No. _____

In The
Supreme Court of the United States

CHILDREN'S HOSPITAL ASSOCIATION OF TEXAS, et al.,

Petitioners,

v.

ALEX M. AZAR II, SECRETARY OF HEALTH AND HUMAN SERVICES, et al.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The District Of Columbia Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Because of Medicaid's low reimbursement rates, hospitals with large Medicaid patient populations have a statutory right to supplemental "Disproportionate Share Hospital" payments. Each year, those payments are capped based on a formula set by Congress: as relevant here, that cap equals the amount of costs the hospital incurred serving Medicaid-eligible patients (as determined by the Secretary of Health and Human Services) minus the payments the hospital received from Medicaid. For years, the Centers for Medicare and Medicaid Services (CMS) followed this formula, subtracting only Medicaid payments from the hospital's costs. But then CMS changed course to also subtract the amount of private insurance payments the hospital receives from treating Medicaid-eligible patients. After its initial attempt to change the policy was enjoined for being inconsistent with existing regulations, CMS promulgated a new regulation—but continued to insist this policy was the same as the prior regulation's policy. The court below, like every court to address the question, rejected CMS's claim of consistency. Yet it upheld CMS's new regulation under *Chevron*.

The questions presented are:

1. Whether an agency may receive *Chevron* deference when it erroneously denies that its current interpretation marks a change in position.

QUESTIONS PRESENTED—Continued

2. Whether the Medicaid Act permits CMS to reduce disproportionate share hospitals' supplemental payment cap based on private insurance payments.

PARTIES TO THE PROCEEDING

Petitioners are the Children's Hospital Association of Texas;* Children's Health Care, doing business as Children's Hospitals and Clinics of Minnesota; Gillette Children's Specialty Healthcare; Children's Hospital of The King's Daughters, Incorporated; and Seattle Children's Hospital.

Respondents are Alex M. Azar II, in his official capacity as Secretary of Health and Human Services; Seema Verma, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services; and the Centers for Medicare and Medicaid Services.

CORPORATE DISCLOSURE STATEMENT

Children's Hospital Association of Texas; Children's Health Care, doing business as Children's Hospitals and Clinics of Minnesota; Gillette Children's Specialty Healthcare; Children's Hospital of The King's Daughters, Incorporated; and Seattle Children's Hospital are nonprofit entities and not publicly traded. There is no parent or publicly held company owning 10% or more of their stock.

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* The members of Children's Hospital Association of Texas are Children's Health; Children's Hospital of San Antonio; Cook Children's Medical Center; Covenant Children's Hospital; Dell Children's Medical Center of Central Texas; Driscoll Children's Hospital; El Paso Children's Hospital; and Texas Children's Hospital.

RELATED PROCEEDINGS

United States District Court (D.D.C.):

Children's Hosp. Ass'n of Tex. v. *Azar*, No. 17-cv-844 (Mar. 7, 2018)

United States Court of Appeals (D.C. Cir.):

Children's Hosp. Ass'n of Tex. v. *Azar*, No. 18-5135 (Aug. 13, 2019), petition for reh'g denied, Nov. 8, 2019

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INTRODUCTION

Chevron U.S.A. Inc. v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), continues to sow disagreement and confusion. Here, the court of appeals chose to "skip" *Chevron* step one, brushed aside canons of statutory construction, and looked past what it acknowledged was a legal error in a key premise of the agency's rulemaking—the agency's insistence that its new regulation merely clarified, and was consistent with, existing policy. In numerous ways, this ruling conflicts with decisions from other circuits and this Court. It also wipes out vital supplemental payments to children's hospitals and other safety-net hospitals, contrary to Congress's express intent. The Court should grant review and either resolve these conflicts, enforce the limitations it has placed on *Chevron*, and restore the statutory formula Congress provided, or reassess *Chevron*'s increasingly questioned foundations.

Petitioners are children's hospitals profoundly harmed by a 2017 CMS Medicaid regulation. With children making up the largest group of Medicaid enrollees,[1] petitioners treat huge numbers of Medicaid-eligible patients every year. And with Medicaid paying far below the actual cost of treatment, petitioners lose tens of millions of dollars annually providing this care.

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[1] Georgetown Univ. Health Policy Inst., Ctr. for Children & Families, Medicaid's Role for Children 1 (Jan. 2017), https://ccf.georgetown.edu/wp-content/uploads/2016/06/Medicaid-and-Children-update-Jan-2017-rev.pdf.

It is for just such hospitals that Congress created Medicaid's "Disproportionate Share Hospital" (DSH) program. Under that program, facilities that meet the statutory definition of a disproportionate share hospital are entitled to receive an "increase in the rate or amount of payment" from Medicaid. 42 U.S.C. 1396r-4(a)(1)(B). Petitioners undisputedly meet that definition because of the massive amounts of inpatient care they provide to Medicaid-eligible patients every year. Indeed, children's hospitals often have the highest percentage of Medicaid-eligible patients in their state. Yet CMS's 2017 regulation shuts them out of the DSH program.

The regulation does so by using privately negotiated payments that hospitals receive from insurance companies to offset the reimbursement shortfalls from Medicaid. Children's hospitals (like many hospitals) rely on higher private insurance payments to offset their Medicaid losses. But lately, CMS has been seeking to use these private payments to reduce hospitals' eligibility for governmental payments. Thirty-three questions into its website's frequently asked questions page, CMS announced in 2010 that the formula for calculating hospitals' annual DSH-payment cap must henceforth factor in private insurance payments received from treating Medicaid-eligible patients.

According to CMS, this policy comports with the statute's DSH-cap formula. The statute says that a particular hospital's annual DSH limit equals:

> the costs incurred during the year of furnishing hospital services (as determined by the

> Secretary and net of payments under [Medicaid] and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State [Medicaid] plan or have no health insurance (or other source of third party coverage) for services provided during the year.

42 U.S.C. 1396r-4(g)(1)(A). But contrary to CMS's new policy, this language "provides a straightforward formula to determine the cap for a hospital's § 1396r-4 payment." *Tenn. Hosp. Ass'n* v. *Azar*, 908 F.3d 1029, 1048 (6th Cir. 2018) (Kethledge, J., concurring in the judgment). "[T]he maximum that a hospital may receive under § 1396r-4 in a given year is the difference between the money it spent serving Medicaid patients that year and certain payments (specifically, payments from Medicaid and from uninsured patients) it received in return." *Ibid.*

After CMS updated its website to announce this new policy, numerous district courts—all affirmed in relevant part on appeal—enjoined it. They held that CMS cannot adopt this policy through a mere website update. A rulemaking would be necessary because existing CMS regulations, promulgated in 2008, precluded using private insurance payments to reduce hospitals' DSH cap. CMS undertook a rulemaking and formally incorporated its website policy into the *Code of Federal Regulations* in 2017.

The district court below vacated the 2017 rule as inconsistent with the statute. The court of appeals reversed. In its view, the Secretary's delegated authority

to determine "the costs incurred during the year of furnishing hospital services" constituted an express delegation that justified "skip[ping] straight" past *Chevron* step one to asking "whether the Rule is reasonable." App., *infra*, 8a (citation omitted). It then found the rule reasonable, declining to apply the canons of construction the district court had followed. *Id.* at 9a-13a. The court of appeals also rejected petitioners' argument that *Chevron* deference was improper because the agency was incorrect in denying that the 2017 rule marked a change in its policies. *Id.* at 16a. The court agreed that the 2017 rule articulated a different policy than its 2008 predecessor. But the court concluded that the agency's shift in position made "no difference" because the agency had articulated reasons for the new position. *Ibid.*

This ruling conflicts with decisions of numerous other circuits. Other courts of appeals hold—contrary to the panel here—that a new agency policy is arbitrary and capricious and undeserving of deference when the agency erroneously insists that the policy is consistent with prior policy. Other courts also observe *Chevron* step one even where the agency has *some* delegated authority, and apply the basic canons of construction in the administrative law setting as they would in any other. True, no court of appeals to date has set aside CMS's 2017 rule. But several district courts have done so, and a court of appeals judge has also endorsed the same interpretation, concluding that the government's contrary position impermissibly

conflates "payments" and "costs," contrary to Congress's express terms and intent. See *Tenn. Hosp. Ass'n*, 908 F.3d at 1050 (Kethledge, J., concurring in the judgment).

This Court's review is warranted on both the specifics of CMS's 2017 rule and the broader principles of *Chevron* deference. The D.C. Circuit's approach strays from this Court's decisions, and the result severely harms children's hospitals' ability to provide vital care to the most vulnerable among us. The Court should grant the petition for certiorari.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-18a) is reported at 933 F.3d 764. The opinion of the district court (App., *infra*, at 22a-63a) is reported at 300 F. Supp. 3d 190.

JURISDICTION

The judgment of the court of appeals was entered on August 13, 2019. A petition for rehearing was denied on November 8, 2019 (App., *infra*, 92a-93a). On January 28, 2020, the Chief Justice extended the time within which to file a petition for a writ of certiorari to and including April 6, 2020. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory and regulatory provisions are reproduced in the appendix to this petition. App., *infra*, 70a-84a.

STATEMENT

A. Statutory And Regulatory Background

1. "Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder* v. *Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). To obtain Medicaid funding, states must comply with various federally imposed conditions. *Armstrong* v. *Exceptional Child Ctr., Inc.*, 575 U.S. 320, 323 (2015). Most fundamentally, states must submit a Medicaid plan for approval by the Secretary of Health and Human Services, who administers Medicaid through CMS. *Pharm. Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 650 & n.3 (2003).

A state plan defines the categories of individuals who are eligible for Medicaid benefits. *Walsh*, 538 U.S. at 650. Certain individuals, however, are categorically eligible for Medicaid by statute. *Ibid.* For example, children who are eligible for Social Security income because of a disability are eligible for Medicaid. 42 U.S.C. 1396a(a)(10)(A)(i)(II)(cc).

Medicaid reimbursement has long been a subject of controversy. Initially, the Medicaid Act "required

States to provide reimbursement for the 'reasonable cost' of hospital services actually provided." *Wilder*, 496 U.S. at 505. But in 1981, Congress switched to a different approach. In Congress's view, the "reasonable cost" approach had yielded "rapidly rising Medicaid costs." *Id.* at 506. The object of the 1981 legislation was to generate cost savings by giving states greater control over reimbursement. *Ibid.*

2. But legislators did not want to jeopardize "hospitals' willingness to treat Medicaid patients." H.R. Rep. No. 158, 97th Cong., 1st Sess. Vol. II, at 293 (1981). So as Congress gave states greater flexibility over reimbursement, it also established a new requirement: states' reimbursement rates would have to "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173(a)(1)(B)(ii), 95 Stat. 808 (42 U.S.C. 1396a(a)(13)(A)(iv)).

a. That exhortation had little immediate effect. Over five years later, the Department of Health and Human Services reported "that only 15 States had defined 'disproportionate share' [hospitals] and actually made payment adjustments to them." H.R. Rep. No. 391, 100th Cong., 1st Sess. Pt. 1, at 525 (1987). Congress accordingly decided to amend the Medicaid Act in two relevant respects.

First, it created a baseline definition of disproportionate share hospitals. A hospital is "deemed" a DSH facility if its "Medicaid inpatient utilization rate"—

based on the proportion of inpatient care provided to Medicaid-eligible patients—"is at least one standard deviation above the mean [M]edicaid inpatient utilization rate for hospitals receiving [M]edicaid payments in the State." Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4112(b), 101 Stat. 1330-149 (42 U.S.C. 1396r-4(b)). The hospitals with the most inpatient care for Medicaid-eligible patients thus qualify as disproportionate share hospitals.

Second, the 1987 legislation required states to provide supplemental funding to DSH facilities. A state Medicaid plan does not comply with the requirement that states "take" the situation of disproportionate share hospitals "into account" unless the plan "provides * * * for an appropriate increase in the rate or amount of payment" for those hospitals. § 4112(a)(1), 101 Stat. 1330-148 (42 U.S.C. 1396r-4(a)(1)). This legislation also established a minimum amount for this mandatory payment increase. § 4112(c), 101 Stat. 1330-149 (42 U.S.C. 1396r-4(c)).

b. By 1993, Congress had become concerned that some states were now making excessive DSH payments to certain hospitals—particularly hospitals that states had classified as DSH facilities even though they provided no inpatient services to Medicaid patients, and state-run hospitals that redirected DSH payments for unrelated government purposes. H.R. Rep. No. 111, 103d Cong., 1st Sess. 211-212 (1993).

So Congress amended the Medicaid Act again. This 1993 legislation established a cap for each specific

hospital's annual DSH payment. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13621(b), 107 Stat. 630 (42 U.S.C. 1396r-4(g)). Specifically, a payment adjustment to a specific hospital may not:

> exceed[ ] the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

42 U.S.C. 1396r-4(g)(1)(A).

CMS described this new hospital-specific limit for DSH payments as "composed of two parts." Letter from Sally K. Richardson, Dir. of CMS's Center for Medicaid and State Operations, to all State Medicaid Dirs. 3 (Aug. 17, 1994) (SMD Letter) (C.A. App. 515). "The first part of the limit," dubbed the "Medicaid 'shortfall,'" equaled "the cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payment method under the State plan." *Ibid.* And "[t]he second part of the formula [was] the cost of services provided to patients who have no health insurance or source of third party payment for services provided during the year, less the amount of payments made by these patients." *Ibid.* Together, the Medicaid shortfall

and the uninsured component provide the overall cap on DSH funding for a given hospital in a given year.

c. In 2003, Congress modified the DSH statute further. This time, Congress chose to require annual reports and independent audits for state DSH programs. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1001(d), 117 Stat. 2430 (42 U.S.C. 1396r-4(j)). The audit must verify that "[o]nly the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in [Section 1396r-4(g)(1)(A)] are included in the calculation of the hospital-specific limits under [Section 1396r-4(g)]." § 1001(d), 117 Stat. 2431 (42 U.S.C. 1396r-4(j)(2)(C)).

CMS implemented this reporting and auditing requirement through a 2008 regulation. 73 Fed. Reg. 77,904 (Dec. 19, 2008). Consistent with the 1994 letter to state Medicaid directors, the 2008 regulation describes the hospital-specific limit as comprising a Medicaid component and an uninsured component. 42 C.F.R. 447.299(c)(11) and (15). Under the 2008 regulation, the Medicaid component—the relevant component here—equaled the "total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals" minus the total non-DSH Medicaid payments to the hospital for inpatient and outpatient services furnished to Medicaid-eligible patients. 42 C.F.R. 447.299(c)(6)-(11) (2016).

B. Factual Background

1. In 2010, CMS announced a major change in its understanding of the DSH-cap formula as the thirty-third item on a "frequently asked questions" (FAQ) page on its website. FAQ 33, as it was known, asked whether the DSH limit should be reduced based on "revenues associated with patients that have both Medicaid and private insurance coverage." C.A. App. 676. CMS answered yes, private insurance revenues received for the treatment of Medicaid-eligible patients counted against a hospital's DSH cap: "hospitals should offset *both* Medicaid *and* third-party revenue associated with the Medicaid eligible day against the costs for that day to determine any uncompensated amount." *Ibid.* (emphasis added).

CMS's enforcement of this new policy prompted the surprise recoupment of millions of dollars of supplemental payments. Several hospitals filed lawsuits challenging the policy's legality. That resulted in a preliminary injunction of the policy on December 29, 2014. *Tex. Children's Hosp.* v. *Burwell*, 76 F. Supp. 3d 224, 247 (D.D.C. 2014). The court concluded that FAQ 33 likely violated the Administrative Procedure Act's notice-and-comment requirements. *Id.* at 241. A number of district courts reached the same conclusion and enjoined the new policy, and four courts of appeals affirmed in relevant part.[2]

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[2] See, *e.g.*, *N.H. Hosp. Ass'n* v. *Burwell*, No. 15-cv-460, 2017 WL 822094, at *16 (D.N.H. Mar. 2, 2017), aff'd, 887 F.3d 62 (1st Cir. 2018); *Children's Hosp. of the King's Daughters, Inc.* v. *Price*,

With FAQ 33 enjoined, CMS undertook a rulemaking to incorporate the FAQ 33 policy—using private insurance payments to reduce hospitals' DSH limit—into its regulations. 81 Fed. Reg. 53,980 (Aug. 15, 2016). Commenters were overwhelmingly critical of the proposal. See C.A. App. 129-608. But CMS adopted the rule nonetheless. 82 Fed. Reg. 16,114 (Apr. 3, 2017).

Under this 2017 rule, a specific hospital's "costs" for the year are now "defined as costs net of third-party payments, including, but not limited to, payments by * * * private insurance." 42 C.F.R. 447.299(c)(10) (2017). From this amount, the remaining portions of the 2008 regulation continue to require subtraction of all non-DSH Medicaid payments. 42 C.F.R. 447.299(c)(6)-(9) and (11).

2. Petitioners are four children's hospitals in Minnesota, Virginia, and Washington and a state children's hospital association representing the eight children's hospitals in Texas. C.A. App. 66-68. These children's hospitals all provide care for disproportionate numbers of Medicaid patients, especially children with chronic and complex conditions, and are "deemed" DSH facilities under the Medicaid Act's definition. *Ibid.*

Supplemental DSH funding is critically important to these hospitals. The situation of petitioner

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258 F. Supp. 3d 672, 693 (E.D. Va. 2017), aff'd in part, vacated in part, 896 F.3d 615 (4th Cir. 2018); *Tenn. Hosp. Ass'n* v. *Price*, No. 16-cv-3263, 2017 WL 2703540, at *8 (M.D. Tenn. June 21, 2017), aff'd and remanded, 908 F.3d 1029 (6th Cir. 2018); *Children's Health Care* v. *CMS*, No. 16-cv-4064, 2017 WL 3668758, at *9 (D. Minn. June 26, 2017), aff'd, 900 F.3d 1022 (8th Cir. 2018).

Children's Hospitals and Clinics of Minnesota (Children's Minnesota) is representative. In 2015, 57% of children with an inpatient stay at Children's Minnesota were eligible for Medicaid. C.A. App. 296. Medicaid payments nonetheless accounted for only 30% of patient care revenue that year, averaging 77 cents for every dollar spent caring for Medicaid patients. *Id.* at 297. Before accounting for DSH funding, Children's Minnesota suffered an $86 million loss from this care. *Ibid.* It received a $21 million DSH payment, but still suffered a net loss of $65 million for these patients. *Ibid.*

Under the FAQ policy and 2017 rule, Children's Minnesota's DSH payment is entirely eliminated. C.A. App. 297. The same is true for other petitioners. See *id.* at 354, 374, 393.

This problem is particularly acute for children's hospitals because a small segment of their patient populations is eligible for Medicaid but also covered by private insurance. The central example is a premature infant. Congress made children who are eligible for Social Security categorically eligible for Medicaid. 42 U.S.C. 1396a(a)(10)(A)(i)(II)(cc). And the Social Security Administration made infants born with low birthweights eligible for Social Security. 20 C.F.R. 416.934(j)-(k). Such infants often have significant health issues or costly stays in neonatal intensive care units. C.A. App. 296-297, 364. For those infants that have private insurance coverage, Medicaid actually pays the hospital nothing because the private insurers pay instead. Those private insurers pay at privately

negotiated rates that not only exceed what Medicaid would pay but also exceed what Medicaid would permit the hospital to treat as allowable costs in its DSH-limit calculation.[3] Because these private insurance payments are not calibrated using Medicaid standards, including them in the Medicaid shortfall calculation drives the hospital's DSH limit to a negative number.

Texas Children's Hospital, a member of petitioner Children's Hospital Association of Texas, provides an apt illustration. Texas Children's Hospital treated approximately 100,000 Medicaid-eligible and uninsured patients in 2011, only 3,330 of whom were Medicaid-eligible patients with private insurance. C.A. App. 394. Under the 2008 regulation, the hospital received a $21.7 million DSH payment. *Id.* at 395. Yet subtracting the $66.9 million in private insurance payments Texas Children's Hospital received from treating the 3,330 privately insured, Medicaid-eligible patients would completely eliminate the amount that the hospital was permitted to receive under the 2008 formula. *Id.* at 393 & n.8.

That hardly means that Texas Children's Hospital profited from treating these 100,000 patients. On the contrary, even factoring in the $66.9 million in private insurance payments received on account of the 3,330 privately insured children, Texas Children's Hospital still suffered an actual net loss of over $116 million

[3] CMS has decided to completely exclude the costs of certain significant services from the DSH-cap calculation. For example, the "costs of providing Medicaid physician services" are excluded. 42 C.F.R. 447.299(c)(11).

treating its 100,000 Medicaid-eligible and uninsured patients. *Ibid.* The hospital's $21.7 million DSH payment did not come close to covering that loss. Eliminating that DSH payment altogether—as the 2017 rule would require—makes an already bad situation even worse.

C. Proceedings Below

1. Petitioners brought this action seeking a preliminary injunction and vacatur of the 2017 rule under the Administrative Procedure Act. Petitioners argued that the rule was arbitrary and capricious in violation of 5 U.S.C. 706(2)(A) and exceeded CMS's statutory authority in violation of 5 U.S.C. 706(2)(C).

2. The district court granted petitioners' motion for summary judgment and vacated the 2017 rule. App., *infra*, 19a-63a. It concluded that the rule was inconsistent with the plain language of the Medicaid Act under the *Chevron* two-step framework.

At step one, the court concluded that, "[o]n its face, the statute clearly indicates which payments can be subtracted from the total costs incurred during the year by hospitals: (1) 'payments under this subchapter,' *i.e.*, payments made by Medicaid; and (2) payments made by uninsured patients." App., *infra*, 53a. Although "the statute expressly delegates to the Secretary the authority to determine 'costs,' the remainder of the statutory text forecloses" CMS's attempt to include only costs net of particular payments. *Ibid.* The statutory structure and context also cut against CMS's

policy. *Id.* at 54a-58a. Elsewhere in the same subsection, the statute includes a different mathematical formula, which expressly excludes payments "from third party payors." *Id.* at 55a (quoting 42 U.S.C. 1396r-4(g)(2)(A)). Congress thus knew how to exclude third-party payments when it wished to do so. *Ibid.* The legislative history was consistent with petitioners' reading as well. *Id.* at 58a-60a.

Having found the 2017 rule inconsistent with the statute, the district court held that the proper remedy was vacatur. App., *infra*, 60a-63a. In light of this holding, the court did not address petitioners' arguments that the rule was arbitrary and capricious. *Id.* at 49a.

3. The court of appeals reversed. App., *infra*, 1a-18a. It began by stating that there was "no need to search for statutory ambiguity" in *Chevron* step one "[b]ecause the delegation at issue here is express rather than implied." *Id.* at 8a. The court said it would "skip straight to asking whether the Rule is reasonable." *Ibid.*

In finding the rule reasonable, the court declined to attach any significance to the statute's identification of particular types of payment that should be subtracted in determining the DSH cap. It observed that D.C. Circuit precedent has called the canon *expressio unius est exclusio alterius* "a 'feeble helper in an administrative setting.'" App., *infra*, 10a. Next, it found the canon against superfluity inapplicable. *Id.* at 11a. It found no significance in the contrasting language of subsection (g)(2)(A) or in the statute's differentiation

between costs and payments. *Id.* at 12a-13a. And it judged the rule consistent with the statutory context and purpose. *Id.* at 14a.

The court of appeals then rejected petitioners' arbitrary-and-capricious arguments. It excused CMS's persistent denials that the rule marked a change in policy. App., *infra*, 15a-16a. The court agreed, however, that "the 2017 Rule and the 2008 Rule establish different policies." *Id.* at 16a. It expressly endorsed the conclusion of the four other courts of appeals that have rejected CMS's claim that "the 2017 Rule is consistent with the 2008 Rule and so does not establish a new policy." *Id.* at 16a n.3. But the court held that CMS's incorrect view of this issue "makes no difference." *Id.* at 16a. CMS had purportedly "explained why the statute's purposes are better fulfilled" by the 2017 rule, and according to the court this was "more than sufficient to survive review." *Id.* at 16a-17a.

4. Petitioners sought rehearing, and the court called for a response. The court denied rehearing on November 8, 2019. App., *infra*, 68a-69a.

REASONS FOR GRANTING THE PETITION

In its understanding of *Chevron* deference and the Medicaid DSH statute, the court of appeals departed from other circuits and this Court's case law. These issues are exceptionally important and warrant the Court's review.

A. The D.C. Circuit's Deference To The Agency's Fervently Denied Change In Position Conflicts With Decisions Of This Court And Other Circuits

A procedurally defective regulation is not entitled to *Chevron* deference. *Encino Motorcars, LLC* v. *Navarro*, 136 S. Ct. 2117, 2125 (2016). And a regulation is procedurally defective when it constitutes an unexplained change in agency policy. "Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change." *Ibid.* "But the agency must at least 'display awareness that it is changing position' and 'show that there are good reasons for the new policy.'" *Id.* at 2126 (quoting *FCC* v. *Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)). Otherwise, the unexplained inconsistency is arbitrary and capricious, and "[a]n arbitrary and capricious regulation of this sort is itself unlawful and receives no *Chevron* deference." *Ibid.*

In *Encino Motorcars*, the Court refused to defer to a Department of Labor regulation that constituted an unexplained change in the agency's position. 136 S. Ct. at 2127. The Department recognized that it was changing position, see *id.* at 2123, but it violated *Fox*'s second requirement: it failed to furnish "good reasons for the new policy," *id.* at 2127 (quoting *Fox*, 556 U.S. at 515).

Here, in contrast, CMS did not even comply with the first *Fox* requirement: it did not "display awareness that it [was] changing position." *Fox*, 556 U.S. at

515 (emphasis added). In fact, CMS has consistently *denied* that the 2017 rule and FAQ 33 are inconsistent with the 2008 regulation. As the court of appeals recounted, the agency "maintains that the 2017 Rule did not effect a legal change but instead continued the preexisting policy." App., *infra*, at 6a (citing 82 Fed. Reg. at 16,119).

Every court to consider the question—including the court below—has rejected CMS's claim of consistency. Here, the D.C. Circuit expressly "agree[d] with [petitioners] that the 2017 Rule and the 2008 Rule establish different policies." App., *infra*, at 16a. Before this case, four other courts of appeals had likewise rejected CMS's contention "that the 2017 Rule is consistent with the 2008 Rule and so does not establish a new policy." *Id.* at 16a n.3. Those courts all held, and the panel below "agree[d]," that "the 2010 FAQs [were] procedurally invalid because the policy established therein, which is the same policy established by the 2017 Rule, marked a departure from the policy established by the 2008 Rule." *Ibid.*; see *N.H. Hosp. Ass'n* v. *Azar*, 887 F.3d 62, 74 (1st Cir. 2018); *Children's Hosp. of the King's Daughters, Inc.* v. *Azar*, 896 F.3d 615, 623 (4th Cir. 2018); *Tenn. Hosp. Ass'n*, 908 F.3d at 1043 (6th Cir.); *Children's Health Care* v. *CMS*, 900 F.3d 1022, 1026-1027 (8th Cir. 2018).

But contrary to this Court's decisions, the D.C. Circuit held that the agency's vehement, but erroneous, denial of the change in position "makes no difference" to the rule's validity and the agency's claims to deference. App., *infra*, at 16a. According to the panel, "CMS

explained why the statute's purposes are better fulfilled by" the policy embodied in the 2017 rule. *Ibid.* In essence, the court excused noncompliance with the first *Fox* requirement (displaying awareness of the change in position) because the agency complied with the second (offering supposedly good reasons for the new policy).

In *Tennessee Hospital Ass'n*, a split panel of the Sixth Circuit took much the same approach. It concluded that CMS's new position is entitled to deference despite the agency's mistaken refusal to acknowledge the inconsistency between its current position and the 2008 regulation. 908 F.3d at 1041-1042; see also *id.* at 1043 (holding that FAQ 33's payment-deduction policy "seeks to amend, rather than merely clarify, the 2008 regulations"). Much like the D.C. Circuit here, the Sixth Circuit majority deemed this inconsistency irrelevant under *Chevron*. *Id.* at 1041. Such "inconsistencies have [no] bearing on CMS's statutory authority to pursue its payment-deduction policy" as reflected in FAQ 33 and now the 2017 rule. *Id.* at 1042.

The approach of those two circuits conflicts not just with *Encino Motorcars* and *Fox*, but also with the approach taken by four other circuits. Those other courts set aside and refuse to defer to agency actions that constitute a policy change the agency refuses to acknowledge.

For instance, in *CBS Corp.* v. *FCC*, 663 F.3d 122 (2011), the Third Circuit set aside an order premised on an FCC policy against broadcasting indecent

material because the agency had "fail[ed] to acknowledge that it [had] changed its policy." *Id.* at 151-152. It held that a "policy change must be set aside as arbitrary and capricious" if the agency "has failed to even acknowledge its departure from its former policy." *Id.* at 147. Failing to acknowledge the change precludes the agency from "supply[ing] a 'reasoned explanation' for the change." *Ibid.*

The Fourth Circuit faced a similar situation in *Jimenez-Cedillo* v. *Sessions*, 885 F.3d 292 (2018). The government did not argue there that the Board of Immigration Appeals (BIA) had "complied with the requirement that it acknowledge and explain any change in agency position." *Id.* at 298. Instead, the government argued "that there [was] no change to be explained." *Ibid.* But the Fourth Circuit's review of past BIA decisions led it to conclude that the agency had adopted a "change in position * * * without explanation or even the requisite acknowledgement that [the change had] happened." *Id.* at 299. So the court set aside the BIA's decision. *Id.* at 299-300.

The Second Circuit later agreed. *Flores* v. *Barr*, 791 Fed. Appx. 222, 226 (2019) (vacating a BIA order and endorsing *Jimenez-Cedillo*'s holding "that the BIA's failure to acknowledge or explain its departure * * * requires a remand"). In the Second Circuit as well, courts do not defer to agencies that fail to address inconsistencies in their positions. See *Mei Fun Wong* v. *Holder*, 633 F.3d 64, 78 (2011) ("Even assuming the Board does not think *In re M-F-W-* represents any change in the agency's view of what constitutes

persecution, the persistent unexplained inconsistency with *Jiang* precludes us from conducting a meaningful review.").

The Ninth Circuit too has not hesitated to enforce the requirement that agencies acknowledge their policy changes. See, *e.g.*, *Amazon.com, Inc.* v. *Commissioner*, 934 F.3d 976, 990 (2019) ("[T]he Commissioner fails to identify any contemporaneous statement by the agency that would 'display awareness' that it was changing its position") (quoting *Fox*, 556 U.S. at 515); *Gomez-Sanchez* v. *Sessions*, 892 F.3d 985, 995 (2018) ("Given that the Board made no attempt to address the apparent inconsistencies between its earlier rule and the rule at issue here, we find its current interpretation to be unreasonable and thus decline to afford it deference."); *Cal. Pub. Utils. Comm'n* v. *FERC*, 879 F.3d 966, 978 (2018) ("[T]he orders on review were a departure from Order 679's terms and the longstanding policy it incorporates. Without any acknowledgment or explanation of that departure, the orders were arbitrary and capricious."). The Ninth Circuit firmly differentiates between *Fox*'s first requirement that the agency "display[] 'awareness that it is changing position'" and its separate requirement that the agency "provide[] 'good reasons' for the new policy." *Organized Vill. of Kake* v. *U.S. Dep't of Agric.*, 795 F.3d 956, 966 (2015) (en banc) (quoting *Fox*, 556 U.S. at 515-516); see also *id.* at 967.

The Second, Third, Fourth, and Ninth Circuits have the better of this argument. As this Court has explained, "a reasoned explanation is needed for

disregarding facts and circumstances that underlay or were engendered by the prior policy," particularly when the agency's prior policy "engendered serious reliance interests." *Encino Motorcars*, 136 S. Ct. at 2126 (quoting *Fox*, 556 U.S. at 515-516). Agencies are unlikely, and indeed unable, to provide that analysis if they adamantly deny a change has taken place.

This case proves the point. A number of commenters asked CMS for a transition period if it chose to adopt the new policy, much as CMS had provided for the 2008 regulation. 82 Fed. Reg. at 16,118. But the agency refused—on the ground that the 2017 "rule is providing clarification to existing policy." *Ibid.* The agency gave the same explanation in rejecting commenters' concern that the 2017 rule would unduly burden states and hospitals: "[t]his rule does not reflect a change in policy." *Ibid.*; see also *id.* at 16,121 ("Because this is not a change in policy, we do not anticipate that this final rule will have significant financial effects on state Medicaid programs" or "other providers").

This is not the first time the D.C. Circuit has shown sympathy for an agency that shows "reluctance to accept [a] court's interpretation of" the agency's prior positions—saying that "even a federal agency is entitled to a little pride." *Verizon* v. *FCC*, 740 F.3d 623, 636-637 (2014). But agencies do not get the last word over "what the law is," *Marbury* v. *Madison*, 5 U.S. 137, 177 (1803), even when the law in question is their own policy. See, *e.g.*, *Kisor* v. *Willkie*, 139 S. Ct. 2400, 2421 (2019); *Decker* v. *Nw. Envtl. Def. Ctr.*, 568 U.S. 597, 618 (2013) (Scalia, J., concurring in part and dissenting in

part). When, as here, the judiciary has authoritatively concluded that the agency is attempting to change its position, the agency must *both* "'display awareness that it is changing position' *and* 'show that there are good reasons for the new policy.'" *Encino Motorcars*, 136 S. Ct. at 2126 (emphasis added) (quoting *Fox*, 556 U.S. at 515). The court below relieved CMS of the first of these requirements—in conflict with four other courts of appeals—and this Court should grant review.

B. The D.C. Circuit's Cursory Review Of The Rule's Compatibility With The Statute Also Reflects Lower Court Disagreements And Warrants Review

In addition to looking past the agency's unacknowledged change in position, the court below went far beyond what *Chevron* permits in deferring to the agency's new interpretation of the DSH statute. Here too, the court of appeals parted ways with its fellow circuits and this Court's decisions, as well as the plain terms of the statute.

1. At the outset, the court of appeals tilted the scales in the agency's favor. It declined to perform a meaningful analysis of the statute's text under *Chevron* step one. In the court's words, "[b]ecause the delegation at issue here is express rather than implied, we have no need to search for statutory ambiguity." App., *infra*, 8a (internal citation omitted). "We skip straight to asking whether the Rule is reasonable." *Ibid.*

But this approach is unsound, especially where, as here, the *core dispute* is the *scope* of the statutory delegation. In particular, the parties disagree over whether authority to determine "costs incurred during the year of furnishing hospital services" permits CMS to identify certain types of *payments* that should be subtracted from the hospital's expenditures. 42 U.S.C. 1396r-4(g)(1)(A). Indeed, the lynchpin of the district court's *Chevron* step-one holding was that the delegation does *not* permit "the Secretary to redefine 'costs' to net out a third category of payments." App., *infra*, 53a. Judge Kethledge reached the same conclusion. *Tenn. Hosp. Ass'n*, 908 F.3d at 1049 (opinion concurring in the judgment) ("[N]othing in the phrase 'costs incurred * * * as determined by the Secretary' allows the agency to redefine 'costs' to include 'payments.' ").

Other courts appropriately recognize that *Chevron* step one is still mandatory—and occasionally dispositive—if there is a dispute over the scope of the agency's delegated authority. See, *e.g.*, *Succar* v. *Ashcroft*, 394 F.3d 8, 20, 23 (1st Cir. 2005) (holding a regulation invalid at *Chevron* step one despite an express delegation of discretion and explaining that "[w]hen an agency action is contrary to the scope of a statutory delegation of authority * * * that action must be invalidated by reviewing courts"); *Bona* v. *Gonzales*, 425 F.3d 663, 670-671 (9th Cir. 2005) (endorsing *Succar* and explaining that "[a]lthough Congress delegated to the Attorney General the discretionary authority to grant or deny an application for an adjustment of status, Congress did not delegate to the Attorney General

the discretion to choose who was *eligible to apply* for such relief") (internal citation omitted).

That is the correct approach, and the D.C. Circuit's abdication of its step-one responsibilities warrants review. *Chevron* explains that the first question, "*always*, is the question whether Congress has directly spoken to the precise question at issue." 467 U.S. at 842 (emphasis added); see also, *e.g.*, *Yellow Transp., Inc.* v. *Michigan*, 537 U.S. 36, 45-46 (2002) (proceeding through both *Chevron* steps even though "Congress [had] made an express delegation of authority"). By concluding otherwise, the court below improperly allowed the agency to jump ahead to a step-two analysis that, under D.C. Circuit precedent, is far more deferential to the agency. See, *e.g.*, *Vill. of Barrington* v. *Surface Transp. Bd.*, 636 F.3d 650, 665 (D.C. Cir. 2011) ("Unlike our *Chevron* step one analysis, our review at [step two] is 'highly deferential.' ") (citation omitted).

2. The court of appeals also gave short shrift to several canons of statutory construction, adopting an interpretation plainly at odds with the statute's terms and purposes.

First, in keeping with the D.C. Circuit's longstanding skepticism of the *expressio unius* canon in *Chevron* cases, the panel described that canon as a "feeble helper in an administrative setting." App., *infra*, 10a (citing *Adirondack Med. Ctr.* v. *Sebelius*, 740 F.3d 692, 697 (D.C. Cir. 2014); and *Cheney R.R. Co.* v. *ICC*, 902 F.2d 66, 68-69 (D.C. Cir. 1990)). The court has frankly acknowledged that this "canon operates differently in

[the court's] review of agency action than it does when [it is] directly interpreting a statute." *Van Hollen* v. *FEC*, 811 F.3d 486, 493 (D.C. Cir. 2016). The court has even said that *expressio unius* is "too thin a reed to support the conclusion that Congress has clearly resolved an issue." *Mobile Commc'ns Corp. of Am.* v. *FCC*, 77 F.3d 1399, 1405 (D.C. Cir. 1996) (brackets omitted) (quoting *Tex. Rural Legal Aid, Inc.* v. *Legal Servs. Corp.*, 940 F.2d 685, 694 (D.C. Cir. 1991)).

Other circuits, in contrast, rightly use the canon in *Chevron* cases, even when that means rejecting the agency's interpretation. See, *e.g.*, *Am. Land Title Ass'n* v. *Clarke*, 968 F.2d 150, 155 (2d Cir. 1992); *Waggoner* v. *Gonzales*, 488 F.3d 632, 636 (5th Cir. 2007); *Blandino-Medina* v. *Holder*, 712 F.3d 1338, 1345 (9th Cir. 2013). This conflict over the applicability of the *expressio unius* canon in *Chevron* cases independently warrants this Court's review.

In declining to apply *expressio unius*, the court of appeals deemed it unlikely that the omitted term—here, payments from third-party insurance companies—was excluded deliberately. App., *infra*, 10a. But the statute makes clear that Congress understood that some of the patients factoring into the DSH-cap calculation would be covered by private insurance, and yet directed that only payments from Medicaid should be deducted from a hospital's allowable costs. Congress specifically included in the calculation the costs for all patients who are "*eligible* for assistance under the State plan," rather than including only the costs for patients that actually receive Medicaid benefits. 42

U.S.C. 1396r-4(g)(1)(A) (emphasis added). In the Medicaid and Medicare settings, Congress and the courts have long recognized a distinction between eligibility and entitlement: "eligibility" refers to "qualification" for the benefit, while "entitlement" refers to a "right" to receive that benefit. *Jewish Hosp., Inc.* v. *Sec'y of Health & Human Servs.*, 19 F.3d 270, 274-275 (6th Cir. 1994); see also, *e.g.*, *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 987 (4th Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996); cf. *Ne. Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 20 (D.C. Cir. 2011) (Kavanaugh, J., concurring in the judgment).

The distinction between eligibility, on the one hand, and entitlement, on the other, is fundamental. Because Medicaid is the payer of last resort, *e.g.*, *Ark. Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268, 291 (2006), the primary reason a Medicaid-eligible patient may not be entitled to a benefit is because he or she has another source of medical coverage, such as private insurance. Thus, by focusing on Medicaid *eligibility* rather than entitlement, Congress expressly included into the calculation the costs for patients who qualify for Medicaid but receive no Medicaid benefits because they have private insurance. Yet despite this required inclusion of costs for Medicaid-eligible patients with private insurance, Congress prescribed the deduction of only the payments received from Medicaid, not private insurance. What CMS here treated as a bug in the system was designed by Congress as a feature.

If there were any doubt about whether Congress's inclusions and exclusions in the DSH statute were purposeful, it would be dispelled by the paragraph that immediately follows the one at issue here. In subsection (g)(2), Congress adopted a different formula to govern certain DSH payment adjustments during a transition period. This second formula expressly required an exclusion of "amounts received * * * from third party payors." 42 U.S.C. 1396r-4(g)(2)(A); see also SMD Letter, *supra*, at 4-5 (C.A. App. 516-517) (explaining the operation of this provision). Of course, "it is a general principle of statutory construction," including when agencies invoke *Chevron*, "that when Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Barnhart* v. *Sigmon Coal Co.*, 534 U.S. 438, 452 (2002) (internal quotation marks omitted) (quoting *Russello* v. *United States*, 464 U.S. 16, 23 (1983)).

But the D.C. Circuit refused to apply this canon of construction based on supposed differences between these two paragraphs in the same subsection. App., *infra*, 12a-13a. It also rejected petitioners' invocation of the canon against superfluity. *Id.* at 11a-12a.

And apart from openly refusing to rely on these three canons, the court of appeals disregarded another without comment. It ignored the undisputed evidence in the administrative record showing that CMS's new policy denies petitioners any DSH payment even though they are "deemed" to be DSH facilities by the

statute, and hence entitled to an "increase in the rate or amount of payment." 42 U.S.C. 1396r-4(a)(1)(B) and (b)(1)(A). In this way, the court of appeals flouted "the canon against reading conflicts into statutes" by allowing the 2017 rule to subvert an express statutory requirement. *Epic Sys. Corp.* v. *Lewis*, 138 S. Ct. 1612, 1630 (2018).

This Court has repeatedly described the canons of construction as important "tools of statutory construction" that should be used to gauge Congress's intentions before resorting to deference. *Chevron*, 467 U.S. at 843 n.9; see also, *e.g.*, *Epic Sys.*, 138 S. Ct. at 1630 ("Where * * * the canons supply an answer, '*Chevron* leaves the stage.'") (citation omitted). Deference is reserved for situations in which the "legal toolkit is empty and the interpretive question still has no single right answer." *Kisor*, 139 S. Ct. at 2415. The court of appeals did not follow that path here. Instead, it seemingly looked for reasons not to find the statute's meaning so that it could defer to CMS's (currently) preferred policy instead.

3. As Judge Kethledge explained in finding CMS's new policy inconsistent with the statute, "[a]gencies have a strong incentive (namely, *Chevron*) to make statutory language seem more complicated than it actually is." *Tenn. Hosp. Ass'n*, 908 F.3d at 1050 (opinion concurring in the judgment). Here, "the statutory formula is straightforward: costs, minus certain clearly enumerated payments, equals the net of a hospital's 'uncompensated costs.'" *Ibid.* CMS clearly "has discretion to prescribe, in the sort of minute detail that

calls upon its expertise, the specific *outlays* that count towards a hospital's 'costs incurred' for a particular service." *Id.* at 1049. But that discretion does not extend to defining the "payments" subtracted from those "costs" in determining the "net" that constitutes the hospital's DSH limit. *Ibid.*

Still less does that discretion extend to defining "costs" to eliminate an express statutory requirement and undermine the statute's evident purpose. As just explained, the children's hospitals in this case are "deemed" to be DSH facilities based on their extremely high rates of inpatient care for Medicaid-eligible patients, and accordingly are entitled to "increase[d]" payment. 42 U.S.C. 1396r-4(a)(1)(B) and (b)(1)(A). But the 2017 rule denies them any such increase, and in the process jeopardizes their ability to provide vital healthcare to a population of patients about whom Congress was especially concerned. See also pp. 36-37, *infra*.

4. Alternatively, if the D.C. Circuit did apply *Chevron* correctly, this is an appropriate case "to reconsider * * * the premises that underlie *Chevron*." *Pereira* v. *Sessions*, 138 S. Ct. 2105, 2121 (2018) (Kennedy, J., concurring). This case illustrates a number of problems with the doctrine that Members of the Court have already identified.

Consider first CMS's dramatic change in position over whether private insurance payments factor into the DSH-cap calculation—a change in position that the agency refuses even to acknowledge. The agency's

ability to undertake such a change and command the courts' deference is unsupported by traditional rules of statutory interpretation. Under those rules, courts should "decline[] to give weight to late-arising or inconsistent statutory interpretations by the Executive." *Baldwin* v. *United States*, 140 S. Ct. 690, 695 (2020) (Thomas, J., dissenting from denial of certiorari). *Chevron* and its progeny nevertheless give agencies enormous power to change their stated interpretation of a statute to promote whatever policies they happen to prefer at the time—regardless of whether courts have construed the statute differently. The *Chevron* framework infringes on the judicial power by making agencies "free to invent new (purported) interpretations of statutes and then requir[ing] courts to reject their own prior interpretations." *Ibid.*; see also *Gutierrez-Brizuela* v. *Lynch*, 834 F.3d 1142, 1150 (10th Cir. 2016) (Gorsuch, J., concurring) ("[T]his means a judicial declaration of the law's meaning in a case or controversy before it is not 'authoritative,' but is instead subject to revision by a politically accountable branch of government.") (internal citation omitted).

Even when agencies are consistent, *Chevron* gives them "a potent brew of executive, legislative, and judicial power." *City of Arlington* v. *FCC*, 569 U.S. 290, 327 (2013) (Roberts, C.J., dissenting). That includes power to determine the scope of the agency's own authority, "leav[ing] it to the agency to decide when it is in charge." *Ibid.* Here, the agency did not even have to overcome de novo step-one review. App., *infra*, at 8a.

And in all cases, again including this one, courts are pressured toward "reflexive deference" instead of rigorous adherence to traditional tools of statutory construction. *Pereira*, 138 S. Ct. at 2120 (Kennedy, J., concurring); Kent Barnett & Christopher J. Walker, Chevron *in the Circuit Courts*, 116 Mich. L. Rev. 1, 30-33 (2017) (finding that, between 2003 and 2013, agency interpretations prevailed in 77.4% of circuit court cases decided under *Chevron*, compared to only 53.6% of cases in which *Chevron* did not apply, and that circuit courts proceeded to step two 70.0% of the time).

All this is hard to reconcile with the constitutional separation of powers. The judiciary's interpretation of the law is supposed to constrain executive agencies no less than any other litigants. See, *e.g.*, *Pereira*, 138 S. Ct. at 2121 (Kennedy, J., concurring); *City of Arlington*, 569 U.S. at 327 (Roberts, C.J., dissenting); *Baldwin*, 140 S. Ct. at 692 (Thomas, J., dissenting from denial of certiorari); *Gutierrez-Brizuela*, 834 F.3d at 1154 (Gorsuch, J., concurring). For the same reason, *Chevron* also strays from the Administrative Procedure Act, which obligates *courts* to "interpret * * * statutory provisions" and "decide all relevant questions of law." 5 U.S.C. 706; see *Baldwin*, 140 S. Ct. at 692 (Thomas, J., dissenting from denial of certiorari); *Kisor*, 139 S. Ct. at 2432-2433 (Gorsuch, J., concurring in the judgment); Brett M. Kavanaugh, *Fixing Statutory Interpretation*, 129 Harv. L. Rev. 2118, 2150 (2018).

Nor does *Chevron* even have the virtue of administrability. The move from steps one to two generally turns on whether a particular statute is ambiguous.

But "there is often no good or predictable way for judges to determine whether statutory text contains 'enough' ambiguity to cross the line." Kavanaugh, 129 Harv. L. Rev. at 2136. "[D]ifferent judges have wildly different conceptions of whether a particular statute is clear or ambiguous," making the *Chevron* doctrine "indeterminate" and maybe even "antithetical to the neutral, impartial rule of law." *Id.* at 2152, 2154.

Besides, as this case exemplifies, lower courts cannot even agree on basic ground rules, such as whether agencies need to acknowledge their changes in position, whether express delegations of authority permit skipping step one, and whether basic canons of construction apply with their usual force. This case is hardly unrepresentative. Both defenders and critics of *Chevron* agree the doctrine is a mess.[4] The Court should clean it up or abandon it altogether.

C. The Issues Presented Are Exceptionally Important

1. Whether and when courts should defer to agency interpretations is unquestionably an issue of

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[4] *E.g.*, Nicholas R. Bednar & Kristin E. Hickman, Chevron*'s Inevitability*, 85 Geo. Wash. L. Rev. 1392, 1398 (2017) ("[J]urisprudential inconsistency has produced a ridiculous degree of doctrinal complexity that provides endless fodder for discussion (and discontent) about *Chevron*."); Jack M. Beermann, Chevron *at the Roberts Court: Still Failing After All These Years*, 83 Fordham L. Rev. 731, 750 (2014) (arguing that *Chevron* has produced "an incoherent, imprecise, and arbitrarily applied set of principles for reviewing agency statutory construction").

tremendous importance. There is reason to wonder whether the lower courts and this Court still approach this fundamental issue the same way.

In the courts of appeals, even counting only published decisions, agencies win many dozens of cases each year thanks to *Chevron*. See Barnett & Walker, 116 Mich. L. Rev. at 32. But agencies have not had such success of late in this Court, which apparently has not accorded *Chevron* deference to a single agency interpretation since 2016.[5] Even when agencies' views have prevailed, it has not been because of *Chevron*. See *Coventry Health Care of Mo., Inc.* v. *Nevils*, 137 S. Ct. 1190, 1198 n.3 (2017); *BNSF Ry. Co.* v. *Loos*, 139 S. Ct. 893, 908-909 (2019) (Gorsuch, J., dissenting).

Given this string of decisions, one Member of this Court recently concluded "that the Court, for whatever reason, [was] simply ignoring *Chevron*" and wondered whether "the Court has overruled *Chevron* in a secret decision." *Pereira*, 138 S. Ct. at 2129 (Alito, J., dissenting). If the Court believes that the doctrine should be reconsidered, it should say so. Otherwise, lower courts will continue deciding cases and controversies based

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[5] See *Cuozzo Speed Techs., LLC* v. *Lee*, 136 S. Ct. 2131, 2144 (2016) (deferring under *Chevron*); cf. *Smith* v. *Berryhill*, 139 S. Ct. 1765, 1778 (2019) (declining to defer under *Chevron*); *Sturgeon* v. *Frost*, 139 S. Ct. 1066, 1080 n.3 (2019) (same); *Pereira*, 138 S. Ct. at 2113 (same); *Wis. Cent. Ltd.* v. *United States*, 138 S. Ct. 2067, 2074 (2018) (same); *Epic Sys.*, 138 S. Ct. at 1629-1630 (same); *SAS Inst., Inc.* v. *Iancu*, 138 S. Ct. 1348, 1358 (2018) (same); *Dig. Realty Tr., Inc.* v. *Somers*, 138 S. Ct. 767, 782 (2018) (same); *Esquivel-Quintana* v. *Sessions*, 137 S. Ct. 1562, 1572 (2017) (same); *Encino Motorcars*, 136 S. Ct. at 2127 (same).

on their own understandings of how *Chevron* works, even if those understandings conflict with the understanding of a majority of this Court.

2. This case underscores that hugely important policies hang in the balance. The D.C. Circuit's ruling here allows CMS to dramatically alter a congressional mandate. Congress obligated states to make an "increase in the rate or amount of payment" to DSH facilities because it did not want hospitals to run away from Medicaid patients. 42 U.S.C. 1396r-4(a)(1).

Petitioners have long run toward these patients. They often treat more Medicaid-eligible patients than any other facilities in their respective states. But CMS's 2017 rule has the effect of cutting them out of the DSH program because some Medicaid-eligible children have private insurance. Instead of living up to the DSH program's promise of having Medicaid compensate DSH facilities for Medicaid's notoriously low rates, the 2017 rule relies on private insurance to carry that burden. But the administrative record in this case shows that this is no satisfactory solution. Even with such private insurance payments, children's hospitals like petitioners suffer enormous net losses treating Medicaid patients. Taking away tens of millions of dollars in DSH payments will make their financial situations much worse, limiting their ability to continue engaging in life-saving care and research to protect the Nation's children. Rather than letting

CMS pursue this unlawful policy, the Court should grant review and reverse.

CONCLUSION

The petition for a writ of certiorari should be granted.

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