitals and hospital system members provide a substantial amount of hospital care to low-income patients, the DSH program is of tremendous importance to those hospitals and the low income patients they serve, and HHS's actions have hamstrung that important program.

The importance of the Medicare DSH program to hospitals and their patients cannot be overstated. Many hospitals that serve low-income communities are struggling to survive—and indeed, hundreds have either closed in the past decade or are at risk of closing.[2] Losses in government funding, including

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[2] According to Becker's Hospital Review, 130 rural hospitals closed between 2010 and June of 2020. *See* Ayla Ellison, *State-by-state breakdown of 130 rural hospital closures*, Becker's Hospital R. (June 8, 2020), available at https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-130-rural-hospital-closures.html (last visited Oct. 18, 2021). *See also* Michael Ollove, *Rural and Safety Net Hospitals Prepare for Cut in Federal Support*, Pew Trusts, available at https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/

DSH funding, could force these hospitals to cut off services or close altogether. When hospitals such as these close, it can have disastrous consequences, cutting off low-income Americans' access to emergency and primary care, eliminating much-needed jobs, and contributing to long-term health crises. Because these hospitals rely on DSH funding, changes to the program—including to its adjustment formula—can have considerable impact on their ability to continue to function and provide essential care to indigent patients.

INTRODUCTION

For the reasons stated in the Brief of the Respondent, the Ninth Circuit was correct to find that the plain language of the Medicare statute dictates that only hospital days paid by Medicare Part A belong in the Medicare fraction of the DSH calculation. However, should the Court disagree that the plain language of the statute requires this result, it should afford no deference to HHS's regulation. As Respondent correctly contends, deference to an agency is not appropriate where, as here, the agency habitually flouts the intent of Congress in administering a program that has been entrusted to said agency. *See* Brief of Respondent at 23-28. The rationale behind deference is that an agency can be

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2019/10/31/rural-and-safety-net-hospitals-prepare-for-cut-in-federal-support (last visited October 18, 2021) ("At least 118 rural hospitals have closed since 2010, and a number of safety net hospitals also have shuttered or merged with for-profit health systems").

expected to possess a special expertise in matters related to its enabling statute and insight as to Congress's intent with respect to that statute. Implicit in the grant of deference is that the agency is obligated to use its expertise and insight to implement *Congress's* intent, and not to further its own agenda or to simply resist making expenditures because it does not believe in the worth of the program that Congress has created.

The overarching intent of Congress in establishing the DSH program is to ensure that safety net hospitals are adequately compensated for caring for America's most poor. But rather than seeking to further Congress's intent, HHS has undermined those goals at every turn.

The Institute of Medicine has defined "safety net hospitals" as "those that deliver a significant level of health care . . . to uninsured, Medicaid, and other vulnerable patients.'"[3] DSH hospitals, including some of Amici, are commonly understood as safety net hospitals. Safety net hospitals struggle to survive, operating at negative margins or at the thinnest of positive margins. They are doubly disadvantaged in that their patients are sicker and cost more to treat than patients at other hospitals, but because a significant portion of their patients are Medicaid eligible or uninsured, safety net hospitals cannot use the generally higher payments associated with other

[3] America's Health Care Safety Net: Intact But Endangered, Institute of Medicine, Washington, DC: National Academies Press; 2000.

payors to offset their losses from the treatment of indigent patients.[4]

Safety net hospitals comprise one-quarter of all hospitals, but accounted for one-third of all inpatient stays in 2014, and for nearly one-half of stays that were paid by Medicaid or were uninsured that same year.[5] Forty-three percent of all inpatient hospital stays for mental health occurred at safety net hospitals in 2014.[6] Families living in markets of urban safety net hospitals typically have lower incomes and are more likely to be living at or below the federal poverty level than those living in the markets of other urban hospitals. Urban safety net hospitals are dependent on Medicare DSH payments and on state and local government subsidies to remain afloat.[7]

These safety net hospitals, despite being so desperately needed, face challenging financial situations which would become dire without the proper DSH payments. Safety net hospitals and those

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[4] Comparison of Change in Quality of Care Between Safety-Net and Non–Safety-Net Hospitals, Rachel M. Werner, MD, PhD, L. Elizabeth Goldman, MD, MCR, R. Adams Dudley, MD, at 2185, JAMA, May 14, 2008—Vol 299, No. 18.

[5] Characteristics of Safety-Net Hospitals, 2014, Agency for Health Care Research and Quality (2016).

[6] *Id*.

[7] Population Characteristics of Markets of Safety-Net and Non-Safety-Net Hospitals, Darrell J. Gaskin, PhD, and Jack Hadley, PhD, Journal of Urban Health: Bulletin of the New York Academy of Medicine, Volume 76, Number 3, September 1999.

which rely on DSH payments have about half the net patient revenue per adjusted patient day as non-DSH hospitals achieve.[8] As a result, "the mean operating margin for members of a safety-net hospital organization was 1.6% compared with 7.8% for all hospitals nationwide."[9] But without the DSH payments at issue here, the mean operating margin for these safety net hospitals could drop to *negative* three percent. These already low margins—and potentially negative ones—leave safety net hospitals with "less financial cushion to weather sustained financial pressure,"[10] which in turn leaves the patients they serve in peril. And *all* hospitals, regardless of their financial circumstances, that participate in the DSH program and treat the indigent deserve to have HHS implement the

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[8] Lisa M. Knowlton, *et al.*, *Financial Stability of Level I Trauma Centers Within Safety-Net Hospitals*, Am. Col. of Surgeons (Aug. 2, 2018), available at https://www.journalacs.org/article/S1072-7515(18)30272-2/fulltext) (last visited October 22, 2021)

[9] Heather E. Hsu, *et al.*, *Association Between Federal Value-Based Incentive Programs and Health Care-Associated Infection Rates in Safety-Net and Non-Safety-Net* Hospitals, JAMA (Jul. 8, 2020) available at https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2767991 (last visited October 22, 2021).

[10] Kristin L Reiter, *et al.*, *Facing the Recession: How Did Safety-Net Hospitals Fare Financially Compared with Their Peers?,* Health Servs. Research (Dec. 2014), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4254123/ (last visited October 22, 2021).

program consistent with the spirit of Congress's intent and with the language of the statute.

SUMMARY OF ARGUMENT

Amici submit that the Court should not grant any deference to HHS in this case for two reasons. First, HHS has shown a longstanding and continuing hostility toward implementing Congress's intent in providing for DSH payments that serve indigent patients. Courts have often found that HHS has disregarded the plain language of its statute or regulations, and HHS has taken other actions to discourage or prevent hospitals from being able to make claims or pursue appeals for DSH payments. When faced with policy choices, HHS has consistently followed the path of least reimbursement to hospitals. Second, HHS did not adequately explain its policy choice in the FY 2005 final rule at issue in this case, did not demonstrate that it considered the impact of its policy choice, and indeed, appears not to have understood the impact.

ARGUMENT

I. HHS Has Shown Consistent Disregard for the Intent of Congress When Making DSH Policy and Therefore Has Forfeited any Right to Deference in This Case

When Congress ended the reasonable cost reimbursement system for hospitals and replaced it with a prospective payment system, it did so with the understanding that a one-size-fits-all prospectively determined rate would not compensate fairly those

hospitals that treat a significant number of low-income patients. Congress's efforts to include a separate DSH payment within the Inpatient Prospective Payment System, and HHS's reluctance or refusal to implement such a payment mechanism, is covered in detail in the Brief of the Respondent at 7-9 and is not repeated here.

Following the 1986 DSH legislation, HHS has pursued an unwavering approach to construing the DSH provisions in ways that lead to less reimbursement for hospitals. HHS has disregarded the plain language of the statute or regulations to diminish these reimbursements. A prime example is HHS's unsuccessful attempt to equate "eligible for [Medicaid]" with "entitled to [Medicaid]" before four Circuit Courts of Appeals in the *Jewish Hospital* line of cases, which cases are covered in detail throughout the Brief of the Respondent. Other courts have had to correct HHS's misreading of both the statute and its own regulations, HHS has impeded hospitals' efforts to receive appropriate DSH payments, it has improperly attempted to make its policies retroactive, and it has unfairly limited hospitals' appeal rights. This broad design of agency non-compliance is important to understanding why HHS should not be given deference in this case.

A. Courts Have Often Found that HHS Disregards the Plain Language of the DSH Statute or Its Own Regulations

HHS has fared poorly in DSH litigation on a variety of issues. The typical scenario throughout this

litigation is: (1) HHS's fiscal intermediary denies reimbursement; (2) the Provider Reimbursement Review Board (Board) reverses the intermediary's adjustment as being contrary to the clear language of the statute or regulations; (3) the CMS Administrator on behalf of HHS reverses the Board by relying on conditions or criteria that do not appear in the statute or regulations; (4) the hospital appeals and HHS makes a pitch for deference; and (5) the courts reverse the CMS Administrator's decision based on the clear language of the statute or regulations. Some of these decisions are quite critical of HHS's unwillingness or inability to implement the statute properly.

For example, in *Alhambra Hospital v. Thompson*, 259 F.3d 1071, 1072 (9th Cir. 2001), the court opened its opinion with "[w]e are again confronted with the failure of [HHS] to implement properly the 'disproportionate share' provision of the Medicare statute" (citation omitted).[11]

In a "waiver days" case,[12] the court described the case before it as "the latest in a series of cases in

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[11] In *Alhambra,* the court found that HHS's policy of excluding days from the hospital's DSH calculation because they were in "subacute units" (e.g., skilled nursing units) despite the fact that the units were not excluded from the IPPS, was contrary to the plain meaning of the regulations.

[12] In addition to requiring that days for which an individual is eligible for Medicaid be counted in the numerator of the Medicaid fraction, the statute also permits HHS to include "patient days of patients not so eligible but who are regarded as such because they receive benefits under a [Medicaid]

which the Secretary has refused to implement the DSH provision in conformity with the intent behind the statute." *Portland Adventist Medical Center v. Thompson*, 399 F.3d 1091, 1099 (9th Cir. 2005).

In another waiver days case, the Fifth Circuit found that HHS "flouted the law's plain language." *Forrest Gen. Hosp. v. Azar*, 926 F.3d 221, 222 (5th Cir. 2019). The Court of Appeals refused to give deference to either HHS's interpretation of the statute or the regulation: "Generalist judges are not policy experts. That said, interpreting the laws under which Americans live is a quintessentially judicial function. And when legal texts are unambiguous, as these are, courts should stand firm and decide, not tiptoe lightly and defer." 926 F.3d at 234.

In still another waiver days case, *HealthAlliance Hospitals, Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018), the court had these pointed remarks for HHS:

> HHS has distorted these Federal Register statements in much the same manner as the text of the regulation at issue; it finds significance in various words plucked from their context, when none actually suggests in the slightest that the Secretary must affirmatively state that patients are authorized to receive inpatient hospital services under

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demonstration project approved under title XI." 42 U.S.C. § 1395ww(d)(1)(F)(vi)(II).

> the demonstration project when the waiver is approved in order for those patients to be deemed eligible for Medicaid for the purpose of computing the Medicare DSH adjustment.
>
> In short, HHS's interpretation is out of sync with both the overall statutory Medicaid scheme and the structure of the Code of Federal Regulations, and thus this Court owes it no deference. *See . . . Christensen v. Harris Cnty.*, 529 U.S. 576, 588 . . . (2000) ("To defer to the agency's position would be to permit the agency, under the guise of interpreting a regulation, to create *de facto* a new regulation.").

346 F. Supp. 3d at 59-60 (citation and parallel citation omitted). *See also Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir. 2020), *affirming Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32 (D.D.C. 2019). The district court rejected HHS's "contortions" and "post-hoc lawyering" and ruled the regulation was clear on its face. 389 F. Supp. 3d at 40.

Other examples include:

- *Clark Regional Medical Center v. United States HHS,* 314 F.3d 241 (6th Cir. 2002), in which the court held that the plain meaning of the regulation permits

counting swing and observation beds[13] toward the total bed count of the hospital;[14]

- *HealthAlliance Hospitals, Inc. v. Burwell*, 130 F. Supp. 3d 277, 291 (D.D.C. 2015) (HHS's decision not to count beds licensed for inpatient care but used for observation care was inconsistent with the plain meaning of the regulation); and

- *Highland Med. Ctr. v. Leavitt*, Civil Action No. 5:06-CV-082-C ECF, 2007 U.S. Dist. LEXIS 97504, *13 (N.D. Tex. May 9, 2007) (HHS's decision on countable beds ignored the plain meaning of the regulation).

B. HHS has Unfairly Impeded Hospitals' Efforts to Obtain the Necessary Data to Obtain DSH Payments

[13] A hospital that is a "swing-bed" facility may use a designated number of acute care beds to provide post-hospital skilled nursing facility care on a temporary basis. Observation beds are acute care beds for patient "observation" to determine whether a patient should be admitted to the hospital. *Clark Regional Medical Center*, 314 F.3d at 242.

[14] Total bed count can be important for DSH hospitals, because, depending on the number of beds a hospital has, the disproportionate patient percentage needed for DSH payments can be higher or lower. *See* 42 U.S.C. § 1395ww(d)(5)(F)(v).

HHS acquiesced in the *Jewish Hospital* cases that held that Medicaid does not have to pay for hospital stay days in order for those days of Medicaid-eligible individuals to be counted in the Medicaid fraction. Yet hospitals are still faced with the burden of proving that a patient was in fact Medicaid eligible. Because of the inherently retroactive nature of Medicaid eligibility,[15] hospitals will not know at the time they file their cost reports the full extent to which their patients are Medicaid-eligible. Hospitals must obtain Medicaid eligibility data from States, but HHS does not require the States to have a timely and accurate Medicaid eligibility process. Some States do not match individuals to their eligibility records based on a single unique identifier, such as a Social Security Number (SSN). For example, such a State may match based on *both* name and SSN. If a hospital submits a matching request for John Adams with the correct SSN, but the State's records show John Q. Adams associated with that SSN, the State will return the request as a non-match. HHS is quite aware of the problem with not matching on the basis of a single unique identifier, and was forced to correct this deficiency with respect to matching its Medicare entitlement information with the Social Security Administration's SSI records. *See Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). Yet HHS has not issued any regulation nor otherwise taken

[15] For example, a hospital patient may be awarded SSI, and thus Medicaid, on the basis of a successful disability appeal that is decided well after the patient is discharged).

any action to compel States to match on the basis of a single identifier. As a result, one of the most common, if not the most common, issues appealed to the Board is Medicaid eligible days.

Moreover, it was not until 2000, 14 years after the DSH program began, that hospitals had access to SSI entitlement information for their patients. That year, HHS permitted hospitals that have a DSH issue pending before the Board to request and receive SSI data by entering into a data use agreement with HHS. *See* 65 Fed. Reg. 50,548 (Aug. 18, 2000). *See also Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1106 (D.C. Cir. 2014) ("since the disproportionate share percentage was calculated by fiscal intermediaries (insurance companies) using privacy protected patient data, the hospitals were unable to confirm that reimbursement rates were correct"). Once hospitals were able to compare the list of individuals HHS said were entitled to SSI (and for which months) with the hospitals' records, they were able to determine that there were significant problems with the matching process between SSA and HHS. The result was the *Baystate* decision and the wholesale overhaul of the matching process in response thereto. *See* 75 *Fed. Reg*. 50,276-284. For years, hospitals were unable to prove the full extent to which HHS was underpaying them because they did not have access to SSI data from the Government. The total costs to these hospitals as a result of this lack of access are unknown to *Amici*, but are likely substantial.

C. HHS Has Attempted to Make Its DSH Policies Retroactive in Order to Deny DSH Payments to Hospitals with Open Appeals

In *Northeast Hospital Corporation v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011), the D.C. Circuit held that HHS's attempt to change its policy retroactively and place Part C days (days that belong to Medicare+Choice or Medicare Advantage enrollees) in the Medicare Fraction ran afoul of the well-established rule that an agency may not promulgate a retroactive rule absent express congressional authorization.

Following its defeat in *Baystate* and its need to recalculate hospitals' Medicare fractions using a more accurate SSI match process, HHS issued CMS Ruling 1498-R.[16] This Ruling, in addition to correcting the errors identified in *Baystate*, purported to strip the Board of jurisdiction for pending DSH appeals related to certain DSH issues, including exhausted days, and forced the Board to remand those appeals to the fiscal intermediaries. The Ruling specifically required the fiscal intermediaries to apply retroactively the FY 2005 final rule at issue in this case which, as Respondent explained at length (Brief of Respondent at 15-16, 50-51) systematically reduces DSH payments. After *Catholic Health Initiatives v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013) rejected HHS's

[16] Available at https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms1498r.pdf.

claim that the statute requires exhausted days to be counted in the Medicare fraction, HHS issued an amended Ruling rescinding the mandatory retroactive application of its FY 2005 final rule. *See* CMS Ruling 1498R2.[17]

Most recently, after this Court held that HHS's attempt to change its prior practice of excluding Part C days from the Medicare fraction required notice and comment rulemaking in *Azar v. Allina Health Services*, 139 S. Ct. 1804, 1812 (2019) (*Allina II*), HHS responded by publishing a proposed rule. 85 *Fed. Reg*. 47,723 (Aug. 6, 2020). That rule would retroactively place Part C days in the Medicare fraction for discharges prior to October 1, 2013, instead of following established law and the status quo ante, in which only "covered" Part A days were counted in the Medicare fraction. Despite having limited authority to engage in retroactive rulemaking, *see* 42 U.S.C. § 1395hh(e), HHS claims that retroactive rulemaking is required by statute and is in the public interest. 85 *Fed. Reg*. at 47,725. HHS acknowledges that most hospitals would benefit from the opposite rule, i.e., from having Part C days excluded from the Medicare fraction, and that this would result in approximately $600 million for calendar year 2013 alone. The Government initially acknowledged the impact of making a retroactive rule change in its Petition for Writ of Certiorari in *Allina*. *See* Pet. at 23 ("HHS has

[17] Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/CMS-1498-R2.pdf.

informed this Office that the particular issue in this case concerning the proper interpretation of the Medicare-fraction statute alone implicates between $3 and $4 billion in reimbursement for [open appeals for] FY2005 through FY2013."). HHS may have greatly under-estimated the true impact of putting Part C days in the Medicare fraction for the retroactive period.

D. HHS Has Unfairly Limited Hospitals' Appeal Rights

Following the *Baystate* decision, in 2010 HHS issued CMS Ruling 1498-R, which, as mentioned above, forced the Board to divest itself of hundreds of DSH appeals and remand them to fiscal intermediaries for the intermediaries to render new DSH payment calculations. Upon information and belief, some of these appeals are still pending at the fiscal intermediaries more than 11 years after the issuance of the Ruling. Similarly, in August 2020, more than a year following its defeat in the *Allina II* Part C days litigation in this Court, HHS issued the proposed retroactive rule discussed *supra.*

Simultaneous with its proposal to adopt a rule that would retroactively treat Part C days as being "entitled to benefits under Part A," HHS issued a Ruling that again requires the Board to remand appeals to the fiscal intermediaries, this time pending a final rule issued by HHS. *See* CMS Ruling 1739R, available at https://www.cms.gov/regulations-and-guidanceguidancerulingscms-rulings/cms-1739-r. In 2019 HHS moved to have dozens of court cases

involving the Part C days issue consolidated and remanded to CMS in light of this Court's decision in *Allina II.* After the cases were consolidated, the district court eventually remanded the cases. *See In Re Allina II-Type DSH Adjustment Cases, Lead Case: Albert Einstein Healthcare Network, et al., v. Azar,* Misc. Action No. 19-0190 (ABJ) (January 19, 2021).

In sum, more than two years after this Court's decision in *Allina II*, and well more than a year after the proposed rule, hospitals' Part C appeals are back to square one, languishing in bureaucratic limbo and awaiting determinations from their Medicare contractors. When the determinations do come, the contractors will simply apply the same Part C policy hospitals appealed more than a decade ago.

II. HHS's Failure to Explain Its Reasons for Its Change in Policy or Understand the Effect of the Change Disqualifies It from Receiving Deference

In addition to its unflagging hostility to the DSH program as evidenced by the above examples, HHS does not deserve deference because it did not provide an adequate explanation for the FY 2005 change in policy to include exhausted days in the Medicare Fraction. An agency must "offer the rational connection between facts and judgment . . . to pass muster under the arbitrary-and-capricious standard." *Motor Vehicle Mfrs.. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, at 56 (1983). "[A]n agency changing its course must supply a reasoned analysis." *Id.* at 57. "While the agency is entitled to change its

view . . . . it is obligated to explain its reasons for doing so." *Id.* at 56.

The closest HHS gets to an explanation in the FY 2005 Final Rule is to "acknowledge the point raised by [a] commenter that beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits." 69 *Fed. Reg.* at 49,098. HHS also (incorrectly) agreed that including exhausted days in the Medicare fraction "necessarily" has a greater impact on a hospital's DSH patient percentage than including the days in the Medicaid fraction.

But "acknowledging a point" and agreeing about the impact of a policy do not provide the explanation demanded by the Administrative Procedure Act (APA). Those statements by the agency do not "explain its reasons" for the change in policy. *See Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 56. HHS did not explain whether it agreed with the commenter's point that it "acknowledged." HHS also did not explain whether it believed the plain language of "entitled to Medicare Part A benefits" in the statute *required* such days to be placed in the Medicare Fraction, or whether it believed it was *permissible* to place them in the Medicare Fraction. If the latter, HHS did not explain why it came to this conclusion, in a reversal of the longstanding policy. This does not suffice under the APA and *Motor Vehicle Manufacturers Ass'n*. HHS also did not explain to what extent, if any, the supposed impact of putting

the exhausted days in the Medicare fraction was a reason for the change in policy.

This is unsurprising, as HHS apparently did not understand the impact in the first place. HHS said that counting exhausted days in the Medicare fraction has a greater impact on a hospital's DSH patient percentage than including the days in the Medicaid Fraction, and that "[t]his is *necessarily so* because the denominator of the Medicare Fraction (total Medicare inpatient days) is smaller than the denominator of the Medicaid Fraction (total inpatient days)." 69 *Fed. Reg.* at 49,098 (emphasis added). But contrary to HHS's claim, such an impact is *not* necessarily so. If a hospital's exhausted days are associated to a greater extent with dual eligible patients who are *not* entitled to SSI than with those who *are* entitled to SSI, excluding such days from the Medicare fraction and instead including such days in the Medicaid fraction will increase the hospital's DSH patient percentage. In fact, putting exhausted days in the Medicare fraction almost always *decreases* hospitals' DSH patient percentage. *See* Brief of the Respondent at 36-37.

Moreover, HHS either avoided the subject of the likely effect of putting exhausted days in one fraction or the other, or did not understand what was the precise policy at issue. It responded to a commenter, which incorrectly claimed that putting any inpatient day in the Medicaid fraction dilutes a hospital's DSH patient percentage, by saying that it disagreed with the commenter's assertion. It said that

in the case of a dually-eligible beneficiary who has *not* exhausted Medicare Part A inpatient benefits, and is not entitled to SSI benefits, "including such patient days in the Medicare fraction has the result of decreasing the Medicare fraction in the DSH patient percentage." 69 *Fed. Reg*. at 49,098. This comment response is notable for both what it says and does not say. Oddly, the response speaks to *non-exhausted* days of dual-eligibles, which is not what the final rule was supposed to be addressing, and the response indicates that HHS did not know or did not want to say what would be the likely effect of putting exhausted days of dual-eligibles in the Medicare fraction, which *is* what the final rule was supposed to be addressing.

Where an agency makes a "predictive judgment" about the impact of a rulemaking, the role of the Court is to "review the record and the agency's decision to assure that '[the agency] identified all relevant issues . . . and formulated a judgment which rationally accommodates the facts capable of ascertainment.'" *Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 822 (D.C. Cir. 1983). Here, HHS's misguided statements about the impact of the policy in its FY 2005 Final Rule demonstrate it did not "identif[y] all relevant issues" and did not "formulate[] a judgment which rationally accommodates the facts capable of ascertainment," *see id.*, as it failed to appreciate the ascertainable impact of this policy on the DSH patient percentage. HHS's failure to formulate a rational judgment

renders its policy arbitrary and capricious and undeserving of deference.

The Court's admonition in *Motor Vehicle Manufacturers Ass'n* is apposite here:

> There are no findings and no analysis here to justify the choice made, no indication of the basis on which the [agency] exercised its expert discretion. We are not prepared to and the [APA] will not permit us to accept such . . . practice. . . . Expert discretion is the lifeblood of the administrative process, but 'unless we make the requirements for administrative action strict and demanding, *expertise*, the strength of modern government, can become a monster which rules with no practical limits on its discretion.' *New York v. United States*, 342 U.S. 882, 884 (dissenting opinion)" (footnote omitted).

463 U.S. at 48, quoting from *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 167 (1962). A "lack of reasoned explication for a regulation that is inconsistent with the Department's longstanding earlier position results in a rule that cannot carry the force of law, and so the regulation does not receive *Chevron* deference." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2120-21 (2016).

For these reasons, Amici respectfully request that the Court deny deference to HHS in this case.

CONCLUSION

The Court should affirm the Ninth Circuit on the basis that the plain language of the statute is that only days paid by Medicare Part A belong in the Medicare fraction of the DSH calculation. However, should the Court find the statute ambiguous, it should deny any deference to HHS and determine for itself the best reading of the statute.

Respectfully submitted,

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