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

SUPPLEMENTAL REPLY BRIEF IN SUPPORT OF VACATUR FOR PLAINTIFFS SHANDS JACKSONVILLE MEDICAL CENTER, *ET AL.* AND ST. HELENA HOSPITAL, *ET AL.*

The *Shands* and *St. Helena* plaintiffs that make up the vast majority (approximately 80%) of the plaintiff hospitals in these consolidated cases submit this reply brief in support of vacatur. The agency's payment cut should be vacated for two fundamental reasons. First, the payment of *inpatient* rates for additional *inpatient* cases is neither artificial nor a windfall to hospitals—it is statutorily required. There is no authority to "offset" additional inpatient expenditures for a projected increase in utilization of *inpatient* services by paying *outpatient* rates. Second, in the proposed rule, the agency gave no notice of its critical no-effect-on-medical-cases assumption. The government all but concedes this fundamental Administrative Procedure Act ("APA") failure cannot be cured through a remand. The Medicare statute requires the agency to set payments in advance of each year by rule, with advance notice and comment, and generally prohibits retroactive rules. While government counsel predicts the agency would reach the same result on remand, the rate cut was *ultra vires* and procedurally deficient from the outset and cannot possibly become otherwise through further agency action on remand.

1. Paying inpatient rates for inpatient cases creates no windfall. In an apparent attempt to portray its budget cut as equitable, the government's supplemental brief repeats the words "artificial" and "windfall" more than a dozen times. *See* Gov. Supp. Br. 1, 2, 8, 9, 14, 15, 16, 17, 18. None of those words or concepts appears in the 2014 rule or the agency's recent "fuller explanation" (Gov. Supp. Br. 2) in its proposed outpatient rule for 2016; both instead describe a rate cut to offset a *projected* net increase in actual "utilization" of inpatient services. *See* 78 Fed. Reg. 50,496, 50,952, 50,953 (Aug. 19, 2013); 80 Fed. Reg. 39,200, 39,370 (July 8, 2015). Indeed, the government did not even defend the cut on this basis in its merits briefs or at argument. And it is flat wrong—there is no "windfall" to hospitals and nothing "artificial" about paying inpatient rates for proper, medically necessary, inpatient services. *See* 78 Fed. Reg. at

50,951 ("inpatient hospital admissions meeting the 2-midnight benchmark would be generally appropriate for Part A payment"). The two-midnight rule did not create some sort of payment inequity; to the contrary, in the agency's view, the rule fixed the "disturbing trend" (the agency's words) of hospitals previously "elect[ing] to treat Medicare beneficiaries as outpatients, rather than inpatients, because of the significant financial risk of admitting Medicare beneficiaries for inpatient stays and having the claims for those services denied." Gov. Summ. J. Br. 1.[1]

What's more, even the agency could not adopt counsel's new "budget neutrality" theory (at 14-15) on remand, nor did it attempt to in the proposed 2016 outpatient prospective payment system rule offered by the government. This is because the statute requires payment under the *inpatient* prospective payment system for *inpatient* cases. 42 U.S.C. §§ 1395d(a)(1), 1395f(b)(1), 1395ww(d). The agency is not entitled to override that payment requirement under the guise of "budget neutrality" unless Congress provides that authority, and it has not. As to inpatient hospital services, the agency's rate reduction actually effects an aggregate budget cut, not budget neutrality. And, there is no statutory permission to make projected inpatient utilization changes "budget neutral." Congress is specific and plain when it wants budget neutrality at all, authorizing certain payment rule changes to be made in a manner that does not increase aggregate inpatient payments *for the same volume of inpatient cases*. *See* 42 U.S.C. §§ 1395ww(d)(2)(F), (d)(3)(C), (d)(4)(D)(vi) (specifically permitting "budget neutrality" adjustments); or *id*. §§ 1395ww(d)(4)(C), (d)(5)(I)(ii) (stating that "the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment"); *Adirondack Med. Ctr. v. Sebelius*, 740 F.3d 692 (D.C. Cir. 2014) (discussing adjustment consistent with congressional

[1] "Windfall" seems particularly far-fetched in light of the actuaries' estimate having been "subject to a much greater degree of uncertainty than usual." 80 Fed. Reg. at 39,370.

decision to implement new diagnosis classification system in budget neutral manner). No statutory authority exists here for true budget neutrality, much less an unprecedented cap on aggregate inpatient payments to offset a projected increase in inpatient volume, and the rule should be vacated for this reason alone. Pls. Supp. Br. 1; *Northpoint Tech., Ltd. v. FCC*, 412 F.3d 145, 156 (D.C. Cir. 2005).

2. The failure to give notice of the medical case assumption warrants vacatur. To avoid vacatur, the government attempts to characterize the multiple APA violations committed by the agency as ones that could be easily corrected on remand. Gov. Supp. Br. 5-9. This does not work. There is no escaping that the agency utterly failed to give notice of the critical assumption underlying the agency's rate reduction—that medical cases would be 100% unaffected by the two-midnight rule. Regardless of whether there is any "per se" rule requiring vacatur in *every* case involving "deficient notice" (Gov. Supp. Br. 9, 10), the government concedes (at 10) that vacatur is the "normal remedy" that is "almost always" required for failure to give notice. *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1110-11 (D.C. Cir. 2014).

An agency's failure to give notice of a critical assumption *is* grounds for vacatur under Circuit precedent, contrary to the government's contention (at 13) that the D.C. Circuit has declined to vacate in "every case" involving inadequate notice of critical underlying assumptions or methodology. *See, e.g.*, *Owner-Operator Indep. Drivers Ass'n, Inc. v. Fed. Motor Carrier Safety Admin.*, 494 F.3d 188, 201 (D.C. Cir. 2007); *Solite Corp. v. EPA*, 952 F.2d 473, 499 (D.C. Cir. 1991); Pls. Supp. Br. 2-3. Moreover, the government's attempt (at 12) to create daylight between so-called "meaningful opportunity" to comment cases and "deficient notice" cases falls flat. The D.C. Circuit is clear that the obligation to disclose critical assumptions is "[i]ntegral to the *notice* requirement." *Solite Corp.*, 952 F.2d at 484 (emphasis added). The government's

attempts to characterize its APA rulemaking violation as something other than a straight "notice" violation only underscores that vacatur is the "normal remedy."

Moreover, the government provides no reason why a remedy other than the "normal" one of vacatur is appropriate here. Quite the opposite. In the Medicare context, a notice failure cannot be cured with a new comment period in 2015 (or 2016, *see* Gov. Supp. Br. at 7) for a 2014 payment rule. Inpatient payment rates must be set through a rule promulgated in *advance* of each fiscal year, 42 U.S.C. § 1395ww(d)(6), with *advance* notice and opportunity to comment, *id*. § 1395h(a), and retroactivity is not permitted here. Pls. Supp. Br. 8-9. After-the-fact notice would repeat, not cure, the violations of those requirements. And that would ignore a complete failure to respond to significant comments or to explain wholly illogical leaps in the agency's rationale. The government could not cite a single case in which the D.C. Circuit has declined to vacate after finding an agency committed all three violations that it committed here.

Further, the government's "serious possibility" refrain (at 4-9) proves too much. The government has assured that it is a *fait accompli* that the agency will reach the same conclusion in any do-over proceeding on remand, especially in view of the "latest regulatory development" in its proposed rule for 2016.[2] Gov. Supp. Br. 2. That the agency has already attempted to shore

[2] The final rule for 2014 cannot, of course, be upheld based on a rationale articulated in a proposed rule in 2015, *see, e.g.*, *Athens Cmty. Hosp. v. Shalala*, 21 F.3d 1176, 1179-80 (D.C. Cir. 1994), much less a proposed outpatient rule issued after the comment period had already closed for the final inpatient rule—which continued to carry forward the rate reduction for 2016. 80 Fed. Reg. 49,326, 49,787 (Aug. 17, 2015) (final inpatient rule); 80 Fed. Reg. 24,324 (Apr. 30, 2015) (comments on inpatient rule due by June 29, 2015). Remarkably, the proposed rule for 2016 does not discuss available data for 2014 showing that in the aggregate and in every length of stay category inpatient utilization *declined* in 2014 compared with 2013 by even greater proportions than was projected before application of the two-midnight rule. The agency instead changes the conversation and looks to changes in the percentages of total cases lasting more and less than two days. *See* 80 Fed. Reg. at 39,370. Those changes in proportion merely reflect that cases under two midnights have declined tremendously, as intended by the policy. There is no suggestion in the proposed rule that inpatient cases increased from the policy change, the Secretary's original justification, because the data demonstrates the opposite. Further, the Secretary no longer even tries to tie the rate reduction to a cost increase. For an in-depth discussion of the analysis in the proposed rule, see the Comment of Federation of American Hospitals, which will be available at www.regulations.gov.

up its failures while this litigation is pending is an argument *for* vacatur, not against. A close-minded approach to rulemaking is precisely what the APA forecloses. Notice-and-comment rulemaking promotes reasoned decisions through "expertise and input" from interested parties when the agency still has a "flexible and open minded attitude towards its own rules." *Nat'l Tour Brokers Ass'n v. United States*, 591 F.2d 896, 902 (D.C. Cir. 1978). The D.C. Circuit has recognized that an agency is unlikely to "seriously consider [comments] after the regulations are a *fait accompli*." *New Jersey, Dep't of Envtl. Prot. v. EPA*, 626 F.2d 1038, 1049-50 (D.C. Cir. 1980). The remedy for the agency's notice violation here is a new rulemaking that would have prospective effect only, not a pro forma do-over that would apply retroactively for a past year.

3. Repayment of amounts due the hospitals for inpatient services would be equitable, not disruptive. The government argues that the Court should exercise equitable discretion not to vacate the rate reduction for 2014, Gov. Supp. Br. 3, 16-18, because it would be disruptive to have to pay hospitals the additional amounts that should have been paid in the first place. Not so: "Having to pay a sum one owes can hardly amount to an equitable reason for not requiring payment." *In re Medicare Reimbursement Litig.*, 414 F.3d 7, 12-13 (D.C. Cir. 2005). Mere inconvenience to an intransigent agency is not the sort of severe disruption, present in the cases the government relies upon, that warrants remand in an exceptional case. There are well-established processes that the agency regularly uses to make payment corrections like those required to undo the unlawful rate reduction for 2014. *See* Pls. Supp. Br. 13-15. Indeed, the statute providing for this Court's jurisdiction calls for such payments and specifically provides for interest to prevailing parties. 42 U.S.C. § 1395oo(f). It is not disruptive, burdensome, or unfair for the agency to pay the inpatient rates it owes for whatever volume of inpatient services were used by Medicare patients in 2014. The agency's rate reduction should be vacated.

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Respectfully submitted,

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