No. 19-1203

In the Supreme Court of the United States

CHILDREN'S HOSPITAL ASSOCIATION OF TEXAS, ET AL., PETITIONERS

v.

ALEX M. AZAR, II, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

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

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Whether the Centers for Medicare & Medicaid Services validly issued a regulation providing that, for purposes of calculating the statutory cap on a supplemental payment to a hospital that treats a disproportionate share of low-income patients, the hospital's "costs incurred" for serving Medicaid-eligible and uninsured patients are "net of" payments received from third parties such as Medicare and private insurers, as well as from Medicaid and uninsured patients. 42 U.S.C. 1396r-4(g)(1)(A).

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-18a) is reported at 933 F.3d 764. The opinion of the district court (Pet. App. 22a-63a) is reported at 300 F. Supp. 3d 190.

JURISDICTION

The judgment of the court of appeals was entered on August 13, 2019. A petition for rehearing was denied on November 8, 2019 (Pet. App. 68a-69a). On January 28, 2020, the Chief Justice extended the time within which to file a petition for a writ of certiorari to and including April 6, 2020, and the petition was filed on that date. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Medicaid is a cooperative venture between the federal government and state governments to provide health coverage to needy individuals. 42 U.S.C. 1396 *et seq.* Federal funds are distributed to qualifying States, which administer their Medicaid programs pursuant to federally approved plans. To be eligible for Medicaid, individuals generally must have "income and resources [that] are insufficient to meet the costs of necessary medical services." 42 U.S.C. 1396-1. Individuals eligible for Medicaid may have other third-party sources of payment for healthcare services, such as Medicare, Tricare, private insurance, worker's compensation, or liability coverage. For example, elderly indigent individuals may be eligible for both Medicaid and Medicare. And children with certain disabilities may be eligible for Medicaid and may also have private health insurance coverage through their parents.

This case involves Congress's authorization of supplemental payments to hospitals that serve disproportionate numbers of Medicaid-eligible and uninsured patients. 42 U.S.C. 1396r-4. States provide for such payments—called Disproportionate Share Hospital (DSH) adjustments—through their Medicaid plans. See *ibid.* Congress has imposed both state-specific and hospital-specific limits on DSH adjustments. 42 U.S.C. 1396r-4(f)(3), (g)(1)(A). Of particular relevance here, Congress imposed a hospital-specific limit in response to reports that, *inter alia*, some hospitals had received payments "that exceed[ed] the net costs, and in some instances the total costs, of operating the facilities." H.R. Rep. No. 111, 103d Cong., 1st Sess. 211 (1993) (House Report). The hospital-specific limit provision,

entitled "Amount of adjustment subject to uncompensated costs," 42 U.S.C. 1396r-4(g)(1), states that a hospital's DSH payment cannot exceed

> the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under [Medicaid, other than DSH payments], and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the [Medicaid] State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

42 U.S.C. 1396r-4(g)(1)(A). The next sentence of the provision states: "For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment." *Ibid.* In subsequent oversight legislation, Congress required States to submit annual reports confirming that the "calculation of the hospital-specific limits" reflects "[o]nly the uncompensated care costs of providing inpatient hospital and outpatient hospital services" to Medicaid-eligible or uninsured patients. 42 U.S.C. 1396r-4(j)(2)(C).

2. In 2008, the Centers for Medicare & Medicaid Services (CMS) issued regulations implementing the requirements of the oversight legislation. 73 Fed. Reg. 77,904 (Dec. 19, 2008). The regulations require each DSH hospital to report, among other amounts, the "total amount of uncompensated care attributable to Medicaid inpatient and outpatient services." *Id.* at 77,950 (42 C.F.R. 447.299(c)(11)). As issued in 2008, the regulations stated that this amount—"Total Medicaid Uncompensated Care"—equaled a hospital's "total annual costs incurred" for furnishing services to Medicaid-

eligible individuals, minus Medicaid payments received. *Ibid.* (42 C.F.R. 447.299(c)(10) and (11) (2016)) (emphasis omitted).

The regulatory text did not further define the phrase "costs incurred" or expressly address possible third-party payments received by hospitals for treating Medicaid-eligible patients, such as payments by Medicare or private insurers. CMS's views on third-party payments were reflected, however, in the preamble to the 2008 rule and subsequent agency guidance. In the preamble, CMS responded to a comment about Medicaid patients who also have Medicare coverage by stating that calculation of a hospital's "uncompensated care costs" requires taking into account both the treatment costs and compensation associated with these patients, including "both the Medicare and Medicaid payments." 73 Fed. Reg. at 77,912.

CMS reiterated that position in a 2010 guidance document addressing frequently asked questions (FAQs), and added that it was equally true for Medicaid-eligible patients with private insurance. See C.A. App. 676 (FAQs 33 and 34). Specifically, CMS again noted that a hospital's uncompensated-care costs calculation must account for treatment costs associated with all Medicaid-eligible patients, including those with Medicare or private insurance. See *ibid.* CMS explained that, concomitantly, it is necessary to "offset both Medicaid and third-party revenue * * * against the costs * * * to determine any uncompensated amount." *Ibid.*

Several hospitals and hospital associations filed suits challenging the validity of the guidance in FAQs 33 and 34. After litigation in multiple district courts, four appellate courts in 2018 agreed that the FAQs constituted substantive amendments to the 2008 regulations and

therefore should have been issued through notice-and-comment rulemaking.[1] Following those decisions, CMS withdrew FAQs 33 and 34 as of December 30, 2018. CMS, *Medicaid Disproportionate Share Hospital (DSH) Payments*, https://go.usa.gov/xERAA.

3. In 2016, while still defending the FAQs in litigation, CMS initiated notice-and-comment rulemaking to amend the 2008 regulations to make explicit CMS's "existing interpretation"—*i.e.*, that calculating a hospital's "uncompensated care costs" for purposes of a DSH payment requires deducting payments received by the hospital from Medicare or private insurers for the treatment of Medicaid-eligible and uninsured patients. 81 Fed. Reg. 53,980, 53,981 (Aug. 15, 2016). CMS issued its final rule in 2017. 82 Fed. Reg. 16,114 (Apr. 3, 2017). The rule amended the DSH regulations to provide expressly that a hospital's "total annual costs incurred" for furnishing services to Medicaid patients is an amount "net of third-party payments, including, but not limited to, payments by Medicare and private insurance." *Id.* at 16,122 (42 C.F.R. 447.299(c)(10)). CMS confirmed that the rulemaking "ensure[d] that existing interpretive policy [wa]s explicitly reflected" in the regulations. *Id.* at 16,119.

In the rulemaking, CMS outlined the history of its policy that third-party payments must be deducted in calculating a hospital's costs incurred, and detailed the statutory basis and policy reasons for that position. 82 Fed. Reg. at 16,114-16,1120. As in the FAQs, the

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[1] See *Tennessee Hosp. Ass'n* v. *Azar*, 908 F.3d 1029 (6th Cir. 2018); *Children's Health Care* v. *CMS*, 900 F.3d 1022 (8th Cir. 2018); *Children's Hosp. of the King's Daughters, Inc.* v. *Azar*, 896 F.3d 615 (4th Cir. 2018); *New Hampshire Hosp. Ass'n* v. *Azar*, 887 F.3d 62 (1st Cir. 2018).

agency explained that the hospital costs of all Medicaid-eligible patients (including those with third-party coverage) are part of the uncompensated-care costs calculation, and that payments on their behalf (including third-party payments) likewise must be part of the calculation. *Id.* at 16,114-16,115. The agency expressly rejected the alternative policy urged by some hospitals—that the costs of hospital services for Medicaid-eligible patients should be regarded as "uncompensated" if they have been paid for by Medicare, private insurers, or other sources of third-party payment. *Id.* at 16,117-16,118. CMS explained that this approach would allow a hospital "to receive DSH dollars in excess of its uncompensated care costs." *Id.* at 16,117.

The final rule stresses that accounting for third-party payments "facilitate[s] the Congressional directive" to limit DSH payments to "a hospital's uncompensated care costs." 82 Fed. Reg. at 16,118. CMS explained that its approach "best fulfills the purpose of the DSH statute," because it "ensures that" a State's "limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients," and "promotes fiscal integrity and equitable distribution of DSH payments among hospitals." *Id.* at 16,116, 16,118; see *id.* at 16,118 (noting that "Medicaid DSH payments will not double pay for costs that have already been compensated"). CMS stressed that, under the final rule, a hospital's maximum DSH payment "reflects [its] real economic burden" of treating Medicaid-eligible and uninsured patients. *Id.* at 16,117.

4. Petitioners are the Children's Hospital Association of Texas, as well as children's hospitals or hospital systems in Minnesota, Virginia, and Washington. Some

of petitioners' Medicaid-eligible patients also have private insurance. Those patients' hospital services are typically paid for by their private insurers, and those payments may well exceed the costs to the hospital of providing those services. Indeed, petitioners have explained that the compensation they receive from private insurers for these patients is generally so high that, when it is included in the calculation of their maximum DSH payments, they have *no* uncompensated care costs. See Pet. 13-14.[2]

Petitioners challenged CMS's final rule in the United States District Court for the District of Columbia, contending that the rule exceeded the agency's statutory authority and was arbitrary and capricious in violation of the Administrative Procedure Act (APA), 5 U.S.C. 701 *et seq.* The district court vacated the rule. Pet. App. 63a. The court agreed with petitioners that the statute unambiguously bars the Secretary from considering payments by private insurers and Medicare when calculating "uncompensated costs" or "costs incurred." *Id.* at 53a (citation and internal quotation marks omitted). The court observed that the statute "indicates which payments can be subtracted" and "nowhere mentions subtracting other third-party payments." *Ibid.* The court acknowledged that the statute expressly confers

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[2] When Medicaid-eligible patients have private insurance or certain other third-party coverage, Medicaid generally serves as a payer of last resort. Because the third-party payments typically exceed what Medicaid would pay, Medicaid generally pays little or nothing for hospital services for these patients. See *Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268, 291 (2006); *Tennessee Hosp. Ass'n*, 908 F.3d at 1035.

authority on the Secretary to determine "costs incurred," but maintained that the conferral of authority did not permit CMS to require hospitals to account for third-party payments, because that would "'render the Congressional definition of "payments" in the very same clause superfluous.'" *Id.* at 53a-54a (citation omitted). The court also acknowledged Congress's repeated references to "uncompensated costs," but found them immaterial. *Id.* at 57a (citation omitted).

Having held that the final rule exceeded CMS's statutory authority in violation of 5 U.S.C. 706(2)(C), the district court did not address whether the rule was arbitrary and capricious in violation of 5 U.S.C. 706(2)(A).

5. The court of appeals reversed the district court's decision and upheld the rule. The panel unanimously concluded that CMS neither exceeded its statutory authority nor acted in an arbitrary or capricious manner in promulgating the rule.

a. On the question of statutory authority, the court of appeals explained that the Secretary was expressly vested with authority to determine "costs incurred," Pet. App. 8a (citation omitted), but was not permitted to do so in a manner that that was "arbitrary, capricious, or manifestly contrary to the [Medicaid] statute," *id.* at 8a-9a (quoting *Chevron U.S.A. Inc.* v. *Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984)). The court considered and rejected each of petitioners' arguments as to why "the statute does not grant the Secretary authority to require that payments by Medicare and private insurers be considered in calculating a hospital's 'costs incurred.'" *Id.* at 9a.

The court of appeals first explained that the plain text of the statute does not preclude CMS's approach: "Although the statute establishes that payments by

Medicaid and the uninsured *must* be considered, it nowhere states that those are the only payments that *may* be considered." Pet. App. 10a. Concluding otherwise, the court observed, would require drawing a negative-implication inference based on the canon *expressio unius est exlusio alterius*. See *ibid.* The court found reliance on that interpretive canon unwarranted because "[t]here is reason to believe th[at] Congress did not intend to exclude Medicare and private insurance payments from consideration." *Ibid.* The court explained that "Congress may have wanted to ensure that the most common sources of payment" for Medicaid-eligible patients—Medicaid itself and payments by the uninsured—"must be considered but at the same time allow the Secretary to decide whether less-common sources of payment should be as well." *Id.* at 11a.

The court of appeals rejected petitioners' related argument that the rule renders the statutory directive to deduct payments by Medicaid and the uninsured "superfluous." Pet. App. 11a. Congress's directive, the court explained, retains meaning under CMS's approach because it "removes the Secretary's discretion as to those two forms of payment." *Id.* at 11a. Moreover, the court explained, the directive to deduct payments from Medicaid and the uninsured undermines petitioners' argument that "payments can never be considered in calculating 'costs incurred.'" *Id.* at 13a.

The court of appeals added that CMS's treatment of third-party payments accords with congressional objectives. Pet. App. 14a. The court explained that, by ensuring that DSH funds go to hospitals whose services to Medicaid-eligible and uninsured patients have gone uncompensated—rather than hospitals where these ser-

vices have already been compensated—the rule "is consistent with the [DSH] statute's context and purpose." *Ibid.*

b. The court of appeals rejected petitioners' alternative argument that the rule is arbitrary and capricious. Pet. App. 15a-18a. Of particular relevance here, the court rejected petitioners' claim that the rule inadequately addressed a change in agency position. The court observed that the third-party payment policy stated in the 2010 FAQs and repeated in the 2017 rule made a change to the 2008 regulations. *Id.* at 16a. But the court found "no unexplained inconsistency with an earlier position" because the rule acknowledged the regulatory history and explained "why the statute's purposes are better fulfilled" by the present policy. *Ibid.*; see *id.* at 17a. In light of the agency's thorough and reasoned explanation, the court concluded, it "ma[de] no difference" that the Secretary described the 2017 rule as clarifying, rather than altering, the prior rule. *Id.* at 16a; see *id.* at 17a (concluding that CMS's explanation was "more than sufficient to survive review under [5 U.S.C.] 706(2)(A)").

c. Petitioners' request for panel rehearing was denied. Pet. App. 68a-69a.

6. Every other appellate court that has considered the 2017 rule has upheld it, with no judge on any court suggesting that the rule is arbitrary and capricious. See *Baptist Mem'l Hosp.-Golden Triangle, Inc.* v. *Azar*, 956 F.3d 689, 693-696 (5th Cir. 2020) (unanimously rejecting statutory-authority argument without addressing arbitrary-and-capricious argument); *Missouri Hosp. Ass'n* v. *Azar*, 941 F.3d 896, 898-900 (8th Cir. 2019) (same); *id.* at 900-901 (Stras, J, concurring) (articulating an additional explanation for why the rule is consistent

with statutory authority); see also *Tennessee Hosp. Ass'n* v. *Azar*, 908 F.3d 1029, 1037-1042, 1047 (6th Cir. 2018) (concluding that CMS adopted "a reasonable interpretation" that is "consistent with the Medicaid Act" through "a procedurally valid rule"); *id.* at 1050 (Kethledge, J., concurring in the judgment) (dissenting on the statutory-authority issue without discussing the arbitrary-and-capricious issue).

ARGUMENT

Petitioners contend (Pet. 17-34) that the final rule is both procedurally and substantively defective. But as the unanimous court of appeals held—and as every other appellate court that has considered the question has agreed—the rule is neither arbitrary and capricious nor beyond the agency's statutory authority. To the contrary, CMS offered a thorough explanation for its exercise of the authority expressly vested in it to determine "costs incurred" for purposes of calculating the limit on a hospital's DSH payment. 42 U.S.C. 1396r-4(g)(1)(A). The agency's decision to require the deduction of payments received by a hospital from third parties such as Medicare and private insurers, as well as payments from Medicaid and uninsured patients, is reasonable and directly advances the purposes underlying Congress's adoption of the hospital-specific limit. Petitioners' challenges have been extensively reviewed by multiple courts of appeals, all of which have correctly rejected them. The petition for a writ of certiorari therefore should be denied.

1. Petitioners' lead claim (Pet. 18-24) is that the final rule is procedurally invalid under the APA because CMS failed to adequately explain a change in policy. But no court has accepted that claim, and for good reason: as the unanimous panel below recognized, CMS's

explanation for the final rule was "more than sufficient" to satisfy all procedural requirements. Pet. App. 17a.

a. Under the APA, agencies "are free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC* v. *Navarro*, 136 S. Ct. 2117, 2125 (2016); see *FCC* v. *Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (explaining that agencies "may not, for example, depart from a prior policy *sub silentio* or simply disregard rules that are still on the books"). The court of appeals correctly concluded—and petitioners no longer seriously dispute—that CMS thoroughly "explained why the [Medicaid DSH] statute's purposes are better fulfilled by a policy that requires consideration of payments by Medicare and private insurers (the 2017 Rule) than one that does not (the 2008 Rule, as [the court] interpret[ed] it)." Pet. App. 16a.

CMS began by addressing the statutory text, explaining that Congress established in 42 U.S.C. 1396r-4(g)(1)(A) and (j)(2)(C) that the hospital-specific limit "only includes uncompensated care costs." 82 Fed. Reg. at 16,115. The agency explained that accounting for third-party payments associated with Medicaid-eligible patients "is necessary to ensure that only actual uncompensated care costs are included." *Id.* at 16,117. Absent such a policy, the agency reasoned, a hospital that receives payments from Medicare or private insurers for any of its Medicaid patients would be able to "overstate [its] uncompensated care costs, thus inappropriately inflating [its] hospital-specific limit." *Id.* at 16,119. In short, the hospital could receive "DSH dollars in excess of its uncompensated care costs," effectively collecting "double pay for costs that have already been compensated." *Id.* at 16,117-16,118.

CMS offered a "simplified example" of "a state that has only two hospitals" to illustrate how its policy ensures that a hospital's DSH payment "reflects [its] real economic burden" of treating Medicaid-eligible and uninsured patients, rather than any "artificial inflation." 82 Fed. Reg. 16,116-16,117. In the example, the first hospital treats Medicaid patients who have no other coverage, and all of its compensation comes from Medicaid. Its hospital-specific DSH payment limit unquestionably equals its treatment costs minus the Medicaid payments received. *Id.* at 16,117. The second hospital treats Medicaid-eligible patients with Medicare coverage. It "receives comparatively generous" payments from Medicare for those patients, and, as a payer of last resort, Medicaid pays little or nothing. *Ibid.* Under the final rule, the second hospital's DSH limit equals its treatment costs minus the Medicare payments and any Medicaid payments. *Ibid.* But if, as petitioners propose, the Medicare payments could be ignored, the second hospital's DSH limit would equal its treatment costs minus only whatever small amount, if any, might have been paid by Medicaid. The second hospital would thus be able to assert higher "uncompensated-care costs"—and therefore a higher DSH limit—than the first hospital, even though it actually collected greater compensation. *Ibid.* Moreover, because States are limited to an annual allotment of federal DSH funding, "the excess DSH payments to the second hospital may be at the expense of the first hospital, which could otherwise receive these DSH dollars." *Ibid.* CMS emphasized that its rule avoids that result, "ensur[ing] that limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients." *Ibid.*

b. Petitioners do not seriously dispute that comprehensive explanation. They instead contend that the final rule is unlawful because CMS failed to "display awareness that it [was] changing position," in a manner consistent with this Court's decision in *Fox*. Pet. 18 (citations omitted). That contention misunderstands both CMS's explanation and *Fox*. As the court of appeals correctly held, the final rule fully complied with the requirement of reasoned decisionmaking discussed in *Fox* because CMS left "no unexplained inconsistency with an earlier position." Pet. App. 16a.

In issuing the final rule, CMS explained in detail the regulatory history that preceded it, including the 2008 regulation implementing the oversight legislation and the FAQs issued in 2010 stating that Medicare and private-insurer payments should be deducted in calculating a DSH hospital's "costs incurred." 42 U.S.C. 1396r-4(g)(1); see 82 Fed. Reg. at 16,114-16,120. At the time it issued the final rule, CMS was defending the FAQs as an interpretation—rather than a substantive amendment—of the 2008 regulation. See pp. 4-5, *supra*. Consistent with that reasonable (though ultimately rejected) understanding, CMS did not frame the position codified in the final rule as a departure from its existing regulations, but rather as consistent with them. See 82 Fed. Reg. at 16,117.

Petitioners seize on that aspect of the agency's explanation in contending that it failed to recognize a change in policy. But petitioners' portrayal mischaracterizes the rulemaking. The agency left no doubt about what its policy had been in the past, how it had articulated its position over time, and what it was codifying in the final rule. See 82 Fed. Reg. at 16,114-16,120. Given the agency's candid and thorough explanation, the court

of appeals correctly held that it "ma[de] no difference" that CMS asserted that "the 2017 Rule [wa]s consistent with the 2008 Rule." Pet. App. 16a & n.3. Petitioners' contrary position essentially attempts to bootstrap CMS's defeat on the procedural validity *of the FAQs* into grounds for finding *the final rule* procedurally invalid. But no basis exists for such a maneuver. Neither this Court's decision in *Fox* nor any other principle of administrative law imposes a freestanding, absolute requirement that an agency correctly identify all departures from previous policies. What *Fox* requires is a "reasoned explanation" for the agency's decision. 556 U.S. at 515. Although that requirement may "*ordinarily* demand that" an agency "display awareness that it *is* changing position," *ibid.* (first emphasis added), CMS readily satisfied the APA's procedural requirements by fully explaining its prior and current policies in a way that left no "*unexplained* inconsistency," Pet. App. 16a (emphasis added).

At a minimum, even if *Fox* did impose a rigid acknowledgment-of-position-change requirement of the kind petitioners assert, the agency's failure to satisfy that requirement here would be a nonprejudical error that does not justify setting aside the rule. See 5 U.S.C. 706 (stating that, in reviewing administrative-law challenges, "due account shall be taken of the rule of prejudicial error"); *Little Sisters of the Poor Saints Peter & Paul Home* v. *Pennsylvania*, 140 S. Ct. 2367, 2385 (2020) (describing the administrative-law "harmless error rule"). Even assuming *arguendo* that CMS failed to adequately acknowledge a change in position, petitioners "do not come close to demonstrating that they experienced any harm from" that asserted error, given that CMS made clear to all involved precisely what its past

and present policies were. *Little Sisters*, 140 S. Ct. at 2385; see Pet. App. 16a (holding that any departure from CMS's prior policy "makes no difference").

c. Petitioners suggest (Pet. 20-22) that the court of appeals' decision upholding the rule conflicts with decisions of other circuits. Notably, however, petitioners do not contend that any of the other courts of appeals that have addressed the validity of the final rule at issue here disagree with the D.C. Circuit. To the contrary, all of those courts have upheld the rule, and no judge (let alone the majority of a panel) has suggested that the rule is procedurally invalid. Cf. Pet. 20 (acknowledging that the Sixth Circuit "took much the same approach" to the procedural question as the court below).

Petitioners instead rely on a more abstract asserted conflict between the decision below and decisions from other courts addressing purportedly similar administrative-law questions in different contexts. But in all of the cases cited by petitioners, the defendant agencies failed to furnish reasoned explanations.[3] Petitioners

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[3] See *Flores* v. *Barr*, 791 Fed. Appx. 222, 226 (2d Cir. 2019) (holding that agency's "failure to acknowledge or explain its departure" required a remand); *Mei Fun Wong* v. *Holder*, 633 F.3d 64, 78 (2d Cir. 2011) (remanding to agency where "persistent unexplained inconsistency with [the earlier decision] precludes * * * meaningful review"); *CBS Corp.* v. *FCC*, 663 F.3d 122, 147 (3d Cir. 2011) (concluding that agency failed to "even acknowledge its departure from its former policy, let alone supply a 'reasoned explanation' for the change"), cert. denied, 567 U.S. 953 (2012); *Jimenez-Cedillo* v. *Sessions*, 885 F.3d 292, 298-299 (4th Cir. 2018) (finding that agency denied policy change and left the court "without a reasoned explanation" for the change); *Amazon.com, Inc.* v. *Commissioner*, 934 F.3d 976, 991 (9th Cir. 2019) (following *Fox*'s admonition that providing a reasoned explanation "would ordinarily demand" a "display [of] awareness" of a changing position) (citation omitted); *Gomez-*

cite no decision holding that a policy change must be rejected as procedurally defective even though the agency is found to have provided a well-reasoned explanation for its adoption. The context-specific holding that the final rule at issue here was procedurally valid because CMS left "no unexplained inconsistency with an earlier position" does not conflict in any way with the decisions cited by petitioners. Pet. App. 16a. This Court's intervention is accordingly unwarranted.

2. Petitioners also contend (Pet. 24-34) that the court of appeals erred in holding that the final rule is within the agency's statutory authority. In petitioners' view, the court erred both by purportedly misapplying the principles of *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), and by rejecting petitioners' statutory-interpretation arguments. Those contentions lack merit and do not warrant this Court's review, particularly in light of the consensus among courts of appeals that have upheld the rule against similar claims. See *Baptist Mem'l Hosp.-Golden Triangle, Inc.* v. *Azar*, 956 F.3d 689, 693-696 (5th Cir. 2020); *Missouri Hosp. Ass'n* v. *Azar*, 941 F.3d 896, 898-900 (8th Cir. 2019); *Tennessee Hosp. Ass'n* v. *Azar*, 908 F.3d 1029, 1037-1042 (6th Cir. 2018).

a. This Court explained in *Chevron* that, when Congress has "explicitly left a gap for the agency to fill," the

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Sanchez v. *Sessions*, 892 F.3d 985, 995 (9th Cir. 2018) (rejecting rule where there was "no attempt to address the apparent inconsistencies" with an earlier rule); *California Pub. Utils. Comm'n* v. *FERC*, 879 F.3d 966, 978 (9th Cir. 2018) (holding an "unacknowledged and unexplained departure" was arbitrary and capricious); *Organized Vill. of Kake* v. *United States Dep't of Agric.*, 795 F.3d 956, 966-969 (9th Cir. 2015) (en banc) (concluding that a policy change, although acknowledged, was inadequately supported), cert. denied, 136 S. Ct. 1509 (2016).

agency's interpretation is "given controlling weight unless [it is] arbitrary, capricious, or manifestly contrary to the statute." 467 U.S. at 843-844; see, *e.g.*, *Household Credit Servs., Inc.* v. *Pfennig*, 541 U.S. 232, 239 (2004) (reiterating that principle). The court of appeals applied that principle here because "the delegation at issue * * * is express rather than implied." Pet. App. 8a; see 42 U.S.C. 1396r-4(g)(1)(A) (setting DSH payment limit based on "the costs incurred * * * *as determined by the Secretary* and net of [Medicaid and uninsured-patient] payments") (emphasis added). The court accordingly determined that the dispositive question was "whether the Rule is reasonable." Pet. App. 8a.

Petitioners contend (Pet. 24-26) that the court of appeals' "approach [was] unsound" because it "allowed the agency to jump ahead" to the second step of the *Chevron* analysis and thereby "tilted the scales in the agency's favor." But petitioners do not dispute either that the statute vests authority in the Secretary to "determine[]" the scope of "costs incurred," or that the rule at issue here is an exercise of that authority. 42 U.S.C. 1396r-4(g)(1)(A); cf. Pet. 25 (recognizing that CMS has "authority to determine 'costs incurred during the year of furnishing hospital services'") (citation omitted). The case thus ultimately comes down to whether the agency's exercise of that express authority is "reasonable" in light of the statutory text, context, history, and purpose—precisely the analysis that the court of appeals performed in thoroughly considering (and rejecting) petitioners' statutory objections. Pet. App. 8a; see *id.* at 8a-14a.

No conflict exists on this basic interpretive issue. All the other courts of appeals that have addressed challenges to the rule have followed an approach similar to

the court of appeals here. See *Baptist Mem'l Hosp.*, 956 F.3d at 693-696; *Missouri Hosp. Ass'n*, 941 F.3d at 898-900; *Tennessee Hosp. Ass'n*, 908 F.3d at 1038. The D.C. Circuit's approach to questions concerning express vesting of interpretive authority, moreover, is ultimately rooted in this Court's decision in *Chevron*, see Pet. App. 8a (citing 467 U.S. at 843-844), and this Court recently declined to review that approach in response to a petition for a writ of certiorari challenging it, see *American Bankers Ass'n* v. *National Credit Union Admin.*, No. 19-1115, 2020 WL 3492665 (June 29, 2020).[4]

b. On the merits of petitioners' statutory arguments, the court of appeals thoroughly considered and correctly rejected each of them, see Pet. App. 8a-14a, holding that the Secretary reasonably determined that a calculation of "uncompensated costs" should not include costs that have been compensated by third-party payments from Medicare or private insurers, 42 U.S.C. 1396r-4(g)(1). Petitioners identify no errors in the court's analysis, and no basis exists for further review given the consensus among the courts of appeals that have addressed this question.

Petitioners first contend (Pet. 26-29) that the court of appeals should have applied the canon *expressio unius est exclusio alterius* to conclude that Congress's

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[4] Petitioners cite (Pet. 25) two immigration cases in which agency rules were found to fall outside the scope of statutory delegations. See *Bona* v. *Gonzales*, 425 F.3d 663 (9th Cir. 2005); *Succar* v. *Ashcroft*, 394 F.3d 8 (1st Cir. 2005). But petitioners do not seriously dispute that a CMS rule prescribing how "costs incurred" are calculated is a rule about how "costs incurred" are "determined by the Secretary." 42 U.S.C. 1396r-4(g)(1)(A). The rule thus falls within the statute's express vesting of authority. *Ibid.*

express statement that Medicaid and uninsured-patient payments must be deducted in calculating "costs incurred" implicitly meant that payments from other sources could not be deducted. 42 U.S.C. 1396r-4(g)(1)(A). But as this Court has explained, the *expressio unius* canon "applies only when circumstances support a sensible inference that the term left out must have been meant to be excluded." *NLRB* v. *SW Gen., Inc.*, 137 S. Ct. 929, 940 (2017) (brackets, citation, and internal quotation marks omitted); see *Barnhart* v. *Peabody Coal Co.*, 537 U.S. 149, 168 (2003) (similar). The court of appeals examined the statutory "circumstances" here and correctly rejected any "inference that" Congress "excluded" Medicare and private-insurance payments from possible deduction in calculating costs incurred. *SW Gen.*, 137 S. Ct. at 940 (citation omitted). Given that Medicaid and uninsured patients are "the most common sources of payment for treating Medicaid-eligible and uninsured individuals," the court explained, Congress may have enumerated those sources simply "to ensure that the most common sources of payment must be" deducted "but at the same time allow the Secretary to decide whether less-common sources of payment should be as well." Pet. App. 10a-11a; see *Baptist Mem'l Hosp.*, 956 F.3d at 694-695 (similar reasoning).[5]

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[5] Petitioners criticize (Pet. 26-27) the court of appeals' statement that the *expressio unius* canon may have limited utility in administrative-law cases because Congress often legislates with the expectation that statutory gaps may be filled by agencies. See Pet. App. 10a (quoting *Adirondack Med. Ctr.* v. *Sebelius*, 740 F.3d 692, 697 (D.C. Cir. 2014)). But there is nothing novel or erroneous about that general observation, see *ibid.*, nor is it unique to the D.C. Circuit, see, *e.g.*, *Alliance for Cmty. Media* v. *FCC*, 529 F.3d 763, 779-780 (6th Cir. 2008), cert. denied, 557 U.S. 904 (2009). In any event,

Petitioners' advocacy for a rigid application of the *expressio unius* canon is also undermined by the second sentence of Section 1396r-4(g)(1), which expressly prohibits the treatment of state and local subsidies for indigent patients as "third party payment[s]." 42 U.S.C. 1396r-4(g)(1)(A). If petitioners were correct that the reference to Medicaid and uninsured-patient payments in the prior sentence must be read to exclude deduction of payments from all other sources, the direction in "this sentence would be superfluous." *Missouri Hosp. Ass'n*, 941 F.3d at 899; see *id.* at 901 (Stras, J., concurring) (same). That is "a result [this Court] typically tr[ies] to avoid," and it can be readily avoided by rejecting petitioners' reading. *SW Gen.*, 137 S. Ct. at 941. Moreover, the second sentence confirms that the focus of the hospital-specific limit in 42 U.S.C. 1396r-4(g)(1)(A) is on "third-party payment[s]" that reduce a hospital's costs incurred in furnishing services "to individuals who either are eligible for medical assistance under the State [Medicaid] plan or have no health insurance." The statute's express directive to net out payments from those specified sources ensures that they will be included in the calculation of costs incurred even though those payments are not from third parties.

In addition to their *expressio unius* argument, petitioners make the related contention that the DSH statute establishes a "formula [that] is straightforward: costs, minus certain clearly enumerated payments, equals the net of a hospital's 'uncompensated costs.'" Pet. 30 (citation omitted). But that description does not comport with the statute. The operative statutory

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the court of appeals did not rely on general principles, but carefully evaluated the particular statutory text, context, history, and purpose at issue here. See Pet. App. 9a-14a.

term is not "costs," but "costs incurred," 42 U.S.C. 1396r-4(g)(1)(A), meaning "uncompensated costs," 42 U.S.C. 1396r-4(g)(1); see *Missouri Hosp. Ass'n*, 941 F.3d at 901 (Stras, J., concurring). And the statute provides no formula; it instead tasks the Secretary with determining how "costs incurred" are calculated, and limits that discretion only insofar as the statute identifies certain payments that must be deducted (payments by Medicaid and by the uninsured) and certain payments that are not to be deducted (state or local payments for services to indigent patients). 42 U.S.C. 1396r-4(g)(1)(A). That statutory text and structure—particularly the directive in the second sentence of Section 1396r-4(g)(1)(A) to exclude state or local payments from the category of "third-party payment[s]"—refutes petitioners' proposal of a particular formula that bars the deduction of payments from other third parties such as Medicare and private insurers. See Pet. App. 11a-13a; *Baptist Mem'l Hosp.*, 956 F.3d at 693-694; *Missouri Hosp. Ass'n*, 941 F.3d at 900; *Tennessee Hosp. Ass'n*, 908 F.3d at 1038-1039.[6]

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[6] Petitioners observe (Pet. 29) that a different statutory provision refers to "third party payors," 42 U.S.C. 1396r-4(g)(2)(A), and they contend that Congress's omission of such a reference in the operative provision here suggests that Congress intended to prohibit consideration of third-party payments. That argument, however, overlooks that the operative provision does in fact refer to "third party payment[s]." 42 U.S.C. 1396r-4(g)(1)(A). And in any event, the court of appeals correctly explained that the statutory provision petitioners invoke is "fundamentally different"—including because it lacks any references to uncompensated costs—and therefore is an inapt basis for drawing inferences about the provision at issue here. Pet. App. 12a; see *Baptist Mem'l Hosp.*, 956 F.3d at 695 (similar); *Tennessee Hosp. Ass'n*, 908 F.3d at 1039 (similar).

Many of petitioners' statutory arguments (Pet. 27-30) turn on the premise that they incur significant costs for treating Medicaid-eligible and uninsured patients and accordingly should, in their view, receive a significant DSH payment. But that ultimately reflects a policy disagreement with Congress, which did not simply tie the amount of DSH payments to the number of patients treated or total outlays, but instead limited such payments to "costs incurred * * * of furnishing hospital services (as determined by the Secretary * * *)," with the overall objective of ensuring that DSH payments do not exceed "uncompensated costs." 42 U.S.C. 1396r-4(g)(1) and (g)(1)(A). Petitioners have acknowledged that they treat a number of privately insured Medicaid-eligible patients whose sizeable insurance payments "eliminate the losses" associated with their Medicaid-eligible and uninsured patient populations. C.A. Pet. for Reh'g 16. Their DSH payment under the final rule may therefore be zero. See Pet. 29. Although petitioners understandably seek to avoid that outcome, the alternative would be to allow them to receive a DSH payment *higher* than that of a similarly situated hospital that provides the same services but does *not* have as many Medicaid patients that are privately insured or eligible for Medicare and therefore does not collect as much compensation. See p. 13, *supra* (example of a State with two hospitals).[7] Such a result would be fun-

[7] The effect of petitioners' position can also be illustrated in numerical terms: If it costs a hospital $1 million to treat Medicaid-eligible patients who have no other coverage, and Medicaid pays the hospital $600,000, it is undisputed that the hospital's uncompensated

damentally at odds with the purpose of the DSH program, which Congress adopted to assist hospitals that "are unlikely to have large numbers of privately insured [or Medicare-eligible] patients" and cannot rely on insurance or Medicare payments to "offset their operating losses on the uninsured." House Report 211; see 82 Fed. Reg. at 16,116-16,117. The court below and other courts addressing similar claims have rightly rejected such claims for just that reason. See Pet. App. 14a; see, *e.g.*, *Tennessee Hosp. Ass'n*, 908 F.3d at 1040.

c. As a last resort, petitioners contend (Pet. 31-34) that, even if the D.C. Circuit applied *Chevron* correctly, this Court should grant certiorari to reconsider the premises of *Chevron*. But this Court has repeatedly denied petitions inviting it to reconsider or overrule *Chevron*. See, *e.g.*, *Guedes* v. *Bureau of Alcohol, Tobacco, Firearms & Explosives*, 140 S. Ct. 789 (2020) (No. 19-296); *United Parcel Serv., Inc.* v. *Postal Regulatory Comm'n*, 139 S. Ct. 2614 (2019) (No. 18-853). And this case would be a poor vehicle for such reconsideration, given that the statute undisputedly contains an express conferral of discretion.

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costs are $400,000, and the hospital should be able to receive DSH payments from the State up to $400,000. But petitioners argue that if it costs a hospital $1 million to treat Medicaid-eligible patients who have private insurance, and the private insurer pays the hospital $1 million for their care (and Medicaid pays nothing), then the hospital's uncompensated costs are *still* $1 million, and the hospital should be able to receive DSH payments from the State up to $1 million. The Secretary, on the other hand, would recognize that this hospital's costs have been compensated, and because this hospital's DSH limit is $0, the pool of supplemental DSH funds are available to hospitals that suffered truly uncompensated costs. Cf. *Tennessee Hosp. Ass'n*, 908 F.3d at 1035 (similar hypothetical).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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