No. 99-1421

In the Supreme Court of the United States

COUNTY OF LOS ANGELES, ET AL., PETITIONERS

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

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

BRIEF FOR THE RESPONDENT IN OPPOSITION

SETH P. WAXMAN
Solicitor General
Counsel of Record
DAVID W. OGDEN
Acting Assistant Attorney General
BARBARA C. BIDDLE
PETER R. MAIER
Attorneys
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

QUESTION PRESENTED

For the years in question, the Medicare Act permitted additional payments to hospitals for "outlier" cases, *i.e.*, those that involve an extraordinarily costly or lengthy period of hospitalization when compared to most discharges in the same diagnosis-related group. Section 1395ww(d)(5)(A)(iv) of Title 42, U.S.C., provides that "[t]he total amount of the additional payments made under this subparagraph [for outlier cases] for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year."

The question presented is whether the court of appeals correctly upheld the Secretary's interpretation that Section 1395ww(d)(5)(A)(iv) does not require her to make retroactive adjustments to payments to hospitals for services they provide in outlier cases when aggregate payments nationwide for such cases are less than the total that she projected at the beginning of the fiscal year.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-39a) is reported at 192 F.3d 1005. The opinion of the district court (Pet. App. 40a-64a) is reported at 992 F. Supp. 26.

JURISDICTION

The judgment of the court of appeals (Pet. App. 65a-70a) was entered on October 1, 1999. Petitions for rehearing were denied on November 30, 1999 (Pet. App. 71a-74a). The petition for a writ of certiorari was filed on February 28, 2000. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Title XVIII of the Social Security Act, 42 U.S.C. 1395-1395ggg (1994 & Supp. III 1997) (Medicare Act), establishes the federally funded Medicare program to provide health insurance to the elderly and disabled. From its inception in 1965 until 1983, the Medicare Act compensated hospitals for the "reasonable cost" or "customary charges" of inpatient services they provided to eligible patients. See 42 U.S.C. 1395f(b) (1994 & Supp. III 1997). Since 1983, Medicare has reimbursed most hospitals for the inpatient costs under the Prospective Payment System (PPS), which generally directs that payments to hospitals be based upon prospectively determined rates for each inpatient discharge.

Prospective payment rates are derived under a statutory formula. 42 U.S.C. 1395ww(d). To set the initial prospective payment rates (for federal fiscal year 1984), the Secretary calculated standard federal rates (known as "standardized amounts") by examining the average actual Medicare allowable costs per discharge during a base year for hospitals participating in the Medicare program. The standard federal rate is then updated each year for inflation. 42 U.S.C. 1395ww(d)(2)(A) and (B); 49 Fed. Reg. 251 (1984). In making payments to a hospital, the applicable standard rate is adjusted by a "wage index" that accounts for regional variations in labor costs. Finally, the rates reflect an additional weighting factor that takes account of the disparate hospital resources required to treat the wide variety of major and minor illnesses. 42 U.S.C. 1395ww(d)(4). For each of several hundred medical conditions, called diagnosis-related groups (DRGs), the Secretary assigns particular weights by which the

federal rate is to be multiplied. Greater weight is assigned to a DRG that encompasses more complex, costly treatment. The Act requires the Secretary to publish the weights and values to be applied in determining patient reimbursement rates before the start of each fiscal year. 42 U.S.C. 1395ww(d)(6) (Supp. III 1997).

For the years relevant here, the Act also provided, in four statutory clauses, for additional payments to hospitals for "outlier" cases, *i.e.*, those that are extraordinarily costly or involve lengthy periods of hospitalization far in excess of the norm for the type of illness being treated. 42 U.S.C. 1395ww(d)(5)(A)(i)-(iv) (Supp. IV 1986). The first two clauses establish two kinds of outlier payments: day outliers, where a patient's length of stay exceeded the mean length of stay for a particular DRG by a fixed number of days or standard deviations, 42 U.S.C. 1395ww(d)(5)(A)(i) (Supp. IV 1986), and cost outliers, where a hospital's cost-adjusted charges exceeded either a fixed multiple of the applicable DRG prospective payment rate or a fixed dollar amount established by the Secretary, 42 U.S.C. 1395ww(d)(5)(A)(ii) (Supp. IV 1986).[1] The third clause directs that outlier payments "shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable" to the day or cost outlier. 42 U.S.C. 1395ww(d)(5)(A)(iii) (Supp. IV 1986). The fourth clause, at issue here, provides that "[t]he total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments

[1] The outlier provisions have been amended to phase out day outlier payments. 42 U.S.C. 1395ww(d)(5)(A)(i) and (v).

projected or estimated to be made based on DRG prospective payment rates for discharges in that year." 42 U.S.C. 1395ww(d)(5)(A)(iv). Finally, the statute requires the Secretary to set outlier thresholds in advance of a fiscal year. 42 U.S.C. 1395ww(d)(6) (Supp. III 1997).

In issuing her final regulation implementing the outlier provisions, the Secretary rejected the suggestion of commenters that the Act contains a "necessary connection between the amount of estimated outlier payments and the actual payments made to hospitals for cases that actually meet the outlier criteria." 49 Fed. Reg. 265 (1984). The Secretary explained that she would "set the outlier criteria so that an estimated six percent of total payments would be made for outliers," and that, "while [she] expect[ed] that under these criteria outlier payments will approximate six percent of total payments, [the Secretary] will pay for any outlier that meets the criteria, even if aggregate outlier payments result in more than six percent of total payments." *Ibid.* Conversely, the Secretary explained that if she "overestimate[d] the amount of outlier payments, [the Secretary] will not adjust the DRG rates to compensate hospitals for funds that were not actually paid for outlier cases." *Id.* at 266.

2. Petitioners are 181 hospitals that brought this action challenging the Secretary's determination concerning the amount of Medicare reimbursement due them for services they provided in fiscal years 1985 and 1986. Petitioners asserted that Section 1395ww(d)(5)(A)(iv) not only instructs the Secretary to set outlier thresholds at the beginning of each fiscal year, but also requires her to adjust outlier payments retroactively if she determines after the end of the fiscal year that aggregate outlier payments do not equal

at least the five-percent statutory target. Petitioners also claimed that the Secretary improperly set the outlier thresholds for fiscal years 1985 and 1986 based on 1981 data that did not reflect reductions in length of hospital stays under the PPS system after it was instituted in 1983. The Provider Reimbursement Review Board authorized petitioners to seek expedited judicial review pursuant to 42 U.S.C. 1395*oo*(f)(1).

3. The district court granted in part and denied in part the parties' cross-motions for summary judgment. Pet. App. 40a-64a. The district court held that Section 1395ww(d)(5)(A)(iv) unambiguously requires the Secretary to adjust outlier payments retroactively if actual payments do not reach the five-percent minimum. The district court, however, rejected petitioners' argument that the Secretary acted in an arbitrary and capricious manner in relying on 1981 data in setting the outlier thresholds for fiscal years 1985 and 1986.

4. The court of appeals reversed. Pet. App. 1a-39a. The court of appeals concluded that the statutory language in Section 13955ww(d)(5)(A)(iv) stating that "[t]he total amount of the additional payments made * * * may not be less than 5 percent" of the total payments "projected or estimated to be made" was ambiguous with respect to whether actual outlier payments must be retroactively adjusted to fall within the statutory targets. *Id.* at 15a-23a. The court of appeals recognized that the language was "certainly capable of accommodating the Hospitals' interpretation * * * of embodying a retrospective inquiry into the amount of outlier payments that *have been* made." *Id.* at 15a. The court of appeals explained, however, that "the phrase 'payments made' * * * can just as easily be read to reflect Congress's intent to 'give directions on actions about to be taken,'" *ibid.*, and therefore the

phrase reflects "a prospective command to the Secretary about how to structure outlier thresholds for payments to be made in advance of each fiscal year," *id.* at 16a (quoting *Regions Hosp.* v. *Shalala*, 522 U.S. 448, 458 (1998)).

The court of appeals further concluded that the Secretary reasonably construed Section 1395ww(d)(5)(A)(iv). Pet. App. 24a-31a. It explained that the Secretary's interpretation implemented Congress's intent in the outlier provision to compensate hospitals only when they experienced aberrational and extraordinary costs. *Id.* at 24a-26a. The court further reasoned that "the Secretary's reading better harmonizes each of the four clauses in paragraph (5)(A)," whereas a contrary interpretation requiring retroactive adjustments could cause the newly computed outlier payments to "not approximate anything close to the marginal cost of care as paragraph (5)(A)(iii) mandates." *Id.* at 26a. Finally, the court of appeals noted that "the Secretary's interpretation avoids the substantial administrative burden attendant with the Hospitals' vision of paragraph (5)(A)(iv)," *id.* at 27a, which would require extensive recalculation of the amount owed to the hospitals, and that the "uncertainty and fluidity in the outlier-payment amounts under the Hospitals' interpretation" was inconsistent with the nature of the PPS system, which "as its name suggests" mandates "prospectively determined reimbursement rates that remain constant during the fiscal year," *id.* at 28a.

Finally, the court of appeals concluded that the Secretary had not provided an adequate explanation for her reliance on 1981 data in calculating the outlier thresholds for the two disputed fiscal years. Pet. App. 31a-38a. The court of appeals accordingly instructed

the district court to remand the case to the Secretary to permit her either to recalculate the outlier thresholds or to offer a reasonable explanation for refusing to use later data in setting the outlier thresholds. *Id.* at 37a-39a.

ARGUMENT

1. Petitioners argue (Pet. 11-14) that this Court should grant certiorari to consider whether 42 U.S.C. 1395ww(d)(5)(A)(iv) clearly requires that actual outlier payments made by the Secretary be not less than five percent (or more than six percent) of projected or estimated DRG payments. The court of appeals' contrary holding, however, does not conflict with any decision of any other court that has construed the statute. In fact, in the only other decision construing the statute, the court upheld the Secretary's construction. *Alvarado Community Hosp.* v. *Shalala*, Nos. 94-0972 et al. (C.D. Cal. May 6, 1996), rev'd on other grounds, 155 F.3d 1115 (1998), amended, 166 F.3d 950 (9th Cir. 1999).

Moreover, the court of appeals correctly concluded (Pet. App. 13a-23a) that nothing in the statutory language bars the Secretary's view that Section 1395ww(d)(5)(A)(iv) prescribes only the methodology to be followed when setting outlier thresholds at the beginning of each fiscal year. Contrary to petitioners' assertion (Pet. 12), the statutory phrase "payments made," when contrasted with the later phrase "payments projected or estimated to be made," does not mean that the earlier phrase unambiguously requires the Secretary to make retroactive adjustment to ensure that actual outlier payments fall within the five to six percent target range. As the court of appeals explained, the phrase "payments made" is "simply an

adjectival phrase," and therefore is temporally ambiguous. Pet. App. 15a (quoting *United States Dep't of the Treasury* v. *FLRA*, 960 F.2d 1068, 1072 (D.C. Cir. 1992)); cf. *Regions Hosp.*, 522 U.S. at 458 (concluding that "the phrase '[amount] recognized as reasonable' might mean costs the Secretary (1) *has* recognized as reasonable * * * or (2) *will* recognize as reasonable").

Furthermore, paragraph (5)(A)(iv) is preceded by paragraph (3)(B), which describes outlier payments as being "estimated by the Secretary." Thus, as the court below noted (Pet. App. 19a), "[g]iven that in paragraph (3)(B) it had already indicated that the Secretary would estimate the amount of outlier payments described in subparagraph (5)(A), Congress could have reasonably concluded that there was no need to provide expressly in paragraph (5)(A)(iv) that the phrase 'payments made' referred to payments estimated to be made."[2]

2. Petitioners also contend (Pet. 14-21) that the Court should grant review to resolve an alleged conflict among the circuits concerning whether a court should defer to an agency's construction of an ambiguous statute when the agency's interpretation is not set forth in a regulation or adjudication. This case, however, is an

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[2] Petitioners also err in relying (Pet. 13-14) on a Senate Report on a recent provision establishing outlier payments for outpatient costs, see Act of Nov. 29, 1999, Pub. L. No. 106-113, App. F, § 201, 113 Stat. 1501A-336 to 1501A-342. This Court has cautioned that "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *United States* v. *Philadelphia Nat'l Bank*, 374 U.S. 321, 348-349 (1963). In any event, a later Conference Report expressed Congress's intent that the Secretary should make outlier payments for outpatient costs "in a similar way *as is currently done* in the inpatient PPS." H.R. Conf. Rep. No. 479, 106th Cong., 1st Sess. 868 (1999) (emphasis added).

inappropriate vehicle to resolve whatever tension exists in the courts of appeals on that question.

As the court of appeals explained (Pet. App. 23a), "for the past fifteen years, the Secretary has never wavered from [her] interpretation" that Section 1395ww(d)(5)(A)(iv) does not require retroactive adjustments to outlier payments. Indeed, the Secretary set forth her interpretation when she promulgated her final rule, and only after proposing regulations that did not contain any provision for retroactively adjusting outlier payments to ensure that actual payments fell within the statutory range. See 49 Fed. Reg. 265-266 (1984). The Secretary therefore reached her interpretation only after notice and comment rulemaking. In those circumstances, the court of appeals correctly deferred to the Secretary's reasoned judgment under this Court's decision in *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984). See *Auer* v. *Robbins*, 519 U.S. 452, 462 (1997) (deferring to an agency's interpretation of its regulation reflected in an amicus brief because interpretation is "in no sense a '*post hoc* rationalizatio[n]' advanced by an agency seeking to defend past agency action against attack," and there is "no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter") (quoting *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204, 212 (1988)); see also *Reno* v. *Koray*, 515 U.S. 50, 61 (1995) (deferring to internal agency guidelines); *Shalala* v. *Guernsey Mem'l Hosp.*, 514 U.S. 87, 101-102 (1995) (deferring to agency's interpretive rules in program manual).

Furthermore, petitioners' request that this Court decide when an agency's interpretation of an ambiguous statute warrants deference under *Chevron* is also inconsistent with petitioners' primary contention that

the statute lacks any statutory ambiguity. See Pet. 11 ("The interpretation of [sub]section (d)(5)(A)(iv) should be resolved under step one of the *Chevron* framework."). Thus, were this Court to grant review and accept petitioners' statutory interpretation, this Court would have no occasion to address the second question petitioners present, which is the only question on which they assert that the law lacks clarity.

Finally, petitioners err in suggesting (Pet. 20–21) that the outcome of this case would be affected were a court, instead of applying *Chevron*, to accord the Secretary's view the weight it merited based upon "the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 140 (1944). As the court of appeals concluded, the Secretary's construction of Section 1395ww(d)(5)(A)(iv) was, in several respects, preferable to petitioners' contrary interpretation. Pet. App. 24a-31a. For instance, "[t]he Secretary's interpretation of paragraph (5)(A)(iv) evinces far greater fidelity to Congress's conception of outlier payments than does the view espoused by the Hospitals," because "if it turns out that actual outlier payments do not meet the five-percent target at the end of the fiscal year, it is because the lengths of stay for DRGs in that year proved to be shorter than the historical averages reflected in the data on which the Secretary based her threshold calculations." *Id.* at 24a. By contrast, under petitioners' interpretation, hospitals would be "guaranteed a substantial and fixed sum of outlier payments," "regardless of actual costs or inpatient lengths of stay during a fiscal year," *ibid*, even though it is "unlikely that Congress * * * wanted

hospitals to reap additional compensation over and above the standard DRG payment where treatment costs for a particular discharge were not extraordinarily costly relative to the mean costs for that DRG," *id.* at 25a-26a.

Similarly, as the court of appeals explained, "[i]t strains credulity to assume that Congress would have directed the Secretary to establish outlier thresholds in advance of each fiscal year, *see* § 1395ww(d)(3)(B), (d)(6), and process millions of bills based on those figures, only to have her at the end of the year recalibrate those calculations, reevaluate anew each of the millions of inpatient discharges under the revised figures, and disburse a second round of payments." Pet. App. 27a-28a. By contrast, the Secretary's construction "promotes certainty and predictability of payment for not only hospitals but the federal government—concerns that played a prominent role in Congress's decision to adopt PPS." *Id.* at 28a-29a; see also *id.* at 30a-31a ("A less determinate policy would not only deprive hospitals of the ability to make accurate projections about outlier payments for the forthcoming year but also threaten them at the end of each year with the prospect of actually having to forfeit a portion of those payments to the Secretary * * * [if] outlier payments * * * exceeded six percent of estimated DRG-related payments.").

3. This case also does not warrant this Court's review because additional proceedings on remand may obviate the need for further consideration of the statutory construction issue. The court of appeals instructed the district court to remand the action to the Secretary to permit her to provide an adequate explanation for her choice of data in calculating the outlier thresholds for the two disputed fiscal years. Pet. App. 37a-39a.

Petitioners of course may challenge any final action made on remand by the Secretary, and a successful challenge might ultimately require the Secretary to provide additional compensation to petitioners that would obviate the need to address the issue of statutory construction presented here.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General
DAVID W. OGDEN
Acting Assistant Attorney General
BARBARA C. BIDDLE
PETER R. MAIER
Attorneys

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