Nos. 13-253 and 13-380

In the Supreme Court of the United States

MANAGED PHARMACY CARE, ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

CALIFORNIA MEDICAL ASSOCIATION, ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, SECRETARY 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

BRIEF FOR THE FEDERAL RESPONDENTS IN OPPOSITION

DONALD B. VERRILLI, JR.
Solicitor General
Counsel of Record
STUART F. DELERY
Assistant Attorney General
MARK B. STERN
LINDSEY POWELL
Attorneys

Department of Justice
Washington, D.C. 20530-0001
SupremeCtBriefs@usdoj.gov
(202) 514-2217

QUESTIONS PRESENTED

To qualify for federal funds under the Medicaid program, participating States must submit to the Secretary of Health and Human Services, and receive approval of, a "plan for medical assistance" detailing the nature and scope of the State's Medicaid program. 42 U.S.C. 1396a(a). A State's plan must, *inter alia*, "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary * * * to 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." 42 U.S.C. 1396a(a)(30)(A). The Secretary (through the Centers for Medicare & Medicaid Services) reviews the State's plan and any amendments thereto, determines whether they comply with the statutory and regulatory requirements and, if so, issues a letter of approval. 42 U.S.C. 1396a(b). The questions presented are:

1. Whether agency interpretations of the Medicaid statute reflected in decisions approving state plan amendments are entitled to deference under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

2. Whether the State's consideration of budgetary concerns and the agency's consideration of the State's monitoring plan rendered approval of the state plan amendments in this case arbitrary and capricious.

3. Whether affording deference to the agency's interpretation in this case violated separation of powers principles.

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OPINIONS BELOW

The opinion of the court of appeals (13-253 Pet. App. 1-45; 13-380 Pet. App. 1a-45a) is reported at 716 F.3d 1235. One of the district court orders in No. 13-253 (Pet. App. 76-106) is unreported, but is available at 2011 WL 6820288. The other district court order in No. 13-253 (Pet. App. 46-75) is unreported. One of the district court orders in No. 13-380 (Pet. App. 46a-88a)

is reported at 848 F. Supp. 2d 1117. The other district court order in No. 13-380 (Pet. App. 89a-128a) is not reported, but is available at 2011 WL 6820229.

JURISDICTION

The judgment of the court of appeals was entered on May 24, 2013. The petition for a writ of certiorari in No. 13-253 was filed on August 21, 2013. On August 14, 2013, Justice Kennedy extended the time within which to file a petition for a writ of certiorari in No. 13-380 to and including September 21, 2013. The petition was filed on September 20, 2013. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The Medicaid program, established in 1965 by Title XIX of the Social Security Act (SSA), 42 U.S.C. 1396 *et seq.*, is a cooperative federal-state program to provide medical care to needy individuals. *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Atkins* v. *Rivera*, 477 U.S. 154, 156 (1986). State participation in Medicaid is voluntary, but those States that elect to participate must comply with requirements imposed by the Medicaid Act and by the Secretary of Health and Human Services (HHS) in her administration of the Act. *Wilder*, 496 U.S. at 502; *Rivera*, 477 U.S. at 156-157. Within those limits, however, each State enjoys great flexibility in both designing and administering its own program. *Pharmaceutical Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 665 (2003); *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985).

To qualify for federal funds, participating States must submit to the Secretary, and receive approval of, a "plan for medical assistance" detailing the nature and scope of the State's Medicaid program. 42 U.S.C.

1396a(a); 42 C.F.R. 430.10; *Wilder*, 496 U.S. at 502. States must also submit any amendments to the plan. See 42 C.F.R. 430.12(c). Among other requirements, a State's plan must

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary to safeguard against unnecessary utilization of such care and services and to 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.

42 U.S.C. 1396a(a)(30)(A). The Secretary (through the Centers for Medicare & Medicaid Services (CMS)) reviews the State's plan and any amendments thereto and determines whether they comply with the statutory and regulatory requirements. 42 U.S.C. 1316(a)(1) and (b), 1396a(b); 42 C.F.R. 430.10 *et seq.* If the plan complies with "the conditions specified," the Secretary "shall" issue a letter approving the plan. 42 U.S.C. 1396a(b).

2. The two certiorari petitions challenge the latest in a series of reductions in Medicaid payment rates adopted by the California Legislature. Faced with significant economic challenges, California lawmakers sought to identify "areas within [California's Medicaid] program where reimbursement levels [we]re higher than required" under the Medicaid statute "[i]n order to minimize the need for drastically cutting enrollment standards or benefits." Cal. Welf. & Inst. Code § 14105.192(a)(2) (West Supp. 2013). Many of

the petitioners here challenged earlier payment rate reductions in litigation that culminated in this Court's decision in *Douglas* v. *Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204 (2012) (*Independent Living Center*). The payment rate reductions at issue here superseded many of the reductions challenged in *Independent Living Center*.

In March 2011, California adopted Assembly Bill 97 (AB 97), which reduced by ten percent payments under California's Medicaid program for many covered services. See Cal. Welf. & Inst. Code § 14105.192(d) (West Supp. 2013). That reduction was contingent on a determination by the State's Medicaid agency that the reductions "will comply with applicable federal Medicaid requirements" and on approval by CMS. *Id.* § 14105.192(m) and (*o*)(1). After studying the "potential impact of rate reductions" on those services and concluding that "reimbursement rates could be reduced consistently with federal law" for certain services, the state agency submitted two state plan amendments to CMS that reflected the proposed reductions. 13-380 Pet. App. 19a.

Upon receipt of the plan amendments, CMS requested further information regarding the likely impact on access to affected services. Cal. Med. Ass'n (CMA) C.A. E.R. 138; see 13-380 Pet. App. 49a, 91a. CMS suggested specific measures that the State might use to demonstrate compliance with Section 1396a(a)(30)(A), such as the utilization of services and provider availability, and it explained that the agency does not interpret that provision to require the consideration of provider cost studies. CMA C.A. E.R. 138-147. For each of the services at issue, the state agency submitted access studies analyzing trends in

service utilization and provider participation over time as a means of evaluating the robustness of the market and predicting the amendments' effect on beneficiary access. Cal. Hosp. Ass'n (CHA) C.A. E.R. 145-147; CMA C.A. E.R. 152-154, 160-166, 278-361; see 13-380 Pet. App. 19a-20a. Based on those studies, the state agency determined that reductions would be inappropriate for certain of the services initially proposed and it excluded those services from the plan amendments. See, *e.g.*, CHA C.A. E.R. 155; CMA C.A. E.R. 165. The state agency also submitted an 82-page plan for monitoring and assuring access to affected services following implementation. 13-380 Pet. App. 20a. Petitioners and other stakeholders submitted studies and offered "extensive input." *Id.* at 20a-21a.

Based on that record, on October 27, 2011, CMS approved both state plan amendments. See 13-380 Pet. App. 21a, 150a-152a, 153a-155a. CMS explained that "the State was able to provide metrics which adequately demonstrated beneficiary access to care in accordance with [42 U.S.C. 1396a(a)(30)(A)]," including the "[t]otal number of providers by type and geographic location," the "[t]otal number of [California Medicaid] beneficiaries by eligibility type," the "[u]tilization of services by eligibility type over time," and an "[a]nalysis of benchmark service utilization where available." 13-380 Pet. App. 151a; see *id.* at 154a. "In light of the data CMS reviewed, the monitoring plan, and [its] consideration of stakeholder input," the agency "determined that the above mentioned amendment[s] compl[y] with [Section 1396a(a)(30)(A)]." *Id.* at 152a, 155a.

3. In November 2011, petitioners filed four separate suits against the Secretary of HHS and the Di-

rector of California's Medicaid program under the Administrative Procedure Act (APA), 5 U.S.C. 701 *et seq.* and the Supremacy Clause.[1] Petitioners alleged that the plan approvals were arbitrary and capricious and inconsistent with Section 1396a(a)(30)(A), and they moved for preliminary injunctive relief.

The district court granted a preliminary injunction in all four cases based on substantially the same reasoning. See 13-253 Pet. App. 46-106; 13-380 Pet. App. 46a-128a. The court concluded that the Secretary's interpretation that cost studies are not required under Section 1396a(a)(30)(A), as embodied in the approval decisions, was not entitled to deference under *Chevron U.S.A. Inc.* v. *National Resources Defense Council, Inc.*, 467 U.S. 837 (1984), because the decisions lacked sufficient indicia of formality. See, *e.g.*, 13-380 Pet. App. 60a-62a & 60a n.6. The district court accordingly determined that it was bound by the contrary interpretation of Section 1396a(a)(30)(A) adopted by the Ninth Circuit in *Orthopaedic Hospital* v. *Belshe*, 103 F.3d 1491, 1496 (1997), cert. denied, 522 U.S. 1044 (1998). See, *e.g.*, 13-380 Pet. App. 60a-66a. Because CMS did not consider whether the state agency had "relied on responsible cost studies" with respect to each affected service, the court concluded that the plan approvals were likely arbitrary and capricious. *Id.* at 66a. The district court also held that petitioners were "likely to succeed on the merits

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[1] Petitioners in No. 13-380 are all providers or associations representing providers. See Pet. ii (noting that individual beneficiaries who were plaintiffs below are not petitioners here). Petitioners in No. 13-253 include providers, associations representing providers, and at least one beneficiary. See Pet. iii-iv (identifying Mark Beckwith as a beneficiary).

of their claim that CMS' acceptance of the [State's] access analyses and monitoring plan was arbitrary and capricious." *Id.* at 78a.

4. The court of appeals unanimously reversed, vacated the preliminary injunctions, and remanded for further proceedings in all four cases. 13-380 Pet. App. 1a-45a.

The court of appeals held that CMS's interpretation that cost studies are not required under Section 1396a(a)(30)(A) is entitled to *Chevron* deference. 13-380 Pet. App. 28a-38a. The court explained that Congress had expressly delegated to the Secretary the authority to determine whether a State's Medicaid program conforms to federal requirements and that the agency approved the plan amendments within the exercise of that delegated authority. *Id.* at 30a-33a. And it noted that this Court's decision in *Independent Living Center* "[a]rguably * * * already concluded that [state plan amendment] approvals meet the *Chevron* * * * standard." *Id.* at 29a (citing 132 S. Ct. at 1210).

The court of appeals explained that when it adopted a contrary interpretation of the statutory provision in *Orthopaedic Hospital*, 103 F.3d at 1496, it did not have the benefit of the agency's views. 13-380 Pet. App. 26a. The court further explained that it had never held that its view "represented the *only* reasonable interpretation of that statute." *Id.* at 28a. Indeed, the court noted, its "sister circuits have [held] that [Section 1396a(a)(30)(A)] does not require any particular methodology," such as cost studies. *Id.* at 37a-38a (internal quotation marks omitted). The court then concluded that the agency's consistent interpretation of Section 1396a(a)(30)(A) was based on a per-

missible reading of the statute. *Id.* at 35a-36a. Accordingly, the court declined to follow its prior decision in *Orthopaedic Hospital*.

The court of appeals also rejected petitioners' claims that the agency's approvals were arbitrary and capricious. 13-380 Pet. App. 38a-41a. The court explained that "[h]undreds of pages of analysis submitted by [the state Medicaid agency] support the Secretary's conclusion that the [state plan amendments] comply with [Section 1396a(a)(30)(A)] and are unlikely to affect beneficiary access in a detrimental way." *Id.* at 40a. The district court, the court of appeals continued, had erred by "delv[ing] into the minutiae of the Secretary's approval, picking apart [the state agency's] research and finding potential flaws—an inappropriate exercise when reviewing agency action under the APA." *Ibid.*[2]

5. The court of appeals denied rehearing en banc with no judge requesting a vote. 13-380 Pet. App. 13a.

ARGUMENT

Petitioners contend (13-253 Pet. 12-16; 13-380 Pet. 34-39) that the court of appeals erred in according deference under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), to administrative decisions approving state plan amendments under the Medicaid program. That decision is correct; it is consistent with this Court's decision in *Douglas* v. *Independent Living Center of Southern*

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[2] Based on its conclusion that petitioners likely could not demonstrate that the payment rate reductions were inconsistent with Section 1396a(a)(30)(A), the court of appeals found it unnecessary to resolve the question left open in *Independent Living Center*, *i.e.*, whether petitioners have a cause of action directly under the Supremacy Clause. See 13-380 Pet. App. 41a-43a.

California, Inc., 132 S. Ct. 1204 (2012); and it does not implicate any conflict among the courts of appeals. In any event, resolution of that issue would have no impact on the outcome of this case because the agency's interpretation of Section 1396a(a)(30)(A) represents the best reading of the statute, as every other court of appeals to consider the issue has held. Further review is not warranted.

Petitioners in No. 13-253 (at 9-12, 17-20) also argue that CMS's approval of the state plan amendments was arbitrary and capricious and that deferring to those decisions would violate separation of powers principles. Those additional arguments are without merit; the constitutional argument was not raised below; and further review is not warranted.

1. Petitioners contend (13-253 Pet. 12-16; 13-380 Pet. 34-39) that the court of appeals erred in according *Chevron* deference to administrative decisions approving state plan amendments under the Medicaid program. The court of appeals' decision is correct.

a. The Medicaid statute is an unusually "complex[]" and "intricate" scheme and the Secretary has "exceptionally broad authority" in construing its provisions. *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981); see *Wisconsin Dep't of Health & Family Servs.* v. *Blumer*, 534 U.S. 473, 496 n.13 (2002); *Bowen* v. *Massachusetts*, 487 U.S. 879, 900 n.31 (1988); *Schweiker* v. *Hogan*, 457 U.S. 569, 571 (1982).

The Medicaid statute provides that the Secretary "shall approve any plan which fulfills the conditions specified" in the statute. 42 U.S.C. 1396a(b). Congress thus expressly assigned to the Secretary the authority to review state Medicaid plans (and amendments thereto) and to determine whether they con-

form to federal requirements, including Section 1396a(a)(30)(A). In approving or disapproving a state plan amendment, the Secretary (through CMS) is exercising that express statutory authority. Those administrative decisions are entitled to *Chevron* deference.

This Court's decision in *Independent Living Center* strongly supports that conclusion. In that case, the Court granted review to determine whether Medicaid providers and beneficiaries may maintain a cause of action against state officials directly under the Supremacy Clause to enforce Section 1396a(a)(30)(A). 132 S. Ct. at 1207. While the case was pending, CMS approved the challenged plan amendments and the Court remanded without resolving the question presented. *Id.* at 1207-1208. In explaining its decision to remand, the Court observed that although the "agency decision" to approve the state plan amendments did not "change the underlying substantive question," "it may change the answer." *Id.* at 1210. The Court explained further that "[t]he Medicaid Act commits to the federal agency the power to administer a federal program"; that "here the agency has acted under this grant of authority"; and "[t]hat [this] decision carries weight" because "the agency is comparatively expert in the statute's subject matter" and because "the language of [Section 1396a(a)(30)(A)] is broad and general, suggesting that the agency's expertise is relevant in determining its application." *Ibid.*

The Court also specifically referenced the Ninth Circuit's decisions in *Orthopaedic Hospital* v. *Belshe*, 103 F.3d 1491 (1997), cert. denied, 522 U.S. 1044 (1998), and its progeny. See *Independent Living Ctr.*, 132 S. Ct. at 1210. The Court explained that, in sus-

taining the plaintiffs' challenges in *Independent Living Center*, the Ninth Circuit had "declined to give weight to the Federal Government's [contrary] interpretation" of the statutory language which, at that time, had been "expressed in" an amicus brief previously filed in this Court at the Court's invitation at the certiorari stage in an earlier case. *Ibid.* (citing Gov't Cert. Amicus Br., *Belshe* v. *Orthopaedic Hosp.*, 522 U.S. 1044 (1998) (No. 96-1742)). The Court noted, however, that "ordinarily review of agency action requires courts to apply certain standards of deference to agency decisionmaking." *Ibid.* The standards of "deference" to which the Court referred were those set forth in *Chevron* and *National Cable & Telecommunications Ass'n* v. *Brand X Internet Services*, 545 U.S. 967 (2005) (*Brand X*). See *Independent Living Ctr.*, 132 S. Ct. at 1210 (citing those cases). The parties, the Court explained, had offered no reason why "courts should not now (*in the changed posture of these cases*) apply those ordinary standards of deference." *Ibid.* (emphasis added).

The only "change[]" in the "posture" of those cases was the fact that CMS had since approved the state plan amendments. *Independent Living Ctr.*, 132 S. Ct. at 1210. In issuing those approvals, the agency acted under an express grant of authority. The agency's decision, as expressed in the plan approvals, was entitled to weight under the standards of deference set forth in *Brand X* and *Chevron*—despite the Ninth Circuit's prior decision in *Orthopaedic Hospital*. The court of appeals correctly followed this Court's reasoning in *Independent Living Center* to its logical conclusion.

b. Petitioners in No. 13-380 (at 34-39) contend that the Secretary's approval of Medicaid state plan amendments lacks sufficient formality to command *Chevron* deference. That argument ignores this Court's decision in *Independent Living Center*.[3] It is also incorrect.

As petitioner acknowledges (13-380 Pet. 36), this Court has made clear that the absence of formal procedure "does not decide the case." *United States* v. *Mead Corp.*, 533 U.S. 218, 231 (2001) (*Mead*). The Court has "found reasons for *Chevron* deference even when no such administrative formality was required and none was afforded." *Ibid.*; see *Barnhart* v. *Walton*, 535 U.S. 212, 221-222 (2002); *NationsBank of N.C., N.A.* v. *Variable Annuity Life Ins. Co.*, 513 U.S. 251, 256-257 (1995). In the absence of formal procedures, courts must determine whether there are "any other circumstances reasonably suggesting" that Congress intended deference to an agency decision. *Mead*, 533 U.S. at 231. Such considerations include, for example, "the interstitial nature of the legal question, the related expertise of the Agency, the importance of the question to administration of the stat-

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[3] Petitioners in No. 13-380 (at 35-36) suggest that "the Secretary's *disapproval* of a State Plan Amendment" may be entitled to *Chevron* deference based on certain formalities attendant to the disapproval process. Although the state plan amendments at issue in *Independent Living Center* were initially disapproved, California sought reconsideration and CMS ultimately approved the amendments without first holding a "formal hearing" or engaging in "multiple levels of review." 13-380 Pet. 35 (quoting *Alaska Dep't of Health & Soc. Servs.* v. *CMS*, 424 F.3d 931, 939 (9th Cir. 2005)). And, in any event, this Court nowhere suggested that the initial disapproval had any bearing on its view that *Chevron* deference was appropriate and warranted.

ute, the complexity of that administration, and the careful consideration the Agency has given the question over a long period of time." *Barnhart*, 535 U.S. at 222.

Here, there are ample reasons to conclude that CMS's approval of the Medicaid state plan amendments are deserving of *Chevron* deference. CMS approval is not merely an expression of a legal opinion. It is an official governmental act with direct operative legal effect, and the State must be able to rely on CMS's approval in its implementation of the state plan. What petitioners characterize as the relative informality of the process for plan approval is a reflection that Medicaid is not a regime for the regulation of primary conduct by private persons, but rather a cooperative federal-state funding program under which the relationship between the federal government and the State is "in the nature of a contract." *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981); see *Arlington Cent. Sch. Dist. Bd. of Educ.* v. *Murphy*, 548 U.S. 291, 296 (2006). Under such an arrangement, it is to be expected, and critical to practical administration, that issues will often be resolved through exchanges between the parties principally concerned, without rigid procedures for participation by others who may be indirectly affected. The application of *Chevron* under Medicaid must take account of these fundamental realities.

Moreover, the Medicaid statute is exceedingly complex. See *Gray Panthers*, 453 U.S. at 43. The agency is "comparatively expert in the statute's subject matter." *Independent Living Ctr.*, 132 S. Ct. at 1210. And, with respect to the particular statutory provision at issue here, "the language of [Section

1396a(a)(30)(A)] is broad and general, suggesting that the agency's expertise is relevant in determining its application." *Ibid.* As the court of appeals explained:

> The Medicaid program is a colossal undertaking, jointly funded by the federal government and the States. Congress explicitly granted the Secretary authority to determine whether a State's Medicaid plan complies with federal law. The Secretary understands the Act and is especially cognizant of the all-important yet sometimes competing interests of efficiency, economy, quality of care, and beneficiary access. It is well within the Secretary's mandate to interpret the statute via case-by-case [state plan amendment] adjudication.

13-380 Pet. App. 35a. The court of appeals thus correctly concluded that interpretations in CMS approval decisions fall within the category of agency actions for which *Chevron* deference is appropriate.[4]

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[4] The state plan amendment approvals at issue here are consistent with the Secretary's longstanding interpretation of Section 1396a(a)(30)(A). Before and after the approval letters in this case, HHS has made explicit in amicus briefs and in other state plan amendment approvals that Section 1396a(a)(30)(A) does not require a State to consider "cost studies" before adjusting provider payment rates. See, *e.g.*, p. 19, *infra*; Managed Pharmacy Care Gov't C.A. Br. A2-A6 (attaching decision approving an Arizona plan amendment). The proposed rule issued by the Secretary, to which the petitioners in No. 13-380 refer (at 10-11), is consistent with that approach. See 76 Fed. Reg. 26,344 (May 6, 2011) (explaining that CMS does not require a State to submit any particular type of data to demonstrate compliance). Although HHS had originally committed to issue a final rule by December 2011, see Gov't Cert. Amicus Br. at 11, *Independent Living Ctr.*, *supra* (No. 09-958), that rule has not been issued. HHS has informed this

c. Petitioners in No. 13-253 (at 12-16) contend that CMS's approval of a state plan amendment should not be afforded *Chevron* deference because the agency purportedly has a "conflict of interest" in the form of cost savings to the federal government. That argument is without merit for several reasons. First, like petitioners in No. 13-380, it ignores this Court's decision in *Independent Living Center*. Second, it relies on a view of *Chevron* deference that was rejected by this Court in *City of Arlington* v. *FCC*, 133 S. Ct. 1863 (2013). See *id.* at 1874 (explaining that "[t]he fox-in-the-henhouse syndrome is to be avoided not by establishing an arbitrary and undefinable category of agency decisionmaking that is accorded no deference, but by taking seriously, and applying rigorously, in all cases, statutory limits on agencies' authority"). Third, Congress expressly assigned authority to the Secretary (not the courts) to approve state plan amendments fully cognizant of the financial consequences of her determinations. And, indeed, petitioners' theory would impact any agency decision that affects the federal fisc.

d. Every court of appeals to consider the question has held (consistent with the Ninth Circuit) that interpretations of the Medicaid statute reflected in agency decisions approving a State's plan for medical assistance under the Medicaid program are entitled to *Chevron* deference. See *Christ the King Manor, Inc.* v. *Secretary U.S. Dep't of HHS*, 730 F.3d 291, 306-307 (3d Cir. 2013); *Harris* v. *Olszewski*, 442 F.3d 456, 467-468 (6th Cir. 2006); *Dickson* v. *Hood*, 391 F.3d 581, 594-596 (5th Cir. 2004); *Pharmaceutical Research &*

Office that it is in the process of considering comments on the proposed rule.

Mfrs. of Am. v. *Thompson*, 362 F.3d 817, 821-822 (D.C. Cir. 2004). As the Third Circuit recently explained, "our sister circuits have held that [state plan amendment] approvals are the type of agency action entitled to *Chevron* deference under *Mead*, and no circuit court precedent holds to the contrary." *Christ the King Manor, Inc.*, 730 F.3d at 306.

Petitioners in No. 13-380 (at 22-27) concede as much. They nevertheless assert a circuit conflict based on decisions that have nothing to do with the approval (or disapproval) of state plan amendments. In *Kai* v. *Ross*, 336 F.3d 650 (2003), the Eighth Circuit declined to give *Chevron* deference to a letter from a Medicaid Regional Administrator providing advice to a State about the relationship between two statutory provisions that the court had already found "plain." *Id.* at 654-655. In *Bryson* v. *Shumway*, 308 F.3d 79 (2002), the First Circuit suggested that the Secretary's approval of a Medicaid plan waiver for non-medical services "*may* not be entitled to *Chevron* deference." *Id.* at 87 (emphasis added). The court did not decide the question (or engage in any analysis) and ultimately "defer[red] to" the Secretary's "expertise in the construction and purpose of the statute." *Ibid.*

The Second Circuit cases are equally unavailing. Three of them concerned the level of deference to be afforded to agency policy manuals. See *Sai Kwan Wong* v. *Doar*, 571 F.3d 247, 258-259 (2009) (CMS manual); *Natural Res. Def. Council, Inc.* v. *FAA*, 564 F.3d 549, 564 (2009) (*NRDC*) (FAA manual); *Estate of Landers* v. *Leavitt*, 545 F.3d 98, 106-107 (2008) (CMS

manual), cert. denied, 557 U.S. 937 (2009).[5] Indeed, in *Estate of Landers*, the court of appeals specifically explained that "agency manuals, as a class, are generally ineligible for *Chevron* deference." 545 F.3d at 106. The different standards of deference, moreover, did not impact the outcome in any of those cases. In *Estate of Landers*, the Second Circuit deferred to CMS's interpretation after noting that, in the Medicaid context, "the various possible standards for deference—namely, *Chevron* and *Skidmore* [v. *Swift & Co.*, 323 U.S. 134 (1944)]—begin to converge." 545 F.3d at 107 (citation and internal quotation marks omitted); see *id.* at 107-111. In *Sai Kwan Wong*, the court of appeals noted that *Mead* "raise[d] an interesting question about the possibility of according *Chevron* deference in this case," but was "content simply to rely on the agency's concession that *Skidmore* properly guides our assessment" because "affirmance" was "warranted under either standard." 571 F.3d at 259. And, in *NRDC*, the court of appeals again deferred to the agency (there, the FAA). See 564 F.3d at 564-565.[6]

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[5] *Rabin* v. *Wilson-Coker*, 362 F.3d 190 (2d Cir. 2004), involved an interpretation expressed in an agency letter and form, as well as a policy manual. Although the court of appeals' analysis is not entirely clear, it appears the court declined to afford *Chevron* deference based on facts specific to the materials in that case. See *id.* at 198. Nothing in that decision suggests (let alone holds) that CMS's approval of a state plan amendment under the Medicaid program is not entitled to *Chevron* deference.

[6] That the decisions on which petitioners rely do not evidence a circuit conflict is further confirmed by the fact that many of the circuits on the purported other side of the split have similarly held that CMS interpretive letters and agency manuals generally are not entitled to *Chevron* deference. See, *e.g.*, *New Jersey Primary*

e. In any event, resolution of the deference issue would have no impact on the outcome of this case. Irrespective of the level of deference due, the agency's interpretation of Section 1396a(a)(30)(A) represents the best reading of the statute. The Ninth Circuit's prior interpretation of Section 1396a(a)(30)(A), as imposing on States an obligation to consider cost studies to ensure that payment rates bear a reasonable relationship to provider's costs, was wrong. There is no general mandate under Medicaid to reimburse providers for all or substantially all of their costs, and Section 1396a(a)(30)(A) does not set forth any requirement that a State consider cost studies in setting payment rates. *Orthopaedic Hospital* misread Section 1396a(a)(30)(A) and, in doing so, frustrated Congress's purpose of giving States wide discretion to set Medicaid payment rates that are consistent with efficiency, economy, and access to quality care.

Every other court of appeals to consider the issue has so held. See *Evergreen Presbyterian Ministries, Inc.* v. *Hood*, 235 F.3d 908, 933 n.33 (5th Cir. 2000), overruled on other grounds, *Equal Access for El Paso, Inc.* v. *Hawkins*, 509 F.3d 697 (5th Cir. 2007), cert. denied, 555 U.S. 811 (2008); *Rite Aid, Inc.* v. *Houstoun*, 171 F.3d 842, 851-852 (3d Cir. 1999); *Minnesota Homecare Ass'n, Inc.* v. *Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam); *Methodist Hosps., Inc.* v. *Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996). As the court of appeals here recognized, the Ninth Cir-

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Care Ass'n Inc. v. *New Jersey Dep't of Human Servs.*, 722 F.3d 527, 541 n.5 (3d Cir. 2013); *Hadden* v. *United States*, 661 F.3d 298, 307-308 (6th Cir. 2011), cert. denied, 133 S. Ct. 106 (2012); *Arizona Health Care Cost Containment Sys.* v. *McClellan*, 508 F.3d 1243, 1254 (9th Cir. 2007); *Dickson*, 391 F.3d at 590 n.6 (5th Cir.).

cuit was an outlier. See 13-380 Pet. App. 37a-38a. And the United States has twice expressed its disagreement with the *Orthopaedic Hospital* decision in petition-stage amicus briefs filed in that case (in 1997) and in *Independent Living Center* (in 2010). See Gov't Cert. Amicus Br. at 7, 9-10, *Independent Living Ctr.*, *supra* (No. 09-958); Gov't Cert. Amicus Br. at 7-9, *Orthopaedic Hosp.*, *supra* (No. 96-1742). There is no reason for the Court to review that longstanding position of the Secretary, now that it has been sustained by the Ninth Circuit as well. Indeed, the Court denied review of that question in *Independent Living Center*. This case accordingly would be an inappropriate vehicle for further review of the question presented even if that question otherwise warranted review.

2. Petitioners in No. 13-253 (at 17-20) additionally contend that the State's consideration of budgetary concerns and CMS's consideration of the State's monitoring plan rendered the agency's approvals arbitrary and capricious. To the extent those arguments were raised below, the court of appeals correctly rejected them, and that case-specific determination does not warrant further review.

Nothing in Section 1396a(a)(30)(A) precludes a State from weighing budgetary considerations when setting Medicaid reimbursement rates. Indeed, Section 1396a(a)(30)(A) requires States to have "methods and procedures" in place to ensure that payments are "consistent with efficiency" and "economy," as well as access to quality care. 42 U.S.C. 1396a(a)(30)(A); see *Pennsylvania Pharmacists Ass'n* v. *Houstoun*, 283 F.3d 531, 537 (3d Cir.) (finding it "clear" that the "efficiency" and "economy" factors require "a state program [to] set payments at levels that make the pro-

gram efficient and economical," *i.e.*, to ensure payments are not "*too high*"), cert. denied, 537 U.S. 821 (2002). Here, the California Legislature directed the State's Medicaid agency to "find areas within the [State's Medicaid] program where reimbursement levels are higher than required under the standard provided in Section [1396a](a)(30)(A)" in order to "minimize the need for drastically cutting enrollment standards or benefits." Cal. Welf. & Inst. Code § 14105.192(a)(2) (West Supp. 2013). The question before CMS was whether the record evidence demonstrated that the proposed payment rate reductions could be effected consistent with the substantive requirements of Section 1396a(a)(30)(A). The agency's reasonable determination that the evidence sufficed to make that showing provides no occasion for further review.

Similarly, nothing in Section 1396a(a)(30)(A) precluded the agency from considering the State's monitoring plan. The comprehensive, "82-page" plan provides a blueprint for monitoring access to services after the state plan amendments are implemented. 13-253 Pet. App. 20, 40. As the court of appeals explained, "[t]he statute cannot logically require that every single potential problem—no matter how unlikely—be predicted, identified, and resolved *before* [state plan amendment] approval." *Id.* at 40. The court correctly concluded that the monitoring plan "supports the reasonable conclusion that the rate reductions are not expected negatively to impact beneficiary access, but that if such problems occur, the State can quickly respond and address them." *Ibid.*

Nor was the monitoring plan the only evidence adduced in this case. CMS amassed hundreds of pages

of evidence relating to each of the plan approvals. 13-253 Pet. App. 40. California submitted predictive analyses for each of the affected services demonstrating that the payment rate reductions would not impair beneficiary access. *Id.* at 20. Those analyses reviewed data on provider availability and per capita utilization of services—precisely the factors that CMS had suggested in its correspondence with the State. *Ibid.*; see CMA C.A. E.R. 142-147. Together, those plans and studies provided ample evidence to support the agency's conclusion that the proposed reductions could be implemented consistent with the substantive requirements of Section 1396a(a)(30)(A). 13-253 Pet. App. 40. CMS also considered studies submitted by petitioners and other stakeholders, and it gave stakeholders the opportunity to discuss their concerns about the pending plan amendments. *Id.* at 20-21. As the court of appeals noted, "CMS considered this 'stakeholder input' when making its determinations, and the agency's decision to credit [the State's] evidence over that submitted by other parties was reasonable." *Id.* at 40.

3. Finally, petitioners in No. 13-253 (at 9-12) contend that deferring to the agency's decisions would violate separation of powers principles. Petitioners did not make a constitutional argument to the court of appeals and the court did not decide one. This Court's "traditional rule * * * precludes a grant of certiorari" when "the question presented was not pressed or passed upon below." *United States* v. *Williams*, 504 U.S. 36, 41 (1992) (internal quotation marks and citation omitted). The Court should adhere to that rule here.

CONCLUSION

The petitions for a writ of certiorari should be denied.

Respectfully submitted.

DONALD B. VERRILLI, JR.
Solicitor General
STUART F. DELERY
Assistant Attorney General
MARK B. STERN
LINDSEY POWELL
Attorneys

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