

No. 05-936

In the Supreme Court of the United States

MICHAEL O. LEAVITT, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

BAYSTATE HEALTH SYSTEMS, DBA BAYSTATE
MEDICAL CENTER, ET AL.

*ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT*

REPLY BRIEF FOR THE PETITIONER

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REPLY BRIEF FOR THE PETITIONER

The court of appeals, based on its prior decisions in *Monmouth Medical Center v. Thompson*, 257 F.3d 807 (2001), and *Paralyzed Veterans of America v. D.C. Arena L.P.*, 117 F.3d 579 (1997), cert. denied, 523 U.S. 1003 (1998), has held that the Secretary must reopen Medicare payment determinations for as many as 2380 cost reports at issue in more than 275 pending cases because the Secretary, without notice-and-comment rulemaking, issued an acquiescence ruling to ensure nationwide uniformity in Medicare payments. The court of appeals reached that unprecedented result even though the acquiescence ruling, Ruling 97-2, explicitly *prohibited* reopening of closed cost reports.

The court of appeals' decision erroneously exposes the Medicare program to staggering (and previously unforeseeable) financial and administrative burdens and threatens to chill future agency acquiescence rulings to the detriment of agencies, private parties, and the courts. It conflicts with decisions of other courts of appeals on whether the Secretary can be ordered to reopen final Medicare determinations contrary to his express direction, and whether an agency may change an interpretive rule absent notice-and-comment rulemaking. And it cannot be reconciled with this Court's decisions compelling the conclusion that mandamus relief is not available for parties, such as respondents, that slept on their rights and now seek a form of administrative relief—reopening—that is inherently discretionary. Review by this Court is warranted.

1. Respondents contend that the circuit conflicts presented by the decision below are not worthy of this Court's review. Br. in Opp. 11-14. That contention lacks merit.

a. Respondents argue that there is no conflict on whether the court of appeals in this case correctly held that *Mon-*

mouth applies to hospitals such as respondents that (unlike the hospitals in *Monmouth*) never sought reopening. Br. in Opp. 8-9, 10-12. Respondents concede (*id.* at 9, 11-12), however, that *Monmouth* conflicts with the Tenth Circuit’s decision in *Bartlett Memorial Medical Center, Inc. v. Thompson*, 347 F.3d 828, 838-840 (2003), on the critical threshold question in this case: whether Ruling 97-2 triggered a mandatory duty to reopen. Respondents do not dispute that *Monmouth*’s holding on that question was a fundamental premise of the decision below. Pet. App. 6a-7a. Thus, resolution of the *Monmouth-Bartlett* conflict in the government’s favor would necessarily require the reversal of the decision below. The conflict therefore is squarely presented and merits this Court’s review. See, e.g., *United States v. Recio*, 537 U.S. 270, 274 (2003) (reviewing the validity of a legal rule announced in a prior decision of Ninth Circuit that had been applied in a subsequent case); cf. *MCI v. AT&T*, 512 U.S. 218 (1994).

Respondents contend that the conflict is “shallow” and “narrow” because it implicates only two circuits. Br. in Opp. 12. The D.C. District Court, however, has nationwide venue in mandamus actions involving the Secretary and in Medicare cases in general. 28 U.S.C. 1391(e); 42 U.S.C. 1395oo(f)(1). Given that nationwide venue and the unprecedented relief granted below, there is no reason to expect that providers in the future will press for reopening in any other forum.

b. As the petition explains, the courts of appeals also are divided on whether an agency may change an interpretation of a regulation without notice-and-comment rulemaking. That issue is of ongoing and obvious significance and worthy of this Court’s review. Pet. 25-26. Respondents do not directly challenge those points, but argue that the issue is not presented here because the Secretary’s DSH regulation was a *legislative* rule and that the circuits agree that amendments to legislative rules must be preceded by notice and comment. Br. in

Opp. 12-14, 25-27; *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 100 (1995). But the question decided by the court of appeals and therefore presented here is whether the Secretary was permitted to change his *interpretation* of that regulation without notice-and-comment rulemaking. On that question, the court of appeals erred, see *id.* at 99 (“[i]nterpretive rules do not require notice and comment”), and the circuits *are* divided. Compare Pet. App. 44a (after an agency interprets a regulation, it cannot alter that interpretation without notice and comment) with *Erringer v. Thompson*, 371 F.3d 625, 632 (9th Cir. 2004) (stating that “[a]ny rule that effectively amends a prior legislative rule is legislative and must be promulgated under notice and comment rulemaking,” *but* that “no notice and comment rulemaking is required to amend a previous *interpretive* rule”). *Monmouth* expressly held that both the Secretary’s original interpretation and his subsequent interpretation as reflected in Ruling 97-2 were *interpretive* rules, but that notice-and-comment rulemaking nonetheless was required before the agency could change course. Pet. App. 34a, 42a-43a (Secretary’s original interpretation), 43a-44a (Secretary’s subsequent interpretation). The circuit conflict is squarely presented here.

2. Respondents argue that the conflicts in the circuits do not warrant this Court’s review because the Secretary did not seek immediate review of *Monmouth*. Br. in Opp. 9, 12. The government, however, should not be penalized for allowing the D.C. Circuit an opportunity to limit the consequences of its erroneous decision in *Monmouth*. Cf. *Cheney v. United States Dist. Ct.*, 542 U.S. 367, 379 (2004) (“the Government cannot be faulted for attempting to resolve the dispute through less drastic means.”). The decision below makes clear that the D.C. Circuit will extend, not limit, *Monmouth*. Thus, review is now appropriate.

Monmouth involved only two providers that had *timely* sought reopening under the Secretary's regulations. The Secretary was not aware of any significant number of other similarly situated hospitals. And because *Monmouth* itself stressed that the two hospitals had sought reopening within the three-year deadline imposed by 42 C.F.R. 405.1885(a) (see Pet. App. 45a), the Secretary reasonably believed that the court would not extend a mandamus remedy to providers, such as respondents, that never made any administrative request for reopening at all.

The decision below makes clear that the court of appeals does not view *Monmouth* as a limited holding. Pet. 27. Moreover, when *Monmouth* was decided, the Tenth Circuit had not yet rendered its conflicting decision in *Bartlett*. Cf. *United States v. Mendoza* 464 U.S. 154, 160 (1984) (agencies immediately seeking review may “deprive this Court of the benefit it receives from permitting several courts of appeals to explore a difficult question”). Now that there is a square conflict with the Tenth Circuit and the D.C. Circuit has dramatically extended the reach of its *Monmouth* decision, review by this Court is plainly warranted.

Respondents also incorrectly assume that this case concerns only the meaning of Ruling 97-2 and a previous version of Section 405.1885(b). *Monmouth* concluded more broadly that an acquiescence ruling, even when it only departs from a prior interpretive rule, must be a nullity because it was not preceded by notice-and-comment rulemaking. Pet. App. 43a-44a. That holding is of significant and ongoing importance to federal agencies that regularly must consider whether to acquiesce in adverse circuit precedent (and often must do so promptly). In this case, the court of appeals held that the Secretary's routine acquiescence for one Medicare cost item resulted in a completely unforeseeable and mandatory duty retroactively to calculate cost reports for providers that

waited five to eight years to challenge those reports. The decision, if not corrected, would create significant confusion and substantial disincentives for agencies to acquiesce in circuit precedent. The net effect of respondents' position would create substantial incentives for unnecessary litigation. The government would need to seek certiorari, rather than try to limit the reach of adverse decisions, and the costs of acquiescence would needlessly increase.

Furthermore, the Secretary's amendment of the reopening rule does not ameliorate the immediate consequences directly imposed by the decision below even in the Medicare context. Pet. 11, 27-30. Respondents argue that the government's \$2.8 billion estimate of the potential costs on the DSH issue alone is speculative, different from previous estimates, and not part of the record below. Br. in Opp. 19-20. But CMS's most recent \$2.8 billion estimate was prepared after a careful analysis and for reasons unrelated to this litigation, *i.e.*, in connection with the agency's *public* financial statement. Pet. 27 & n.7. The Secretary has *always* estimated that the hospitals' claims, if fully successful, could result in payments totaling between \$1 billion and \$3.25 billion. *Ibid.*; Br. in Opp. 19. Such a massive drain on the Medicare Trust Fund, as well as the tremendous administrative burden associated with reopening potentially thousands of previously settled cost reports at issue in the 275 cases pending in the district court, merits this Court's review.¹

¹ Contrary to respondents' assertion (Br. in Opp. 1, 10, 19-21), the Secretary has not suggested that the potential financial and administrative impact of the court of appeals' decision is speculative. The government has simply objected to further proceedings in the district court until this Court has completed its review of the decision below. In addition, the Secretary reasonably believes that compliance with the decision will impose a tremendous burden on the agency and divert its scarce auditing resources to reviewing stale cost report information. Pet. 28. Respondents challenge that assertion as "exaggerate[d]."

Finally, respondents do not dispute that many providers have filed similar mandamus actions that are governed by the Secretary's prior reopening regulation and that seek to extend *Monmouth* to cost issues other than DSH payments. Pet. 29-30. Indeed, respondents' counsel has urged hospitals to file similar mandamus actions, "[f]ollowing [*Monmouth's*] line of reasoning," in the District of Columbia based on other prospective-only changes in policy. C. L. Keogh, *CMS Reverses Application Of Payment-Reduction Factor To Part B Inpatient Ancillary Services*, Healthcare Fin. Mgmt. (2002).

3. In defense of the court of appeals' decision on the merits, respondents attack the Secretary's original methodology for DSH payment determinations. Br. in Opp. 3-5, 22-23. The Secretary believes (as Ruling 97-2 itself stated) that his prior, longstanding interpretation was proper,² but that acquiescence nonetheless was appropriate to ensure national uniformity in light of adverse circuit precedent. Pet. App. 51a. The issue here, however, is not the validity of the Secretary's prior interpretation. The relevant question rather is whether respondents are entitled, through the extraordinary remedy of mandamus, to force the Secretary to recalculate Medicare payments even though they first challenged those payments *five to eight years* after the determinations became final. The answer to that question is clearly no, because respondents both failed to invoke the prescribed statutory and regulatory remedies and failed to show an indisputable right of recovery.

"overblown," and "misleading" (Br. in Opp. 21), but the Secretary respectfully submits that he is in a far superior position than respondents to judge the complexity and burdens from review and recalculation of DSH payments for cost years more than ten years old.

² Strong dissents in two decisions approved the Secretary's position. See *Cabell Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984, 991 (4th Cir. 1996) (Luttig, J., dissenting); *Jewish Hosp., Inc. v. Secretary of HHS*, 19 F.3d 270, 276 (6th Cir. 1994) (Batchelder, J., dissenting).

a. Admitting that they did “nothing” (Br. in Opp. 18) to exhaust their claims before the Secretary, respondents argue that seeking reopening would have been futile because reopening was prohibited by Ruling 97-2. But respondents could have *appealed* their initial DSH payment determinations to the Provider Reimbursement Review Board (PRRB), and then sought *direct* judicial review in the manner provided by the Medicare Act. Pet. 12-13. If they had, they might have obtained precisely the relief that they now seek: recalculation of their original DSH determinations under the methodology later adopted in Ruling 97-2. Other hospitals in fact obtained that relief after they appealed and sought judicial review. Pet. 13 n.3; Br. in Opp. 5 & n4. Respondents thus did not invoke that “adequate remedy * * * for challenging all aspects of the Secretary’s denial of their claims for payment.” *Heckler v. Ringer*, 466 U.S. 602, 617 (1984).

In all events, even if reopening were the only relevant focal point, as respondents maintain (Br. in Opp. 16-18), they never invoked that remedy either, unlike the hospitals in *Monmouth* that timely sought reopening within three years of the determinations as required by Section 405.1885(a)—the only regulation that permits reopening at the behest of providers. Pet. 20. Any effort by respondents to obtain reopening therefore is time-barred, in addition to being foreclosed on the merits. The hospitals’ excessive delay before challenging their final Medicare payment determinations is alone sufficient to preclude them from the *equitable* remedy of mandamus.³

³ Given the government’s consistent position that reopening of DSH determinations would impose wholly unwarranted and potentially far-reaching liability on the Medicare Trust Fund in favor of hospitals that slept on their rights, respondents’ suggestion (Br. in Opp. 9, 19) that the government has conceded that the equities lie in their favor and that the Secretary suffers no prejudice from the court of appeals’ decision is baseless.

b. Respondents' reliance on the principle that an agency must follow its own regulations is misplaced. Br. in Opp. 15-16. Since the inception of the reopening regulation in 1972, the Secretary has always considered that regulation to be entirely discretionary. Pet. 15-17. Respondents have pointed to nothing in the regulation that gives them a right to demand reopening (much less a clear and undisputable right), and to do so contrary to the Secretary's express directive in Ruling 97-2. In fact, they admit that "[t]he only reopening that a hospital has any role in initiating is *discretionary* reopening under subsection (a)." Br. in Opp. 17 (emphasis added).

Respondents nonetheless argue (Br. in Opp. 24) that Section 405.1885(b) must be read to require reopening, even when the Secretary has prohibited it, or subsection (b) "would serve no purpose not already subsumed within subsection (a)." But any arguable superfluity would not justify reading the regulation contrary to the Secretary's manifest intent. *E.g.*, *Scheidler v. NOW*, 126 S. Ct. 1264, 1273-1274 (2006). In any event, there is nothing superfluous about subsections (a) and (b). Section 405.1885(a) confers discretion not only on intermediaries, but also on the PRRB and the Secretary if they (rather than an intermediary) entered the decision that the provider seeks to reopen, if a motion is made within three years. By contrast, Section 405.1885(b) is directed only to intermediaries and specifies that reopening "shall" occur when the Secretary himself explicitly instructs the intermediary to reopen. Pet. 14-17. Thus, while Section 405.1885(a) "generously gives [providers] a second chance to get the decision changed" (*Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449, 455 (1999)), Section 405.1885(b) allows the Secretary, on his own initiative, to identify errors in intermediary determinations and to *direct* the intermediaries to correct them. As we demonstrate in the petition (at 15-17), Section 405.1885(b) creates a contingent duty owed by the

intermediary *to the Secretary* in accordance with their bilateral contractual arrangement; it creates no duty owed by either an intermediary or the Secretary to providers. Respondents make no effort to refute this showing that Section 405.1885(b) creates no clear duty owed *to them*, a necessary prerequisite for mandamus relief. Pet. 15-16 & n.4.

The Secretary's reading not only comports with the text and his longstanding interpretation, but also with the well-settled understanding of reopening as inherently discretionary and non-reviewable. Pet. 17. It also comports with Congress's stringent time-requirements for appealing payment determinations under a program as complex and massive in size as Medicare. The Secretary's eminently reasonable interpretation was therefore binding on the court of appeals. *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 505 (1994).

Respondents defend the court of appeals' reading of Ruling 97-2 as the Secretary's concession of an error of law (despite the Ruling's express statement to the contrary) on the ground that any other reading would have required the Secretary to promulgate a new legislative regulation in order to acquiesce in circuit precedent. Br. in Opp. 24-27. But it has never been the law that an agency must issue such a regulation to effectuate what quintessentially is a *litigation* judgment. Pet. 25-26. Moreover, any procedural defect in Ruling 97-2 would, at most, permit a court to invalidate the Ruling until notice and comment had been completed. It would not authorize a court to strike the Ruling's critical provision expressly *prohibiting* reopening while enforcing its substantive provision. Pet. 19.

Respondents also err in arguing that the Secretary's prior DSH determinations must have been void *ab initio* because Ruling 97-2 applied the new DSH payment methodology for costs incurred by hospitals in prior years if the cost reports were not yet finally settled or were still pending on review. Br. in Opp. 6-7, 27-28. In respondents' view (*ibid.*), the Ruling

was impermissibly retroactive under *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988). If respondents' contention were correct, however, the only proper relief would be to invalidate Ruling 97-2, which would remove any basis for holding that the Ruling triggered mandatory reopening. In any event, Ruling 97-2 is not impermissibly retroactive as applied to hospitals with open cost reports or pending appeals for prior cost years because the Ruling was *favorable* to them. Ruling 97-2's bar to reopening of closed cost reports simply reflects the settled principle that a new rule of law applies only to cases pending on direct review. *E.g.*, *Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 214 (1995).

By requiring the reopening of as many as 2380 cost reports in the more than 275 cases pending in the district court, the court of appeals has imposed extraordinary burdens and potential liability that would not have arisen if the Secretary had simply plowed ahead with litigation and lost in every circuit or in this Court. Because acquiescence is intended to be a substitute for continued pursuit of litigation, the Secretary's decision to acquiesce on a nationwide basis—to save providers, the government, and the courts from further litigation burdens—should not result in penalizing the Secretary and the Medicare Trust Fund. Such a rule could not help but chill the sound and flexible administration of federal programs.

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For the foregoing reasons and those stated in the petition for a writ of certiorari, the petition for a writ of certiorari should be granted.

Respectfully submitted.

PAUL D. CLEMENT
Solicitor General

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