No. 12-589

In the Supreme Court of the United States

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, 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 SIXTH CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Whether the court of appeals correctly held that the Centers for Medicare & Medicaid Services properly reimbursed psychiatric hospitals for care provided to Medicare beneficiaries during the transition from one Medicare reimbursement scheme to another.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-33a) is unreported but is available at 2012 WL 3608610. The opinion of the district court (Pet. App. 34a-48a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on August 23, 2012. The petition for a writ of certiorari was filed on November 7, 2012. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

This case involves the manner in which psychiatric hospitals were reimbursed for care provided to Medi-

care beneficiaries during the transition from one Medicare reimbursement scheme to another.

1. The Medicare program, established in 1965 by Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*, was initially a reasonable-cost payment system whereby hospitals were reimbursed for reasonable costs incurred. Pet. App. 3a. In 1982, Congress replaced that system with the Prospective Payment System (PPS). See Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, § 101(a)(1), 96 Stat. 331. Under the PPS, hospitals are paid at a fixed amount for each patient discharged, regardless of the actual costs incurred. Pet. App. 3a.

a. Inpatient psychiatric services were initially exempted from the PPS. TEFRA § 101(a)(1), 96 Stat. 332. Providers of psychiatric services instead continued to be reimbursed for their actual allowable operating costs—so long as their costs did not exceed a defined "ceiling." The reimbursement ceiling was based primarily on the hospital's "target amount" for that fiscal year. For the first reporting period (*i.e.*, the base period), the hospital's target amount was the "allowable operating costs of inpatient hospital services" for the previous year plus a percentage increase (*i.e.*, the update factor). 42 U.S.C. 1395ww(b)(3)(A)(i); see 42 C.F.R. 413.40(c)(4)(i) (1996).[1] For each subsequent reporting period, the hospital's target amount was "the target amount for the preceding 12-month cost reporting period" plus the update factor. 42

[1] The implementing regulations were first promulgated as 42 C.F.R. 405.463, see 47 Fed. Reg. 43,291-43,293 (Sept. 30, 1982), but later became 42 C.F.R. 413.40 when most of Subpart D of 42 C.F.R. Part 405 was redesignated as a new Part 413, see 51 Fed. Reg. 34,790 (Sept. 30, 1986).

U.S.C. 1395ww(b)(3)(A)(ii); see 42 C.F.R. 413.40(c)(4)(ii) (1996). The target amount was then multiplied by the number of Medicare beneficiaries the hospital discharged over the year in order to determine the hospital's reimbursement ceiling. See 42 C.F.R. 413.40(a)(3) (1996). The hospital was reimbursed for its actual allowable costs, or the ceiling amount, whichever was lower. 42 U.S.C. 1395ww(b)(1).

b. In the Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, § 4414, 111 Stat. 405, Congress responded to concerns that "[p]ayments to PPS-exempt hospitals represent some of the fastest growing expenditures to Medicare." H.R. Rep. No. 149, 105th Cong., 1st Sess. 1336 (1997). To address "significant variation" in the reimbursement ceilings for different psychiatric hospitals (*ibid.*), Congress adopted an additional cap on reimbursement for fiscal years (FYs) 1998 through 2002. For FY 1998, the hospital's target amount could not exceed the 75th percentile of the target amounts for the same class of hospitals in FY 1996. 42 U.S.C. 1395ww(b)(3)(H)(ii)(I). For FYs 1999 through 2002, the hospital's target amount could not exceed that same percentile plus the updated factor. 42 U.S.C. 1395ww(b)(3)(H)(ii)(III).

The Secretary of Health and Human Services (Secretary) amended the existing regulations to implement the BBA cap by adding Subsection (c)(4)(iii) to 42 C.F.R. 413.40. See 62 Fed. Reg. 46,032-46,033 (Aug. 29, 1997); 63 Fed. Reg. 26,344-26,347 (May 12, 1998). That provision explains that "the target amount is the lower of—

> (A) The hospital-specific target amount (the net allowable costs in a base period increased by the applicable update factors); or
>
> (B) One of the following for the applicable cost reporting period—
>
> (*1*) For [FY 1998], the 75th percentile of target amounts for hospitals in the same class * * * for [FY 1996], increased by the applicable market basket percentage * * *
>
> (*2*) For [FYs 1999 through 2002], the amount determined under paragraph (c)(4)(iii)(B)(*1*) of this section, increased by the [applicable] market basket percentage[.]

42 C.F.R. 413.40(c)(4)(iii) (1998). The Secretary also amended the preexisting definition of target amount in Subsection (c)(4)(ii) to specify that it is "[s]ubject to the provisions of" Subsection (c)(4)(iii). 42 C.F.R. 413.40(c)(4)(ii) (1998). As before, the annual target amount (*i.e.*, the lower of the hospital-specific amount and the capped amount) was then multiplied by the number of Medicare beneficiaries to determine the hospital's reimbursement ceiling. See 42 C.F.R. 413.40(a)(3) (1998). And the hospital was reimbursed for its actual allowable costs, or that ceiling amount, whichever was lower. 42 U.S.C. 1395ww(b)(1).

c. Two years later, Congress again confronted the rising costs of inpatient psychiatric services. This time Congress directed the Secretary to move psychiatric hospitals from the reasonable-cost payment system to the PPS "beginning on or after October 1, 2002." Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. No. 106-113, § 124, 113 Stat. 1501A-332. "Because

diagnosis in psychiatry is complicated and the criteria for diagnosis and treatment are less well defined in psychiatry than in general medicine and surgery," developing a PPS for psychiatric hospitals proved complex and time-consuming. 69 Fed. Reg. 66,923 (Nov. 15, 2004). As a result, the Secretary did not begin moving psychiatric hospitals to the PPS until January 1, 2005. *Id.* at 66,922, 66,924; see 42 C.F.R. 412.426(a). By January 1, 2008, payment to psychiatric hospitals was based entirely on the PPS. See 42 C.F.R. 412.426(a)(4).

d. During the interim period (*i.e.*, after the BBA cap expired and before implementation of the PPS), hospital target amounts were calculated according to the preexisting statutory and regulatory formula: the previous year's target amount plus the update factor. See 42 U.S.C. 1395ww(b)(3)(A)(ii); 42 C.F.R. 413.40(c)(4)(ii); 67 Fed. Reg. 50,103 (Aug. 1, 2002). For example, a hospital's target amount for FY 2003 was the hospital's actual target amount for FY 2002 (which would have either been the hospital-specific amount or the BBA cap amount, whichever was lower), plus the update factor. In 2005, the Secretary amended the regulations again to clarify that Subsection (c)(4)(iii) applied only to "cost reporting periods beginning on or after October 1, 1997 through September 30, 2002." 42 C.F.R. 413.40(c)(4)(iii). The agency explained that it never intended "the provisions of [42 C.F.R.] 413.40(c)(4)(iii) to apply beyond FY 2002" and that the clarifying amendment was "neither a new policy nor a change in policy." 70 Fed. Reg. 47,464 (Aug. 12, 2005).

2. Petitioners are inpatient psychiatric hospitals. From FYs 1998 to 2002, petitioners' actual target

amounts were equal to the BBA cap because their hospital-specific amounts exceeded the 75th percentile for other hospitals within the same class. Pet. App. 8a. As directed by the agency, the fiscal intermediary calculated petitioners' target amounts for FY 2003 based on the target amounts actually used for FY 2002 (which had been capped), plus the update factor. *Id.* at 9a. In turn, for FYs 2004 through 2006, the fiscal intermediary calculated petitioners' target amounts based on the previous year's target amounts, plus the update factor. *Ibid.*

Petitioners appealed to the Provider Reimbursement Review Board (Board). The Board determined that it lacked authority to decide the appeal because it involved a challenge to the Secretary's regulations and granted petitioners' request for expedited judicial review. Pet. App. 49a-55a; see 42 U.S.C. 1395*oo*(f)(1).

3. Petitioners then filed this action in district court. Both parties moved for summary judgment. Petitioners argued that the fiscal intermediary erred in calculating their target amounts for FYs 2003 through 2006. According to petitioners, the target amounts for FY 2003 should not have been based on the target amounts actually used for the previous year (which, in their case, had been capped), but instead should have been calculated the same as the base period (*i.e.*, "allowable operating costs" for the previous year, plus the update factor). The district court disagreed and granted the government's motion. The court held that the statute unambiguously provides that "the target amount for 2003 was based on the previous year's target amount multiplied by the applicable updated factor." Pet. App. 46a (citing 42 U.S.C. 1395ww(b)(3)(A)(ii)). The "previous year's target

amount," the court explained, is the target amount actually used in the previous year, which was subject to the cap. *Id.* at 46a-47a. The court further held, in the alternative, that even if the statute were ambiguous, the Secretary's regulations and her interpretation of those regulations were reasonable and entitled to deference. *Id.* at 47a.

4. The court of appeals affirmed in an unpublished opinion. Pet. App. 1a-33a. The unambiguous statutory language, the court explained, required the agency to calculate petitioners' target amounts based on paragraph (ii) of Section 1395ww(b)(3)(A), because paragraph (i) applied only to the "first such reporting period." *Id.* at 15a (quoting 42 U.S.C. 1395ww(b)(3)(A)(i)). The court explained further that, "[u]nder paragraph (ii), the target amount for fiscal year 2003 was based on the previous year's target amount multiplied by the applicable update factor." *Ibid.* As the court observed, that plain reading is consistent with Congress's intent "to reimburse psychiatric hospitals based on objective patient characteristics and consistent national standards, and to rein in the disproportionately expensive treatment provided by certain hospitals." *Id.* at 17a. Petitioners' contention that the reimbursement rate should instead be "based on each hospital's actual costs," the court concluded, "would turn Congress's intent on its head." *Ibid.* (quoting *id.* at 46a-47a).

In the alternative, the court of appeals held that, even if the statute were ambiguous, the "regulations are entitled to deference and the Agency's interpretation of its regulations is entitled to deference." Pet. App. 22a. The court explained that, after the BBA cap expired, "the Agency reverted to calculating hos-

pital reimbursements according to 42 C.F.R. 413.40(c)(4)(ii)." Pet. App. 29a. Petitioners had argued that such an approach was "contrary to the text of the regulation" which, in their view, required the agency to continue to calculate the target amounts "subject to" Subsection (c)(4)(iii)—even though the BBA cap had expired. *Id.* at 30a. The court disagreed, finding it "reasonable for the Agency to conclude that subsection (iii) had a specific purpose which expired simultaneously with the expiration of the statute that mandated the cap provisions." *Id.* at 32a.

ARGUMENT

Petitioners contend (Pet. 19-25) that the court of appeals erred in concluding that the agency had properly reimbursed psychiatric hospitals for care provided to Medicare beneficiaries during the transition from one Medicare reimbursement scheme to another. Petitioners also contend (Pet. 25-27) that this Court should revisit its decision in *Auer* v. *Robbins*, 519 U.S. 452 (1997). The court of appeals' unpublished decision is correct and does not conflict with any decision of this Court. The disagreement among the courts of appeals on the appropriate reimbursement is narrow, transitory, and of diminishing importance. This Court should not revisit *Auer* and, in any event, this case presents an unsuitable vehicle for doing so. Further review is not warranted.

1. The court of appeals' unpublished decision is correct. Under the plain language of the statute, the hospitals' "target amounts" for the fiscal years at issue (2003-2006) are the target amounts actually used for the previous year, increased by the update factor. Even if the statute were ambiguous, the Secretary's

regulation and her interpretation of that regulation are entitled to deference.

a. During the relevant time period, the Medicare statute provided that "the term 'target amount' means" one of two things. 42 U.S.C. 1395ww(b)(3)(A). "[I]n the case of the first such reporting period," it means "the allowable operating costs of inpatient hospital services * * * for the preceding 12-month cost reporting period," increased by the update factor. 42 U.S.C. 1395ww(b)(3)(A)(i). "[I]n the case of a later reporting period," it means "the target amount for the preceding 12-month cost reporting period," plus the update factor. 42 U.S.C. 1395ww(b)(3)(A)(ii). It is undisputed that FY 2003 was not the "first such reporting period" for any of the petitioner hospitals. Accordingly, paragraph (i) does not apply. See Pet. App. 15a. The target amounts must therefore be computed according to paragraph (ii): the target amounts for the preceding year increased by the update factor.

In this case, the preceding year was FY 2002. In that year, a hospital's "target amount" was subject to an additional limitation set forth in paragraph (H)—it could "not exceed" the 75th percentile of target amounts for a similar class of hospitals in FY 1996 (as adjusted). 42 U.S.C. 1395ww(b)(3)(H); see 42 U.S.C. 1395ww(b)(3)(A) (defining "target amount" "[e]xcept as provided in * * * succeeding subparagraphs"). To the extent a hospital's target amount exceeded that cap, the capped amount became the target amount. That is what happened here. For petitioners, the target amounts actually used in FY 2002 were the capped amounts; the target amounts for FY 2003 were those 2002 target amounts (plus the update factor);

the target amounts for FY 2004 were those 2003 target amounts (again, plus the update factor); and so forth. The court of appeals correctly held that the statute unambiguously provided for precisely that reimbursement calculation. Pet. App. 13a-16a.

That interpretation is consistent with congressional intent. See Pet. App. 16a-18a, 46a-47a. "Congress anticipated the BBA caps [would] immediately [be] replaced with the PPS, another system like the BBA cap system that is not based on hospital-specific target amounts." *Id.* at 16a. Although the complexities of that transition prevented such immediate action, "[t]he legislation unequivocally demonstrates a progressive effort" to place additional limits on reimbursement, to "reimburse psychiatric hospitals based on objective patient characteristics and consistent national standards, and to rein in the disproportionately expensive treatment provided by certain hospitals." *Id.* at 17a. Computing a hospital's target amount based on the prior year's target amount (whether that target amount was hospital-specific or capped), rather than reverting back to an actual-cost regime that Congress had long since abandoned, best effectuates legislative intent.

b. Petitioners nevertheless contend (Pet. 20) that the "target amount for the preceding 12-month cost reporting period," 42 U.S.C. 1395ww(b)(3)(A)(ii), is not the target amount the agency actually used for FY 2002. Instead, petitioners argue, the "target amount" for FY 2003 should be calculated in the same manner as the base-period target amount, *i.e.*, "allowable operating costs of inpatient hospital services" for the previous year plus the update factor, 42 U.S.C. 1395ww(b)(3)(A)(i). That interpretation is incon-

sistent with the statutory text and with congressional intent.

As explained above, the only statutory provision that bases the target amount on actual allowable costs is paragraph (i) and, by its terms, that provision applies only to the "first such reporting period." 42 U.S.C. 1395ww(b)(3)(A)(i). Because FY 2003 is not the "first such reporting period" for any of the petitioner hospitals, their target amounts must be calculated pursuant to paragraph (ii), *i.e.*, the target amounts for the preceding year (which, in petitioners' case, was equal to the capped amount), plus the update factor.

Petitioners contend (Pet. 20) that the preceding year's "target amount" is different than the "cap amount." As the court of appeals explained, however, that argument "ignores the plain language in subsection (H)," which defines the "target amount" for FYs 1998 through 2002 and never uses the term "cap amount." Pet. App. 18a-19a; see *id.* at 19a (explaining why "subsection (J) logically uses different terms to distinguish two different figures in the same provision, either of which could qualify as the target amount depending on whether the cost reporting period falls into the years governed by the BBA provisions found in subsection (H)").

Petitioners also argue (Pet. 20-21) that the court of appeals' interpretation "thwarts congressional intent" because it effectively makes the temporary BBA cap permanent. That is incorrect. As the court of appeals explained, the agency did not apply the 75th percentile cap in 2003 (or in subsequent fiscal years). Pet. App. 19a. Rather, it simply used "the 2002 target amount, which [in petitioners' case] was capped, to calculate the 2003 target amount." *Ibid.* "Given [the]

statutory structure where target amounts are supposed to grow by a specific inflationary percentage each year, it is neither surprising nor obviously contrary to Congressional intent that a limitation imposed in one year would have a kind of 'echo' effect in subsequent years." *Ancora Psychiatric Hosp.* v. *Secretary of the U.S. Dep't of Health & Human Servs.*, 417 Fed. Appx. 171, 176 (3d Cir. 2011) (*Ancora*). Moreover, it is petitioners' interpretation, and not the court of appeals', that "would turn Congress's intent on its head." Pet. App. 17a (quoting *id.* at 45a). Petitioners would "revert back to a system based upon hospital-specific target amounts"—a system Congress expressly rejected in 1999 when it replaced the temporary BBA cap with the PPS. *Id.* at 16a.[2]

c. The court of appeals also correctly held, in the alternative, that even if the statute were ambiguous, the Secretary's regulation and her interpretation of that regulation are entitled to deference. See Pet. App. 22a-33a.

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[2] Petitioners additionally contend (Pet. 21) that the court of appeals' reading is "illogical" because a psychiatric hospital that opened in 2002 would be "saddled" by the 75th-percentile BBA cap, whereas a hospital that opened in 2003 would not. That too is incorrect. Any hospital certified after October 1, 1997, was subject to a different cap altogether—110 percent of the national median of target amounts for the same class of hospitals. See 42 U.S.C. 1395ww(b)(7)(A); see 42 C.F.R. 413.40(f)(2)(ii). As a result, neither the 2002 nor the 2003 hospitals that petitioners hypothesize would have been subject to the 75th-percentile BBA cap, and both would have been subject to a different, but roughly comparable, 110th-percentile median cap. Thus, petitioners' reading would lead to the "illogical" result that a psychiatric hospital that opened (and was certified) in November 1996 would be reimbursed for actual allowable costs, whereas a hospital that opened in November 1997 would be subject to a statutory cap.

Before the BBA cap, the implementing regulation, like the statute, specified that, for non-base periods, "the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor." 42 C.F.R. 413.40(c)(4)(ii) (1998). To implement the BBA cap, the Secretary amended that regulation in two relevant respects. See 62 Fed. Reg. at 46,032-46,033; 63 Fed. Reg. at 26,344-26,347. First, she added Subsection (c)(4)(iii), which explained how to calculate a hospital's target amount consistent with the statutory cap. More specifically, the new subsection provided that "the target amount is the lower of" the hospital-specific amount or the capped amount for the relevant fiscal year (1998-2002). 42 C.F.R. 413.40(c)(4)(iii) (1998). Second, she made the preexisting definition of "target amount" in Subsection (c)(4)(ii) "subject to" that newly added subsection. 42 C.F.R. 413.40(c)(4)(ii) (1998).

After the statutory cap expired in 2002, the agency again began calculating a hospital's target amount based on Subsection (c)(4)(ii).[3] Petitioners argue (Pet.

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[3] In 2005, the Secretary made that interpretation express by amending the regulation to clarify that Subsection (c)(4)(iii) applies only to "cost reporting periods beginning on or after October 1, 1997 through September 30, 2002." 42 C.F.R. 413.40(c)(4)(iii). Contrary to petitioners' suggestion (Pet. 24-25), and as explained in the preamble, the Secretary never intended "the provisions of [42 C.F.R.] 413.40(c)(4)(iii) to apply beyond FY 2002." 70 Fed. Reg. at 47,464; see 63 Fed. Reg. at 26,344 (explaining that the agency had specifically amended Subsection (c)(4)(iii) in 1998 in order to "clarify" that "the target amount for FYs 1998 through 2002 is equal to the lower of" the hospital-specific amount or the capped amount). The clarifying amendment therefore was "neither a new policy nor a change in policy." 70 Fed. Reg. at 47,464.

22-23) that the agency should have continued to calculate a hospital's target amount based on Subsection (c)(4)(iii). Petitioners acknowledge that the agency could not calculate a capped amount pursuant to subparagraph (B), since that provision sets forth only the calculations applicable to FYs 1998 through 2002. See 42 C.F.R. 413.40(c)(4)(iii)(B). In their view, however, that simply means that the "lower" of the two target amounts is necessarily the hospital-specific amount in subparagraph (A). Even if that interpretation were plausible, it is not the only reasonable interpretation of the regulation. See *Auer*, 519 U.S. at 461 (agency interpretation of its own regulation is "controlling unless plainly erroneous or inconsistent with the regulation") (internal quotation marks and citation omitted); *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994) ("broad deference is all the more warranted" when the regulation concerns "a complex and highly technical regulatory program") (internal quotation marks and citation omitted).

As the court of appeals explained, after expiration of the statutory cap, the agency was "faced with a decision: Was it required to continue the implementation of subsection (iii), which was designed specifically to address the cap provisions mandated by Congress, or was the Agency permitted to return to subsection (ii) and logically conclude that subsection (iii) expired with the expiration of the cap provisions?" Pet. App. 31a-32a. In making that decision, it was entirely "reasonable for the Agency to conclude that subsection (iii) had a specific purpose which expired simultaneously with the expiration of the statute that mandated the cap provisions." *Id.* at 32a. The agency's decision to calculate petitioners' target amounts ac-

cording to Subsection (c)(4)(ii), and not (c)(4)(iii), is not "plainly erroneous or inconsistent with the regulation." *Thomas Jefferson*, 512 U.S. at 512 (internal quotation marks and citation omitted).[4]

2. Petitioners contend (Pet. 19-25) that this Court's review is warranted because the courts are divided on the proper interpretation of the statutory and regulatory provisions governing Medicare reimbursement for psychiatric hospitals. That disagreement is narrow, transitory, and of diminishing importance, and it does not warrant this Court's review.

Three courts of appeals have considered the question presented and only one has issued a published and, thus, precedential decision. In the only published opinion, the Fifth Circuit concluded that (i) the statute is ambiguous; (ii) the Secretary's regulation is reasonable; but (iii) the Secretary's interpretation of that regulation is inconsistent with its plain language. See *Hardy Wilson Mem. Hosp*. v. *Sebelius*, 616 F.3d 449, 460-461 (2010) (*Hardy Wilson*). In unpublished decisions, the court below and the Third Circuit disagreed with the Fifth Circuit on (i) and (iii). See Pet. App. 20a-22a, 29a-33a; *Ancora*, 417 Fed. Appx. at 172. Those unpublished decisions do not create binding circuit precedent and, thus, do not give rise to the sort

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[4] Petitioners note (Pet. 7-8, 15-16) that the fiscal intermediary in this case agreed with petitioners' interpretation, but this Court has made clear that the Secretary is not bound by the statements of a fiscal intermediary. See *Heckler* v. *Community Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 64 (1984); Pet. App. 20a (citing cases).

of circuit conflict that might in turn warrant this Court's review.[5]

In any event, the question presented is transitory and of diminishing importance. Since 2008, inpatient psychiatric services have been reimbursed entirely under the PPS. See 42 C.F.R. 412.426(a). Accordingly, the limited disagreement is relevant only to psychiatric hospitals that actually exceeded the BBA cap in FY 2002 and, as to that subset of hospitals, only for the interim period between expiration of the BBA cap (in 2002) and full implementation of the PPS (in 2008).

3. The Court should also decline petitioners' invitation (Pet. 25-27) to revisit its decision in *Auer*. The Court recently reaffirmed that deference is due "to an agency's interpretation of its regulations * * * unless the interpretation is plainly erroneous or inconsistent with the regulation[s] or there is any other reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question." *Talk Am., Inc.* v. *Michigan Bell Tel. Co.*, 131 S. Ct. 2254, 2261 (2011) (*Talk Am.*) (internal quotation marks and citations omitted; brackets in original); see *PLIVA, Inc.* v. *Mensing*, 131 S. Ct. 2567, 2575-2576 (2011); *Chase Bank USA, N.A.* v. *McCoy*, 131 S. Ct. 871, 880 (2011); *Federal Express Corp.* v. *Holowecki*, 552 U.S. 389, 397 (2008). Many of

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[5] Petitioners also rely on two unpublished district court decisions. See Pet. 17-19 (citing *Chalmette Med. Ctr., Inc.* v. *United States Dep't of Health and Human Servs.*, No. 08-4027, 2009 WL 2488265 (E.D. La. Aug. 11, 2009), and *Arkansas State Hosp.* v. *Leavitt*, No. 4:07-cv-624, 2008 WL 4531714 (E.D. Ark. Oct. 8, 2008)). One is out of the Fifth Circuit and, thus, is no longer good law after *Hardy Wilson*. In any case, the Court's ordinary practice is to resolve conflicts among the courts of appeals, not among district courts.

petitioners' arguments (see Pet. 27) fail to acknowledge the limitations already recognized by this Court's case law. See *Talk Am.*, 131 S. Ct. at 2261 (deference is not warranted if there is reason to believe that the agency's interpretation does not reflect its "fair and considered judgment"). Alternatively, those arguments are better understood as challenges to the application of *Auer* deference, and not to the principles underlying it.

Even if reconsideration were appropriate, this case would not be a suitable vehicle. The court of appeals correctly held that the relevant statutory language is unambiguous, Pet. App. 13a-23a, and that holding is sufficient to resolve this case. Accordingly, even if this Court were to grant the petition, it may never reach the issue of *Auer* deference.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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