No. _____

In the Supreme Court of the United States

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, CARO CENTER, KALAMAZOO PSYCHIATRIC HOSPITAL, AND NORTHVILLE PSYCHIATRIC HOSPITAL, PETITIONERS

v.

KATHLEEN SEBELIUS AND CENTER FOR MEDICARE & MEDICAID SERVICES

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Centers for Medicare and Medicaid Services correctly calculated psychiatric-hospital reimbursement payments in fiscal years 2003 through 2008 based on a permissible interpretation of 42 U.S.C. § 1395ww(b)(3)(A)(ii) and the agency's implementing regulation.

2. Whether the Court should revisit the rule articulated in *Auer* v. *Robbins*, 519 U.S. 452, 461 (1997), of deferring to an agency's interpretation of its own regulations.

PARTIES TO THE PROCEEDING

There are no parties to the proceedings other than those listed in the caption. The Petitioners are the Michigan Department of Community Health, the Caro Center, Kalamazoo Psychiatric Hospital, and Northville Psychiatric Hospital. The Respondents are Kathleen Sebelius, Secretary of Health and Human Services, and the Centers for Medicare and Medicaid Services.

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The opinion of the Sixth Circuit Court of Appeals, App. 1a–33a, is not reported but is available at 2012 WL 3608610. The opinion of the District Court, App. 34a–48a, is not reported.

JURISDICTION

The Sixth Circuit Court of Appeals' decision was entered on August 23, 2012, App. 1a–33a. Petitioner invokes this Court's jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1395ww(b)(3) states, in pertinent part:

(A) Except as provided in subparagraph (C) and succeeding subparagraphs, and in paragraph (7)(A)(ii), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

> (i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of this section) recognized under this subchapter for such hospital for the preceding 12-month cost reporting period, and
>
> (ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

* * *

(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

(ii) (I) In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996, as adjusted under clause (iii).

(II) The Secretary shall update the amount determined under subclause (I), for each cost reporting period after the cost reporting period described in such subclause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

(III) For cost reporting periods beginning during each of fiscal years 1999 through 2002, subject to subparagraph (J), the Secretary shall update such amount by a factor equal to the market basket percentage increase.

* * *

(J) For cost reporting periods beginning during fiscal year 2001, for a hospital described in subsection (d)(1)(B)(iv) of this section—

(i) the limiting or cap amount otherwise determined under subparagraph (H) shall be increased by 2 percent; and

(ii) the target amount otherwise determined under subparagraph (A) shall be increased by 25 percent (subject to the limiting or cap amount determined under subparagraph (H), as increased by clause (i)).

* * *

Before 2005, 42 C.F.R. § 413.40(c)(4) stated:

Target amounts. The intermediary will establish a target amount for each hospital. The target amount for a cost reporting period is determined as follows:

(i) Except as provided in paragraph (c)(4)(iv) of this section, and subject to the provisions of paragraph (c)(4)(iii) of this section, for the first cost reporting period to which this ceiling applies, the target amount equals the hospital's allowable net inpatient operating costs per case for the hospital's base period increased by the update factor for the subject period.

(ii) Subject to the provisions of paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period,

unless the provisions of paragraph (c)(5)(ii) of this section apply.

(iii) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, 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 cost reporting periods beginning during fiscal year 1998, the 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital) for cost reporting periods ending during FY 1996, increased by the applicable market basket percentage up to the first cost reporting period beginning on or after October 1, 1997.

(2) For cost reporting periods beginning during fiscal year 1999, the amount determined under paragraph (c)(4)(iii)(B)(1) of this section, increased by the market basket percentage up through the subject period . . . .

(3) For cost reporting periods beginning during fiscal year 2000 . . .

(4) For cost reporting periods beginning during fiscal years 2001 and 2002 . . .

* * *

After CMS's 2005 amendment, 42 C.F.R. § 413.40(c)(4) stated, in pertinent part (changes in *italics*):

(iii) *For cost reporting periods beginning on or after October 1, 1997 through September 30, 2002*, in the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of the amounts specified in paragraph (c)(4)(iii)(A) or paragraph (c)(4)(iii)(B) of this section.

INTRODUCTION

This dispute concerns the manner in which the federal government reimbursed psychiatric hospitals for care they provided to Medicare beneficiaries after the 2002 expiration of a temporary cap on reimbursed amounts. Before Congress enacted the temporary cap in 1997, the mechanism for funding psychiatric hospitals enrolled in Medicare was a reasonable-cost basis. Costs were established in a hospital's first full year of operation, which created a baseline known as the "target amount." Each year, the target amount was adjusted upward to account for inflationary factors.

In 1997, Congress closed a budget gap by imposing a temporary reimbursement cap for fiscal years 1998 through 2002. During that time, the statutory scheme continued to require an annual determination of a psychiatric hospital's "target amount." But the hospital could receive no more than the capped amount.

In 1999, Congress directed the Centers for Medicare & Medicaid Services (CMS) to implement a new scheme, the prospective-payment system, beginning in fiscal year 2003. But when that time arrived, CMS was not yet ready to implement the new system and instead left the now uncapped target-amount system in place. The plain language of the relevant statutory provisions and CMS's own interpretive regulation indicated that the 2002 target amount should be updated and used to calculate reimbursement in 2003. Accordingly, CMS's Fiscal Intermediary, National Government Services, approved Petitioners' reimbursement requests based on the updated target amount.

But CMS overrode its Intermediary's approval, re-interpreted CMS's own regulation, and used the 2002 *capped* amount as the 2003 *target* amount. The result was that the temporary cap—which no longer existed—continued to have an "echo effect" that reduced psychiatric-hospital reimbursement by millions of dollars, using rates that treated the capped amount as the baseline rather than the inflation-adjusted target amount. And then, in 2005, CMS tried to justify its interpretation *post hoc* by amending the regulation.

CMS's re-interpretation has hurt psychiatric hospitals, which set budgets and made decisions based on the statutory and regulatory provisions actually in effect from 2003 to 2006. The re-interpretation has also divided the federal courts, including a split between the Sixth Circuit's decision here and similar decisions from the Third Circuit and the Eastern District of Louisiana, on the one hand, and decisions of the Fifth Circuit and the Eastern District of Arkansas, on the other. And that multi-circuit conflict also raises squarely the question Justice Scalia asked in *Talk America*, *Inc.* v. *Michigan Bell Tel.*, 131 S. Ct. 2254 (2011): whether the Court should reconsider the practice of giving *Auer* deference, see *Auer* v. *Robbins*, 519 U.S. 452 (1997), to an agency's interpretation of its own regulations. *Talk America*, 131 S. Ct. at 2265–66 (Scalia, J. concurring) ("We have not been asked to reconsider *Auer* in the present case. When we are, I will be receptive to doing so."). For all these reasons, certiorari is warranted.

STATEMENT OF THE CASE

A. Psychiatric-hospital reimbursement from 1982 to 1998

Congress enacted the Tax Equity and Fiscal Responsibility Act in 1982. Pub. L. No. 97-248. Under the act, the federal government reimbursed a psychiatric hospital on a reasonable-cost basis up to a ceiling equal to the hospital's number of Medicare discharges times a "target amount." 42 U.S.C. § 1395ww(b)(1)(A). The statute established a base year "target amount" tied to the hospital's operating costs, to be updated annually by inflationary factors:

> [T]he term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period –
>
> > (i) in the case of the *first* such reporting period for which this subsection is in effect, the allowable *operating costs* of inpatient hospital services . . . for such hospital for the preceding 12-month cost reporting period, and
> >
> > (ii) in the case of a *later* reporting period, *the target amount for the preceding 12-month cost reporting period*, *increased by the applicable percentage increase* under subparagraph (B) for that particular cost reporting period. [42 U.S.C. § 1395ww(b)(3)(A) (emphasis added).]

Thus, a hospital's target amount was always derived from its base-year operating costs.

CMS implemented § 1395ww(b)(3)(A) by promulgating 42 C.F.R. § 413.40. Subsection 413.40(c)(4), "Target Amount," contained sub-provisions (i) and (ii) that paralleled § 1395ww(b)(3)(A)'s sub-provisions (i) and (ii), i.e., calculating a hospital's target amount based on operating costs.

B. The "capped" years, 1998 to 2002

In 1997, Congress enacted the Balanced Budget Act, Pub. L. No. 105-33, which modified the target-amount system by imposing a temporary, five-year cap on psychiatric-hospital reimbursement for fiscal years 1998 to 2002. 42 U.S.C. § 1395ww(b)(3)(H)(i)–(ii). The 1997 act did not alter subsection (b)(3)(A), which requires the annual target-amount adjustment. Instead, it required an *additional* calculation to be made during fiscal years 1998 through 2002 in a newly created subsection (b)(3)(H), to arrive at an amount Congress defined as "the limiting or cap amount," 42 U.S.C. § 1395ww(b)(3)(J). The cap amount equaled the 75th percentile of the target amount for hospitals within the same class as the subject hospital for the preceding year. If a hospital's target amount exceeded the 75% cap, the federal government reimbursed the hospital at the lower, capped rate:

> (H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), *for a cost reporting period beginning during fiscal years 1998 through 2002*, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

> (ii)(I) In the case of a hospital or unit that is within a class of hospital described in clause (iv), *the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class* for cost reporting periods ending during fiscal year 1996, as adjusted under clause (iii).
>
> (II) The Secretary shall update the amount determined under subclause (I), for each cost reporting period after the cost reporting period described in such subclause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.
>
> (III) For cost reporting periods beginning during each of fiscal years 1999 through 2002, subject to subparagraph (J), the Secretary shall update such amount by a factor equal to the market basket percentage increase. [42 U.S.C. § 1395ww(b)(3)(H) (emphasis added).]

To implement the cap, CMS amended 42 C.F.R. § 413.40(c)(4) in two ways. First CMS, modified subsection (c)(4)(ii), the provision that updates a hospital's target amount annually, to make it "*subject to* the provisions" of a new paragraph (c)(4)(iii). Second, tracking § 1395ww(b)(3)(H), CMS promulgated in (c)(4)(iii) a requirement that set the target amount at "the lower of" (A) the hospital's base-period costs, updated by the applicable inflationary factors, and (B) a fiscal-year specific 75% cap:

(A) The hospital-specific target amount.

> (1) In the case of all hospitals and units . . . the hospital-specific target amount is the *net allowable costs in a base period increased by the applicable update factors*.
>
> . . . .

(B) One of the following for the applicable cost reporting period—

> (1) For cost reporting periods *beginning during fiscal year 1998*, the 75th percentile of target amounts for hospitals in the same class . . . .
>
> (2) For cost reporting periods *beginning during fiscal year 1999*, the amount determined under paragraph (c)(4)(iii)(B)(1) of this section, increased by the market basket percentage up through the subject period . . . .
>
> (3) For cost reporting periods *beginning during fiscal year 2000* . . . .
>
> (4) For cost reporting periods *beginning during fiscal years 2001 and 2002* . . . . [42 C.F.R. § 413.40(c)(4)(iii).]

Importantly, each of the sub-provisions in paragraph (B) is tied to a specific year of the five-year temporary cap. So when the cap expired in fiscal year 2003, there was nothing to be calculated under (c)(4)(iii)(B); the only choice was a subsection (A), cost-based calculation.

C. Target amount after 2002

In 1999, Congress enacted the Medicare, Medicaid, and SCHIO Balanced Budget Refinement Act, directing CMS to set psychiatric-hospital payments post 2002 based on a prospective payment system. Pub. L. No. 106-113, 113 Stat. 1501 (1999). But CMS was unable to implement the 1999 act until several years later. Thus, for fiscal years 2003, 2004, 2005, and 2006, CMS and providers continued to use the now-uncapped target-amount ceiling in § 1395ww(b)(3) and CMS's regulation § 413.40(c)(4).

D. CMS's 2002 interpretation

National Government Services, CMS's Fiscal Intermediary,[1] gave Petitioners the "target amount" figures that Petitioners used to make their Medicare reimbursement calculations for fiscal years 2003 and 2004. These target amounts, which came directly from CMS's own contractor, did not include the cap and calculated the target amount correctly as though the cap had never been in place. National Government Services approved Petitioners' reimbursement requests for fiscal years 2003 and 2004 based on these figures.

National Government Services performed its analysis based on its reading of CMS's guidance in the Federal Register published August 1, 2002. In response to a comment seeking clarification regarding how to

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[1] The title "Fiscal Intermediary" was created and defined by 42 U.S.C. § 1395k but has since been supplanted by the title "Medicare administrative contractor." CMS contracted with Intermediaries to administer the complex Medicare reimbursement system.

calculate the fiscal year 2003 (i.e., post-cap) target amount, CMS referred solely to its regulation 413.40(c)(4)(ii). 67 Fed. Reg. 50,104 (Aug. 1, 2002). Recall that this provision directed hospitals to update their target amount annually by the statutory inflation factors. 42 C.F.R. § 413.40(c)(4)(ii). The cap-implementing provision appeared in regulation 413.40(c)(4)(*iii*), which, by its own terms, applied only to fiscal years 1998 to 2002. Later, in the same 2002 guidance statement, CMS made clear that the cap no longer existed, and psychiatric hospitals should return to the target-amount approach:

> Each [psychiatric] hospital-specific target amount is adjusted annually, at the beginning of each hospital's cost reporting period, by an applicable update factor. Under existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), effective for cost reporting period beginning during FY 2003, payments to existing excluded hospitals and hospital units *will no longer be subject to a 75th percentile cap*. [67 Fed. Reg. 50,133 (emphasis added).]

Nowhere did CMS suggest that the temporary cap would continue to exist by becoming the fiscal year 2002 target amount and artificially lowered the ceiling for all future reimbursement years. Quite the opposite, CMS doubled down on its interpretation in 2004:

> [E]ffective for cost reporting periods beginning on or after October 1, 2002, payments to [psychiatric hospitals] are *no longer subject to caps on the target amounts*. In accordance with existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, these excluded hospitals and

> hospital units continue to be paid on a *reasonable cost basis* and payments are based on their Medicare inpatient operating costs, not to exceed the ceiling. The ceiling will be computed *using the hospital's or unit's target amount from the previous cost reporting period* updated by the rate-of-increase specified in § 413.40(c)(3)(viii) of the regulations and then multiplying this figure by the number of Medicare discharges. [69 Fed. Reg. 48,916, 49,189 (Aug. 11, 2004) (emphasis added).]

So not only did CMS disclaim any continuation of the temporary reimbursement cap, it affirmatively explained that reimbursement was back to a "reasonable cost basis" system. That concept is quite different than reimbursement based on a capped amount.

E. CMS's post-2002 interpretation

During a subsequent desk audit, CMS denied Petitioners' reimbursement requests and adjusted payment to reflect use of the expired cap as the 2003 target amount. Confused by this action, National Government Services sought additional guidance from CMS. Michael Bernel, manager of the Reimbursement and Policy section of National Government Services' Provider Audit Department (and therefore CMS's agent), expressed his frustration with the new, cap-extending position CMS was taking:

> I can certainly go back to CMS on this issue. However, the specifics detailed in this thread were previously addressed and mirrored by CMS and BCBSA (one example attached . . .

> 12/2004). Frankly, *we are in agreement that there does not appear to be any direct regulatory or official CMS documented policy* (change request, JSM) *in support of [CMS's new] position* and yes, the national cap in effect becomes the provider's new TEFRA rate, if they were hit in the last year. . . .
>
> It appears that CMS is posturing itself for the onslaught of group appeals expected in implementing this [new] policy. [Pet'rs' Summ. J. Br., Ex. D, attachment, p. 11 (emphasis added).]

Indeed, even in this litigation, National Government Services has expressed its belief that CMS's position is at odds with the statute and the Federal Register language. Pet'rs' Summ. J. Br., Ex. D., p. 2, Resp. to Interrog. #3.

In the face of mounting hospital criticism, CMS amended subsection (c)(4)(iii) in 2005 to expressly limit the *entire* subsection (not just that portion of the subsection referencing the capped amounts) to "cost reporting periods beginning on or after October 1, 1997 through September 30, 2002." 42 C.F.R. § 413.40(c)(4)(iii) (effective Oct. 1, 2005). CMS said the amendment was necessary to "clarify the language in § 413.40(c)(4)(iii) [ ] to emphasize that because § 413.40(c)(4)(iii) was no longer applicable for cost reporting periods beginning on or after October 1, 2002 . . . the target amount for FY 2003 would be the cap amount paid in FY 2002, updated to FY 2003." 70 Fed. Reg. 47,278, 47,465 (Aug. 12, 2005).

F. Proceedings below

Petitioners appealed CMS's decision to the Provider Reimbursement Review Board, as 42 U.S.C. § 1395oo(a) provides. The Board granted the Providers' request for expedited judicial review.

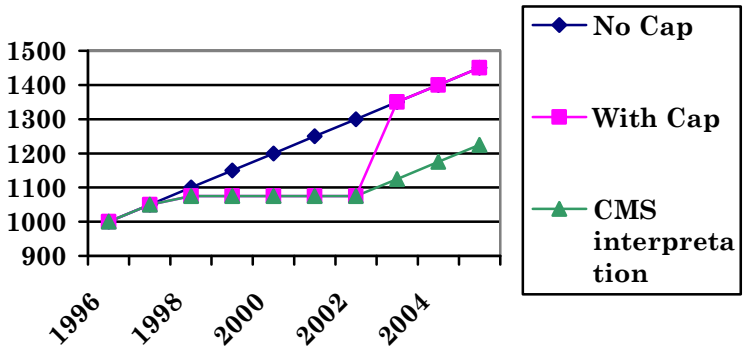
Petitioners sued CMS, and the parties filed cross-motions for summary judgment. The district court granted CMS's motion, holding that the relevant statutory provision unambiguously based the 2003 target amount on the previous year's target amount (updated for inflation), and that the 2002 target amount was the capped amount, rather than base year figure updated to the present day. App. 42a–47a. Alternatively, even if the statute was ambiguous, CMS's regulations were reasonable under *Chevron U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), and entitled to deference, as was CMS's interpretation of those regulations. App. 47a.

The Sixth Circuit affirmed all aspects of the district court's ruling. App. 1a–33a. In so holding, the Sixth Circuit noted that its first conclusion—that the statutory language unambiguously supports CMS's position—was the same conclusion reached by the Third Circuit in *Ancora Psychiatric Hosp.* v. *Secretary of the U.S. HHS*, 417 F. App'x 171 (3d Cir. 2011), and the Eastern District of Louisiana in *Chalmette Medical Center, Inc.* v. *U.S. HHS*, 2009 U.S. Dist. LEXIS 75819 (E.D. La. Aug. 10, 2009). But the court also recognized that its holding was "at odds" with the Fifth Circuit's decision in *Hardy-Wilson Memorial Hospital* v. *Sebelius*, 616 F.3d 449 (2010), and the Eastern District of Arkansas' opinion in *Arkansas State Hospital* v.

Leavitt, 2008 WL 4531714 (E.D. Ark. Oct. 8, 2008). App. 15a–16a, 20a–21a.

Also in conflict with the Fifth Circuit's *Hardy-Wilson* decision is the Sixth Circuit's second conclusion—that courts should defer to CMS's interpretation of its own regulations. App. 22a–33a. As the Fifth Circuit explained, if "CMS intended its regulation in subsection (c)(4)(iii) to apply only from 1998 to 2002, it should have expressly limited the time period of the whole section, not just subjection (c)(4)(iii)(B)." 616 F.3d at 460.

The Sixth Circuit's holding approved CMS's artificially low reimbursement approach for fiscal years 2003 through 2006. Depicted graphically, the CMS approach shows a (hypothetical) reimbursement level (in thousands of dollars) that continues to "echo" the cap that expired in 2005:



REASONS FOR GRANTING THE PETITION

I. The petition should be granted to resolve a circuit conflict regarding § 1395ww(b)(3)(A).

The first question presented is whether the plain language of § 1395ww(b)(3)(A) contemplates unambiguously that the final "capped" reimbursement year in 2002 becomes the basis for calculating a psychiatric hospital's "target amount" for fiscal year 2003. The Sixth Circuit said yes, following the Third Circuit in *Ancora Psychiatric Hospital* and the Eastern District of Louisiana in *Chalmette Medical Center*. App. 15a–16a. These courts start with § 1395ww(b)(3)(A)(ii), which says that a hospital's "target amount" equals "the target amount for the preceding 12-month reporting period," increased by inflationary factors. Under the 1997 Balanced Budget Act, the target amount for 2002 was capped at the 75th percentile of target amounts for all hospitals in the same class of providers. 42 U.S.C. §1395ww(b)(3)(H). Thus, these courts have concluded, the admittedly temporary reimbursement cap in effect from 1998 to 2002 had an irreversible "echo effect" that continued indefinitely after the cap expired.

In contrast, the Fifth Circuit in *Hardy-Wilson* and the Eastern District of Arkansas in *Arkansas State Hospital* read the same statutory language and concluded it was ambiguous. *Hardy-Wilson*, 616 F.3d at 457 ("Because neither side is able to demonstrate that Congress unambiguously spoke to the precise issue of how to calculate the target amount in 2003, 2004, and 2005, we find that under the first step of *Chevron* analysis, the statute is ambiguous."); *Ark. State Hosp.*, 2008 WL 4531714, at *4–5 (describing the

statute as "somewhat unclear . . . as to the factors to be taken into account in calculating the target amounts after . . . 2002."). In fact, to the extent the statute is unambiguous, it is in *Petitioners'* favor, not CMS's.

Subsection (b)(3)(A)(i) creates a base year "target amount" based on a hospital's actual operating costs. Subsection (b)(3)(A)(ii) then defines the target amount for later years with reference to "the preceding 12-month cost reporting period." Subject to the temporary reimbursement cap, (b)(3)(A)(ii) inextricably links subsequent target amounts to the baseline, which is itself tied to operating costs.

Congress did not intend to change that relationship when it created the temporary, five-year reimbursement cap in the 1997 Balanced Budget Act. Congress did not even delete the mandatory calculation in (b)(3)(A)(ii), but instead created a second, supplemental calculation in § 1395ww(b)(3)(H), denominated "the limiting or cap amount." 42 U.S.C. § 1395ww(b)(3)(J). It does not make sense to equate subsection (b)(3)(A)(ii)'s "target amount" with § 1395ww(b)(3)(H)'s "cap amount." When read in context, it is plain that once the temporary cap expired, the applicable "target amount" was that defined by subsection (b)(3)(A). Indeed, CMS's own regulations required cost-based target amounts for non-capped years. 42 C.F.R. § 413.40(c)(4)(iii)(A).

The Third and Sixth Circuits' reading thwarts congressional intent. No one disputes that Congress intended the reimbursement cap to be temporary, expiring in 2002. Yet the Third and Sixth Circuits' interpretation has the effect of perpetuating the cap indefinitely. Under that interpretation, "Congress

could have achieved the same result by enacting [a cap] for only a single year. But it did not do so. Rather, it imposed caps for a limited time period of five years." *Hardy-Wilson*, 616 F.3d at 456. That is because Congress believed the cap—and its effects—would end in 2002.

The Third and Sixth Circuits' reading is also illogical. If a psychiatric hospital opened in 2003, its baseline target amount would be set according to subsection (b)(3)(A)(i), and subsequent years would flow from that baseline without reference to the temporary reimbursement cap. 42 U.S.C. § 1395ww(b)(3)(A)(ii). But a psychiatric hospital that opened in 2002 would forever be saddled with the temporary 75th-percentile cap as its baseline. There is no principled basis in the statutory language for such differing outcomes, yet that is precisely the outcome of the Third and Sixth Circuits' interpretation.

The end result of the conflict is that psychiatric hospitals are subjected to differing reimbursement rates depending on their location. If Petitioners were located in the Fifth Circuit, rather than the Sixth, there is no question that they would have received the full amount of their Medicaid reimbursement in 2003, 2004, and 2005. And since only this Court can resolve that conflict, certiorari is warranted.

II. The petition should be granted to resolve a circuit conflict regarding the meaning of 42 C.F.R. § 413.40(c)(4).

The Third and Sixth Circuits also part ways with the Fifth Circuit in how they interpret CMS's "clarifying" regulation, 42 C.F.R. § 413.40(c)(4).

CMS first promulgated 42 C.F.R. § 413.40(c)(4) in 1983, see 48 Fed. Reg. 39,413, 39,417–19 (Aug. 30, 1983), and as noted above, the regulation tracks exactly §1395ww(b)(3)(A)(i) and (ii). "For the first cost reporting period to which this ceiling applies, the target amount equals the hospital's allowable net inpatient operating costs per case for the hospital's base period increased by the update factor for the subject period." 42 C.F.R. § 413.40(c)(4)(i). "For subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by" inflationary factors. 42 C.F.R. § 413.40(c)(4)(ii).

In response to the 1997 imposition of the temporary reimbursement cap, CMS added subpart (iii) to regulation 413.40(c)(4), which began: "In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of the amounts specified in paragraphs (c)(4)(iii)(A) or (c)(4)(iii)(B)."

Subsection (c)(4)(iii)(A) was the same cost-based approach to calculating the target amount that had been in place since 1982. 42 C.F.R. § 413.40(c)(4)(iii)(A) ("the hospital-specific target amount is the *net allowable costs* in a base period increased by the applicable update factors.") (emphasis added).

Subsection (c)(4)(iii)(B) allowed CMS to apply the lower, 75th-percentile cap "for the applicable cost reporting period," defined as the 1998, 1999, 2000, 2001, and 2002 fiscal years. Beginning in fiscal year 2003, there was nothing to be calculated under (c)(4)(iii)(B); the only choice was a subsection (A) cost-based calculation.

CMS could only get around this plain language by arguing that subsection (c)(4)(iii) no longer applied after 2002. In other words, CMS treated the "subject to" language in (c)(4)(ii) as having expired after 2002. But as the Fifth Circuit explained, the "subject to" qualifier in subsection (c)(4)(i) and (ii) "is an unambiguous requirement that the target amount be calculated according to subsection (c)(4)(iii), and only subsection (c)(4)(iii)." *Hardy-Wilson*, 616 F.3d at 460. And "[a]fter the caps expired in 2002, the *only* way to calculate reimbursements was the 'hospital-specific target amount' under (c)(4)(iii)(A) because (c)(4)(iii)(B), *by its terms*, no longer applied." *Id*. (emphasis added).

Rather than apply the plain language of CMS's regulation, the Sixth Circuit here deferred to CMS's interpretation of that regulation in this litigation. App. 29a ("This dispute requires us to review the Agency's interpretation of its own regulation, which as indicated *supra*, is entitled to a 'highly deferential' review to see only if the Agency decision is 'arbitrary, capricious, an abuse of discretion, or otherwise not in accord with law.'"). Concluding that the Agency's litigation position satisfied this low bar, the Sixth Circuit deferred to it, noting that "[p]articularly broad deference is warranted when a regulation concerns a complex and highly technical regulatory program such as Medicare reimbursements to psychiatric hospitals." App. 33a.

As explained in Part III, *infra*, there are numerous reasons to reconsider this Court's traditional deference to an agency's interpretation of its own regulations, especially when that interpretation is advanced in support of a litigation position.

But deference is not warranted here in any event. *Hardy-Wilson*, 616 F.3d at 460 ("Having determined that the regulation is unambiguous, we conclude that CMS's interpretation of the regulation is not entitled to deference."). As the Fifth Circuit explained:

> Tellingly, until 2005, only subsection (c)(4)(iii)(B)—which contains the caps—had explicit time limits. Section (c)(4)(iii) and subsection (A) contained no time limits. If CMS intended its regulation in subsection (c)(4)(iii) to apply only from 1998 to 2002, it should have expressly limited the time period of the whole section, not just subsection (c)(4)(iii)(B). But CMS did not do so when it initially promulgated subsection (c)(4)(iii). [*Hardy-Wilson*, 616 F.3d at 460.]

Indeed, it was only after the temporary reimbursement cap's expiration—and the ensuing firestorm of criticism from psychiatric hospitals—that CMS amended subsection (c)(4)(iii) to limit the *entire* subsection (i.e., including subprovision (A)) to "cost reporting periods beginning on or after October 1, 1997 through September 30, 2002." 42 C.F.R. § 413.40(c)(4)(iii) (effective October 1, 2005).

CMS claims that the 2005 amendment was simply clarifying. But CMS's clarification "is a substantive change to the regulatory text, one that imposes express time limits on the whole of subsection (c)(4)(iii) where previously only subsection (c)(4)(iii)(B) was time-limited." *Hardy-Wilson*, 616 F.3d at 461.

Moreover, as the Fifth Circuit observed, "the 2005 amendment betrays CMS's contemporaneous understanding that subsection (c)(4)(iii), as it existed in fiscal years 2003, 2004, and 2005, did not expire according to its own terms." If CMS is right that "the whole of subsection (c)(4)(iii) reasonably could be viewed as having no further effect after 2002, then there would have been no need to amend the regulation in 2005." *Hardy-Wilson*, 616 F.3d at 461 (numerous citations omitted).

Again, the circuit divergence regarding CMS's regulations (and the deference those regulations deserve) results in differing reimbursement rates for different psychiatric hospitals based on nothing more than the circuit where the hospitals happen to operate. Hospitals located in the Sixth Circuit no longer receive the target amount, but instead receive an updated cap amount. Only this Court can resolve the conflict.

III. The Court should reconsider the wisdom of deferring to an agency's interpretation of its own rule.

In *Auer* v. *Robbins*, 519 U.S. 452 (1997), this Court clarified that it will defer to an agency's interpretation of its own regulations. *Id.* at 461. On its face, *Auer* deference appears to be a "natural corollary" to *Chevron*. *Talk America, Inc.* v. *Michigan Bell Tel. Co.*,

131 S. Ct. 2254, 2266 (2011) (Scalia, J., concurring). If the courts defer to an agency's interpretation of a statute, then they should also defer to that same agency's construction of an interpretive regulation.

But as Justice Scalia explained in his *Talk America* concurrence, that is not the case. "When Congress enacts an imprecise statute that it commits to the implementation of an executive agency, it has no control over that implementation." 131 S. Ct. at 2266 (Scalia, J., concurring). "But when an agency promulgates an imprecise rule, it leaves *to itself* the implementation of that rule, and thus the initial determination of the rule's meaning." *Id*. And it "seems contrary to fundamental principles of separation of powers to permit the person who promulgates a law to interpret it as well." *Id*. (citing Montesquieu, Spirit of the Laws bk. XI, ch. 6, pp. 151–52 (O. Pies ted., T. Nugent transl. 1949)). Whereas Congress has no incentive to enact a vague statute (thus ceding power to the Executive Branch), "deferring to an agency's interpretation of its own rule encourages the agency to enact vague rules which give it the power, in future adjudications, to do what it pleases." *Id*.

Here, CMS regulation § 413.40(c)(4) is clear: "After the caps expired in 2002, the only way to calculate reimbursements was the 'hospital-specific target amount' under (c)(4)(iii)(A) because (c)(4)(iii)(B), by its terms, no longer applied." *Hardy-Wilson*, 616 F.3d at 460. Yet CMS has successfully used *Auer* deference to transform a litigation position into a regulatory interpretation entitled to judicial deference.

Auer deference would appear least appropriate when an agency claims deference to a post-hoc position advanced in litigation. To begin, once litigation has ensued, it is too late for the regulated party to change its conduct. Here, for example, Petitioners will never be able to go back and modify their expenditures based on CMS's post-hoc interpretation. Such a result violates the core due-process principle that citizens are entitled to notice of a legal rule to which they must conform their conduct. *State Farm Mut. Auto. Ins. Co.* v. *Campbell*, 538 U.S. 408, 418 (2003) ("'Indeed, the point of due process—of the law in general—is to allow citizens to order their behavior.'") (quotation omitted).

In addition, applying *Auer* deference at the litigation stage allows an agency to change its interpretive position at a moment's notice and still receive the benefit of deference. Regulated parties correctly assume that agency interpretations may change when Executive Branch leadership changes following a general election. But such changes should not be motivated by the agency's self-interest in response to a lawsuit.

Particularly in the litigation context, then, the principle of *Auer* deference deserves a second look. Petitioners respectfully submit that this case presents the ideal vehicle for such reconsideration to take place. See *Talk America*, 131 S. Ct. at 2266 (Scalia, J., concurring) ("We have not been asked to reconsider *Auer* in the present case. When we are, I will be receptive to doing so.").[2]

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[2] Respondent in *Decker* v. *Northwest Environmental Defense Center*, Nos. 11-338 & 11-347, makes a similar request in its

IV. The issues presented are of great economic significance psychiatric hospitals.

Petitioners' claims against HHS in this proceeding total nearly $10 million just for fiscal years 2003 to 2006 alone. (FY 2003: $2,510,029.12; FY 2004: $2,879,200.62; FY 2005: $1,775,665.00; FY 2006: $2,511,540.21; Total: $9,676,434.95.) Petitioners also have yet-to-be-litigated claims for fiscal years 2007 and 2008. Moreover, the Petitioners constitute less than 1% of the 435 non-federal psychiatric hospitals.[3]

The loss figures that result from CMS's improper calculations may well result in a long-term reduction in the number of psychiatric hospitals in the United States. Consider Hardy-Wilson Memorial, the hospital whose reimbursement was at issue in the Fifth Circuit. According to Hardy-Wilson, CMS's unlawful extension of the five-year temporary cap caused Hardy-Wilson to lose approximately *two thirds* of its federal Medicare reimbursement. Hardy-Wilson Br. for Appellants, p. 10 (noting that the hospital's 2003 target amount dipped 62.6%, from $26,867.08 to $10,035.72 per Medicaid discharge). In sum, the issues presented affect many psychiatric hospitals and will likely have a meaningful impact on the number of hospitals that survive the economic downturn and concomitant decreases in public funding.

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merits briefing. Br. for Respondent, p. 42 n.12. But as explained at length in the same brief, there are numerous reasons why the Court need not reach the *Auer*-deference issue in *Decker*. For additional explanation of *Auer*'s irregularity, see the *amicus* brief filed in the *Decker* case by Law Professors on the Propriety of Administrative Deference.

[3] American Hospital Association, Fast Facts on US Hospitals, http://www.aha.org/research/rc/stat-studies/fast-facts. shtml.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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