No. 13-______

In The
Supreme Court of the United States

CALIFORNIA MEDICAL ASSOCIATION, ET AL.,
PETITIONERS,

v.

KATHLEEN SEBELIUS, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

California's Department of Health Care Services formulated new rates at which health-care providers are reimbursed for providing services to Medicaid beneficiaries. It did so without considering studies of the affected health-care providers' service costs, despite Ninth Circuit precedent requiring such cost studies. The federal Centers for Medicare & Medicaid Services ("CMS"), relying on authority delegated to it by the Secretary of the United States Department of Health and Human Services, approved amendments to California's Medicaid program. The Ninth Circuit concluded that CMS's perfunctory approval letter was an implicit interpretation that the federal Medicaid Act did not require States to consider cost studies. The Ninth Circuit gave that implicit interpretation deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), and thus did not follow its own, contrary circuit precedent. Such an implicit and informal agency interpretation would not have been given *Chevron* deference in the First, Second, or Eighth Circuits.

The question presented is:

Whether the Ninth Circuit erred when, in conflict with the First, Second, and Eighth Circuits, it accorded *Chevron* deference to an implicit and informal agency interpretation.

PARTIES TO THE PROCEEDING

Petitioners are California Medical Association, California Hospital Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, California Dental Association, and American Medical Response West. California Hospital Association was the plaintiff-appellee below in case numbers 12-55068 and 12-55331 and a plaintiff-appellant in 12-55535. All other petitioners were plaintiffs-appellees below in case numbers 12-55315 and 12-55335 and plaintiffs-appellants in 12-55550.

AIDS Healthcare Foundation and Jennifer Arnold also were plaintiffs-appellees in case numbers 12-55315 and 12-55335 and plaintiffs-appellants in 12-55550. Individuals identified with the initials G.G., I.F., R.E., A.W., and A.G. also were plaintiffs-appellants below in case number 12-55535. These parties are not petitioners here.

Managed Pharmacy Care; Independent Living Center of Southern California, Inc.; California Foundation for Independent Living Centers; Gerald Shapiro, Pharm D, dba Upton Pharmacy and Gift Shoppe; Sharon Steen, dba Central Pharmacy; Tran Pharmacy, Inc.; Odette Leonelli, dba Kovacs-Frey Pharmacy; Market Pharmacy, Inc.; and Mark Beckwith were plaintiffs-appellees below in case numbers 12-55067 and 12-55332. California Medical Transportation Association, Inc.; GMD Transportation, Inc.;

PARTIES TO THE PROCEEDING—Continued

and Lonny Slocum were plaintiffs-appellees below in case numbers 12-55103 and 12-55334 and plaintiffs-appellants in 12-55554. These parties are petitioners in this Court in case number 13-253.

Respondents are Kathleen Sebelius, Secretary of the United States Department of Health and Human Services, and Toby Douglas, Director of the Department of Health Care Services of the State of California.

CORPORATE DISCLOSURE STATEMENT

California Medical Association, California Hospital Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, and California Dental Association have no parent corporations, and no publicly held company owns 10% or more of their stock.

American Medical Response West has the following parent companies: Envision Healthcare Holdings Inc. (formerly known as CDRT Holding Corporation); Envision Healthcare Corporation (formerly known as Emergency Medical Services Corporation); AMR Holdco Inc.; and American Medical Response, Inc.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners California Medical Association, California Hospital Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, California Dental Association, and American Medical Response West respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The opinion of the Ninth Circuit (App., *infra*, 1a-45a) is reported at 716 F.3d 1235. The opinion of the district court in *California Medical Association v. Douglas* (App., *infra*, 46a-88a) is reported at 848 F. Supp. 2d 1117. The opinion of the district court in *California Hospital Association v. Douglas* (App., *infra*, 89a-128a) is unreported.

JURISDICTION

The Ninth Circuit issued an opinion on December 13, 2012. Petitioners filed petitions for rehearing en banc. On May 24, 2013, the Ninth Circuit withdrew its December 13, 2012 opinion, issued a superseding opinion, and denied the petitions for rehearing en banc. App., *infra*, 12a-13a.

On August 14, 2013, Justice Kennedy granted an extension of time within which to file a petition for a writ of certiorari to and including September 21, 2013.

This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Title 42 U.S.C. §§ 1316, 1396a(a)(30); 42 C.F.R. §§ 430.15, 430.16, 430.18; and Section 14105.192 of the California Welfare and Institutions Code are set forth in the appendix to the petition. App., *infra*, 129a-149a.

INTRODUCTION

The courts of appeals are intractably divided over what level of deference courts must give to informal agency interpretations of statutes that the agencies administer.

Three circuits—the First, Second, and Eighth—hold that cursory or implicit statutory interpretations made by an agency outside the context of formal rulemaking or formal adjudication receive deference only under *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944). That is so even where Congress expressly has delegated authority to the agency to promulgate regulations interpreting or implementing the statute. Those circuits hold that if the agency's interpretation is not performed in the exercise of that formal rulemaking or formal adjudicative authority, only *Skidmore* deference is warranted. That is especially true where no meaningful explanation of the agency's interpretation is given.

By contrast, five other circuits—the Third, Fifth, Sixth, Ninth, and D.C.—hold that implicit agency interpretations made by an agency outside a formal rulemaking or adjudicatory process are entitled to deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). In those circuits, as long as the agency is acting pursuant to authority granted by Congress, *Chevron* deference is given. That is so even if the agency's interpretation is only implicit—i.e., where the court believes the agency must have interpreted the statute in a particular way, even if the agency never explained its interpretation.

The disagreement among the courts of appeals has profound consequences here. This case involves, at best, an implicit interpretation by a regional officer of the federal Centers for Medicare and Medicaid Services ("CMS"), which is a division of the United States Department of Health and Human Services ("HHS"). The CMS officer approved California's steep cuts to the rates at which many Medicaid providers (e.g., doctors, hospitals, pharmacies, and 911 ambulance providers) are paid for providing services to beneficiaries. California's reimbursement rates under its state-run Medicaid program, Medi-Cal, already were among the Nation's lowest. Yet California proposed 10% or steeper cuts for many Medi-Cal service providers.

Having appropriate reimbursement rates in place is critical to ensure Medicaid beneficiary access. Medicaid provides crucial access to health care for some

60 million Americans, nearly 9 million of whom are in California. Medicaid beneficiaries are among the most vulnerable members of society, including needy children and the disabled. Health-care providers are not required, however, to accept Medicaid patients. If Medicaid reimbursement rates are set too low, providers of quality care will drop out of the system. Medicaid beneficiaries therefore will lose sufficient access to quality health-care services.

To prevent that, Congress established a standard in the Medicaid Act for setting Medicaid-provider reimbursement rates. Congress mandated that each State's Medicaid program set payment rates that "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)").

The Secretary of HHS ("Secretary") has never promulgated authoritative rules establishing any particular process that a State must go through to show that its proposed reimbursement rates are sufficient to meet the Section 30(A) standard. That is true despite the Secretary's assurance to this Court in December 2010 that such a formal regulation was forthcoming within a year.

Lacking any guidance from the Secretary, the Ninth Circuit previously had interpreted Section 30(A) as requiring States to set reimbursement rates that "bear a reasonable relationship" to the "costs of

providing quality services." *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997). The State has "the burden of justifying any rate that substantially deviates from such determined costs." *Id.* at 1500. The court of appeals held that States "must rely on responsible cost studies" to evaluate provider costs. *Id.* at 1496.

The California Department of Health Care Services ("DHCS") submitted the State's reimbursement rate cuts to CMS for approval. It is undisputed, however, that DHCS did not consider any cost studies for most of the categories of service for which DHCS proposed rate cuts. Had it done so, DHCS would have seen that the new payment rates for many services are substantially below the providers' own costs. Consequently, implementing the cuts likely would drive Medicaid providers out of the program and impede access by beneficiaries to the quality health care required by the Medicaid Act.

Despite DHCS's failure to consider cost studies, a CMS Associate Regional Administrator—acting under authority delegated by the Secretary—approved the cuts. The approval was in a succinct letter without any discussion of whether cost studies are required under Section 30(A).

Although there was no evidence the CMS Associate Regional Administrator considered whether cost studies were required, the Ninth Circuit concluded that the Secretary necessarily must have interpreted Section 30(A) as not requiring any particular

methodology on the part of States. The Ninth Circuit presumed that the CMS Associate Regional Administrator had rejected the Ninth Circuit's prior authoritative construction of Section 30(A). The court so concluded even though there was no indication that this supposed interpretation by the CMS Associate Regional Administrator represented the views of the Secretary.

Not only did the Ninth Circuit conclude this represented an implicit "interpretation" of the statute, the court gave that supposed interpretation *Chevron* deference that trumped the court of appeals' prior precedent. App., *infra*, 27a-28a (citing *National Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967 (2005)). The Ninth Circuit consequently held that CMS's approval of the new rates was not arbitrary and capricious under the Administrative Procedures Act ("APA").

Four other circuits—the Third, Fifth, Sixth, and D.C. Circuits—likewise would have given *Chevron* deference to the approval letters. But had this case been brought in the First, Second, or Eighth Circuits, the CMS Regional Administrator's implicit informal interpretation would have received only *Skidmore* deference. Under the *Skidmore* framework, CMS's approval would have been arbitrary and capricious (as the district court here held).

Thus, not only is the circuit conflict real and entrenched, it has serious consequences in this case

for millions of Medicaid beneficiaries and thousands of service providers.

The petition should be granted.

STATEMENT OF THE CASE

A. Statutory And Regulatory Framework

1. Medicaid is a federal-state partnership that provides health coverage to nearly 60 million Americans, including children, pregnant women, needy families, the blind, the elderly, and the disabled. States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services provided. Medicaid is jointly funded by the federal government and States, with the federal government providing the majority of the financial contribution.

To receive federal funding, States' individualized Medicaid plans must comply with federal law governing matters such as which population groups are entitled to services and what services are provided at what cost. Those requirements are imposed by the Medicaid Act and regulations promulgated by the Secretary.

2. Before a State may modify its Medicaid plan, it must receive federal approval. CMS must review and approve or reject any proposed amendment to a state Medicaid plan. App., *infra*, 18a. Such an amendment is referred to as a State Plan Amendment. *Ibid.*

The ten CMS Regional Administrators review State Plan Amendments under authority delegated to them by the Secretary. *Ibid.*; 42 U.S.C. § 1396a(b); 42 C.F.R. § 430.15(b). The CMS Regional Administrator has 90 days in which to review and either approve or reject a State Plan Amendment. 42 U.S.C. § 1316(a)(1). If the CMS Regional Administrator fails to act within 90 days, the proposed amendment is deemed approved by operation of law. 42 C.F.R. § 430.16(a).

No formal hearing is required when the CMS Regional Administrator approves a State Plan Amendment. *See* 42 C.F.R. § 430.15(b). CMS Regional Administrators approve hundreds of State Plan Amendments each year, generally in perfunctory letters stating simply that the amendment is approved.

By contrast, for rejections, the process is more formal. Only the CMS Administrator (as opposed to one of the Regional Administrators) has authority to disapprove a State Plan Amendment. 42 C.F.R. § 430.15(c)(1). The "Administrator does not make a final determination of disapproval without first consulting the Secretary." *Id.* § 430.15(c)(2). If the State Plan Amendment is rejected, the State is entitled to petition for reconsideration, and the Secretary is required to conduct a formal adjudication pursuant to the APA. 42 U.S.C. § 1316(a)(2). If the State remains dissatisfied, it may petition for review in the court of appeals for the circuit in which the State is located. *Id.* § 1316(a)(3).

Beneficiaries, providers, and other interested parties have no express opportunity for input unless CMS denies a State Plan Amendment and the State appeals that denial to the Secretary. *See* 42 C.F.R. § 430.18.

3. The Medicaid Act establishes a particular standard that every State's Medicaid plan must meet concerning payment rates to benefit providers (e.g., doctors, hospitals, pharmacies, and 911 ambulance providers) for services provided under the plan. 42 U.S.C. § 1396a(a)(30)(A). Under Section 30(A), a State's Medicaid plan must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." *Ibid.*

The Secretary has not promulgated any regulation concerning what criteria States must consider under Section 30(A) before setting new provider-reimbursement rates, even though the statute was last amended in 1989.

In the absence of any such regulation, the Ninth Circuit interpreted Section 30(A) in 1997 as requiring States to set reimbursement rates that "bear a reasonable relationship" to the "costs of providing quality services." *Orthopaedic Hospital*, 103 F.3d at 1496. The court of appeals held that States have the "burden of justifying any rate that substantially deviates from such determined costs." *Id.* at 1500. States

"must rely on responsible cost studies" to evaluate provider costs. *Id.* at 1496.

In the more than 16 years since the decision in *Orthopaedic Hospital*, the Secretary has not promulgated any regulation either agreeing or disagreeing with the court of appeals' interpretation of Section 30(A). That is true despite that, in December 2010, the Secretary "committed to conducting a rulemaking proceeding over the next year that will result in an authoritative interpretation of Section 1396a(a)(30)(A)." Brief for United States as Amicus Curiae at 8, 11, *Maxwell-Jolly v. Independent Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (No. 09-958). The Secretary made that commitment in the context of successfully urging this Court to deny review of a question of Section 30(A)'s interpretation. *Maxwell-Jolly v. Independent Living Ctr. of S. Cal., Inc.*, 131 S. Ct. 992 (2011) (granting certiorari only on other question presented).

In 2011, the Secretary did propose, through notice-and-comment rulemaking, a regulation to implement Section 30(A). Medicaid Program; Methods for Assuring Access to Covered Services, 76 Fed. Reg. 26342 (May 6, 2011). The proposed rule, however, has not been implemented. The proposed rule would have required a State to allow interested providers and beneficiaries an opportunity to comment upon proposed provider payment rates if an amendment would reduce those rates. The rule also would have required a State to demonstrate that beneficiaries will continue to have sufficient access to services under the

new rates. *Id.* at 26361. Similar to the Ninth Circuit's requirement, the proposed rule would require the State's submission to include data concerning the impact of the new rates on providers, including a comparison of the proposed rates and provider costs. *Ibid*.

B. Factual Background

The California legislature in 2011 enacted legislation authorizing the Director of DHCS ("Director") to implement a 10% (and in some instances more than 10%) across-the-board rate cut for Medi-Cal fee-for-service benefits. Cal. Welf. & Inst. Code § 14105.192(d)(1). The statute provides that the rate cuts "shall be implemented only if the director determines that the payments that result from the application of this section will comply with applicable federal Medicaid requirements." *Id.* § 14105.192(m).

Pursuant to that legislation, the Director decided to implement reimbursement-rate cuts for virtually all categories of Medi-Cal services: pharmacy services; durable medical equipment; emergency and non-emergency medical transportation; certain physician, clinic, and dental services; and services provided by distinct-part nursing facilities (i.e., skilled nursing facilities operated by hospitals as distinct parts within those hospitals). App., *infra*, 19a.

DHCS then submitted two State Plan Amendments to CMS for approval of the Medi-Cal cuts. *Ibid.* DHCS submitted reports purporting to demonstrate that the rate cuts would not significantly affect beneficiary

access to health coverage. Even though the Ninth Circuit's interpretation of Section 30(A) required DHCS to consider providers' costs, DHCS's studies "did not review cost data with respect to most of the services subject to the rate reduction." App., *infra*, 19a-20a.

Petitioners were denied an opportunity timely to review the materials submitted by DHCS. C.A. Supp. E.R. 2-8. Once a State Plan Amendment is submitted, negotiations occur exclusively and privately between CMS and the State, and most disputes between CMS and the State are resolved during these negotiations. Petitioners nonetheless submitted comments to CMS explaining that the proposed rate reductions would harm beneficiary access to needed services. App., *infra*, 20a. The comments contained, for example, a report demonstrating that most distinct-part nursing facilities already operate at a loss. *Ibid.*

Notwithstanding DHCS's failure to consider the cost of providing the affected services, the Associate Regional Administrator of the Division of Medicaid & Children's Health Operations for Region IX approved both State Plan Amendments. App., *infra*, 21a, 49a, 91a.

The approval letters were "succinct." App., *infra*, 21a; *see* App., *infra*, 150a-155a. The approval letters stated that the "State was able to provide metrics which adequately demonstrated beneficiary access." App., *infra*, 21a, 151a, 154a. There is no reference in the letters to any interpretation of Section 30(A) adopted by the Secretary. Nor did either letter

provide "any reasons on its face as to why provider costs should not be considered in determining whether the [State Plan Amendment's] rate reduction will result in lower quality of care or decreased access to services." App., *infra*, 63a.

The State Plan Amendment approvals did not involve a formal adjudication. App., *infra*, 60a; *see* 42 U.S.C. § 1316(a). There was no opportunity for interested members of the public (including beneficiaries or providers) to brief legal arguments, to be heard at a hearing, to receive reasoned decisions at multiple levels within the agency, or to submit exceptions to those decisions. App., *infra*, 61a; *see* 42 C.F.R. § 430.18. Indeed, there was "no formal decision in which the Secretary set forth her reasoning." App., *infra*, 61a-62a.

C. Proceedings Below

Petitioners are professional and trade associations representing the interests of Medi-Cal service providers, including physicians, hospitals, pharmacists, national pharmacy chains, dentists, and durable-medical-equipment suppliers. App., *infra*, 47a-48a. Petitioners also include a Medi-Cal provider of emergency-medical-transportation services. App., *infra*, 48a.

Petitioners and other Medi-Cal providers and beneficiaries filed four suits against the Secretary and the Director, challenging the reimbursement-rate reductions. App., *infra*, 21a. Petitioners were plaintiffs in two of those suits. The challengers brought

claims against the Secretary under the APA and against the Director under the Supremacy Clause of the United States Constitution. App., *infra*, 14a.[1]

1. Proceedings in the district court

The district court granted preliminary injunctions restraining the Director from implementing the rate cuts and staying the Secretary's approval of the reductions. App., *infra*, 87a-88a, 127a-128a.

In so concluding, the district court rejected the Secretary's contention that *Chevron* deference is owed her implicit interpretation that Section 30(A) does not require cost studies. The district court explained it was "significant that the Secretary's approval of [the State Plan Amendments] did not involve a formal adjudication accompanied by the procedural safeguards justifying *Chevron* deference." App., *infra*, 60a-61a, 102a. "[T]here was no hearing, no record, no opportunity for interested parties to present evidence, and

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[1] The issue here is distinct from that reviewed in *Douglas v. Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204 (2012). There, the question presented was whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce Section 30(A) by asserting that the provision preempts a state law reducing reimbursement rates. The Ninth Circuit did not reach the Supremacy Clause issue in this case. App., *infra*, 41a-43a. It is not presented here. Moreover, unlike *Douglas*, this case involves an APA action against the Secretary for which there indisputably is a private right of action. *See Douglas*, 132 S. Ct. at 1210 ("respondents' basic challenge now presents the kind of legal question that ordinarily calls for APA review").

no formal decision in which the Secretary set forth her reasoning." App., *infra*, 61a-62a, 102a-103a.

Having concluded *Chevron* deference was inappropriate, the district court declined to follow the implicit interpretation of the approval letters because that "proffered interpretation directly contradicts the law in the Ninth Circuit." App., *infra*, 65a, 106a. Under that law, "because CMS failed to consider whether DHCS relied on responsible cost studies," the district court held that "CMS failed to consider a relevant factor." App., *infra*, 66a, 107a.

Finding that there thus was a strong probability that the approval of the State Plan Amendments would be found to be arbitrary and capricious, and considering the balance of hardships, the district court issued preliminary injunctions. App., *infra*, 66a, 107a.

2. Proceedings in the Ninth Circuit

The Ninth Circuit vacated the injunctions. The court acknowledged that DHCS "did not review cost data with respect to most of the services subject to the rate reduction," as required by the Ninth Circuit's decision in *Orthopaedic Hospital*. App., *infra*, 20a. Nevertheless, the court held that "*Orthopaedic Hospital* does not control the outcome in these cases." App., *infra*, 15a. Instead, the court held that the "succinct" approval letters were entitled to controlling deference under *Chevron*, and thus trumped the circuit's own previous interpretation of the statute. App., *infra*, 27a-38a.

The Ninth Circuit granted *Chevron* deference even though the approval letters contained no explicit interpretation of Section 30(A). The court reasoned that "the Secretary has now set forth her interpretation, through her approvals of the [State Plan Amendments], that § 30(A) does not prescribe any particular methodology a State must follow before its proposed rates may be approved." App., *infra*, 27a.

The court acknowledged that State Plan Amendment approvals lack any procedural formality. "When the Secretary disapproves a proposed plan amendment, a State has the 'opportunities to petition for reconsideration, brief its arguments, be heard at a formal hearing, receive reasoned decisions at multiple levels of review, and submit exceptions to those decisions.'" App., *infra*, 31a (citation omitted). By contrast, for State Plan Amendment approvals, "the Medicaid program does not provide interested parties with similar opportunities." *Ibid.* Nevertheless, the court held that, "despite the lack of formal procedures available for interested parties, the Secretary's exercise of discretion in the 'form and context' of a [State Plan Amendment] approval deserves *Chevron* deference." App., *infra*, 33a.

REASONS FOR GRANTING THE PETITION

THE LEVEL OF DEFERENCE OWED AN AGENCY'S IMPLICIT, INFORMAL STATUTORY INTERPRETATION IS AN IMPORTANT QUESTION DIVIDING THE COURTS OF APPEALS

This case presents a straightforward but important legal question of agency deference that has sharply divided the courts of appeals. Three circuits would apply only *Skidmore* deference to the CMS Regional Administrator's implicit interpretation of Section 30(A) here. Five other circuits would give *Chevron* deference to the mere act of approving the State Plan Amendment, whether or not accompanied by an express meaningful explanation of the agency's interpretation of the statute.

This Court's review of the question presented is needed now. The appropriate level of deference has enormous consequences for millions of Medicaid beneficiaries and providers in this case alone. And outside the Medicaid context, the level of formality required to warrant *Chevron* deference is an important, recurring question. This case is an ideal vehicle for the Court to decide the issue. The petition should be granted.

A. The Courts Of Appeals Are Intractably Divided Over The Level Of Deference Owed Informal Agency Interpretations Of Statutes That The Agency Is Charged With Administering

The courts of appeals are in conflict about the measure of deference owed to cursory agency approvals. This significant divide shows no sign of resolving itself. Rather, it is well developed and ripe for this Court to intervene.

1. Unlike the Ninth Circuit here, three circuits accord only **Skidmore** *deference to informal agency interpretations with perfunctory reasoning*

The First, Second, and Eighth Circuits grant only *Skidmore* deference to informal agency approvals or interpretations. This is so even where Congress delegated authority to interpret the statute at issue. The question these circuits consider is whether the agency exercised that authority pursuant to procedures "tending to foster the fairness and deliberation that should underlie a pronouncement of such force." *United States v. Mead Corp.*, 533 U.S. 218, 230 (2001).

a. For example, in *Estate of Landers v. Leavitt*, the Second Circuit refused to extend *Chevron* deference to an informal CMS interpretation of a Medicare statute. 545 F.3d 98, 105-107 (2d Cir. 2008). There, CMS had set forth its interpretation in an agency manual, and it expressly had applied that

interpretation in denying Medicare benefits to three beneficiaries. *Id.* at 104.

The Second Circuit acknowledged that Congress had delegated rulemaking authority to the Secretary. *Id.* at 105. But the court concluded that was only "the first half" of the test for *Chevron* deference. *Ibid.* Examining the nature of CMS's interpretation, the court concluded it was insufficiently formal to receive *Chevron* deference. *Id.* at 105-107. The court explained that "agency manuals, as a class, are generally ineligible for *Chevron* deference." *Id.* at 106 (citing *Mead*, 533 U.S. at 234). Instead, the Second Circuit construed the statute in the first instance, giving only *Skidmore* deference. *Id.* at 108-111.

Similarly, in *Rabin v. Wilson-Coker*, the Second Circuit considered how much deference to give CMS's interpretation of a provision of the Medicaid Act. 362 F.3d 190, 198 (2d Cir. 2004). CMS's interpretation had been "stated or implied in several different sources, none of which is a published regulation." *Id.* at 197. The State in that case sought "a heightened and all but conclusive deference to CMS's interpretation," arguing that Congress had re-enacted the statute without change subsequent to CMS's interpretation. *Ibid*. The Second Circuit refused to accord such deference, in part because of an unwillingness to "assume Congress's awareness of an administrative interpretation that does not result from notice and comment rulemaking." *Ibid.*

Instead, the Second Circuit held that the level of deference owed the agency's interpretation depended on "'the agency's expertise, the care it took in reaching its conclusions, the formality with which it promulgates its interpretations, the consistency of its views over time, and the ultimate persuasiveness of its arguments.'" *Id.* at 198 (quoting *Community Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 138 (2d Cir. 2002) (citing *Mead*, 533 U.S. at 234-235)).

Considering those factors, the Second Circuit declined to adopt CMS's interpretation and instead interpreted the statute itself. *Id.* at 198-200. The court observed that "[t]he formality of CMS's interpretation is at an intermediate level between a published recommendation and an interpretation advanced only in litigation." *Id.* at 198. Moreover, "there is no indication in the record of the process through which CMS arrived at its interpretation." *Ibid.* There also was no evidence CMS took into account a contrary appellate interpretation. *Ibid.* The Second Circuit explained it therefore could not "say with confidence that CMS's interpretation came about as the result of a reasoned process." *Ibid. See also Sai Kwan Wong v. Doar*, 571 F.3d 247, 258-259 (2d Cir. 2009) (according *Skidmore* deference to informal CMS interpretation where the agency had not exercised its rulemaking authority); *Natural Res. Def. Council, Inc. v. FAA*, 564 F.3d 549, 564 (2d Cir. 2009) (refusing to extend *Chevron* deference to agency interpretive orders where interpretation was not set forth in promulgated regulation through formal rulemaking).

b. Similarly, the Eighth Circuit does not extend *Chevron* deference to perfunctory interpretations by CMS administrators.

In *Kai v. Ross*, the Eighth Circuit refused to accord *Chevron* deference to a letter from an Associate Regional Administrator of the Health Care Financing Administration, now known as CMS. 336 F.3d 650, 655 & n.1 (8th Cir. 2003). The letter set forth a statutory interpretation under which the plaintiffs were ineligible for benefits. *Ibid.* In refusing to accord *Chevron* deference, the Eighth Circuit reasoned that "the letter is not a regulation of the Department of Health and Human Services, nor is it part of generally published advice, for example, a practice manual distributed nationwide." *Ibid.* Rather, "[i]t is simply a letter from the Associate Administrator of the region of Health Care Financing Administration of which Nebraska is a part." *Ibid.*

The Eighth Circuit explained: "We should consider it respectfully, and, indeed, we have done so, but it is worth no more than its inherent persuasive value." *Ibid.* (citing *Skidmore*, 323 U.S. at 140). Applying *Skidmore*, the court concluded that the letter was not persuasive and was therefore entitled to "no legal weight." *Ibid.*

c. The First Circuit likewise has accorded only *Skidmore* deference to CMS's implicit interpretation of the Medicaid Act made in the context of administrative approvals.

In *Bryson v. Shumway*, the plaintiffs challenged a state Medicaid program that CMS had approved through a statutory waiver provision. 308 F.3d 79, 82-83 (1st Cir. 2002). Like an approval of a State Plan Amendment, no formal process is required for CMS to approve a waiver request. *Id.* at 82. The plaintiffs argued that the challenged approval violated the waiver provision of the Medicaid Act because the waiver did not accommodate at least 200 individuals. *Id.* at 84-85. The First Circuit rejected the plaintiffs' view as not the best reading of either the statutory language or the relevant regulation promulgated by the agency. *Id.* at 85-87.

Of significance here, the First Circuit also looked to the fact that CMS had "approved waiver plans that anticipate serving fewer than 200 individuals, such as the plan at issue" there. *Id.* at 87. But in contrast to the regulation, which the First Circuit gave *Chevron* deference, *id.* at 86-87, the court reasoned: "[b]ecause the approval process did not utilize formal procedures, it may not be entitled to *Chevron* deference, but there remains the deference owed agencies due to their 'specialized experience.'" *Id.* at 87 (citation omitted).

2. *Five circuits give* **Chevron** *deference to implicit agency interpretations made in the course of routine approvals of state plans*

On the other side of the divide, the Third, Fifth, Sixth, Ninth, and D.C. Circuits have interpreted this

Court's precedents to allow *Chevron* deference to informal agency actions. They have so held even where there is little or no evidence of agency deliberation, and in some cases no explicit agency interpretation at all.

a. The D.C. Circuit accords *Chevron* deference to a statutory interpretation implicit in a CMS Regional Administrator's approval of a State Plan Amendment. *Pharmaceutical Research & Mfrs. of Am. v. Thompson* ("*PhRMA*"), 362 F.3d 817, 821-822 (D.C. Cir. 2004).

According to the D.C. Circuit, because "Congress expressly conferred on the Secretary authority to review and approve state Medicaid plans," that conferral manifests Congress' "intent that the Secretary's determinations, based on interpretation of the relevant statutory provisions, should have the force of law." *Id.* at 822. The court rejected an argument that *Chevron* deference should not apply because implicit statutory interpretations in State Plan Amendment approvals "are not the result of a formal administrative process, do not involve agency expertise," and are akin to interpretations contained in agency policy statements and manuals. *Id.* at 821.

b. Relying on the D.C. Circuit's decision in *PhRMA*, the Fifth Circuit similarly accords *Chevron* deference to CMS approvals of state Medicaid proposals, despite the cursory nature of the approvals.

In *S.D. ex rel. Dickson v. Hood*, the Fifth Circuit held that a CMS Regional Administrator's approval of

a State Plan Amendment is "an implicit interpretation of the [Medicaid] Act," which is entitled to *Chevron* deference. 391 F.3d 581, 595-596 & n.13 (5th Cir. 2004). The court explained that CMS's previous "approval of state plans affording coverage for the provision of incontinence supplies as a proper cost of home health care services demonstrates that the agency construes § 1396d(a)(7) as encompassing that type of medical care or service." *Id.* at 596 (citing *PhRMA*, 362 F.3d at 821-822). Accordingly, the court deferred to that implicit interpretation under *Chevron*, concluding that the statutory term "home health care services" must be construed to include incontinence supplies. *Ibid.*

c. Likewise relying on the D.C. Circuit, the Sixth Circuit gives *Chevron* deference to statutory constructions made implicitly in the course of CMS's routine review of State Plan Amendments.

In *Harris v. Olszewski*, CMS reviewed and approved Michigan's proposal to use a single-source contract for providing incontinence products to all Medicaid recipients in Michigan. 442 F.3d 456, 460, 467 (6th Cir. 2006). The Medicaid Act normally proscribes such contracts under a freedom-of-choice provision requiring States to allow eligible individuals to obtain medical assistance from any qualified provider. *Id.* at 460. But that provision contains an exception for "medical devices." *Id.* at 465-466.

The Sixth Circuit concluded that by approving Michigan's single-source contract, CMS must have

interpreted the "medical devices" exception to encompass incontinence products. *Id.* at 467. The court explained CMS "was required to find that the amendment satisfied all statutory requirements." *Ibid*. In carrying out its duties, CMS "was exercising Congress's express delegation of specific interpretive authority, and accordingly the agency's approval of the state plan amendment is entitled to *Chevron* deference." *Ibid.* (citation and internal quotation marks omitted) (citing *PhRMA*, 362 F.3d at 821; *S.D.*, 391 F.3d at 596). The Sixth Circuit expressly rejected the notion that the lack of administrative formality precluded *Chevron* deference. *Id.* at 470.

d. In the decision below, the Ninth Circuit joined the D.C., Fifth, and Sixth Circuits, expressly "agree[ing] with the D.C. Circuit's reasoning" in *PhRMA*. App., *infra*, 34a-35a.

The Ninth Circuit concluded that the "Secretary has now set forth her interpretation, through her approvals of the [State Plan Amendments]." App., *infra*, 27a. The court acknowledged that those approval letters were "succinct" and that there was a "lack of formal procedures available for interested parties." App., *infra*, 21a, 33a. Indeed, the interpretations were purely implicit: the CMS Associate Regional Administrator gave no explanation for her interpretation of the Medicaid Act, nor was there any indication that this represented the views of the Secretary. The approval of the State Plan Amendments did nothing more than implicitly reject the Ninth Circuit's prior settled construction; they offered no alternative

construction of the statute. App., *infra*, 63a. Nevertheless, the court held that *Chevron* deference was warranted.

e. Finally, the Third Circuit recently followed the decision in this case, purporting to accord *Chevron* deference to an agency interpretation of the Medicaid Act "inherent" in CMS's approval of a State Plan Amendment, while nevertheless holding that approval arbitrary and capricious. *Christ the King Manor, Inc. v. Secretary, U.S. Dep't of Health & Human Servs.*, Nos. 12-3401, 12-3501, slip op. at 25-44 (3d Cir. Sept. 19, 2013).

In *Christ the King Manor*, the Third Circuit reviewed a challenge to CMS's approval of a State Plan Amendment that adjusted Pennsylvania's method for determining Medicaid reimbursement rates to private nursing facilities. *Id.* at 5. Turning first to the level of deference, the Third Circuit acknowledged that any interpretation in the approval was merely "inherent." *Id.* at 26. Nevertheless, the court analyzed that interpretation under the *Chevron* framework, reasoning that "Congress delegated to the agency the responsibility to make interpretive decisions regarding which state plans satisfy the [Medicaid] Act's requirements." *Id.* at 28.

The Third Circuit then held that CMS's inherent interpretation in that case was "not a 'permissible construction of the statute' entitled to deference under *Chevron*." *Id.* at 41. Because CMS's interpretation was only inherent, the Third Circuit had to infer the interpretation by "examin[ing] the record [CMS]

had before it during the SPA approval process." *Id.* at 32. The court of appeals noted that the "record [wa]s remarkably thin" regarding the State's proposed rate methodology. *Id.* at 32-33. The court of appeals concluded that "[t]here is no indication that the agency 'examine[d] the relevant data,' nor did it 'articulate a satisfactory explanation for its action.'" *Id.* at 44. The court thus held the agency's approval arbitrary and capricious. *Ibid.*

3. The conflict is substantial and often outcome-determinative

The courts of appeals' disagreement over the appropriate level of deference is established, developed, and entrenched—and often, as here, outcome determinative. This Court's review is warranted.

a. The outcome of this case would have been different in the First, Second, and Eighth Circuits.

Had the State Plan Amendment here been proposed by New York, the informality of the interpretation, as well as the lack of any "indication in the record of the process through which CMS arrived at its interpretation," would have meant only *Skidmore* deference would have applied. *Rabin*, 362 F.3d at 198. Indeed, the Second Circuit has explained that the type of "nonprecedential letter ruling" here is even less formal than an interpretation in an agency manual, which is itself "'beyond the *Chevron* pale.'" *Estate of Landers*, 545 F.3d at 106, 110 (quoting *Mead*, 533 U.S. at 234).

Likewise, had it been Nebraska's State Plan Amendment, no *Chevron* deference would have been accorded the letter from the Associate Regional Administrator because it "is not a regulation of the Department of Health and Human Services." *Kai*, 336 F.3d at 655.

Finally, had the State Plan Amendment been proposed by Massachusetts, the CMS Regional Administrator's approval would not have received *Chevron* deference. The mere fact of approval is not enough in the First Circuit where, as here, "the approval process did not utilize formal procedures." *Bryson*, 308 F.3d at 87.

b. One need look no further than this case to see the effect of applying the different deference standards. The merits of the APA claims here turn entirely on the question presented.

Applying *Skidmore* deference, the district court held that the CMS Regional Administrator's approval was arbitrary and capricious. App., *infra*, 66a. Under *Skidmore*, the CMS Regional Administrator's implicit interpretation of Section 30(A) was not entitled to controlling weight and could not trump prior Ninth Circuit precedent. App., *infra*, 65a. Under that governing precedent, the State's consideration of responsible cost studies is a requisite to approval of a State Plan Amendment that proposes to cut provider reimbursement rates. App., *infra*, 66a. CMS's failure to consider the lack of cost studies thus "entirely failed to consider an important aspect of the problem" and

constituted arbitrary and capricious agency action. *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983); *see* 5 U.S.C. § 706(2)(A).

By contrast, the Ninth Circuit applied the *Chevron* framework, and the result was the opposite. Deferring to the agency, the Ninth Circuit held that the State Plan Amendment approval was *not* arbitrary and capricious because under the CMS Associate Regional Administrator's implicit interpretation, consideration of cost studies is unnecessary. But for the Ninth Circuit's application of *Chevron*, prior Circuit precedent would have foreclosed that conclusion. As this Court explained in *Brand X*, an agency lacks discretion to interpret a statute differently from a pre-existing judicial decision "as to agency interpretations to which *Chevron* is inapplicable." 545 U.S. at 983. As to those interpretations, "the court's prior ruling remains binding law." *Ibid.*

B. This Issue Is Important And Recurring

The issue presented in this case is too consequential to let it percolate. The lower courts are in disarray regarding the level of deference that should be given routine, informal agency approvals. Yet the choice between *Chevron* and *Skidmore* deference can make an enormous difference. In this case alone, the deference issue decided the outcome, thereby impacting millions of individuals' access to health care.

1. CMS's approval of a State Plan Amendment is a routine, commonplace event. Over just the past four years, CMS Regional Administrators approved

over 1300 State Plan Amendments.[2] Simply by virtue of the sheer volume of State Plan Amendments that are processed by local CMS offices, the Ninth Circuit's decision has the result of potentially bestowing *Chevron* deference on hundreds of decisions by mid-level CMS personnel each year. Each approval decision can be of critical importance to Medicaid beneficiaries and providers, affecting access to needed medical care for impoverished residents. The sheer frequency with which CMS reviews and approves changes to state Medicaid plans makes it extremely important to have a settled understanding of the effects of those choices.

The significance becomes all the more clear once one understands the import of even a single State Plan Amendment. Between both the federal and state contributions, Medi-Cal alone is a nearly $70 billion program.[3] The State Plan Amendments here implement 10% (or greater) cuts for many services. Accordingly, literally billions of dollars ride on the issue presented in just this single case. And the number of beneficiaries that could be affected is staggering; there are nearly 9 million beneficiaries of Medi-Cal. That is not to mention the impact on doctors, hospitals, and other employees in the healthcare industry.

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[2] http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html.

[3] http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2013_May_Estimate/May_2013_Approp_Changes.pdf.

Ultimately at stake here is the ability of Medi-Cal beneficiaries to access quality services. Medicaid payment rates are closely linked with the willingness of physicians to serve Medi-Cal beneficiaries. *See* Steven Zuckerman, et al., *Health Affairs, Trends: Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation* (June 2004).[4] Yet numerous medical specialists, including pediatric surgeons, obstetricians and gynecologists, otolaryngologists, and dentists all have reported that the actual cost of providing care is already well above what Medi-Cal reimburses for their services. *See Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1116 n.5 (E.D. Cal. 2003) (finding Medi-Cal reimbursement rates for Ob/Gyn services set below provider costs), *rev'd on other grounds*, 140 F. App'x 677 (9th Cir. 2005); David Skaggs, et al., *Access to Orthopedic Care for Children with Medicaid Versus Private Insurance in California*, 107 Pediatrics 1405, 1406 (2001) (finding that cost of treatment by pediatric orthopedic surgeon exceeded Medi-Cal reimbursement); Evan Halper, *Further Fee Cuts Force a Medi-Cal Exodus: Doctors are Rejecting New Patients*, L.A. Times, Mar. 24, 2008 (reporting Medi-Cal reimbursement for tonsillectomies is insufficient to cover surgical costs).[5]

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[4] *Available at* http://content.healthaffairs.org/content/early/2004/06/23/hlthaff.w4.374.full.pdf.

[5] *Available at* http://articles.latimes.com/2008/mar/24/local/me-medical24.

Indeed, California already suffers from a critically low provider-to-beneficiary ratio: there are only 46 primary-care providers for every 100,000 beneficiaries in the State, well below the commonly cited minimum guideline of 60 to 80 providers per 100,000 people. California HealthCare Foundation, *California Health Care Almanac: Medi-Cal Facts and Figures* 52 (2009).[6] Moreover, rates of participation in Medi-Cal are even lower among medical and surgical specialists. *Ibid.* "The supply of physicians available to Medi-Cal patients is significantly less than that available to the general population." Andrew B. Bindman, et al., *California HealthCare Foundation, Physician Participation in Medi-Cal, 2008*, at 14 (2010).[7] More broadly, a recent study conducted by the Government Accountability Office indicated that 95% of physicians who have opted out of participating in Medicaid cite low reimbursement rates as a reason. Government Accountability Office, *Report GAO-11-624, Medicaid and CHIP: Most Physicians Serve Covered Children But Have Difficulty Referring Them for Specialty Care* 18 (2011).[8]

Delaying resolution of the question presented would therefore needlessly hinder access to health care for millions of the most vulnerable citizens. It is

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[6] *Available at* http://www.chcf.org/publications/2009/09/medical-facts-and-figures.

[7] *Available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysicianParticipationMediCal2008.pdf.

[8] *Available at* http://www.gao.gov/assets/330/320559.pdf.

therefore critical that the deference issue be decided now, and in this case.

2. Because of the conflict among the circuits, the effect of even a single regional officer's agency actions will vary geographically. CMS Regional Administrators make the decision to approve or disapprove a State Plan Amendment. But the geographic jurisdiction of CMS's regional offices is not aligned with that of the federal circuits. For example, CMS Region 6 is responsible for reviewing State Plan Amendments submitted by Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.[9] The federal courts in those same States are governed by one of the Fifth, Eighth, or Tenth Circuits—and at least two of these circuits have conflicting views about the deference owed to implicit agency "interpretations" like those issued through State Plan Amendment approvals. *See supra* pp. 21, 23-24.

This means that the same regional officer, applying the same interpretation and using the same procedures, may receive different levels of deference depending on which State's amendment she is reviewing and where her actions are challenged. Particularly because Medicaid is a federal-state cooperative, this disparity in treatment undermines the effectiveness of the program. This Court should establish much needed uniformity now.

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[9] http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/Downloads/DallasRegionalOffice.pdf.

C. The Ninth Circuit's Decision Is Incorrect

The decision below not only exacerbates a circuit conflict, the Ninth Circuit also chose the wrong side of the divide. The decision below incorrectly granted *Chevron* deference to agency action that does not warrant it.

1. "*Chevron* deference * * * is not accorded merely because the statute is ambiguous and an administrative official is involved." *Gonzales v. Oregon*, 546 U.S. 243, 258 (2006). Nor is it enough that Congress "delegated authority to the agency generally to make rules carrying the force of law." *Mead*, 533 U.S. at 226-227. Rather, the agency interpretation at issue also must have been "promulgated in the exercise of that authority." *Id.* at 227.

Here, although Congress has given the Secretary authority to issue regulations implementing the Medicaid Act and having the force of law, that authority has not been exercised. The Secretary committed in 2010 that within a year she would exercise that authority and issue a definitive interpretation of Section 30(A). She announced a proposed rule in the Federal Register and elicited comments. But no rule having the force of law has been promulgated. All that happened here was approval by a CMS Associate Regional Administrator of a State Plan Amendment in a perfunctory letter without any statement of how the agency views Section 30(A).

Such an approval is a routine event that occurs hundreds of times each year.[10] Each approval governs only the specific application at hand. 42 C.F.R. §§ 430.15, 430.16. The process used to approve State Plan Amendments is "cursory at best." *AMISUB (PSL), Inc. v. Colorado Dep't of Soc. Servs.*, 879 F.2d 789, 794 (10th Cir. 1989). Indeed, since approvals are not intended to have precedential value, approvals are not published or made readily available in any accessible form to the public or the participating States.

The Ninth Circuit was wrong to conclude that such approvals are worthy of the same level of deference as the Secretary's *disapproval* of a State Plan Amendment. App., *infra*, 31a. A disapproval affords a State and other affected parties "'opportunities to petition for reconsideration, brief its arguments, be heard at a formal hearing, receive reasoned decisions at multiple levels of review, and submit exceptions to those decisions.'" *Ibid.* (quoting *Alaska Dep't of Health & Soc. Servs. v. Centers for Medicare & Medicaid Servs.*, 424 F.3d 931, 939 (9th Cir. 2005)). In "the

[10] For example, for the approximate two-year period from June 1, 2009 through July 31, 2011, CMS approved 640 State Plan Amendments. Centers for Medicare & Medicaid Services, Medicaid State Plan Amendments, https://www.cms.gov/MedicaidGenInfo/StatePlan/list.asp (accessed July 11, 2011). During that same period, there were only four state requests for reconsideration. 74 Fed. Reg. 29703 (June 23, 2009); 75 Fed. Reg. 80058 (Dec. 21, 2010); 76 Fed. Reg. 34711 (June 14, 2011); 76 Fed. Reg. 44591 (July 26, 2011).

case of an approval, however, the Medicaid program does not provide interested parties with similar opportunities." *Ibid.*

As such, a disapproval has far more of the hallmarks of an agency interpretation meriting *Chevron* deference. *Mead*, 533 U.S. at 229-231. "It is fair to assume generally that Congress contemplates administrative action with the effect of law when it provides for a relatively formal administrative procedure tending to foster the fairness and deliberation that should underlie a pronouncement of such force." *Id.* at 230. No such formal process occurred here.

2. To be sure, this Court in certain specific circumstances has "found reasons for *Chevron* deference even when no such administrative formality was required and none was afforded." *Id.* at 231. But that requires an indication that Congress and the agency intended the pronouncements to have the "force of law." *Id.* at 232. Determining whether agency action satisfies this test "depends in significant part upon the interpretive method used and the nature of the question at issue." *Barnhart v. Walton*, 535 U.S. 212, 222 (2002). It requires, at a minimum, "the legislative type of activity that would naturally bind more than the parties to the ruling." *Mead*, 533 U.S. at 232.

There is no statutory indication that Congress intended approval of State Plan Amendments by CMS Regional Administrators to have the force of law and to be binding on anyone other than the State. The statute governing State Plan Amendment

approvals provides simply that "[w]henever a State plan is submitted to the Secretary by a State for approval * * * , [she] shall, not later than 90 days after the date the plan is submitted to [her], make a determination as to whether it conforms to the requirements for approval under such subchapter." 42 U.S.C. § 1316(a)(1). Nothing in that text demonstrates any congressional intent for State Plan Amendment approvals to have the effect of making new law to implement the Medicaid Act.

Nor is there "in the agency practice itself any indication" that CMS "ever set out with a lawmaking pretense in mind when it undertook" to review the State Plan Amendments. *Mead*, 533 U.S. at 233. There is no indication on the face of the approval letters here that CMS even considered, much less adopted, any particular interpretation of Section 30(A). The only purported interpretation of Section 30(A) is an implicit one inferred by the Ninth Circuit. That inference amounts to nothing more than a presumed rejection of the court of appeals' prior settled statutory interpretation; it contains no affirmative interpretation of the statute's intended meaning or proper application.

There was no process involving "fairness and deliberation" concerning the interpretation of Section 30(A). *Id.* at 230. There was no opportunity for interested parties to be heard or to petition for review at higher levels within the agency. Nor was there even a reasoned opinion or statement explaining the approval or the interpretation.

In short, "the agency did not engage in rulemaking procedures, it did not carefully consider differing points of view of those affected, it did not set forth its views in a manual intended for widespread use, nor has it in any other way announced an interpretation that Congress would have 'intended * * * to carry the force of law.'" *Wos v. E.M.A. ex rel. Johnson*, 133 S. Ct. 1391, 1403 (2013) (Breyer, J., concurring) (quoting *Mead*, 533 U.S. at 221).

Indeed, the supposed interpretation of Section 30(A) here has even fewer signs of a legal pronouncement having the force of law than an interpretation set forth in an agency's opinion letter or manual. At least with respect to policy statements, agency manuals, and enforcement guidelines, the agency's interpretation actually is set forth in writing. Yet interpretations in those settings are not entitled to *Chevron* deference. *Christensen v. Harris County*, 529 U.S. 576, 587 (2000); *see Wos*, 133 S. Ct. at 1402.

The same should be true here. An interpretation that must be inferred from a letter that was issued with no procedural protections or formality whatsoever is the antithesis of a pronouncement having the force of law. It is "beyond the *Chevron* pale." *Mead*, 533 U.S. at 234. If it were otherwise, agencies might avoid promulgating regulations altogether. Such a result would severely undermine "the notice and predictability" to regulated parties that formal rulemaking is meant to promote. *Christopher v. SmithKline Beecham Corp.*, 132 S. Ct. 2156, 2168 (2012) (quoting *Talk Am., Inc. v. Michigan Bell Tel.*

Co., 131 S. Ct. 2254, 2266 (2011) (Scalia, J., concurring)).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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