UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SHANDS JACKSONVILLE MEDICAL CENTER, INC., *et al.*, Plaintiffs, v. SYLVIA MATHEWS BURWELL, Defendant.	Case No. 1:14-cv-00263

PLAINTIFFS' SUPPLEMENTAL BRIEF IN SUPPORT OF VACATUR

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INTRODUCTION

At the close of the hearing on the parties' cross-motions for summary judgment, this Court sought supplemental briefing on the question of remedy: namely, if it concludes CMS either ran afoul of its statutory authority or of the Administrative Procedure Act (APA), what remedy follows – a mere remand without vacatur, or a remand with vacatur? The answer is the latter.

If the Court concludes CMS lacks the statutory authority to make an across-the-board cut to "offset" expenditures associated with a projected net increase of 40,000 inpatient stays, the system-wide rate reduction should be vacated, full stop. *See Hearth, Patio & Barbecue Ass'n v. Dep't of Energy*, 706 F.3d 499, 506 (D.C. Cir. 2013); *Humane Soc'y of U. S. v. Jewell*, 76 F. Supp. 3d 69, 137 (D.D.C. 2014) (vacating rule that "falls outside the [agency's] statutory authority . . . and is predicated on an interpretation of the [Act] that is contrary to the statute's purpose"); *see* also Transcript of Hearing on Cross-Motions for Summary Judgment at 30:7-8, Aug. 3, 2015 (hereinafter "Tr.") (noting that "in your case, with respect to [the statutory argument], the remedy is pretty clear").[1]

And even if CMS permissibly invoked the Medicare statute's targeted "exceptions and adjustments" provision to promulgate its across-the-board rate cut, the agency went about it in total disregard of the APA's most fundamental requirements. The remedy for that is equally straightforward: Vacatur is the appropriate remedy under the APA and this Circuit's precedents. The narrow exceptions to vacatur under this Circuit's precedents do not apply where CMS's attempt to promulgate the cut violated the APA at nearly every turn, where CMS could not cure

[1] For that reason, and to avoid burdening the Court with additional pages in an already extensively briefed case, this supplemental brief addresses the remedy question only with respect to CMS's APA violations.

those defects on remand, and where CMS cannot justify the cut in any event. Moreover, to the extent it is relevant at all, the consequences to the agency of vacating a past fiscal year's payment cut are narrow and contained.

ARGUMENT

VACATUR IS THE PROPER REMEDY.

Section 706(2) of the APA "states . . . in the clearest possible terms" that a reviewing court *shall* "hold unlawful *and set aside*" agency action found to be arbitrary and capricious, ultra vires, or without observance of the required procedure. *Checkosky v. SEC*, 23 F.3d 452 (D.C. Cir. 1994) (Randolph, J., writing separately) (emphasis added). "Setting aside means vacating; no other meaning is apparent." *Id.* That is why this Circuit repeatedly has explained that "[v]acatur is the normal remedy" for an APA violation, rather than a mere remand without vacatur. *See Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1110-11 (D.C. Cir. 2014); *see also Advocates for Highway & Auto Safety v. Fed. Motor Carrier Safety Admin.*, 429 F.3d 1136, 1151 (D.C. Cir. 2005) ("unsupported agency action normally warrants vacatur"). And while APA violations may take many forms, an agency's failure to give notice and an opportunity to comment "typically" requires vacatur. *Daimler Trucks N. Am. LLC v. EPA*, 737 F.3d 95, 103 (D.C. Cir. 2013). In *Owner-Operator Independent Drivers Ass'n, Inc. v. Fed. Motor Carrier Safety Admin.*, 494 F.3d 188, 201 (D.C. Cir. 2007), for example, the agency defendant failed to provide sufficient notice of, and failed to explain, a methodology it used for calculating an aspect of a trucking rule. The D.C. Circuit vacated that aspect of the rule. *Id.* at 206; *see also Am. Trucking Ass'n v. Motor Carrier Safety Admin.*, 724 F.3d 243, 253 (D.C. Cir. 2013) (rejecting agency's "conclusory, post-hoc rationalization" and vacating portion of the rule for which agency failed to explain basis for its conclusion); *Daimler*, 737 F.3d at 103 (vacating part of rule

where agency gave inadequate notice and opportunity to comment); *Solite Corp. v. EPA*, 952 F.2d 473, 477, 499 (D.C. Cir. 1992) (same).

The D.C. Circuit has recognized, however, that vacatur may prove unwarranted in "certain limited circumstances." *EME Homer City Gen., L.P. v. EPA*, No. 11-1302, 2015 WL 4528137, at *10 (D.C. Cir. July 28, 2015). To determine whether those narrow circumstances exist, a reviewing court may consider "the seriousness of the . . . deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed." *Allied–Signal, Inc. v. Nuclear Regulatory Comm'n,* 988 F.2d 146, 150–151 (D.C. Cir. 1993) (internal citation omitted). Assuming *Allied-Signal* applies in this case,[2] both of its factors weigh strongly in favor of vacatur. The rule challenged here was deficient in nearly all the ways it is *possible* for a rule to be deficient: CMS failed to make available in the proposed rule the actuarial analysis on which it relied, failed to respond adequately to criticisms of the proposed rule, and failed to explain the basis for its conclusions in the final rule. And the second *Allied-Signal* factor does not apply here; there can be no "*interim* change that may itself be changed" because retroactive rulemaking is impermissible in this context. Even if CMS could impose a retroactive rate cut for a past fiscal year, moreover, it cannot justify its actuaries' critical assumptions, rendering any remand futile. And in any event,

[2] *Allied-Signal, Inc.* involved a challenge to an *adjudicative* order refusing to grant an exemption to the petitioner-companies, not a prospective rulemaking. Although the *Allied-Signal* factors have occasionally been invoked in cases involving agency actions other than adjudications, *see, e.g.*, *Chamber of Commerce v. SEC*, 443 F.3d 890, 908 (D.C. Cir. 2006), the factors are more appropriate in the context of an adjudication – a necessarily retrospective determination. An adjudication, after all, is a backward-looking decision, meaning that it is much more likely that an agency could "cure" the defects in that decision, such as by offering an alternative rationale. *See Allied-Signal*, 988 F.2d at 151. And because an adjudication is necessarily a retrospective determination, vacating a decision that may later be reinstated on remand using a different rationale is much more likely to cause "disruptive consequences."

vacatur poses little risk of "disruption"; established mechanisms exist for CMS to repay hospitals the additional Medicare reimbursement they are owed for services provided in fiscal year 2014.

A. The Rate Reduction Is Riddled With Deficiencies.

There are three stages in the administrative process where an agency can commit a serious APA violation: the beginning, the middle, and the end. CMS went three-for-three.

1. The basis for the agency's across-the-board rate reduction was its actuaries' conclusion projecting a net increase of 40,000 inpatient stays resulting from the agency's new two-midnight rule. *See* RR 728**.** We have already explained the paucity of support for that conclusion: the proposed rule identifies the annual claims data the actuaries apparently consulted and the bottom-line numbers resulting from their analysis, but reveals *nothing at all* about anything in between – meaning their method, assumptions, or calculations. *E.g.*, Tr. 15:19-16:6, 17:20-18:25; 36:20 -37:6; 53:11-25. The agency's failure to disclose that "critical factual material" is a classic APA violation. *Am. Radio Relay League v. FCC*, 524 F.3d 227, 239-240 (D.C. Cir. 2008). As the D.C. Circuit put it in *Am. Radio Relay League*, it is a "fairly obvious proposition that studies upon which an agency relies in promulgating a rule must be made available during the rulemaking," because notice and comment are "safety valves in the use of . . . sophisticated methodology." *Id.* at 236-237. *See also Owner-Operator Indep. Drivers Ass'n, Inc.*, 494 F.3d at 206 (agency must release data, technical studies, calculations, and methods used to arrive at its assumptions); *Time Warner Ent. Co. v. FCC*, 240 F.3d 1126, 1140 (D.C. Cir. 2011) (noting that an agency "cannot rest a rule on data that, in critical degree, is known only to the agency") (internal quotation and citation omitted). "To allow an agency to play hunt the peanut with technical information, hiding or disguising the information that it employs, is to condone a practice in which the agency treats what should be a genuine

interchange as mere bureaucratic sport." *Conn. Light & Power Co. v. Nuclear Regulatory Comm'n*, 673 F.2d 525, 530 (D.C. Cir. 1982). As all these cases and many others show, the requirement that an agency reveal its studies and methods is not buried in the fine print of the rulemaking process. It is a basic element of the notice-and-comment bargain, and CMS flouted it utterly.

2. Commenters pointed out the lack of necessary support for the actuaries' conclusions. *See, e.g.*, RR 3710, 4148, 4411, 4653, 4883-84, 4954, 5010, 5235, 5312, 5778; Tr. 19:6-14. A few intrepid commenters – despite lacking any understanding of the actuaries' key assumptions or methodology – even attempted to reverse-engineer CMS's numbers with reference to CMS yearly claims data, without success; indeed, their results were wildly different from the agency's. *See, e.g.*, RR 4306, 4645-53, 5235. The APA required CMS to address the lack of necessary empirical support for the proposed cut, as well as the analysis commenters offered. *See Delaware Dep't of Nat. Res. & Envtl. Control v.* EPA, 785 F.3d 1, 15 (D.C. Cir. 2015) (agency's "wan responses" and "refus[al] to engage" with comments arbitrary and capricious; "EPA must respond to serious objections"); *Owner-Operator Indep. Drivers Ass'n, Inc.*, 494 F.3d at 205 (when agency's methodology is challenged, the "agency must provide a complete analytic defense"); *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 212 (D.C. Cir. 2011) (agency must "respond to relevant and significant public comments"); *HBO v. FCC*, 567 F.2d 9, 35-36 (D.C. Cir. 1977) ("The opportunity to comment is meaningless unless the agency responds to significant points raised by the public"). But CMS did nothing of the sort. Instead, it merely "disagreed" with commenters, and then repeated, nearly verbatim, the same inadequate information it already had provided. RR 1361. A mere statement of "disagreement" does not do the trick: CMS was required to "demonstrate the rationality of its decision-making process" with

a reasoned analysis. *Grand Canyon Air Tour Coal. v. FAA*, 154 F.3d 455, 468 (D.C. Cir. 1998). This foundational anti-ipse-dixit requirement, too, has been settled for decades, and CMS fell well short of it.

3. The Final Rule gave rise to the agency's third violation. In the Final Rule, CMS failed – again – to explain the basis for its actuaries' assumptions.[3] Instead, CMS simply repeated its prior numerical conclusions: 400,000 patients in, 360,000 patients out, 40,000 differential, $220 million increase, 0.2 percent cut. The APA requires far more than that. *See supra* at 4-5; *W. Va. v. EPA*, 362 F.3d 861, 870 (D.C. Cir. 2004) (agency must "reasonably explain[] why it chose to rely on" its assumptions); *Advanced Micro Devices v. CAB*, 742 F.2d 1520, 1543 (D.C. Cir. 1984) (chiding agency for its failure to "advert to the data and methods of calculation it used in such a way as to allow . . . opponents and reviewing courts to understand how [it] reached its conclusions").

The agency did, however, offer one tantalizing (though partial) new clue: namely, that its actuaries' projections excluded *all inpatient stays involving medical cases* from the analysis. *See* RR 1361. It stopped short of explaining *why* its actuaries went that route, however. A partial answer to that critical question emerged only after the Final Rule, in a post-hoc "Actuary Memo," where the agency vaguely stated that medical claims were excluded "because it was assumed that

[3] As we elsewhere have noted, CMS also did not explain why the rate cut is "appropriate" and comports with the statute, given that it cements in historical underpayments by effectively paying outpatient rates for the estimated additional 40,000 medically necessary inpatient cases, or how it can be reconciled with the agency's prior interpretations of its limited exceptions-and-adjustments authority. *See* Plaintiffs' Memorandum in Support of Motion for Summary Judgment at 19-24, ECF No. 17-1; Plaintiffs' Opp. to Defendants' Motion to Dismiss and Motion for Summary Judgment and Reply in Support of Plaintiffs' Motion for Summary Judgment at 2-7, ECF No. 27; RR 1361, 3743, 5312.

these cases would be unaffected by the policy change." RR 2046-48. CMS offered no explanation or support for that assumption even then, and the trail goes cold after that.[4]

Any one of these APA violations would count as a "serious deficiency." *See Allina Health Servs.*, 746 F.3d at 1110-11 (vacating final rule for lack of sufficient notice); *Chamber of Commerce v. SEC*, 443 F.3d 890, 908 (D.C. Cir. 2006) (vacating rule where Commission relied on critical extra-record material, but staying mandate of vacatur in light of widespread industry compliance with rule); *Cape Cod Hosp.*, 630 F.3d at 216 (vacating portions of two rules for failure to respond to relevant and significant public comments and failure to justify those rules); *Ill. Pub. Telecomms. Ass'n v. FCC*, 123 F.3d 693, 693-94 (D.C. Cir. 1997) (vacating portions of rule based on agency's "failure to respond to contrary arguments"). And given that the agency committed all three in combination, its deficiencies are triply serious. This was not some passing procedural foot-fault. *Compare Heartland Reg'l Med. Ctr. v. Sebelius,* 566 F. 3d. 193, 198 (D.C. Cir. 2009) (remand without vacatur where requirement that hospital be located in a "rural" area was invalid "solely" because of the agency's failure adequately to respond to reasonable alternative ways for defining "urban areas"); *Southeast Ala. Med. Ctr. v. Sebelius*, 572 F.3d 912, 920 (D.C. Cir. 2009) (finding that CMS reasonably explained the treatment of two of three types of costs in determining the proportion of hospitals' costs attributable to wages, but remanding to agency to explain its counting postage costs towards that proportion); *Sec. Indus. & Fin. Markets Ass'n v. U.S. Commodity Futures Trading Comm'n*, 67 F. Supp. 3d 373, 433-434 (D.D.C. 2014)

[4] At oral argument, government counsel argued that it was "somewhat of a self-evident assumption" that medical cases would be subject to a less "predictable" length of stay than surgical cases, thus apparently warranting the wholesale exclusion of that entire category of cases from the actuaries' analysis. *See* Tr. 39:17-18. We have responded to that late-breaking, self-serving, completely-not-self-evident point already. *See* Tr. 54:12-13; *Marks v. CIR*, 947 F.2d 983, 986 (D.C. Cir. 1991) (referring to the D.C. Circuit's "developing 'chutzpah' doctrine"); *Bowen v. Georgetown Univ. Hosp*., 488 U.S. 204, 212 (1988). The government's late argument also is meritless. *See infra* at 10-12.

(remanding without vacatur where agency failed to consider costs and benefits of one aspect of rule). This, in contrast, was a wholesale abdication of the agency's responsibility at every turn. Vacatur plainly is warranted.

B. The Agency Cannot Re-Promulgate A Payment Cut For A Past Fiscal Year.

The second *Allied-Signal* factor considers the "disruptive consequences of an interim change that may itself be changed." 988 F.2d at 150-151. That inquiry poses a question that is an impossibility here: The "change" occasioned by vacating the payment cut cannot be an "*interim change that may itself be changed*," *id.* (emphasis added), because CMS cannot on remand cure its failures with respect to a rule governing a *past* fiscal year.

In some circumstances, the remedy for notice-and-comment violations is to provide stakeholders with a new notice making the missing studies available and providing a further opportunity to comment on them. *See, e.g.*, *Chamber of Commerce*, 443 F.3d at 901-902, 908; *Am. Radio Relay*, 524 F.3d at 236-237. But even assuming CMS could develop the necessary support for some future across-the board rate cut – a highly charitable assumption, *see infra* at 10-12 – that cut could apply *only to future payment years*. CMS cannot re-promulgate a rate reduction for fiscal year 2014. *See Georgetown Univ. Hosp.*, 488 U.S. at 208-209; 42 U.S.C. § 1395hh(e)(1)(A) (prohibiting a "substantive change" from being applied "retroactively to items and services furnished before the effective date of the change" unless one of two specified narrow exceptions applies).

CMS is required by statute to publish inpatient hospital payment rates in advance of the year in which the treatment will be given. 42 U.S.C. § 1395ww(d)(6). The agency may not apply a payment rate cut retroactively; that is precisely the approach attempted and rejected in *Georgetown Univ. Hosp.*, 488 U.S. at 208-209. The agency there had re-promulgated a

Medicare cost-limit rule, with purported retroactive effect, after its first attempt was set aside for failing notice and comment requirements. Hospitals then challenged that rule's retroactive application. On review, the Supreme Court found the agency's tactic impermissible, explaining that "[r]etroactivity is not favored in the law" and holding that an agency had "no authority to promulgate retroactive cost-limit rules." *Id.* at 215. The D.C. Circuit similarly has made clear that CMS "may not promulgate a retroactive rule absent express congressional authorization." *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 13 (D.C. Cir. 2011).

Following the Supreme Court's decision in *Georgetown Univ. Hosp.*, Congress expressly *codified* the prohibition on retroactive payment cuts in the Medicare statute. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. Law 108-173 § 903(a), 117 Stat. 2066 (2003) (codified at 42 U.S.C. § 1395hh(e)(1)(A)); H.R. Rep. No. 108-391 at 756-757 (2003). To be sure, that statute has exceptions, but they are quite narrow: a substantive regulatory change may be given retroactive application *only* if retroactive application is necessary to comply with statutory requirements, *or* where the failure to apply the change retroactively would be contrary to the public interest. And while the issue is not before the Court at this time, plaintiffs submit that neither consideration is present here. Nothing in the Medicare statute *requires* an across-the-board payment cut (quite the opposite, in fact, as we have explained). And the rarely invoked "public interest" exception plainly does not attach merely when an agency is required to pay money it owes. *See In re Medicare Reimbursement Litig.*, 414 F.3d 7, 12-13 (D.C. Cir. 2005) ("Having to pay a sum one owes can hardly amount to an equitable reason for not requiring payment."). There is no support in the Medicare statute, its history, or in logic, for a rule to be given retroactive effect simply because its predecessor was challenged and vacated.

CMS's across-the-board rate cut should be vacated.

C. Remand Without Vacatur Would Be Futile.

Even if CMS had the authority to impose a retroactive rate cut, the agency could not offer any plausible basis – much less a reasonable one – to justify the cut on remand. Remand without vacatur thus would be futile.

To take only one example of the several incurable defects in CMS's purported rationale, the agency cannot justify on remand its decision to exclude *all* short medical inpatient stays from its analysis of the impact of the two-midnight rule. And without that exclusion, the math underlying the rate cut simply will not add up.

Publicly available claims data show that more than *one and a half million* inpatient admissions lasted less than 48 hours. Yet CMS concluded without explanation that only 360,000 inpatient encounters would shift to outpatient status under the two-midnight rule. We now know it reached that conclusion by excluding medical cases, even though the two-midnight rule applies equally to them.

At oral argument, counsel for the government offered a belated theory for CMS's failure to consider medical cases, surmising that when a doctor encounters a medical case, "the doctor cannot assume or make any judgment about how long that patient will be in," so it is "reasonable to consider surgical cases as shifting and medical cases as being unaffected." Tr. 38:24- 39:13. In other words, the agency's litigation counsel now suggests CMS concluded that length of stay is less predictable for medical cases and, as a result, physicians would make sure that *every* medical case – 100 percent of them – previously lasting less than 48 hours would be extended to last more than 48 hours. The government's counsel went so far as to "ask[] [the Court] to accept

as somewhat of a self-evident assumption that surgical cases are predictable in length of stay, medical cases are not." *Id.* 39:16-18.[5]

Far from being "self-evident," the government's "half-hearted attempt to defend [the agency's] decision in this court is but another indication that the [rate reduction] is a hopeless cause." *Fox Television Stations v. FCC*, 280 F.3d 1027, 1053 (D.C. Cir. 2002). CMS's assumption – that *all* short-stay medical cases would remain inpatient under the new two-midnight rule – is indefensible. Even assuming CMS could articulate a valid basis for the explanation its counsel offered for the first time at the hearing about why the duration of medical cases might be extended in some cases – which is doubtful at best – why *100 percent*?

The answer is, because CMS's actuaries *had to* exclude every single medical case in order to make their numbers sort out. Imagine if CMS had concluded that fully 94 percent, instead of 100 percent, of short-stay medical cases would remain inpatient, despite the new two-midnight rule – again a wildly improbable assumption, but for demonstration purposes, we can indulge it. CMS's data show that about half of the 1.5 million short-stay admissions, meaning about 750,000 of them, are medical cases. *See* CMS, Chapter 5: Medicare Short Stay Hospitals, Table 5.9: Discharges, Total Days of Care, and Program Payments for Medicare Beneficiaries Discharged from Short-Stay Hospitals, by Total Days of Care: Calendar Year 2012, Medicare & Medicaid Statistical Supplement,(2013), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/

[5] No commenters discovered that "self-evident" assumption during the rulemaking. And they would have had no reason to guess that medical cases were completely excluded, much less conjure up a reason for their wholesale exclusion. Had CMS given notice that it was excluding medical cases, moreover, Plaintiffs not only would have challenged the assumption that 100 percent of medical cases would be unaffected by the rule; they also would have used CMS's own data to show that the lengths of stays in medical cases are *less* variable, not more variable, than those in surgical cases.

2013_Section5.pdf#Table5.9. If CMS had included short inpatient stays involving medical cases in its analysis, and assumed that just *six percent* of those medical cases had shifted, that would mean about 45,000 short-stay inpatient encounters (750,000 x .06) would shift to outpatient. That would erase the 40,000 net inpatient increase altogether.

And the impossible math is not all CMS would have to contend with on remand. CMS also made a behavioral assumption during the rulemaking that flatly contradicts its new assumption that zero medical cases would shift to outpatient under the two-midnight rule. Some commenters opposed the two-midnight rule on the ground that it might encourage hospitals to hold beneficiaries in the hospital in order to meet the 2-midnight presumption. RR 1359. CMS dismissed these concerns, assuring commenters that its enforcement efforts would deter hospitals from any gamesmanship: the agency would "monitor[] for such patterns of systemic delays indicative of fraud or abuse" and audit claims for inpatient stays. *Id.* Now that CMS is pressed to defend the numbers behind its rate reduction, however, the agency is positing that hospitals will in fact hold *all* of their medical cases in the hospital in order to meet the 2-midnight presumption.

CMS thus has yet to offer "any plausible reason for" its decision, *Fox Television Stations*, 280 F.3d at 1053, and the agency cannot "justify [its] choices by shoring up its reasoning on remand." *NRDC v. EPA*, 489 F.3d 1364, 1374 (D.C. Cir. 2007). "Although the [agency] presumably made its best effort, the reasons it gave . . . were at best flimsy," and the belated explanation offered in court is not enough to save the rule from vacatur. *Fox Television Stations*, 280 F.3d at 1053.

D. The Consequences Of Vacatur Are Not "Disruptive".

The second *Allied-Signal* factor asks – in service of examining the "interim change" that would not in this instance be "interim" at all – whether such an "interim change" would be disruptive. To the extent this factor applies here, given everything explained above, it also plainly weighs in favor of vacatur, because the "disruption" caused by vacating the payment cut for one federal fiscal year is slim-to-none.

Vacating the rate cut does not present the kind of "invitation to chaos" that counsels against vacating a rule with serious APA defects. *Sugar Cane Growers Co-op of Fla. v. Veneman*, 289 F.3d 89, 97-98 (D.C. Cir. 2002). That kind of disruption exists in situations in which the "the egg has been scrambled and there is no apparent way to restore the status quo ante," *id.* at 97, or where "vacating would have serious adverse implications for public health and the environment," *North Carolina v. EPA*, 550 F.3d 1176, 1178 (D.C. Cir. 2008) (Rogers, J., concurring) or similar vast systemic consequences, *see Chamber of Commerce*, 443 F.3d at 909.

In *Sugar Cane Growers*, for example, it was not possible to restore the status quo ante because the program at issue – a payment-in-kind program encouraging sugar-beet farmers to destroy or divert their crops – had been in place for more than a year, and crops already had been plowed under as part of that program. *Id.* If the program were vacated, the Federal Court of Claims would have been forced to take on the responsibility of allocating damages. *Id.* In *North Carolina v. EPA*, the court of appeals concluded that it would remand without vacatur where vacating would threaten environmental protections. 550 F.3d at 1178; *see also id.* at 1179 (Rogers, J., concurring) (noting that vacatur would "sacrifice clear benefits to public health and the environment while EPA fixes" the deficient rule). And in *Chamber of Commerce*, the D.C. Circuit expressed concern that a "significant portion of the [regulated] industry appears to have

come into substantial compliance" with the rule found defective in that case, such that immediate vacatur would "risk[] substantial disruption" to the industry "because of the resultant inconsistent . . . practices that would arise within the industry," and might also "sow confusion in the investing public." 443 F.3d at 909. Yet even in that case, the court opted to vacate the defective rule; it withheld the mandate for ninety days to allow the Commission an opportunity to reopen the record for comment on the costs of implementing the rule, which the court expressed confidence the Commission could "readily" address. *Id.*

Vacating the rate cut here does not risk the same kind of disruption present in *Sugar Cane Growers* or threatened in *North Carolina v. EPA* or *Chamber of Commerce*. It does not give rise to takings claims, or come too late to relieve farmers from plowing under entire crops, or threaten the environment or public health, or throw an entire regulated industry into turmoil. Vacatur simply would reinstate the payment rates that CMS otherwise would have used in fiscal year 2014 without the invalid rate cut. There are multiple methods in place for hospitals to receive reimbursement for the underpayments.

One approach would be for CMS to use its existing automated claims payment software program (called the "Pricer") to reinstate the 0.2 percent and reprocess claims for all inpatient stays submitted by the hospitals during fiscal year 2014.[6] The mechanics for implementing the correction are not difficult; the Pricer program is routinely updated to incorporate new Medicare payment rates for hospital claims. Alternatively, CMS could use the established process for reconciling hospitals' Medicare reimbursement with the amounts that they are owed via hospitals'

[6] CMS will also have to re-process the claims for inpatient stays during fiscal year 2015, because the 2015 payment rates are based on the flawed 2014 amounts. *See* 42 U.S.C. § 1395ww(d)(3); Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates, Table 1: Comparison of FY 2014 Standardized Amounts to the FY 2015 Standardized Amounts, 79 Fed. Reg. 49,854, 50,382-83 (Aug. 22, 2014).

Medicare cost reports to compute and make lump-sum payments and to pay any interest owed on those amounts.[7] 42 U.S.C. § 1395oo(a), (f); 42 C.F.R. §§ 405.1800 *et seq*. The fact that the government might incur some administrative costs in reprocessing hospitals' claims or calculating the appropriate lump-sum payments, in addition to paying hospitals back the additional Medicare reimbursement they are owed, hardly constitutes the kind of "disruptive consequences" counseling against vacatur.[8] Vacatur of the across-the-board Medicare rate cut is the proper remedy.

CONCLUSION

Toward the close of oral argument on the parties' cross-motions, this Court posed a question: is it "fair[ ]" to CMS for its deficient fiscal-year payment cut to be vacated without giving the agency an opportunity to correct that rulemaking on remand? Tr. 56:15.

Certainly it is. The APA, after all, is a regime designed to *introduce* fairness into what might otherwise be a fundamentally lopsided process. It requires an agency forthrightly to disclose the basis for its proposal; it requires an agency to engage with commenters when

[7] Although the Medicare program reimburses hospitals pursuant to prospectively determined rates, hospitals receive payment on an interim basis throughout the year and final settlement of the total amount of Medicare payment due the hospital is made on a retroactive basis at the end of the hospital's accounting period. 42 C.F.R. § 413.60. Hospitals must submit an annual cost report, which includes the total amount of payments received for each inpatient discharge during the hospital's accounting year, to a Medicare Administrative Contractor. *See* 42 C.F.R. §§ 413.20(b); 413.24(f)(1)-(2). Those contractors review the cost report and issue a "written notice reflecting the contractor's determination of the total amount of reimbursement due the provider." 42 C.F.R. § 405.1803(a).

[8] Moreover, even if CMS somehow *could* lawfully re-promulgate a payment rule for fiscal years 2014 and 2015, and even if the agency were able in the ensuing proceedings somehow to justify excluding *one hundred percent* of medical cases from its actuaries' calculations (a hopeless task, *see supra* at 11), thus requiring an eventual recoupment of the money repaid to the hospitals, even that would not result in significant "disruptive consequences" counseling against vacatur. CMS could use its existing cost-report reconciliation process to recoup any funds for fiscal years 2014 and 2015 it had already paid out.

challenged; and it requires an agency to explain itself adequately in its final rule. CMS violated the APA six ways to Sunday here. The remedy the statute and this Circuit imposes for those violations is vacatur. Fair is as fair does.

If CMS wishes to impose a payment cut on the hospitals for a future fiscal year, it can promulgate a proposed rule that would do that for a future year; and if it can both explain why an across-the-board rate cut is consistent with the statute and adequately supported by evidence, then it can impose that cut. But CMS does not get another opportunity now to impose a rate cut for 2014. To hold otherwise would permit CMS to flout the APA with total impunity, to the detriment of every hospital, knowing that if it is called out for its violations on appeal, the agency will get a costless and leisurely do-over. *That* would be unfair. *See* Tr. 57:5-16.

For all of the foregoing reasons, and for those offered in the plaintiffs' summary-judgment papers, the agency's rate reduction should be vacated.

Dated: August 24, 2015

Respectfully submitted,

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