No. 20-1113

# In the Supreme Court of the United States

AMERICAN HOSPITAL ASSOCIATION, ET AL., PETITIONERS

*v.*

XAVIER BECERRA,
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 UNITED STATES IN OPPOSITION**

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## QUESTIONS PRESENTED

Under the Outpatient Prospective Payment System (OPPS), the Department of Health and Human Services (HHS) sets annual Medicare payment rates in advance through notice-and-comment rulemaking. To control costs, the OPPS statute directs HHS to "develop a method for controlling unnecessary increases in the volume of covered [outpatient-department] services." 42 U.S.C. 1395*l*(t)(2)(F). The OPPS statute expressly precludes judicial review of specified agency actions, including "methods described in paragraph (2)(F)." 42 U.S.C. 1395*l*(t)(12)(A).

In a series of reports, the Medicare Payment Advisory Commission (MedPAC) found an unnecessary increase in the volume of "evaluation and management" (E&M) services at outpatient departments, which MedPAC attributed in part to the higher rate that Medicare paid when E&M services were provided in outpatient departments as opposed to in physicians' offices. In the rule setting OPPS payment rates for the 2019 year, HHS eliminated the payment differential that was driving what it determined was an unnecessary increase in volume. The questions presented are as follows:

1. Whether petitioners' suit challenging HHS's method for controlling unnecessary increases in the volume of certain covered outpatient-department services is precluded by 42 U.S.C. 1395*l*(t)(12).

2. Whether, assuming arguendo that judicial review is not precluded, the court of appeals correctly determined that the particular method HHS adopted to control unnecessary increases in the volume of E&M services was a permissible exercise of its statutory authority.

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## OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-32a) is reported at 964 F.3d 1230. The district court's opinion (Pet. App. 33a-67a) is reported at 410 F. Supp. 3d 142.

## JURISDICTION

The judgment of the court of appeals was entered on July 17, 2020. A petition for rehearing was denied on October 16, 2020 (Pet. App. 68a-69a). On March 19, 2020, this Court extended the time within which to file any petition for a writ of certiorari due on or after that date to 150 days from the date of the lower-court judgment, order denying discretionary review, or order denying a timely petition for rehearing. The effect of that order was to extend the deadline for filing a petition for a writ of certiorari in this case to March 15, 2021. The petition for a writ of certiorari was filed on

February 10, 2021. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

**STATEMENT**

1. The Medicare program, established in 1965 by Title XVIII of the Social Security Act (Medicare Act), 42 U.S.C. 1395 *et seq.*, provides health-insurance coverage to individuals who are at least 65 years old and are entitled to monthly Social Security benefits, and to disabled individuals who meet certain requirements. 42 U.S.C. 426(a) and (b). Part A provides insurance coverage for inpatient hospital care, home health care, and hospice services. 42 U.S.C. 1395c *et seq.* Part B is a voluntary program that provides supplemental coverage for other types of care, including services provided by outpatient departments of hospitals. 42 U.S.C. 1395j *et seq.*

This case involves Medicare Part B payment rates for hospital outpatient-department services. Before 1997, the Medicare program paid for such services based on the reasonable costs actually incurred by the hospital. By the late 1990s, sharp increases in the cost of medical care and demographic changes in the population threatened the Medicare trust fund with insolvency. H.R. Rep. No. 436, 106th Cong., 1st Sess. 33 (1999) (House Report). The Balanced Budget Act of 1997 (Balanced Budget Act), Pub. L. No. 105-33, 111 Stat. 251, made significant revisions in Medicare payment policies in an effort to reduce the program's escalating costs. House Report 33-34. As relevant here, the Act directed the Secretary of Health and Human Services (HHS) to establish an Outpatient Prospective Payment System (OPPS), under which hospitals are reimbursed based on predetermined rates for outpatient-department services. Balanced Budget Act, Tit. IV, Subtit. F, Ch. 2,

sec. 4523(a), § 1833, 111 Stat. 445 (42 U.S.C. 1395*l*(t)), The rates are revised each year through notice-and-comment rulemaking and are published before they take effect. See 42 U.S.C. 1395hh(a) and (b), 1395*l*(t)(9).

The Balanced Budget Act included three principal mechanisms to control Medicare costs for outpatient-department services. First, to encourage hospital efficiency, Congress directed HHS to base the Medicare payment amount for a particular service on the median cost of that service. 42 U.S.C. 1395*l*(t)(2)(C). To that end, HHS establishes classifications for covered services, or groups of covered services that are comparable clinically and in terms of cost, 42 U.S.C. 1395*l*(t)(2)(A) and (B); establishes relative payment weights for each classification, based on historical data regarding the median cost of the service (or group of services) within the classification, 42 U.S.C. 1395*l*(t)(2)(C); and uses a multiplier, known as the conversion factor, to translate the relative payment weights into dollar amounts, 42 U.S.C. 1395*l*(t)(3)(C). HHS then adjusts the payment amounts, in a budget-neutral manner, to account for regional differences in labor costs and other specified variations. 42 U.S.C. 1395*l*(t)(2)(D) (wage adjustments); 42 U.S.C. 1395*l*(t)(2)(E) (other adjustments).

Second, the Balanced Budget Act required that total prospective-payment amounts be no greater than the amounts that would have been paid under a "reasonable cost" approach. 42 U.S.C. 1395*l*(t)(3)(A) and (C). The Act established a formula for calculating increases in this baseline amount to reflect, among many other factors, population growth, demographic changes, and inflation. See *ibid.* In any given fiscal year, total prospective payments may not exceed the adjusted baseline amount. Although the Secretary is required to make annual updates

to payment classifications, relative payment weights, and various other components of the prospective-payment system to reflect changes in technology, medical practice, cost data, and other factors, 42 U.S.C. 1395*l*(t)(9)(A), those adjustments must be "[b]udget neutral[]," *i.e.*, they may not cause the estimated amount of expenditures for the year to "increase or decrease." 42 U.S.C. 1395*l*(t)(9)(B) (emphasis omitted).

Third, to prevent unnecessary increases in the *volume* of outpatient-department services—which the foregoing cost-control measures did not address—the Balanced Budget Act directed the Secretary to establish a means of doing so. 42 U.S.C. 1395*l*(t)(2)(F). Specifically, subparagraph (2)(F) of Section 1395*l*(t) directed the Secretary to "develop a method for controlling unnecessary increases in the volume of covered [outpatient-department] services." 42 U.S.C. 1395*l*(t)(2)(F). The statute does not specify the type of method HHS must adopt or prescribe particular criteria or parameters the method chosen must employ. And another provision of the OPPS statute, paragraph (12), provides that "[t]here shall be no administrative or judicial review" of various agency actions relating to the OPPS, among which the statute specifically enumerates "the development of the classification system under paragraph (2), including the establishment of * * * methods described in paragraph (2)(F)." 42 U.S.C. 1395*l*(t)(12)(A).

2. This litigation involves a volume-control method that HHS established pursuant to subparagraph (2)(F) and implemented as part of the OPPS rule for the 2019 year.

a. In a series of reports, the Medicare Payment Advisory Commission (MedPAC)—an independent agency established by Congress in the Balanced Budget Act to advise HHS, see Balanced Budget Act, Tit. IV, Subtit. A, Ch.

3, § 4022, 111 Stat. 350 (42 U.S.C. 1395b-6)—determined that an unnecessary increase existed in the volume of a particular type of outpatient services, known as "evaluation and management" (E&M) services. MedPAC attributed that increase in volume to the fact that Medicare was paying a higher rate when E&M services were provided by outpatient departments than it paid when the same services were performed in freestanding physicians' offices, which are governed by a different Medicare fee schedule. For example, in 2014, MedPAC reported that outpatient departments increased their volume of such services while physicians' offices had seen a decrease. MedPAC, *Report to the Congress: Medicare Payment Policy* 42 (Mar. 2014) (MedPAC 2014 Report), https://go.usa.gov/xdCzV. MedPAC later reported that the volume of outpatient-department services per beneficiary grew by 47% from 2005 to 2015, and that one-third of the growth in outpatient volume from 2014 to 2015 was due to an increase in the number of E&M visits billed as outpatient services. MedPAC, *Report to the Congress: Medicare Payment Policy* 69 (Mar. 2017), https://go.usa.gov/xdCzG. From 2012 to 2015, outpatient E&M services per beneficiary grew by 22%, compared with a 1% decline in physician-office-based visits. *Id.* at 70. MedPAC attributed that growth in the volume of such outpatient-department services in part to hospitals' purchasing freestanding physician practices and converting their billing from the lower-paying physician fee schedule to the higher paying OPPS schedule applicable to hospital outpatient departments. MedPAC 2014 Report 69.

In 2015, Congress intervened to reduce the incentive for hospitals to continue acquiring additional freestanding physician practices. In the Bipartisan Budget Act

of 2015, Pub. L. No. 114-74, 129 Stat. 584, Congress provided that newly established off-campus outpatient departments would not receive payment under the OPPS, *id.* Tit. VI, sec. 603(2), § 1833(t)(21), 129 Stat. 597 (42 U.S.C. 1395*l*(t)(21)). That amendment applied to all services that a newly established off-campus outpatient department provides—not just to E&M services.[1]

The 2015 amendment did not, however, affect preexisting off-campus outpatient departments, which continued to receive payment under the OPPS, and thus remained subject to the agency's general volume-control authority. Growth in outpatient-department services continued. In its 2018 report to Congress, MedPAC found that the Medicare program had spent $1.8 billion more in 2016 than it would have spent if the payment rates for E&M services at outpatient departments were the same as the rates for freestanding physician offices. MedPAC, *Report to the Congress: Medicare Payment Policy* 73 (Mar. 2018), https://go.usa.gov/xdCzu. MedPAC emphasized that routine clinic visits to outpatient departments for such services had increased by 43.8% (an average of 7.5% per year) between 2011 and 2016, whereas visits to freestanding offices rose by only 0.4%. See *ibid.*

b. In light of such reports by MedPAC, as part of the OPPS rulemaking for the 2019 year, HHS exercised its authority under subparagraph (2)(F) of the OPPS statute, 42 U.S.C. 1395*l*(t)(2)(F), to control unnecessary increases in the volume of covered outpatient-department

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[1] In 2016, Congress provided that certain hospitals that were "mid-build" at the time the 2015 amendment was enacted would continue to receive payment under the OPPS. See 21st Century Cures Act, Pub. L. No. 114-255, Tit. XVI, sec. 16001, § 1833(t)(21), 130 Stat. 1324 (42 U.S.C. 1395*l*(t)(21)).

services. In its proposed rule for the 2019 year, HHS determined that the growth of E&M services at off-campus hospital outpatient departments was likely due to the differential between the OPPS payment rate and the lower Medicare rate paid under the physician fee schedule. See 83 Fed. Reg. 37,046, 37,141-37,142 (July 31, 2018). HHS "consider[ed] the shift of services from the physician office to the hospital outpatient department unnecessary if the beneficiary can safely receive the same services in a lower cost setting but is instead receiving services in the higher paid setting due to payment incentives." *Id.* at 37,142. And it determined that E&M services "could likely be safely provided in a lower cost setting," *i.e.*, at physician offices. *Ibid.*

In the final rule for 2019, HHS concluded that "capping the OPPS payment at the [physician-fee-schedule]-equivalent rate would be an effective method to control the volume of these unnecessary services because the payment differential that is driving the site-of-service decision will be removed." 83 Fed. Reg. 58,818, 59,009 (Nov. 21, 2018); see *id.* at 58,822. HHS accordingly reduced the Medicare payment rate for E&M services for off-campus outpatient departments to equal the rate paid to physicians for the same services, and it indicated that the rate reduction would be phased in over two years. *Id.* at 59,014. HHS estimated that, for the 2019 year, that volume-control method would result in savings of approximately $300 million to Medicare, and that it also would reduce the copayments that Medicare beneficiaries make by approximately $80 million. *Ibid.* In its rulemaking for the 2020 year, HHS estimated that the volume-control method it adopted would result in savings in that year of approximately $640 million to

Medicare and would reduce the beneficiaries' copayments by approximately $160 million. 84 Fed. Reg. 61,142, 61,369 (Nov. 12, 2019).

3. Petitioners, which include several hospitals, commenced this action challenging the rate that they received for E&M services, contending that HHS had exceeded its statutory authority under Section 1395*l*(t)(2)(F) in adopting the volume-control rate-reduction measure described above. Pet. App. 3a, 11a-12a. The district court granted summary judgment to petitioners. *Id.* at 33a-67a. After concluding that petitioners' suit was not barred by the OPPS statute's express preclusion-of-review provision, 42 U.S.C. 1359*l*(t)(12), Pet. App. 49a-51a, the court held (as relevant) that HHS's volume-control method was ultra vires and vacated the portion of HHS's rule adopting that rate reduction for the 2019 year, *id.* at 54a-67a.

The district court did not question HHS's determination that its rate reduction was an effective method to control the unnecessary increase in the volume of E&M services. Pet. App. 42a-43a. The court inferred from the statutory scheme, however, that HHS may not use a rate reduction as a volume-control method unless the rate cut applies to all OPPS services "across-the-board," through an update to the conversion factor. *Id.* at 57a. The court concluded that the OPPS statute does not allow "service-specific, non-budget-neutral cuts" as a method of volume control. *Ibid.*

4. The court of appeals reversed. Pet. App. 1a-32a.

a. The court of appeals first held that petitioners' challenge to HHS's volume-control method was not barred by Section 1395*l*(t)(12). Pet. App. 12a-16a. The court acknowledged that subparagraph (t)(12)(A) expressly forecloses judicial review of the agency's "establishment of methods described in paragraph (2)(F)"

of Section 1395*l*(t), *id.* at 12a-13a, the provision directing HHS to develop a volume-control method. But the court deemed that judicial-review bar inapplicable here because petitioners' "claim is that the payment reduction at issue is *not* a 'method[] described in paragraph (2)(F)' within the meaning of the statute." *Id.* at 13a (brackets in original). The court stated that the judicial-review bar "'merges consideration of the legality of agency action with consideration of the court's jurisdiction,'" and that therefore, "[a]s a practical matter," the court "c[ould] simply skip to the merits question in its analysis." *Ibid.* (brackets and citation omitted).

The court of appeals rejected the government's contention that judicial review of petitioners' claim that HHS's volume-control measure "exceeded the agency's statutory authority" under subparagraph (2)(F), Pet. App. 11a-12a, was unavailable under the framework the court of appeals applies to claims that an agency action is ultra vires. See *id.* at 14a-15a. As the government explained, the court of appeals had previously held that a court may consider a claim challenging agency action as ultra vires, notwithstanding a statutory preclusion of review, only where "'the statutory preclusion of review is implied rather than express,'" and only where "'the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.'" Gov't C.A. Br. 15 (quoting *DCH Reg'l Med. Ctr.* v. *Azar*, 925 F.3d 503, 509 (D.C. Cir. 2019)); see *DCH Reg'l Med. Ctr.*, 925 F.3d at 509-510 (discussing *Leedom* v. *Kyne*, 358 U.S. 184 (1958), and *Board of Governors of the Fed. Reserve Sys.* v. *MCorp Fin., Inc.*, 502 U.S. 32 (1991)); *id.* at 509 (additionally requiring that there be "no alternative procedure for review of the statutory claim" (citation omitted)). The

government observed that neither prerequisite for review despite a statutory preclusion of review was satisfied here. Gov't C.A. Br. 15. The court, however, deemed the framework for "*ultra vires* review" inapposite, reasoning that petitioners did not seek to circumvent a statutory preclusion of review but contended that the judicial-review bar does not apply in the first instance. *Id.* at 14a (citation omitted); see *id.* at 14a-15a.

b. On the merits, the court of appeals upheld HHS's volume-control rate reduction as a permissible exercise of the agency's statutory authority. Pet. App. 16a-32a. In considering that question, the court applied this Court's precedent recognizing that courts "defer to [an] agency's reasonable interpretation of an ambiguous statute" that it administers. *Id.* at 16a (citing *Chevron U.S.A. Inc.* v. *Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984)). The court rejected petitioners' contention that the *Chevron* framework should not apply. *Id.* at 16a-19a. As relevant here, the court found unpersuasive petitioners' contention that deference under *Chevron* is inappropriate where a court's "consideration of the agency's statutory authority merges with [the court's] consideration of the applicability of a preclusion provision." *Id.* at 18a. The court observed that petitioners' contention "would mean that Congress's decision to enact a preclusion provision operated to enhance judicial scrutiny and restrict the agency's leeway." *Ibid.* The court explained that, "[i]n precluding judicial review of certain HHS actions, * * * Congress necessarily intended the opposite outcome." *Id.* at 18a-19a. And the court noted the "havoc that piecemeal judicial review of OPPS payments" in many contexts "could bring about." *Id.* at 19a (brackets and citation omitted).

Addressing HHS's volume-control rate reduction at issue here, the court of appeals determined that HHS had "reasonably read subparagraph (2)(F) to allow a service-specific, non-budget-neutral reimbursement cut in the circumstances" of this case and that HHS therefore had "acted within its statutory authority." Pet. App. 19a-20a; see *id.* at 20a-30a. The court observed that "a service-specific, non-budget-neutral rate reduction falls comfortably within the plain text of subparagraph (2)(F)." *Id.* at 20a. It explained that "[r]educing the payment rate for a particular OPPS service readily qualifies, in common parlance, as a 'method for controlling unnecessary increases in the volume' of that service." *Ibid.* The court reasoned that, "[t]he lower the reimbursement rate for a service, the less the incentive to provide it, all else being equal," and "[r]educing the reimbursement rate thus is naturally suited to addressing unnecessary increases in the overall volume of a service provided by hospitals." *Ibid.*

The court of appeals rejected petitioners' contention that subparagraph (2)(F) prohibits rate cuts that are not budget neutral, explaining that "the provision simply says nothing about budget-neutrality." Pet. App. 20a. The court observed that it would be "anomalous" for the statute to require a rate reduction made for the purpose of "controlling unnecessary increases in the volume" of certain services, 42 U.S.C. 1395*l*(t)(2)(F), "to be implemented budget-neutrally." Pet. App. 21a. The court reasoned that, if HHS were required "to redistribute the costs traceable to the provision of unnecessary services throughout the OPPS," the result would be "no net savings to Medicare," which would "largely negat[e] the point of reducing reimbursement in the first place." *Id.* at 21a-22a.

The court of appeals additionally observed that the "broader statutory context bolster[ed]" its conclusion that service-specific rate cuts are a permissible method of volume control. Pet. App. 21a. The court noted, for example, that subparagraph (2)(E) affords HHS broad discretion to adjust payment rates as necessary "to ensure equitable payments." *Ibid.* The court explained that "HHS's robust 'discretion' to adjust payment rates is a central feature of the statutory scheme." *Ibid.* (citations omitted).

The court of appeals rejected petitioners' contention that subparagraph (2)(F) "does no more than enable the agency to develop an 'analytical mechanism for determining whether there is an unnecessary increase in volume,'" which may be controlled only through an across-the-board update to the conversion factor. Pet. App. 22a (citation omitted); see *id.* at 22a-23a. The court noted that petitioners' "interpretation of subparagraph (2)(F) is difficult to square with the provision's language," which "directs the agency to develop 'a method for *controlling* unnecessary increases' in volume, not just a method for *assessing* whether unnecessary increases exist." *Id.* at 23a-24a. And the court found it "unlikely that Congress would have confined the agency's volume-control arsenal to the very blunt instrument of reducing the across-the-board conversion factor." *Id.* at 24a. The court emphasized that "[c]utting the conversion factor would reduce reimbursement equally for every OPPS service, a poorly tailored, ineffectual 'method' of controlling undesirable volume growth in a specific service." *Ibid.*

Finally, the court of appeals determined that the particular rate reduction at issue here was permissible under the circumstances of this case. Pet. App. 28a-32a.

The court found it "reasonable to think that Congress, which cared enough about unnecessary volume to instruct the agency to 'develop a method for controlling' it, would have wanted the agency to avoid causing unnecessary volume growth with its own reimbursement practices." *Id.* at 29a. The court noted that it had no occasion to decide whether a rate reduction would be permissible in other circumstances. See *ibid.* The court also found unpersuasive petitioners' contention that the 2015 legislation prohibited HHS from controlling an unnecessary increase in the volume of E&M services. *Id.* at 30a-32a. Expressing uncertainty as to whether that contention, not based on an interpretation of Section 1395*l*(t)(2)(F), was reviewable in light of Section 1395*l*(t)(12)'s preclusion of review, the court rejected it on the merits. *Ibid.* The court reasoned that, although the 2015 legislation removed certain newly established off-campus outpatient departments from the OPPS, that legislation left preexisting off-campus outpatient departments—such as those operated by petitioners—within the OPPS and subject to HHS's subparagraph (2)(F) authority. See *id.* at 32a.

**ARGUMENT**

The court of appeals concluded that HHS permissibly exercised its express statutory authority to "develop a method for controlling unnecessary increases in the volume of covered [outpatient-department] services," 42 U.S.C. 1395*l*(t)(2)(F), by adopting a rate reduction designed to eliminate a Medicare payment differential that HHS had found incentivized an unnecessary increase in the volume of certain outpatient-department services. Pet. App. 16a-32a. That conclusion is correct and does not conflict with any decision of this Court or of another court of appeals.

Petitioners do not ask this Court to review the court of appeals' conclusion upholding HHS's exercise of its statutory authority. Instead, they contend (Pet. 20-23) that the court of appeals erred by applying *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), and other decisions of this Court recognizing that courts should defer to an agency's reasonable interpretation of a statute that it administers. In particular, they assert (Pet. 20-23) that an exception to the *Chevron* framework should apply in circumstances in which an agency's interpretation of a statute that bears on the lawfulness of a particular agency action may have an effect on the scope of the jurisdiction of a court reviewing that action, and that the court of appeals erred in failing to apply such an exception here. That contention lacks merit and does not warrant this Court's review. In any event, this case does not provide a suitable vehicle for addressing that contention. The court of appeals here did address the merits of petitioners' challenge to HHS's volume-control measure, notwithstanding the preclusion-of-review provision, precisely because, in the court's view, the jurisdictional and merits analyses "merge[d]." Pet. App. 13a (citation omitted). Any overlap between those analyses did not affect the outcome. Moreover, the court of appeals' invocation of the deferential *Chevron* framework made little if any difference to the outcome of its analysis of the merits. Further review is not warranted.

1. As an initial matter, this Court's review is not warranted because a provision of the OPPS statute, 42 U.S.C. 1395*l*(t)(12), precludes judicial review of petitioners' challenge to HHS's volume-control rate reduction. This Court would have no occasion to reach the

merits of petitioners' challenge unless it first determined that judicial review is available notwithstanding that provision.

Section 1395*l*(t)(12) states that "[t]here shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title, or otherwise of" certain actions by HHS under Section 1395*l*(t), the OPPS statute. 42 U.S.C. 1395*l*(t)(12). The court of appeals has previously recognized that this express preclusion of review is "unsurprising," because in many contexts covered by the provision, "review could result in the retroactive ordering of payment adjustments after hospitals have already received their payments for the year," and "judicially mandated changes in one payment rate would affect the aggregate impact of the Secretary's decisions by requiring offsets elsewhere." *Amgen Inc.* v. *Smith*, 357 F.3d 103, 112 (D.C. Cir. 2004).

That preclusion-of-review provision applies by its terms to HHS's action at issue here adopting a volume-control rate reduction under 42 U.S.C. 1395*l*(t)(2)(F). Among the agency actions that Section 1395*l*(t)(12) expressly makes unreviewable is HHS's "establishment of * * * methods described in paragraph (2)(F)." 42 U.S.C. 1395*l*(t)(12)(A). Subparagraph (2)(F) provides that "the Secretary shall develop a method for controlling unnecessary increases in the volume of covered [outpatient-department] services." 42 U.S.C. 1395*l*(t)(2)(F). That is the authority HHS exercised in implementing the rate reduction at issue here. In the proposed rule for the 2019 year, HHS stated that, "given the unnecessary increases in the volume of clinic visits in hospital outpatient departments, for the [2019 year], [it was] proposing to use [its] authority under section 1833(t)(2)(F) of the Act [*i.e.*, 42 U.S.C. 1395*l*(t)(2)(F)]" to adopt the rate reduction, as

a means of controlling the unnecessary volume increases that HHS identified. 83 Fed. Reg. at 37,142. In the final rule, HHS reiterated that statutory basis for its action, see 83 Fed. Reg. at 59,009, and it disagreed with comments questioning HHS's authority to adopt the rate reduction under that provision, *id.* at 59,011 ("After consideration of [such] comments, we continue to believe that section 1833(t)(2)(F) of the Act gives the Secretary broad authority to develop a method for controlling unnecessary increases in the volume of covered outpatient department (OPD) services, including a method that controls unnecessary volume increases by removing a payment differential that is driving a site-of-service decision, and as a result, is unnecessarily increasing service volume."). "[J]udicial review" of HHS's exercise of that authority to "establish[] * * * methods described in paragraph (2)(F)," 42 U.S.C. 1395*l*(t)(12)(A), is therefore unavailable, and petitioners' challenge was precluded.

The court of appeals nevertheless deemed Section 1395*l*(t)(12)(A)'s bar to judicial review inapplicable in this case, on the theory that petitioners contended that the volume-control rate reduction HHS adopted "is *not* a 'method described in paragraph (2)(F)'" and therefore not subject to the statutory preclusion of review. Pet. App. 13a (brackets omitted). The court concluded that its analyses of whether petitioners' suit was precluded and of the merits of their challenge to HHS's action "merge[d]" and that the court "c[ould] simply skip to the merits question in its analysis." *Ibid.* (citation omitted). We respectfully submit that the court's conclusion on that point was mistaken.

Petitioners' suit asserts that HHS did not properly exercise its authority under subparagraph (2)(F) in adopting a rate reduction as a "method for controlling unnecessary

increases in the volume of covered [outpatient-delivery] services," 42 U.S.C. 1395*l*(t)(2)(F), and that its action is inconsistent with another statutory provision. Pet. App. 11a-12a. But Section 1395*l*(t)(12)(A)'s bar exists precisely to preclude such challenges to HHS's actions under that provision. Petitioners' disagreement with the manner in which the agency exercised that authority does not take petitioners' suit outside the plain terms of the preclusion-of-review provision.

The court of appeals' contrary view threatens effectively to nullify that provision in any case where a plaintiff contends that the agency's asserted failure to adhere to statutory requirements places its action outside subparagraph (2)(F). Many if not all suits challenging the substance of HHS's exercise of its authority to adopt volume-control measures could be recast as alleging that the agency, by purportedly failing to comply with a requirement or limitation that they ascribe to subparagraph (2)(F), was not exercising the authority conferred by that provision. Cf. *City of Arlington* v. *FCC*, 569 U.S. 290, 297 (2013). It is very unlikely that Congress, in expressly precluding review of HHS's adoption of volume-control measures under that provision, intended such an unstated, easily manipulated exception. Even if circumstances might exist in which Section 1395*l*(t)(12)(A)'s bar to review would be inapplicable to agency action that cannot plausibly be understood as a volume-control measure "described in paragraph (2)(F)," 42 U.S.C. 1395*l*(t)(12)(A); cf. *Bell* v. *Hood*, 327 U.S. 678, 682-683 (1946), this is not such a case, as the court of appeals' ultimate conclusion that HHS's action was a permissible exercise of its authority under subparagraph (2)(F) confirms.

At the outermost, any judicial review should not extend beyond determining whether the "agency plainly act[ed] in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory." *DCH Reg'l Med. Ctr.* v. *Azar*, 925 F.3d 503, 509 (D.C. Cir. 2019) (citation omitted). That is the standard that the court of appeals, relying on this Court's precedent, has applied where a statute bars judicial review but a plaintiff contends that the agency has exceeded its authority.[2] See *ibid.* (discussing *Leedom* v. *Kyne*, 358 U.S. 184 (1958), and *Board of Governors of the Fed. Reserve Sys.* v. *MCorp Fin., Inc.*, 502 U.S. 32 (1991)). As the court of appeals recognized, petitioners' principal contention is that "HHS's reduction in reimbursement for E&M services exceeded the agency's statutory authority" under subparagraph (2)(F). Pet. App. 11a-12a. Judicial review in these circumstances should thus be subject at least to the same or similar limitations.

Petitioners cannot satisfy that standard here. The court of appeals' determination that HHS permissibly construed the statute to authorize the volume-control measure it adopted shows that it did not "plainly act[] in excess of its delegated powers." *DCH*, 925 F.3d at 509 (citation omitted). And petitioners have not identified any "specific prohibition in the statute that is clear and mandatory" that HHS's action contravenes. *Ibid.* (citation omitted). Their suit was therefore barred by Congress's judgment not to afford judicial review of

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[2] The court of appeals additionally restricts such review to cases where "the statutory preclusion of review is implied rather than express." *DCH*, 925 F.3d at 509. To the extent review is available despite subparagraph (2)(F)'s express preclusion of review, however, it should be no broader than in cases of implied preclusion.

HHS's establishment of the volume-control method at issue. At a minimum, that issue presents a substantial obstacle to this Court's consideration of the merits of petitioners' challenge that counsels strongly against review.

2. In any event, assuming arguendo that petitioners' challenge to HHS's volume-control rate reduction is reviewable, the court of appeals correctly determined that the reduction was a permissible exercise of HHS's statutory authority in the circumstances presented here. That decision does not warrant further review.

a. The court of appeals properly determined that the rate reduction at issue here was a permissible exercise of HHS's subparagraph (2)(F) authority to control an unnecessary increase in the volume of outpatient-department services. Pet. App. 16a-32a. As explained above, evidence before HHS indicated that E&M services had grown dramatically at outpatient departments because Medicare paid a higher rate when those services were provided in outpatient departments rather than in physicians' offices. See pp. 4-7, *supra*. HHS determined that this increase in volume was unnecessary, because E&M services can safely be provided in physicians' offices. See 83 Fed. Reg. at 37,141-37,143 (proposed rule); 83 Fed. Reg. at 59,009-59,012 (final rule). Exercising its authority under subparagraph (2)(F) to control an unnecessary increase in the volume of outpatient-department services, HHS thus eliminated the payment differential that was driving the unnecessary increase in E&M services at outpatient departments. See *ibid.*

As the court of appeals recognized in upholding HHS's action, the "service-specific, non-budget-neutral rate reduction" the agency adopted, far from being "foreclosed" by the statute, "falls comfortably within the plain text of subparagraph (2)(F)." Pet. App. 20a.

"Reducing the payment rate for a particular OPPS service readily qualifies, in common parlance, as a 'method for controlling unnecessary increases in the volume' of that service." *Ibid.* As the court explained, "[t]he lower the reimbursement rate for a service, the less the incentive to provide it, all else being equal," and therefore "[r]educing the reimbursement rate * * * is naturally suited to addressing unnecessary increases in the overall volume of a service provided by hospitals." *Ibid.* As the court additionally recognized, nothing in the statutory language requires volume-control measures to be budget neutral. *Ibid.* The "statutory context" further undermined petitioners' arguments that "service-specific" or "non-budget-neutral" rate reductions are impermissible. *Id.* at 21a. And the court found it "reasonable to think that Congress, which cared enough about unnecessary volume to instruct the agency to 'develop a method for controlling' it, would have wanted the agency to avoid causing unnecessary volume growth with its own reimbursement practices." *Id.* at 29a.

b. In this Court, petitioners do not attempt to refute the court of appeals' determination or the specific and detailed reasoning that the court set forth in support. They address the merits (Pet. 27) in a single, conclusory sentence that does not engage with the reasoning of the decision below. Instead, petitioners contend (Pet. 20-23) that the court of appeals should not have applied the well-established *Chevron* framework at all, and they urge this Court to create an exception to *Chevron* for circumstances in which an agency's interpretation of a substantive statute that may affect or have certain parallels to a court's assessment of the scope of its review. That contention is incorrect, and in any event this case would not provide a suitable context to address it. The

court of appeals here did adjudicate the merits of petitioners' challenge to HHS's volume-control measure. Petitioners' concern (Pet. 3-4, 20-23) that affording deference to an agency's position on the interpretation of a statute it administers would enable an agency to prevent or circumscribe judicial review is not implicated by the decision below. Moreover, the court of appeals' invocation of the *Chevron* framework made little if any difference to its analysis of the merits.

i. This Court has long recognized that HHS's interpretations of the Medicare statute are generally entitled to *Chevron* deference. See *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 414 (1993). As the Court has observed, "a very good indicator of delegation meriting *Chevron* treatment is express congressional authorizations to engage in the process of rulemaking or adjudication that produces regulations or rulings for which deference is claimed." *United States* v. *Mead Corp.*, 533 U.S. 218, 229 (2001). That is true of Medicare payment rules, which are developed through notice-and-comment rulemaking. See 42 U.S.C. 1395hh(a)(2); *Azar* v. *Allina Health Servs.*, 139 S. Ct. 1804, 1809 (2019).

Petitioners do not dispute that HHS's interpretations of the Medicare statute are routinely accorded *Chevron* deference. They assert instead (Pet. 20-23) that HHS's statutory interpretation should not be accorded deference here because the question at the center of petitioners' substantive challenge—whether the rate reduction is a "method for controlling unnecessary increases in the volume of covered [outpatient-department] services," 42 U.S.C. 1395*l*(t)(2)(F)—overlaps with the question whether Section 1395*l*(t)(12)(A) bars judicial review of that challenge. This Court, however, has never recog-

nized such a carve-out from *Chevron*'s general framework. And as the court of appeals explained, such an illogical exception would contravene Congress's manifest intent, which is the touchstone of that framework, see *Chevron*, 467 U.S. at 842-845.

The preclusion-of-review provision that Congress enacted exists to shield the broad discretion that the statute confers on HHS in establishing and modifying OPPS from interference by private plaintiffs. As the court of appeals has previously observed, that bar to administrative or judicial review is "unsurprising" in this context. *Amgen*, 357 F.3d at 112. Medicare rates are determined and published in advance of the year to which they apply, enabling providers to make a business judgment about their participation for that year. See p. 3, *supra*. In many contexts covered by the bar, however, after-the-fact judicial review "could result in the retroactive ordering of payment adjustments after hospitals have already received their payments for the year," and "judicially mandated changes in one payment rate would affect the aggregate impact of the Secretary's decisions by requiring offsets elsewhere." *Amgen*, 357 F.3d at 112. And "piecemeal judicial review" could cause "havoc" for the administration of the OPPS. Pet. App. 19a (brackets and citation omitted). Where the preclusion-of-review provision applies, it thus eliminates even the deferential review that otherwise would apply under *Chevron*.

Petitioners' approach, however, "would mean that Congress's decision to enact a preclusion provision operated to enhance judicial scrutiny and restrict the agency's leeway." Pet. App. 18a. Petitioners identify no sound basis to impute that perplexing intention to Congress. Indeed, as the court of appeals recognized,

by "precluding judicial review of certain HHS actions, * * * Congress necessarily intended the opposite outcome." *Id.* at 19a.

None of the decisions of this Court on which petitioners rely (Pet. 3, 21-22) supports their contrary position. In those cases, the relevant issue was the meaning of a particular provision governing judicial review—rather than a substantive provision that an agency was charged with implementing. For example, in *Smith* v. *Berryhill*, 139 S. Ct. 1765 (2019), the question before this Court was whether a dismissal by the Appeals Council of the Social Security Administration on timeliness grounds, after a claimant for disability benefits has received a hearing before an administrative law judge on the merits, "qualifies as a 'final decision . . . made after a hearing' for purposes of allowing judicial review under [42 U.S.C.] 405(g)." *Id.* at 1774. The Court held that such a dismissal does qualify, and it rejected the suggestion of the Court-appointed amicus that it should defer to the agency's prior interpretation of that judicial-review provision (which the government did not defend). See *id.* at 1778. In that context, the Court's unremarkable statement that the "scope of judicial review * * * is hardly the kind of question that the Court presumes that Congress implicitly delegated to an agency," *ibid.*, did not suggest that agency statutory interpretations governing substantive eligibility for benefits would not be accorded *Chevron* deference.

Similarly, in *Salinas* v. *United States Railroad Retirement Board*, 141 S. Ct. 691 (2021), the question presented was whether the refusal of the Railroad Retirement Board "to reopen a prior benefits determination is a 'final decision' within the meaning of [45 U.S.C.] § 355(f), and therefore subject to judicial review." *Id.*

at 701. The Court held that the "denial of reopening qualifies for review under the language Congress chose," and that, to the extent there was ambiguity in the meaning of "final decision," it must be resolved in the claimant's favor under the "strong presumption favoring judicial review of administrative action." *Id.* at 698 (citation omitted). Likewise, in *Kucana* v. *Holder*, 558 U.S. 233 (2010), the question was the meaning of the provision of federal immigration law that barred judicial review of any action of the Attorney General "the authority for which is specified under this subchapter to be in the discretion of the Attorney General." *Id.* at 237 (quoting 8 U.S.C. 1252(a)(2)(B)(ii) (emphasis omitted). This Court agreed with the government that "specified under this subchapter" limited the provision's scope to determinations made discretionary by statute, and not to determinations declared discretionary by an administrative regulation. See *ibid.* None of those decisions has a bearing on the court of appeals' determination that the well-established *Chevron* framework applied to its consideration of the scope of HHS's authority to "develop a method for controlling unnecessary increases in the volume of covered [outpatient-department] services." 42 U.S.C. 1395*l*(t)(2)(F).

ii. In any event, this case would be an unsuitable context in which to address the question petitioners present regarding the applicability of the *Chevron* framework. The court of appeals' application of *Chevron* here did not cause it to forgo review of the merits. Based on its view that the jurisdictional and merits analyses "merge[d]," the court considered petitioners' challenge to HHS's volume-control measure and rejected it. Pet. App. 13a (citation omitted); see *id.* at 16a-32a. Although we respectfully disagree with that

view, see pp. 14-19, *supra*, as a result of the course that the court followed, the case does not implicate the concern petitioners raise (Pet. 3-4, 20-23) that application of *Chevron* to an agency's position on the interpretation of a statute it administers might enable the agency to prevent or restrict judicial review.

Moreover, the court's invocation of the *Chevron* framework made little if any difference to the outcome of this case. The court of appeals found that HHS's interpretation "falls comfortably within the plain text of subparagraph (2)(F)," and that the provision's language "lends considerable support to the agency's reading of the statute at *Chevron* step one." Pet. App. 20a. And the court rejected the limitations petitioners proposed on HHS's authority under subparagraph (2)(F) because it determined that they lacked a sound basis in the statutory text or context. *Id.* at 20a-21a. For example, emphasizing that subparagraph (2)(F) "says nothing about budget-neutrality," the court of appeals rejected petitioners' argument that volume-control methods must be budget neutral. *Id.* at 20a. And the court noted that it would be "anomalous" for the statute to require a rate cut made for the purpose of volume control "to be implemented budget-neutrally" because, if HHS were required "to redistribute the costs traceable to the provision of unnecessary services throughout the OPPS," the result would be "no net savings to Medicare," "largely negating the point of reducing reimbursement in the first place." *Id.* at 21a-22a (citing 83 Fed. Reg. at 37,142-37,143). Similarly, the court of appeals rejected as unsupported by the text petitioners' assertion that subparagraph (2)(F) "does no more than enable the agency to develop an 'analytical mechanism for determining whether there is an unnecessary increase in volume,'"

*id.* at 22a (citation omitted), which may be controlled only through an across-the-board update to the conversion factor, *id.* at 23a.

The court of appeals' reasoning strongly indicates that it found HHS's statutory interpretation persuasive and that, contrary to petitioners assertion (Pet. 27), the court would have reached the same conclusion had it not invoked the *Chevron* framework at the outset. Petitioners identify nothing in the court's decision showing that, but for that framework, it would have adopted their construction. That the court articulated its conclusion in terms of whether the statute "unambiguously foreclose[d]" HHS's interpretation (*ibid.* (quoting Pet. App. 28a)) simply reflects that this Court's precedents did not require the court of appeals to go further and state explicitly how it would decide the issue absent HHS's rule. See, *e.g.*, *Holder* v. *Martinez Gutierrez*, 566 U.S. 583, 591 (2012). And its conclusion that the agency's interpretation is "permissible," Pet. App. 28a (citation omitted), is entirely compatible with a conclusion that it is the best interpretation, whether or not other plausible but less persuasive interpretations also exist. Cf. *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 & n.4 (2009). At a minimum, the substantial uncertainty as to whether the question petitioners present would make any difference to the outcome counsels against review in this case.

3. Petitioners err in contending (Pet. 13-20) that review is warranted to resolve a conflict among the courts of appeals regarding the applicability of the *Chevron* framework in these circumstances. To our knowledge, no other court of appeals has interpreted the volume-control authority conferred by subparagraph (2)(F) of the OPPS statute. More generally, as petitioners recognize (Pet. 5-6), the Medicare statute contains many

provisions that expressly preclude judicial review of specified agency actions taken to implement Medicare programs. Yet petitioners do not identify any decision of another court of appeals that deemed such a judicial-review bar a basis to depart from this Court's precedent by declining to apply the generally applicable *Chevron* framework under Medicare, and we are not aware of any.

The cases petitioners discuss involving various other contexts are inapposite and do not reflect a conflict warranting this Court's review. For example, in *Soliman* v. *Gonzales*, 419 F.3d 276 (4th Cir. 2005), the court held that the "principles of *Chevron*" did "apply" to the Board of Immigration Appeals' interpretation of the relevant provision of federal immigration law at issue, 8 U.S.C. 1101(a)(43)(G), which defined the term "aggravated felony" to include certain "theft offens[es]," *ibid.*; *Soliman*, 419 F.3d at 281. The court stated that it "need not accord deference to the [Board's] ultimate finding that [the petitioner's] particular offense was an aggravated felony" for purposes of determining the court's "appellate jurisdiction" under a separate provision, 8 U.S.C. 1252(a)(2)(C), an issue that also involved "an interpretation of [state] criminal law, neither of which l[ay] within the [Board's] authority or expertise." *Soliman*, 419 F.3d at 281. Here, by contrast, the court of appeals addressed an issue at the heart of HHS's authority and expertise: the appropriate method to control an unnecessary increase in the volume of Medicare-covered outpatient-department services, pursuant to Congress's express delegation to the agency in subparagraph (2)(F) of the OPPS statute.

Other cases petitioners discuss are similarly or even further afield. See, *e.g.*, *Solorzano-Patlan* v. *INS*, 207 F.3d 869, 872-876 (7th Cir. 2000) (concluding on de

novo review that, because the petitioner "burglarized a motor vehicle and not a 'building or structure,'" his conviction under Illinois law was not a "burglary offense" making him removable, but without mentioning *Chevron* or deference); *Nehme* v. *INS*, 252 F.3d 415, 427 (5th Cir. 2001) (declining to apply *Chevron* in concluding that the court lacked jurisdiction under 8 U.S.C. 1252(a)(2)(C) because the petitioner's parents were not legally separated and thus that he did not become a naturalized citizen by virtue of one parent's naturalization); *National Ass'n of Agriculture Employees* v. *Federal Labor Relations Board*, 473 F.3d 983, 985 (9th Cir. 2007) (concluding, without affording deference to agency, that the court lacked jurisdiction to review the agency's finding that certain inspectors were not "professional employees," which was a component of an "appropriate unit determination" exempted from judicial-review provision). Further review is not warranted.

**CONCLUSION**

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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