UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALLINA HEALTH SERVICES, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No.: 14-01415 (RMC)
	)	
SYLVIA M. BURWELL, Secretary, United States Department of Health and Human Services,	)	
	)	
Defendant.	)	
_____	)	

PLAINTIFFS' MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

The plaintiff Hospitals in this case were all plaintiffs in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014). In *Allina*, the D.C. Circuit affirmed this Court's vacatur of a 2004 rule reversing policy on the treatment of part C patients in the Medicare part A disproportionate share hospital ("DSH") calculation. *Id.* at 1111. That vacatur restored the agency's prior rule treating part C days as non-part A days. But just a few weeks after the D.C. Circuit's mandate issued, as though writing on a blank slate, the agency announced without any notice or process that it would again treat part C days as part A days.

And so the Hospitals have been forced to bring this second suit. Whether the agency newly applied the vacated 2004 rule, or re-adopted the same policy from the botched rule, its action is equally invalid. The Secretary may not apply the same policy that she first unsuccessfully attempted to adopt in 2004 without going through notice and comment rulemaking. The Medicare Act and the Administrative Procedure Act ("APA") both flatly bar the agency's latest attempt to reverse course. Moreover, the agency's new and utterly unexplained *ipse dixit* that part C days will henceforth be treated as part A days is wholly arbitrary and inconsistent with congressional intent.

BACKGROUND

A. The Prior *Allina* Litigation

In the first *Allina* case, the D.C. Circuit affirmed this Court's holding that "the Secretary's final [2004] rule was not a logical outgrowth of the proposed rule." 746 F.3d at 1109. With respect to remedy, the D.C. Circuit held that this Court "correctly concluded that vacatur was warranted." *Id* at 1111. The court reversed, however, that part of this Court's remedy that "ordered the Secretary to recalculate the hospitals' reimbursements without using the interpretation set forth in the 2004 Final Rule." *Id*. (internal quotation marks omitted). The

D.C. Circuit held that the "question whether the Secretary could reach the same result" on remand as would have applied under the vacated rule "was not before the district court" and therefore this Court should have simply "remand[ed] after identifying the error." *Id*. The D.C. Circuit's mandate issued on May 28, 2014.

B. The Agency's 2013 Rulemaking on Part C Days

While the *Allina* appeal was pending, the agency engaged in a new rulemaking through which, "in an abundance of caution," it "readopt[ed] the policy of counting the days of patients enrolled in [part C] plans in the Medicare fraction" and excluding them from the Medicaid fraction. 78 Fed. Reg. 50,496, 50,615 (Aug. 19, 2013). That rule became effective prospectively on October 1, 2013. *Id*. at 50,619.

C. The Agency's 2014 Determination Regarding the Treatment of Part C Days in the 2012 Part A/SSI Fractions

On June 13, 2014, after the D.C. Circuit's decision became final, the agency published 2012 part A/SSI fractions with notice that the agency had determined to treat part C days as part A days for purposes of calculating those fractions for every hospital in the country. The agency provided no explanation for this determination, merely stating that the part A/SSI fractions "includ[e] MA [*i.e.*, Medicare Advantage part C] Claims Submissions."[1] The determination is binding on the agency's contractors in making DSH payment determinations. 42 C.F.R. § 412.106(b)(2); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, 24 (D.D.C. 2008).

D. The Medicare Appeals Process

Pursuant to 42 U.S.C. § 1395oo(a)(l)(A)(i), a hospital may appeal to the Secretary's Provider Reimbursement Review Board ("Board") if the hospital is dissatisfied with an

[1]2012 Part A/SSI Fraction Data File. *Available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY-2012-SSI-Ratios-for-web-posting.zip.

intermediary's determination as to the amount of Medicare payment due the hospital for a cost reporting period. Congress recognized, however, that a hospital's right to challenge a Medicare payment policy should not be delayed indefinitely because a Medicare contractor fails timely to issue this determination. Accordingly, pursuant to 42 U.S.C. § 1395oo(a)(1)(B), a hospital may also appeal when its intermediary has failed to issue a final determination for its perfected cost report within 12 months of the date of receipt of the cost report.

A hospital may also obtain expedited judicial review of a legal question when "the Board determines . . . that it is without authority to decide the question." 42 U.S.C. § 1395oo(f)(l); *see also* 42 C.F.R. § 405.1842(a)(1). A hospital may initiate an action for judicial review of that question of law in this Court within 60 days of the Board's determination. *Id*.

FACTS SPECIFIC TO THIS CASE

All nine plaintiff Hospitals in this case were also plaintiffs in *Allina*. After the agency published its determination to treat part C days as part A days for fiscal year 2012, the plaintiff Hospitals notified the Secretary of their view that the determination was impermissible and sought assurances from the Secretary that new 2012 fractions that exclude part C days would be calculated for the plaintiff Hospitals. Request for Expedited Judicial Review, at 10 [AR___]; Gov. Opp. to Mot. for Further Relief, Aug. 4, 2014, No. 10-1463, ECF No. 63, Exhibit B. The Secretary did not agree to issue new fractions for the plaintiff Hospitals. *Id.* [AR___].

The Hospitals filed a motion in the *Allina* case seeking an order enjoining the Secretary from applying the 2004 rule in the calculation of the Hospitals' DSH payments. Pls.' Mot. for Further Relief, July 24, 2014, No. 10-1463, ECF No. 62. Because they have not timely received final payment determinations on their 2012 cost reports, the plaintiff Hospitals also appealed to the Board, pursuant to 42 U.S.C. § 1395oo(a)(1)(B), and requested that the Board grant expedited judicial review over whether Secretary can validly treat part C days as part A days in

their 2012 DSH calculations after the vacatur in *Allina*. Request for Expedited Judicial Review [AR___]. By letter dated August 13, 2014, the Board found jurisdiction over the plaintiff Hospitals' appeals and granted expedited judicial review because it lacked authority to decide the questions of law presented by the Hospitals. Board Decision on Expedited Judicial Review [AR____]. The Hospitals timely filed this suit within 60 days of that determination. 42 U.S.C. § 1395oo(f)(l).

This Court transferred the motion for further relief in the original *Allina* case to this case and converted it to a motion for summary judgment. Minute Order, Sept. 29, 2014. This brief provides additional points and authorities in support of that motion and the relief requested in the Complaint. *See* Compl. ¶¶ 44-53.

STANDARD OF REVIEW

The APA governs this Court's review of the Hospitals' challenge to the Secretary's new determination. 42 U.S.C. § 1395oo(f)(1). The applicable provisions of the APA provide that the "reviewing court shall . . . hold unlawful and set aside agency action . . . found to be . . . (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; . . . (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (D) without observance of procedure required by law; [or] (E) unsupported by substantial evidence[.]" 5 U.S.C. § 706(2). In cases involving review of agency action, this Court's role at summary judgment is to "decid[e], as a matter of law, whether the agency action is supported by the administrative record and otherwise consistent with the APA standard of review." *Sierra Club v. Mainella*, 459 F. Supp. 2d 76, 90 (D.D.C. 2006).

SUMMARY OF ARGUMENT

The D.C. Circuit upheld this Court's *Allina* decision vacating the 2004 rule change on part C days in the DSH calculation. When issuing the 2012 fractions, the Secretary

impermissibly continued to apply the now-vacated rule as if the 2004 rule were still in force and the *Allina* judgment had never been issued. But even if the Secretary did not rely on the vacated rule, her determination would still be invalid for lack of notice and comment.

Under the Medicare Act, the Secretary is not starting from scratch. Because the 2004 final rule failed the logical outgrowth test, the Secretary cannot again apply the revised part C days policy first announced in that rule until the Secretary provides an opportunity for further comment and, thereafter, adopts a new final rule. And regardless of the prior rulemaking attempt, the Medicare Act unambiguously requires notice and comment rulemaking to change the counting of part C days in the DSH calculation, which is indisputably a substantive legal standard governing payment.

The APA also requires notice and comment rulemaking to change the now-reinstated rule. That rule requires the agency to treat part C patients as *not* entitled to benefits under part A for purposes of the DSH calculation unless it is amended or repealed through notice and comment rulemaking. In addition, the law of this Circuit precludes the Secretary from effectively amending the now-restored regulation by altering her longstanding interpretation of it without the required notice and comment.

These procedural infirmities are more than sufficient to invalidate the recent determination to treat part C days as part A days. But that determination is also unreasonable because it is wholly arbitrary and inconsistent with congressional intent. As in the original *Allina* case, the Secretary again failed to explain her 180-degree shift in policy regarding part C days. Indeed, the Secretary said far less here than in the 2004 rule, which this Court has already found too "cursory" to pass muster under the APA. *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 93 (D.D.C. 2012). Moreover, the Secretary's new policy is inconsistent with

congressional intent regarding the Medicare DSH provision, which separately measures care provided to more costly part A patients in order to adjust part A payments. The Secretary's decision to lump the quite different part C population in with Medicare part A patients frustrates this purpose.

ARGUMENT

I. THE SECRETARY MUST UNDERTAKE NOTICE AND COMMENT RULEMAKING TO TREAT PART C DAYS AS PART A DAYS

The D.C. Circuit's mandate upholding this Court's vacatur of the 2004 rule did not wipe the slate clean for the Secretary. Rather, it triggered a provision of the Medicare Act precluding the Secretary from putting the 2004 interpretation into effect without further rulemaking. And it restored the *status quo ante*, which was the agency's treatment of part C days as *not* part A days under the pre-existing regulation. The Medicare Act and the APA prevent the Secretary from altering that status quo without notice and comment. Yet without any notice, opportunity for comment, or explanation, the agency nonetheless determined to treat part C days as part A days for periods before October 1, 2013. That determination either represents the application of the vacated 2004 rule, as the Hospitals argued in their motion, or the independent adoption of the same policy without notice and comment. Regardless, it is impermissible.

A. The Medicare Act Requires the Secretary to Undertake Notice and Comment Rulemaking to Change Its Substantive Standard on Part C Days

In *Allina*, this Court specifically held that the 2004 rule on part C days was not a logical outgrowth of the proposed rule, 904 F. Supp. 2d at 89-92, and the Court of Appeals affirmed that holding, 746 F.3d at 1109. The Medicare Act prescribes the exact action to be taken when a final rule of the Secretary is not the logical outgrowth of a proposed rule: it "*shall* be treated as a proposed regulation and *shall not take effect* until there is the further opportunity for public comment and a publication of the provision again as a final regulation." 42 U.S.C.

§ 1395hh(a)(4) (emphasis added). This is not optional. But in determining that it would treat part C days as part A days when it calculated the 2012 part A/SSI fractions, the Secretary neither provided a further opportunity for public comment nor published the provision "again" as a "final regulation." *Id.*

Instead, as the Hospitals argued in their original motion, *see* Pls.' Mot. Summ. J., Sept. 29, 2014, ECF No. 8, at 7, the agency put the same vacated 2004 rule into effect just weeks after the mandate issued in *Allina*. The agency's June publication was identical in all material respects to the issuance of part A/SSI fractions for prior years when the 2004 rule governed. As in prior years, the agency published a data file on the agency's website listing the part A/SSI fractions for all hospitals nationwide, and at the top of the file the agency simply stated that the calculations "includ[e] MA [*i.e.*, part C] Claims Submissions." *Compare* DSH Adjustment and 2011-2012 File (2012 fractions) ("including MA Claims Submissions"), *with* DSH Adjustment and 2010-2011 File (2011 fractions) (same), *and* DSH Adjustment and 2009-2010 File (2010 fractions) (same).[2] The agency proceeded just as though the *Allina* judgment had never been issued.

Whether it represents the invalid application of the old rule or the putative adoption of a new one, the Secretary's action still must be set aside. The recent re-determination to treat part C days as part A days, just like the determination in the now-vacated rule, is a change in the substantive legal standard governing payment that can only be accomplished through notice and comment rulemaking. The Medicare Act mandates that "[n]o rule, requirement, or other statement of policy … that . . . changes a substantive legal standard governing … the payment for services … shall take effect unless it is promulgated by the Secretary by regulation." 42

[2] Available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html.

U.S.C. § 1395hh(a)(2). The agency's treatment of part C days is a substantive legal standard because it defines and regulates the rights of hospitals to DSH payments. *See* Black's Law Dictionary 1567 (9th ed. 2009) (defining "substantive law" as "[t]he part of the law that creates, defines, and regulates the rights, duties, and powers of parties"). It regulates the Hospitals' rights and "governs payment for services" because it binds the Secretary's contractors when they issue DSH payment determinations on behalf of the agency. 42 C.F.R. § 412.106(b)(2); *Baystate*, 545 F. Supp. 2d at 24. And the 2014 determination changed that substantive legal standard. The vacatur of the 2004 rule in *Allina* reinstated the pre-2004 policy, which treated part C days as *not* part A days. *See* 42 U.S.C. § 1395hh(a)(4) (Medicare final rule "shall not take effect" where no logical outgrowth); *Croplife Am. v. EPA*, 329 F.3d 876, 879 (D.C. Cir. 2003) (vacating policy announcement and holding that "[a]s a consequence, the agency's previous practice ... is reinstated"); *Allina Health Servs*., 746 F.3d at 1106 (Prior to 2004, "the Secretary treated Part C patients as *not* entitled to benefits under Part A.").[3] The 2014 determination to treat part C days as part A days therefore is a change in the substantive legal standard that requires notice and comment rulemaking.

The agency's publication of its policy determination on its website with no notice, no comment, and no analysis implicates all of the reasons why Congress specially imposed this distinct requirement for regulations on substantive Medicare standards. Congress enacted this

[3] The government has argued that the agency had no governing legal standard regarding the treatment of part C days prior to 2004, *see* Gov. Opp. to Mot. for Further Relief, No. 10-1463, ECF No. 63, at 7, which this Court and the D.C. Circuit have repeatedly refuted, *Allina Health Servs*., 746 F.3d at 1108; *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 16 (D.C. Cir. 2011); *Allina Health Servs*., 904 F. Supp. 2d at 77 n.2. Even if this were true, the agency would nonetheless need to undertake rulemaking now because it would be establishing a substantive legal standard regarding the treatment of part C days, which also requires notice and comment rulemaking under 42 U.S.C. § 1395hh(a)(2). Furthermore, the APA precludes the agency from effectively announcing a new rule without compliance with notice and comment, when the announcement unequivocally expresses "binding norm[s]" that are "finally determinative of … issues or rights," *Croplife Am*., 329 F.3d at 881 (internal quotation marks omitted), and "'grant rights, impose obligations, or produce other significant effects on private interests,'" *Nat'l Ass'n of Home Builders v. U.S. Army Corps of Eng'rs*, 417 F.3d 1272, 1285 (D.C. Cir. 2005) (quoting *Batterton v. Marshall*, 648 F.2d 694, 701-02 (D.C. Cir. 1980)).

obligation in Section 1395hh precisely because it was concerned—notwithstanding that the agency was bound by APA requirements—that "important policies [were] being developed without the benefit of the public notice and comment period," and that policies issued without notice and comment "do not have the benefit of widespread discussion and analysis or the contributions of additional information and perspectives that could be made by interested parties." H.R. Rep. No. 100-391, at 430 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1. The release of the agency's new determination on the agency's website, once again reversing course on part C days without any explanation or acknowledgement, contravenes Congress's intent to require the agency to proceed deliberately, through processes requiring public comment and resulting in published regulations, before altering the payment rules for hospitals in the Medicare program. The Medicare Act's rulemaking requirements were designed to keep this agency from doing exactly what it did here.

B. The APA Requires Notice and Comment Rulemaking to Change the Regulation or the Agency's Original and Longstanding Interpretation of It

Under the APA, the agency is also precluded from treating part C days as part A days until it properly changes the original, pre-2004 regulation. It is "axiomatic that an agency must adhere to its own regulations." *Exportal Ltda v. United States*, 902 F.2d 45, 49 (D.C. Cir. 1990) (quoting *Brock v. Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533, 536 (D.C. Cir. 1986) (Scalia, J.)). "Unless and until [an agency] amends or repeals a valid legislative rule or regulation, [the] agency is bound by such a rule or regulation," *Am. Fed'n of Gov't Emps. v. Fed. Labor Relations Auth.*, 777 F.2d 751, 759 (D.C. Cir. 1985), and the Secretary may amend her regulations only through notice and comment rulemaking. *See* 5 U.S.C. § 551(5) (defining "rule making" to include the "agency process for … amending … a rule"). Those fundamental APA principles render invalid the agency's policy determination here.

1. The Now-Governing Pre-2004 Regulation Binds the Agency to Treat Part C Days as Non-Part A Days Until Changed by Notice and Comment Rulemaking

The reinstated pre-2004 version of the DSH regulation precludes the Secretary's 2014 determination to treat part C days as if they were part A days. The regulation provides that the numerator of the part A/SSI fraction includes only "covered patient days that … [a]re furnished to patients who during that month were entitled to both Medicare Part A and SSI." 42 C.F.R. § 412.106(b)(2)(i) (2003). As explained by the Secretary when the rule was adopted, this regulation mandates that only "covered *Medicare Part A* inpatient days" be included in the part A/SSI fraction. 51 Fed. Reg. 16,772, 16,777 (May 6, 1986) (emphasis added); *see also Catholic Health Initiatives-Iowa v. Sebelius*, 718 F.3d 914, 921 n.5 (D.C. Cir. 2013) (noting that the pre-2004 regulation unambiguously limited the part A/SSI fraction to "covered Medicare Part A inpatient days"); 51 Fed. Reg. 31,454, 31,460 (Sept. 3, 1986) (establishing rule designating days as covered Medicare part A days only if part A is the primary payor). And, by "necessary implication," it likewise means that non-part-A days must be included in the Medicaid fraction. *Allina Health Servs*., 746 F.3d at 1108.

The original DSH regulation thus barred the agency from treating any days not paid under part A as part A patient days. It therefore by its terms precluded the treatment of part C days as part A days, because payment by private part C Medicare Advantage plans for services furnished to their part C patients is *not* made under the Medicare part A fee-for-service program. *See* 42 U.S.C. § 1395w-21(a)(1), (i); *Northeast Hosp.*, 657 F.3d at 6. Indeed, in the 2007 regulation text revision belatedly implementing the 2004 rulemaking, the Secretary recognized as much: the Secretary amended the regulation to include in the part A/SSI fraction days for patients entitled to part A "*or* Medicare Advantage (Part C)." *See* 72 Fed. Reg. 47,130, 47,411

(Aug. 22, 2007) (emphasis added). The use of the disjunctive "or" confirms that the plain text of the now-reinstated regulation, including only "patient days that … [a]re furnished to patients who during that month were entitled to … Medicare Part A," does not include patients who were entitled to payment under part C rather than part A.

It would be contrary to both the regulation's text and the Secretary's intent at the time of the regulation's promulgation to now interpret the DSH regulation to permit the agency to count part C days as covered part A days. *See, e.g.*, *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (courts may not accept regulatory interpretations that are contrary to "the regulation's plain language or other indications of the Secretary's intent at the time of the regulation's promulgation"); *Fina Oil & Chem. Co. v. Norton*, 332 F.3d 672, 677 (D.C. Cir. 2003) (rejecting new interpretation of regulation where it was inconsistent with the "regulation's overall structure and statements of agency intent at the time of promulgation" as well as regulation's text). Thus, the reinstated DSH regulation binds the agency and requires it to exclude part C days from the part A/SSI fraction and to include them in the Medicaid fraction unless it alters that regulation through notice and comment rulemaking.

2. The Secretary May Not Change Her Prior Definitive Interpretation of the DSH Regulation Except By Rulemaking

The agency must also engage in notice and comment rulemaking because, prior to 2004, the agency had definitively interpreted the DSH regulation to exclude part C days from the part A/SSI fraction (and require them in the Medicaid fraction if Medicaid eligible). The agency may not change that interpretation without notice and comment rulemaking. *See Envtl. Integrity Project v. EPA*, 425 F.3d 992, 995 (D.C. Cir. 2005) ("[A]n interpretation of a legislative rule cannot be modified without the notice and comment procedure that would be required to change the underlying regulation—otherwise, an agency could easily evade notice and comment

requirements by amending a rule under the guise of reinterpreting it."); *Paralyzed Veterans of Am. v. D.C. Arena L.P.*, 117 F.3d 579, 586 (D.C. Cir. 1997).

An agency is barred from altering its interpretation of a regulation if that interpretation is "definitive[]" and the alteration is a "significant revision." *Mortgage Bankers Ass'n v. Harris*, 720 F.3d 966, 969 (D.C. Cir. 2013), *cert. granted*, 134 S. Ct. 2820 (2014) (mem.).[4] Both are satisfied here. There can be no doubt that the position the Secretary attempted to adopt in 2004 was a "significant revision," as the D.C. Circuit has now held—twice—that the 2004 rulemaking represented a complete reversal of the prior interpretation. *Allina Health Servs.*, 746 F.3d at 1106; *Northeast Hosp.*, 657 F.3d at 16. The Secretary reversed her interpretation of "entitled to benefits under part A" in the regulation and the same term in the statute. *See Ball Mem'l Hosp. v. Leavitt*, No. 04-2254, 2006 WL 2714920, *8-9 (D.D.C. Sept. 22, 2006) (Collyer, J.) (rejecting Secretary's argument that the agency had at most "changed an informal interpretation of a statute" rather than a regulation when the Secretary "did, in fact, issue a regulation essentially mirroring the statutory text, and … both the statute and the implementing regulation left the phrase 'outpatient hospital services' undefined" such that it was only "the Secretary's interpretation of the *regulation*" "in the CMS-prescribed reimbursement forms" that "gave meaning to the phrase 'outpatient hospital services'"); *see also Northeast Hosp.*, 657 F.3d at 16 (holding the Secretary "changed her interpretation of the DSH provision in 2004").

The Secretary's prior interpretation was also definitive. *Allina Health Servs.*, 746 F.3d at 1108 ("[A] party reviewing the Secretary's notice of proposed rulemaking understandably would

[4] The Supreme Court has granted certiorari on the question whether "a federal agency must engage in notice-and-comment rulemaking before it can significantly alter an interpretive rule that articulates an interpretation of an agency regulation." *Perez v. Mortgage Bankers Ass'n*, 134 S. Ct. 2820 (2014) (mem.). Because both the Medicare Act and the APA otherwise require notice and comment, plaintiff Hospitals need not rely on the *Paralyzed Veterans* rule, but it remains the law of the Circuit.

have assumed that the Secretary was proposing to 'clarify' a then-existing policy, *i.e.*, one of excluding Part C days from the Medicare fraction and including them in the Medicaid fraction."). The interpretation was reflected in substantial written guidance, including agency instructions about submission of data regarding part C patients, as well as program memoranda transmitting the part A/SSI fractions on an annual basis from the enactment of part C through the 2004 rulemaking. *See, e.g.*, *Northeast Hosp.*, 657 F.3d at 15 (describing guidance instructing non-teaching hospitals not to file "no-pay" bills for services furnished to part C patients that would have been necessary to count part C days in the part A/SSI fraction); HCFA Pub. 60A, Transmittal No. A-98-36 (Oct. 1, 1998), *reprinted in* Medicare & Medicaid Guide (CCH) ¶ 150,103 (transmitting part A/SSI fractions that excluded part C days, specifying that the fractions include only "covered Medicare days," and referring to the ratio of SSI days and "covered Medicare days" as "the ratio of Medicare Part A patient days attributable to SSI recipients"); HCFA Pub. 60A, Transmittal No. A-99-42 (Sept. 1, 1999), *reprinted in id.* ¶ 150,769 (same); HCFA Pub. 60A, Transmittal No. A-00-54 (Aug. 17, 2000), *reprinted in id.* ¶ 151,363 (same); CMS Pub. 60A, Transmittal No. A-01-109 (Sept. 13, 2001), *reprinted in id.* ¶ 152,216 (same); CMS Pub. 60A, Transmittal No. A-02-086 (Sept. 11, 2002), *reprinted in id.* ¶ 152,922 (same); CMS Pub. 60A, Transmittal No. A-03-067 (Aug. 8, 2003), *reprinted in id.* ¶ 153,554 (same); CMS Pub. 100-04, Transmittal 275 (Aug. 13, 2004), *reprinted in id.* ¶ 154,468 (same).

The Secretary's regulatory interpretation was also reflected in the agency's long-standing practice. *Northeast Hosp.*, 657 F.3d at 16-17 ("The Secretary's interpretation, as set forth in the 2004 rulemaking and resulting amendment to § 412.106, contradicts her former practice of excluding M+C days from the Medicare fraction."). That is more than enough to establish her

prior definitive interpretation. *See Ball Mem'l Hosp.*, 2006 WL 2714920, at *9 (finding regulatory interpretation "reflected, albeit silently, in the CMS-prescribed reimbursement forms"); *Mercy Med. Skilled Nursing Facility v. Thompson*, Nos. 99-2765, 01-2014, 02-2252, 2004 WL 3541332, at *3 (D.D.C. May 14, 2004) (holding "length and consistency of … practice is sufficient to establish a definitive agency interpretation"). The written guidance and the agency's consistent and unbroken policy and practice establish the Secretary's definitive interpretation of the pre-2004 (and now restored) DSH regulation as excluding part C patients from the patients counted as entitled to benefits under part A. Accordingly, the Secretary may not change that interpretation without notice and comment rulemaking.

II. THE SECRETARY'S WHOLLY UNEXPLAINED REVERSAL ON PART C DAYS IS UNREASONABLE AND ARBITRARY AND CAPRICIOUS

In addition to its procedural invalidity, the Secretary's determination to treat part C days as part A days is unreasonable and arbitrary and capricious, considering "both whether the interpretation is arguably consistent with the underlying statutory scheme in a substantive sense and whether the agency considered the matter in a detailed and reasoned fashion." *ITT Indus., Inc. v. NLRB*, 251 F.3d 995, 1004 (D.C. Cir. 2001) (internal quotation marks omitted). The determination announced in the 2012 fractions fails on both grounds.[5]

A. The Secretary's Determination Is Not the Product of Reasoned Decision Making

The first problem is that the Secretary failed (again) to explain the agency's policy reversal. An agency's determination is not reasoned decision making, and constitutes arbitrary and capricious agency action, when the agency fails "to acknowledge and provide an adequate

[5] For the reasons discussed in Judge Kavanaugh's concurring opinion in *Northeast Hospital*, 657 F.3d at 18-24, the Hospitals contend that the statute also unambiguously forecloses an interpretation that treats part C days as part A days in the DSH calculation. The Hospitals recognize, however, that this Court is bound by the contrary decision of the panel in *Northeast Hospital*, 657 F.3d at 2, and make this argument to preserve it to the extent that en banc review in the D.C. Circuit or certiorari review in the Supreme Court is ever granted in this case.

explanation for its departure from established precedent." *Dillmon v. Nat'l Transp. Safety Bd.*, 588 F.3d 1085, 1089-90 (D.C. Cir. 2009). The Secretary's determination to treat part C days as part A days for 2012 DSH calculations does not even attempt to meet this test—rather, it gives no explanation whatsoever for the reversal in policy notwithstanding this Court and the D.C. Circuit's repeated holdings explaining the agency's prior policy. The agency's complete silence about the prior policy failed to "display awareness that it is changing position" and impermissibly "depart[ed] from a prior policy *sub silentio*." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). Given that the agency said even less here than in its insufficient 2004 rulemaking, the recent determination to treat part C days as part A days is patently invalid under these tests. *See Allina Health Servs.*, 904 F. Supp. 2d at 93 ("[T]he Secretary's cursory explanation in the 2004 Final Rule failed to meet the requirements of the APA.").

Second, the Secretary's revived policy choice is arbitrary and capricious. Even if "not barred by statute, an agency's action is also arbitrary and capricious [if] the agency has not considered certain relevant factors or articulated any rationale for its choice." *Republican Nat'l Comm. v. FEC*, 76 F.3d 400, 407 (D.C. Cir. 1996). An agency may not simply "pick[] a permissible interpretation out of a hat." *Vill. of Barrington, Ill. v. Surface Transp. Bd.*, 636 F.3d 650, 660 (D.C. Cir. 2011). It must "articulate a satisfactory explanation for its action including a rational connection between the facts found and the choices made." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983) (internal quotation marks omitted). In particular, the agency must provide an "explanation of how [its] interpretation serves the statute's objectives." *Northpoint Tech., Ltd. v. FCC*, 412 F.3d 145, 151 (D.C. Cir. 2005). Given that the agency provided no rationale at all, it clearly failed to meet all of these markers for reasoned decision making.

In its decision in the first round of *Allina* litigation, this Court explained some of the things that the agency failed to grapple with in the now-vacated 2004 rule, including (i) the "need to reconcile Congressional intent regarding the DSH fraction and the M+C program"; (ii) "the financial impact of counting Part C days in the Medicaid fraction"; and (iii) "how regulated entities should reconcile the possibility of two different definitions of the word 'entitled' in the same sentence in 42 U.S.C. §1395ww(d)(5)(F)(vi)(I)." *Allina Health Servs.*, 904 F. Supp. 2d at 94.[6] The agency's utter silence in connection with its 2014 determination fares no better. In short, the agency was "intolerably mute" and therefore unreasonable and arbitrary. *Jicarilla Apache Nation v. U.S. Dep't of Interior*, 613 F.3d 1112, 1120 (D.C. Cir. 2010).

B. The Readopted Policy Is Impermissibly Inconsistent with Legislative Intent

An agency interpretation also fails *Chevron* if it is not "consistent with the underlying statutory scheme in a substantive sense." *ITT Indus., Inc.*, 251 F.3d at 1004. The recent policy determination fails that test because it "conflict[s] with the policy judgments that undergird the statutory scheme." *Health Ins. Ass'n of Am., Inc. v. Shalala*, 23 F.3d 412, 416 (D.C. Cir. 1994). For this reason, it is impermissible under *Chevron* step two. *See Goldstein v. SEC*, 451 F.3d 873, 883 (D.C. Cir. 2006) (rejecting policy under *Chevron* step two where it was not "rational when viewed in light of the policy goals underlying the" applicable statute); *Coal Emp't Project v. Dole*, 889 F.2d 1127, 1131 (D.C. Cir. 1989) (finding agency's interpretation impermissible where it was not "consistent with the statutory purpose").

[6] The DSH statute provides that the numerator of the part A/SSI fraction includes the days for patients who "were entitled to benefits under part A ... and were entitled to supplemental security income benefits." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). Under the recent determination to treat part C days as part A days, the Secretary interprets "entitled" to mean "eligible" in the first clause—referring to entitlement to benefits under part A—but interprets "entitled" to require actually receiving payment of a benefit, not simple eligibility, in the second clause referring to entitlement to SSI. *See* 75 Fed. Reg. 50,042, 50,280-81 (Aug. 16, 2010). As put by Judge Kavanaugh, "[t]he only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible." *Northeast Hosp.*, 657 F.3d at 20 n.1 (Kavanaugh, J., concurring).

Although this issue has been presented before, *see Allina Health Servs.*, 904 F. Supp. 2d at 87, neither this Court nor the D.C. Circuit have had occasion to resolve it in light of the myriad other problems with the agency's previous attempts to change its policy on part C days. *See Allina Health Servs.*, 746 F.3d at 1107 ("We did not reach the question whether the Secretary's interpretation [of the DSH statute] was reasonable under step two" in *Northeast Hospital*.); *id.* at 1111; *Allina Health Servs.*, 904 F. Supp. 2d at 87 ("[T]he Court agrees with the Hospitals as to the first two of their procedural arguments" and therefore "does not reach the Hospitals' other arguments"). In light of the procedural invalidity and arbitrariness described above, this Court yet again need not reach the ultimate unreasonableness of the Secretary's interpretation. On the merits, however, the interpretation embodied in the June 2014 determination is inconsistent with congressional intent and therefore impermissible under *Chevron*.

The purpose of the DSH adjustment is to provide additional payment under the part A prospective payment system for hospitals that incur higher than average costs in treating part A patients because they treat large numbers of low-income patients. *See* H.R. Rep. No. 99-241(I), at 16 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 594. There are two reasons why hospitals treating a high proportion of low-income patients incur higher Medicare costs. The first reason, relevant to the part A/SSI fraction, is that the low-income patients whose care is actually paid under Medicare part A are more costly than average to treat. *Id*. The second reason, relevant to the Medicaid fraction, is that even if hospitals do not treat a substantial number of low-income patients whose care is reimbursed by Medicare part A, hospitals that treat a large proportion of low-income patients overall tend to incur higher costs per case for *all* patients due, in part, to the specialized services they provide and other structural characteristics of these hospitals. *Id*.

Thus, the purpose of the DSH adjustment is specifically to compensate for the higher

costs incurred to treat the low-income patients whose care is paid for under part A, *see id.*, but it accomplishes this purpose by separately measuring two patient populations. The June 2014 determination to treat part C days as part A days frustrates this purpose by delinking the first measure, the part A/SSI fraction, from the patient population receiving benefits under part A. It makes no sense to adjust that fraction by reference to part C patients whose care is not paid for under the part A prospective payment system. In fact, part C patients differ from part A patients in that they have the means to pay part B premiums, and are therefore less likely to be low-income and qualify for SSI benefits. *See Northeast Hosp.*, 657 F.3d at 5. The inclusion of part C days in the part A/SSI fraction thus dilutes the part A/SSI fraction, departing from the measurement Congress intended of the percentage of a hospital's services that are paid under the part A rate but are more costly-than-average to treat.

This summer's part C days policy determination is inconsistent with the Secretary's own understanding of this statutory purpose. The Secretary does not count all Medicare beneficiaries' patient days in the part A/SSI fraction. The agency has always, for example, excluded patient days paid under Medicare part B from the part A/SSI fraction, directing that they instead be included in the numerator of the Medicaid fraction (as "not entitled to benefits under part A") if Medicaid eligible. Questions and Answers Related to Program Memorandum A-99-62 (Mar. 13, 2000), Q3 (attached as Exhibit A). Moreover, when Medicare patients receive hospice care, the Secretary does not count those days in the DSH calculation because hospice services are not payable under the part A prospective payment system. 76 Fed. Reg. 51,476, 51,681-683 (Aug. 18, 2011); *see also* 42 C.F.R. § 412.106(a)(1)(ii) (2010) (excluding patient days in areas of a hospital that are not *paid* under the part A prospective payment system). The Secretary has actually relied on the very same legislative history the Hospitals cite here in confining the DSH

measure to part A paid days. *See* 68 Fed. Reg. 45,346, 45,418 (Aug. 1, 2003) (citing the legislative history of the DSH statute in H.R. Rep. 99-241(I)).

In sum, the June 2014 reincarnation of the new part C policy does not "conform[]to statutory purposes," *Goldstein*, 451 F.3d at 881, to limit the part A/SSI fraction to days paid under the part A prospective payment system. Thus, even if it were procedurally valid or explained in any fashion—which it is not—the agency's determination to treat part C days as part A entitled days again must be set aside.

CONCLUSION

For the foregoing reasons, the plaintiff Hospitals respectfully request that the Court grant the plaintiff Hospitals' motion for summary judgment and enter an order vacating the Secretary's determination to treat part C days as part A days in the 2012 part A/SSI fractions, enjoining the Secretary from treating part C days as part A days in the calculation of the Hospitals' DSH payments for periods prior to October 1, 2013, and requiring the Secretary to recalculate the Hospitals' DSH payments consistently with the order.

Respectfully Submitted,

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