No. 20-__

IN THE
Supreme Court of the United States

AMERICAN HOSPITAL ASSOCIATION, *ET AL.*,
Petitioners,

v.

NORRIS COCHRAN, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF HEALTH AND HUMAN SERVICES,
Respondent.

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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QUESTION PRESENTED

Whether *Chevron* deference applies to a statutory interpretation question that determines both the lawfulness of agency action and the court's jurisdiction.

PARTIES TO THE PROCEEDING

The following Petitioners were appellees in the court of appeals: American Hospital Association; Association of Medical Colleges; Barnes-Jewish Hospital; Barnes-Jewish West County Hospital; Blue Ridge Healthcare System, Inc., d/b/a CHS Blue Ridge; Carilion Medical Center; Central Vermont Medical Center, Inc.; The Charlotte-Mecklenburg Hospital Authority, d/b/a Atrium Health Lincoln; The Charlotte-Mecklenburg Hospital Authority, d/b/a Atrium Health Pineville; The Charlotte-Mecklenburg Hospital Authority, d/b/a Atrium Health Union; The Charlotte-Mecklenburg Hospital Authority, d/b/a Atrium Health University City; The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System North-East; The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Medical Center; Clallam County Public Hospital No. 2, d/b/a Olympic Medical Center; Columbus Regional Healthcare System, Inc.; East Baton Rouge Medical Center, LLC, d/b/a Ochsner Medical Center; Florida Health Sciences Center Inc., d/b/a Tampa General Hospital; Franciscan Missionaries of Our Lady Health System, d/b/a Our Lady of Lourdes Regional Medical Center; Franciscan Missionaries of Our Lady Health System, d/b/a Our Lady of the Lake Regional Medical Center; Hackensack Meridian Health, d/b/a Bayshore Medical Center; Hackensack Meridian Health, d/b/a Jersey Shore University Medical Center; Hackensack Meridian Health, d/b/a Riverview Medical Center; Heartland Regional Medical Center; Lima Memorial Health System; Mercy Health Muskegon; Mercy Medical Center, Inc.; Missouri Baptist Medical Center; Montefiore Health System, Inc., d/b/a Montefiore Medical Center;

Montefiore Health System, Inc., d/b/a St. Luke's Cornwall Hospital; Montefiore Health System, Inc., d/b/a White Plains Hospital; Northwest Medical Center; NYU Langone Health System; NYU Winthrop Hospital; Ochsner Clinic Foundation, d/b/a Ochsner Medical Center; OSF Healthcare System, d/b/a Saint Anthony's Health Center; OSF Healthcare System, d/b/a Saint Anthony Medical Center; OSF Healthcare System, d/b/a Saint Francis Medical Center; OSF Healthcare System, d/b/a St. Joseph Medical Center; Piedmont Newnan Hospital, Inc.; Progress West Healthcare Center, d/b/a Progress West Hospital; The Rector and Visitors of the University of Virginia, d/b/a University of Virginia Medical Center; Rush University Medical Center; Sarasota Memorial Hospital; Southwest General Health Center; Stanford Health Care; Tarrant County Hospital District, d/b/a JPA Health Network; University Hospitals Health System, Inc., d/b/a UH Cleveland Medical Center; University Hospitals Health System, Inc., d/b/a UH Elyria Medical Center; University Hospitals Health System, Inc., d/b/a UG Geauga Medical Center; University of Kansas Hospital Authority; University of Vermont Medical Center, Inc.; Vanderbilt University Medical Center; and York Hospital.

Alex M. Azar II, in his official capacity as the Secretary of Health and Human Services, was the appellant in the court of appeals. Respondent is Norris Cochran, in his official capacity as the Acting Secretary of Health and Human Services.

RULE 29.6 DISCLOSURE STATEMENT

Petitioner American Hospital Association has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Association of American Medical Colleges has no parent corporation and no publicly held company has a 10% or greater ownership interest.

Petitioner Barnes-Jewish Hospital is owned by BJC Health System, which is not a publicly traded company.

Petitioner Barnes-Jewish West County Hospital is owned by BJC Healthcare, which is not a publicly traded company.

Petitioner Blue Ridge Healthcare System, Inc., d/b/a CHS Blue Ridge, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Carilion Medical Center is owned by Carilion Clinic, which is not a publicly traded company.

Petitioner Central Vermont Medical Center, Inc. is owned by the University of Vermont Medical Center Inc, which is not a publicly traded company.

Petitioner The Charlotte-Mecklenburg Hospital Authority, d/b/a Atrium Health Lincoln, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner The Charlotte-Mecklenburg Hospital Authority, d/b/a Atrium Health Pineville, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner The Charlotte-Mecklenburg Hospital Authority, d/b/a Atrium Health Union, has no parent

corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner The Charlotte-Mecklenburg Hospital Authority, d/b/a Atrium Health University City, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas HealthCare System North-East, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Clallam County Public Hospital No. 2, d/b/a Olympic Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Columbus Regional Healthcare System, Inc. has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner East Baton Rouge Medical Center, LLC, d/b/a Ochsner Medical Center, is owned by Ochsner Health System, which is not a publicly traded company.

Petitioner Florida Health Sciences Center Inc., d/b/a Tampa General Hospital, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Franciscan Missionaries of Our Lady Health System, Inc., d/b/a Our Lady of Lourdes Regional Medical Center, has no parent corporation and

no publicly held company owns a 10% or greater ownership interest.

Petitioner Franciscan Missionaries of Our Lady Health System, Inc., d/b/a Our Lady of the Lake Regional Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Hackensack Meridian Health, d/b/a Bayshore Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Hackensack Meridian Health, d/b/a Jersey Shore University Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Hackensack Meridian Health, d/b/a Riverview Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Heartland Regional Medical Center is owned by Mosaic Health System, which is not a publicly traded company.

Petitioner Lima Memorial Health System is owned by the Lima Memorial Joint Operating Company, which is not a publicly traded company.

Petitioner Mercy Health Muskegon has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Mercy Medical Center, Inc. has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Missouri Baptist Medical has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Montefiore Health System, Inc., d/b/a Montefiore Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Montefiore Health System, Inc., d/b/a St. Luke's Cornwall Hospital, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Montefiore Health System, Inc., d/b/a White Plains Hospital, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Northwest Medical Center is owned by Community Health Systems, which is publicly traded as CHSPSC, LLC.

Petitioner NYU Langone Health System has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner NYU Winthrop Hospital is owned by NYU Langone Health System, which is not a publicly traded company.

Petitioner Ochsner Clinic Foundation, d/b/a Ochsner Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner OSF Healthcare System, d/b/a Saint Anthony Medical Center, is owned by the Sisters of The Third Order of St Francis, which is not a publicly traded company.

Petitioner OSF Healthcare System, d/b/a Saint Anthony's Health Center, is owned by the Sisters of The Third Order of St Francis, which is not a publicly traded company.

Petitioner OSF Healthcare System, d/b/a Saint Francis Medical Center, is owned by the Sisters of the Third Order of St Francis, which is not a publicly traded company.

Petitioner OSF Healthcare System, d/b/a St. Joseph Medical Center, is owned by the Sisters of the Third Order of St Francis, which is not a publicly traded company.

Petitioner Piedmont Newnan Hospital, Inc. is owned by Piedmont Hospital, Inc., which is not a publicly traded company.

Petitioner Progress West Healthcare Center, d/b/a Progress West Hospital, is owned by BJC Health System, which is not a publicly traded company.

Petitioner The Rector and Visitors of the University of Virginia, d/b/a University of Virginia Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Rush University Medical Center is owned by Rush System for Health, which is not a publicly traded company.

Petitioner Sarasota Memorial Hospital is owned by Sarasota Memorial Hospital and Health Care System, which is not a publicly traded company.

Petitioner Southwest General Health Center has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Stanford Health Care is owned by Leland Stanford Junior University, which is not a publicly traded company.

Petitioner Tarrant County Hospital District, d/b/a JPS Health Network, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner University Hospitals Health System, Inc., d/b/a UH Cleveland Medical Center, is an affiliate hospital of Case Western Reserve University. It has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner University Hospitals Health System, Inc., d/b/a UH Elyria Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner University Hospitals Health System, Inc., d/b/a UH Geauga Medical Center, has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner University of Kansas Hospital Authority has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner University of Vermont Medical Center, Inc. has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner Vanderbilt University Medical Center has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

Petitioner York Hospital has no parent corporation and no publicly held company owns a 10% or greater ownership interest.

RELATED PROCEEDINGS

The following proceedings are directly related to this petition:

American Hospital Association v. *Azar*, No. 1:18-cv-02841-RMC (D.D.C. Sept. 17, 2019) (reported at 410 F. Supp. 3d 142), *rev'd*, No. 19-5352 (D.C. Cir. July 17, 2020) (reported at 964 F.3d 1230).

University of Kansas Hospital Authority v. *Azar*, No. 1:19-cv-00132-RMC (D.D.C. Sept. 17, 2019) (reported at 410 F. Supp. 3d 142), *rev'd*, No. 19-5353 (D.C. Cir. July 17, 2020) (reported at 964 F.3d 1230).

Hackensack Meridian Health v. *Azar*, No. 1:19-cv-01745-RMC (D.D.C. Sept. 17, 2019) (reported at 410 F. Supp. 3d 142), *rev'd*, No. 19-5354 (D.C. Cir. July 17, 2020) (reported at 964 F.3d 1230).

American Hospital Association v. *Azar*, No. 1:20-cv-00080-TFH (D.D.C. complaint filed Jan. 13, 2020). This case remains pending before the United States District Court for the District of Columbia.

University of Kansas Hospital Authority v. *Azar*, No. 1:20-cv-00075-JDB (D.D.C. complaint filed Jan. 10, 2020). This case remains pending before the United States District Court for the District of Columbia.

TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF AUTHORITIES

Page(s)

CASES:

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

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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

Petitioners respectfully seek a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS BELOW

The District Court's order granting Petitioners' motion for summary judgment and vacating the applicable portions of the Final Rule is reported at 410 F. Supp. 3d 142. Pet. App. 33a-67a. The D.C. Circuit's opinion instructing the District Court to dismiss the case for lack of jurisdiction is reported at 964 F.3d 1230. Pet. App. 1a-32a. The D.C. Circuit's order denying rehearing en banc is not reported. *See id.* at 68a-69a.

JURISDICTION

The D.C. Circuit entered judgment on July 17, 2020. Petitioner filed a timely petition for rehearing en banc, which was denied on October 16, 2020. On March 19, 2020, this Court by general order extended the deadline to petition for a writ of certiorari to 150 days from the date of the lower court judgment. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Article III, Section 1 of the United States Constitution provides, in relevant part:

> The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish.

Article I, Section 8 of the United States Constitution provides, in relevant part:

> The Congress shall have Power To * * * constitute Tribunals inferior to the supreme Court.

The relevant statutory provisions are reproduced in the appendix to this petition. *See* Pet. App. 70a-72a.

INTRODUCTION

At issue in this case is a fundamental question of Article III power. In *Adams Fruit Co.* v. *Barrett*, 494 U.S. 638 (1990), this Court declined to defer to an administrative agency's interpretation of the court's jurisdiction, holding that agencies cannot "regulate the scope of the judicial power vested by the statute." *Id.*

at 650. In *Smith* v. *Berryhill*, 139 S. Ct. 1765 (2019), the Court reiterated that the "scope of judicial review * * * is hardly the kind of question that the Court presumes that Congress implicitly delegated to an agency," *id.* at 1778-79, a point that the Court confirmed again this Term in *Salinas* v. *United States Railroad Retirement Board*, 592 U.S. __ (2021) (slip op. at 12).

Yet five circuit courts—including the court below—have forged an exception to that fundamental rule. The D.C., Second, Third, Eighth, and Eleventh Circuits hold that where the same statutory provision determines both the courts' jurisdiction *and* the lawfulness of the agency action under challenge, the court can defer under *Chevron* to an agency's interpretation of that provision. *See* Pet. App. 13a, 18a-19a; *Mugalli* v. *Ashcroft*, 258 F.3d 52, 54-55 (2d Cir. 2001); *Valansi* v. *Ashcroft*, 278 F.3d 203, 208 (3d Cir. 2002); *Key Med. Supply, Inc.* v. *Burwell*, 764 F.3d 955, 962-964 (8th Cir. 2014); *Garces* v. *U.S. Att'y Gen.*, 611 F.3d 1337, 1343-44 (11th Cir. 2010).

In contrast, four circuits hold that *Chevron* deference does not apply when the same statutory provision sets the boundary of the court's jurisdiction and the authority of an administrative agency. As the Fifth Circuit put it, "*Chevron* deference is not due with respect to the enforcement of [the] court's jurisdictional limitations." *Nehme* v. *INS*, 252 F.3d 415, 421 (5th Cir. 2001) (internal quotation marks omitted); *see also Solimon* v. *Gonzales*, 419 F.3d 276, 281 (4th Cir. 2005); *Solorzano-Patlan* v. *INS*, 207 F.3d 869, 872 (7th Cir. 2000); *Nat'l Ass'n of Agric. Emps.* v. *Fed. Lab. Relations Auth.*, 473 F.3d 983, 986-987 (9th Cir. 2007).

The Court should grant the petition to resolve this clear split on an important question of federal law. In the proceedings below, Petitioners challenged the Department of Health and Human Services (HHS)'s novel interpretation of 42 U.S.C. § 1395*l*(t)(2)(F), a sub-sub-sub provision of the Medicare statute, which the agency said allowed it to cut Medicare reimbursements to hospitals by more than $600 million *per year*. *See* Pet. App. 10a-11a. The D.C. Circuit held that under the Medicare statute, its jurisdiction to review the agency's action depended on whether that action was permitted by statute. *See id.* at 12a-16a. If the Medicare statute authorized the agency's action, the court lacked jurisdiction to review it; if not, the court could exercise jurisdiction and declare the agency action unlawful. *See id.* The D.C. Circuit held that Section (2)(F) was ambiguous, and it deferred under *Chevron* to the agency's interpretation of it, ultimately ruling that the court lacked jurisdiction to hear Petitioners' suit. *See id.* at 30a. In doing so, the court acquiesced to the agency's attempt to assert nearly unfettered power to set Medicare reimbursement rates—and its concomitant effort to limit judicial review of its actions.

Chevron "is premised on the theory that a statute's ambiguity constitutes an implicit delegation from Congress to the agency to fill in the statutory gaps." *Smith*, 139 S. Ct. at 1778 (internal quotation marks omitted). This Court has repeatedly held that Congress *does not* delegate authority to administrative agencies—implicitly or otherwise—to interpret statutes governing the scope of federal court jurisdiction. Such a conclusion would not only contravene *Chevron* but Article III itself, which requires the federal courts to "independent[ly]" determine "whether subject-

matter jurisdiction exists." *Arbaugh* v. *Y&H Corp.*, 546 U.S. 500, 514 (2006).

This Court should grant certiorari and reverse.

STATEMENT

A. Judicial Review Of Agency Action

This Court "applies a 'strong presumption' favoring judicial review of administrative action." *Mach Mining, LLC* v. *EEOC*, 575 U.S. 480, 486 (2015) (quoting *Bowen* v. *Michigan Acad. of Family Physicians*, 476 U.S. 667, 670 (1986)). Statutes divesting jurisdiction are narrowly construed, and "judicial review of a final agency action by an aggrieved person will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress." *Whitman* v. *Dep't of Transp.*, 547 U.S. 512, 513 (2006) (per curiam).

To determine whether Congress intended to strip review of "particular types of administrative action," federal courts must construe the statutory text to decide "whether the challenged agency action is of the sort shielded from review." *Amgen, Inc.* v. *Smith*, 357 F.3d 113 (D.C. Cir. 2004). "Otherwise, agencies could characterize reviewable or unauthorized action as falling within the scope of no-review provisions whose application to such action Congress did not intend." *Id.* In these circumstances, "the determination of whether the court has jurisdiction is intertwined with the question of whether the agency has authority for the challenged action." *Id.*

No-review provisions exist throughout the U.S. Code. The Medicare statute alone has dozens. *See, e.g.*, 42 U.S.C. § 1395w-3(b)(12)[1] (precluding judicial

[1] Formerly 42 U.S.C. § 1395w-3(b)(11).

review of HHS's competitive bidding process); *Texas All. for Home Care Servs.* v. *Sebelius*, 681 F.3d 402, 409-410 (D.C. Cir. 2012) (applying this provision); *Key Med.*, 764 F.3d at 962 (applying this provision); 42 U.S.C. § 1395ww(d)(7) (precluding review of payment adjustments for low-volume hospitals and for the establishment of payment methodologies for diagnosis-related groups); 42 U.S.C. § 1395ww(r)(2)-(3) (precluding judicial review of HHS's estimated payments to hospitals for inpatient services); *Florida Health Scis. Ctr., Inc.* v. *Sec'y of Health & Human Servs.*, 830 F.3d 515, 522-523 (D.C. Cir. 2016) (applying this provision); 42 U.S.C. § 1395ww(o)(11)(B)(i) (precluding review of HHS's "determination of" the "amount of the value-based incentive payment"); *id.* (precluding review of the "methodology used to determine the amount of the value-based incentive payment"); *id.* § 1395w-3a(g)(3) (precluding review of "method[s] to allocate rebates, chargebacks, and other price concessions").

Statutes governing the Transportation and Security Administration and the Federal Communications Commission contain no-review provisions, which prohibit review of agency-imposed fees authorized by statute, while permitting review of unauthorized fees. *See Southwest Airlines Co.* v. *TSA*, 554 F.3d 1065, 1069-71 (D.C. Cir. 2009) (exercising jurisdiction and holding that TSA fee is unauthorized); *COMSAT Corp.* v. *FCC*, 114 F.3d 223, 226–227 (D.C. Cir. 1997) (exercising jurisdiction and holding that FCC fee is unauthorized). The Immigration and Nationality Act also precludes review of removal orders in certain circumstances. *See, e.g.*, *Solimon*, 419 F.3d at 280-281 (exercising jurisdiction to hold removal unlawful); *infra* pp. 13-14. Many other statutes contain similar

provisions. *See, e.g.*, 7 U.S.C. § 2025(c)(6)(D) (precluding review of "national performance measure[s]" under the Supplemental Nutrition Assistance Program); 42 U.S.C. § 247d-6d(b)(7) (precluding review of agency action declaring immunity from suit for companies that design, manufacture, or distribute products to address a pandemic).

B. HHS Issues A Final Rule Dramatically Reducing Reimbursement Rates For Hospital Services Provided In An Outpatient Setting

The dispute in this case involves HHS's authority to set Medicare reimbursement rates for certain outpatient services furnished by hospitals—and the federal courts' jurisdiction to review actions the agency claims are taken under that authority.

Medicare reimburses services provided by hospitals at outpatient clinics including "off-campus provider-based departments" or PBDs. *See* 42 U.S.C. §§ 1395*l*(t); 1395k. The Outpatient Prospective Payment System specifies the amount HHS must reimburse hospitals for outpatient services. *See id.* § 1395*l*(t); *see generally* Medicaid Program; Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition, 73 Fed. Reg. 66,187 (Nov. 7, 2008). A different payment scheme—called the Medicare Physician Fee Schedule—determines the reimbursement rates for doctor's offices. *See* 42 U.S.C. § 1395w-4.

Some services, such as "evaluation and management" services, may be provided either by an off-campus PBD or a doctor's office. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 83 Fed. Reg. 58,818,

59,006 (Nov. 21, 2018). The Outpatient Prospective Payment Scheme typically provides a higher rate of reimbursement than the Physician Fee Schedule, in part to compensate for the higher costs borne by hospitals. *See* 73 Fed. Reg. at 66,191 (noting the "high facility overhead expenses that are associated with the delivery of services unique to an outpatient hospital").

In recent years, the Medicare-eligible population has grown, increasing demand for off-campus PBD services. *See* Pet. App. 38a. Advances in medical technology have also permitted more services to be provided on an outpatient basis. *See id.* at 40a. And in a considerable number of rural areas, off-campus PBDs are a critical source of medical care, especially for vulnerable patient populations. *See* 83 Fed. Reg. at 59,013. As a result, hospitals have established more off-campus PBDs to serve an increasing patient base, with a corresponding increase in the total amount Medicare pays for those services. *See* Pet. App. 40a.

In 2014, the Medicare Payment Advisory Commission recommended that Congress set the same reimbursement rates for services provided by both off-campus PBDs and doctor's offices. *Id.* at 40a-41a. According to the Commission, this would decrease Medicare reimbursements for services that could be provided in either setting. *Id.* In response, hospitals advised Congress that the Commission's "recommendation ignored the higher costs required to operate a hospital and would force some existing off-campus provider-based departments * * * to reduce their services or close completely," including in rural areas. *Id.* at 41a; *see* 83 Fed. Reg. at 59,013.

Congress addressed those competing concerns in Section 603 of the Bipartisan Budget Act of 2015, Pub. L. No. 114-74, § 603, 129 Stat. 584, 597-598; *see also* Pet. App. 41a-42a. Its solution was to create two classes of off-campus PBDs. Congress required HHS to continue to pay *existing* off-campus PBDs—called "excepted" PBDs—at the higher Outpatient Prospective Payment System rates. *See* 42 U.S.C. § 1395*l*(t)(1)(B)(v), (t)(21)(B)(ii). But going forward, Congress instructed HHS to pay newly created or acquired off-campus PBDs—called "non-excepted" PBDs—under the "applicable payment system," which HHS has interpreted as the equivalent of the lower Physician Fee Schedule rates. *See id.* § 1395*l*(t)(21)(C); Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 81 Fed. Reg. 79,562, 79,720, 79,726 (Nov. 14, 2016).

HHS was not satisfied with this congressional compromise. In 2018, the agency issued a Final Rule providing that reimbursement rates for evaluation and management services provided by *excepted* PBDs "would now be equivalent to the payment rate" for services provided by *non-excepted* PBDs. 83 Fed. Reg. at 59,004-15. In other words, despite Congress's express instruction that excepted PBDs would continue to be paid at different rates than non-excepted PBDs, HHS declared it would reimburse *all* PBDs at the lower Physician Fee Schedule rate. HHS estimated that this change would reduce reimbursements to hospitals by more than $600 million per year. *See id.* at 59,009; Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory

Surgical Center Payment Systems and Quality Reporting Programs, 84 Fed. Reg. 61,142, 61,369 (Nov. 12, 2020).

HHS claimed that Section 1395*l*(t)(2)(F) of the Medicare statute authorized it to make this dramatic reduction in reimbursement rates. *See* 83 Fed. Reg. at 58,822, 59,005-11. Section (2)(F) is a sub-sub-sub provision of the Medicare statute that does not discuss reimbursement rates at all. Instead, it states that HHS "shall develop a method for controlling unnecessary increases in the volume of covered [outpatient department] services." 42 U.S.C. § 1395*l*(t)(2)(F). Section (2)(F) has been on the books for over two decades, and HHS had never interpreted it to permit cuts to reimbursement rates. Yet HHS maintained in the Final Rule that cutting reimbursement rates is a "method" of volume control, *see* Pet. App. 49a, meaning that the agency can set any reimbursement rate it wants to discourage off-campus PBDs from serving Medicare beneficiaries. And even better for the agency: Section 1395*l*(t)(12) of the Medicare statute states that "[t]here shall be no administrative or judicial review" of "methods described in paragraph (2)(F)." 42 U.S.C. § 1395*l*(t)(12)(A).

C. The District Court Exercises Jurisdiction To Vacate The Final Rule In Relevant Part

The American Hospital Association, the Association of American Medical Colleges, and a number of individual hospitals challenged the Final Rule in federal district court. *See* Pet. App. 34a. Petitioners argued that HHS's decision to cut Medicare reimbursement to hospitals by more than $600 million per year was not a "method" of volume control authorized by Section (2)(F), and that Congress had already dictated

that excepted off-campus PBDs should receive *higher* reimbursement rates than non-excepted off-campus PBDs. The District Court agreed, granting summary judgment to Petitioners and vacating pertinent parts of the Final Rule. *See id.* at 66a.

The District Court explained that under Section (t)(12), "whether what [HHS] calls a 'method' [of volume control] satisfies the statute" would determine both the court's jurisdiction and the validity of Petitioners' claims. *Id.* at 50a-51a. The merits of the agency's action and the court's jurisdiction were thus "intertwined." *Id.* at 50a. The District Court ruled that it would "address the merits" of Petitioners' challenge to the Final Rule "to the extent necessary to determine whether the challenged agency action falls within the scope of the preclusion on judicial review." *Id.*

Interpreting Section (2)(F), the District Court held that the statute is "clear" that a method of volume control "is not a price-setting tool, and the government's effort to wield it in such a manner is manifestly inconsistent with the statutory scheme." *Id.* at 56a. According to the District Court, Congress did not grant HHS "unilateral authority to pick and choose what to pay for [outpatient] services." *Id.* at 65a. Quite the opposite: Congress "directed" that any volume-control "methods" would be "implemented through other provisions of the statute," which "pervasively" require "budget neutrality"—a far cry from HHS's one-sided, $600 million cut. *Id.* at 63a; *see also* 42 U.S.C. § 1395*l*(t)(2)(D)-(E), (9)(B) (permitting HHS to cut reimbursement in a budget-neutral fashion).

The District Court accordingly concluded that because the Final Rule "does not constitute a 'method'

within the meaning of the statute," Section (t)(12)'s jurisdictional bar did not apply. Pet. App. 50a-51a. Assuming jurisdiction, the court vacated relevant parts of the Final Rule. *Id.* at 66a-67a.

D. The D.C. Circuit Holds That It Lacks Jurisdiction To Review The Final Rule

The D.C. Circuit reversed. It explained that "the question whether the Hospitals are correct and the question whether the preclusion provision bars review of their claim are one and the same." *Id.* at 15a-16a. Rejecting Petitioners' argument "that *Chevron* does not apply when, as here, our consideration of the agency's statutory authority merges with our consideration of the applicability of a preclusion provision," the court held that it would "examine that question under the traditional *Chevron* framework, under which we defer to the agency's reasonable interpretation of an ambiguous statute." *Id.* at 16a, 18a.

Because "HHS is generally entitled to *Chevron* deference on judicial review of its interpretation of the Medicare statute," the court held that it would apply *Chevron* deference to the agency's interpretation of Section (2)(F). *Id.* at 16a. At *Chevron* step one, the D.C. Circuit concluded that the Medicare statute was "at least ambiguous as to whether [HHS's] rate adjustment lies within the agency's (2)(F) authority." *Id.* at 28. Moving to "*Chevron* step two," the D.C. Circuit concluded that the agency's interpretation of the Medicare statute was "permissible" because it was reasonable to expect that when the agency cut reimbursement to off-campus PBDs, the volume of services provided by those PBDs would decrease. *Id.* at 28a-30a (internal quotation marks omitted).

The D.C. Circuit held that "under *Chevron*," HHS's decision to slash reimbursement "qualifies" as a volume-control method under Section (2)(F). *Id.* at 30a. "Consequently," the D.C. Circuit ruled, "neither we nor the district court has jurisdiction over the Hospital's challenge." *Id.*

This petition follows.

REASONS FOR GRANTING THE PETITION

I. THERE IS A DEEP CIRCUIT SPLIT ON THE QUESTION PRESENTED.

The courts of appeals are deeply divided on the question presented. Four circuits—the Fourth, Fifth, Seventh, and Ninth—hold that courts must review *de novo* statutory interpretation questions that determine both the court's jurisdiction to hear a challenge to agency action and the lawfulness of the action under challenge. Five circuits—the D.C., Second, Third, Eight, and Eleventh—defer to an agency's interpretation of a statutory provision that determines the court's jurisdiction, where the jurisdictional inquiry merges with the merits. Given this clear circuit split, the Court's intervention is plainly warranted.

1. Four circuits hold that *Chevron* deference does not apply to statutory interpretation questions that determine the court's jurisdiction.

In *Nehme* v. *INS*, 252 F.3d 415 (5th Cir. 2001), the petitioner challenged a deportation order on the ground that he was a naturalized citizen rather than an alien. *See id.* at 420-421. The Fifth Circuit acknowledged that under 8 U.S.C. § 1252(d)(1), it lacked "jurisdiction to review deportation orders for aliens who are removable because they were convicted of aggravated felonies." *Id.* at 420. If the petitioner

was "not an alien," the Fifth Circuit explained, then it "must conclude both that we have jurisdiction, and that [the petitioner] is not deportable." *Id.* at 421. Conversely, if the petitioner was an alien, then the court lacked jurisdiction, and the petitioner could be deported. *Id.* Thus, the court's jurisdictional ruling would "effectively decide the merits of [the] case." *Id.* at 420-421.

The Immigration and Naturalization Service argued that the court "should give *Chevron* deference" to the INS's interpretation of the Immigration and Naturalization Act "in the course" of the court's "jurisdictional inquiry." *Id.* at 421. The Fifth Circuit concluded that the INS's "contention lacks merit." *Id.* "*Chevron* deference," the court explained, "is not due with respect to the enforcement of this court's jurisdictional limitations." *Id.* (internal quotation marks omitted). Rather, "[t]he determination of our jurisdiction is exclusively for the court to decide." *Id.* (quoting *Lopez-Elias* v. *Reno*, 209 F.3d 788, 791 (5th Cir. 2000)). Applying *de novo* review, the court concluded that the petitioner was an alien, and that the court lacked jurisdiction to hear his petition. *See id.* at 426-433; *see also Bustamante-Barrera* v. *Gonzales*, 447 F.3d 388, 394 (5th Cir. 2006) (*Chevron* deference does not apply where the court's interpretation of a merits question goes "straight to [the court's] jurisdiction").

The Ninth Circuit agrees. In *National Association of Agriculture Employees* v. *Federal Labor Relations Board*, 473 F.3d 983 (9th Cir. 2007), the court analyzed the meaning of the term "appropriate unit determination" in the Federal Service Labor-Management Relations Statute. *Id.* at 985. The Ninth Circuit stated that it would "typically defer to an agency's

interpretation of the statute it is charged with administering." *Id.* at 986. Under 5 U.S.C. § 7123(a), however, Congress stripped the courts of jurisdiction to review final orders of the Federal Labor Relations Authority involving "an appropriate unit determination." *Id.* at 986-987. The Ninth Circuit held that it would decide its "own subject matter jurisdiction *de novo*," without deference to the agency's interpretation of the relevant statute. *Id.* at 986.

The Fourth Circuit has adopted the same approach. In *Solimon* v. *Gonzales*, 419 F.3d 276 (4th Cir. 2005), the petitioner challenged a removal order on the ground that he had not committed an "aggravated felony," as that term is defined in the Immigration and Naturalization Act. *Id.* at 278. The Board of Immigration Appeals argued that its interpretation of "aggravated felony" was "entitled to deference under *Chevron*." *Id.* at 280. The Fourth Circuit disagreed. The court acknowledged that in the ordinary course, "the special deference rules of *Chevron* apply to BIA interpretations of the statutes it administers." *Id.* at 281. Because the court's jurisdiction turned on the definition of "aggravated felony," however, the court held it "need not accord deference to the BIA's ultimate finding that [the petitioner's] particular offense was an aggravated felony, which involves an issue of our appellate jurisdiction." *Id.* (citing *Lopez-Elias*, 209 F.3d at 791). Applying *de novo* review, the court held that the petitioner had not committed an aggravated felony, and that the court had jurisdiction to vacate the removal order. *Id.* at 284-286.

The Seventh Circuit has likewise held that *Chevron* deference does not apply to jurisdictional questions that merge with the merits. In *Solorzano-Patlan* v.

INS, 207 F.3d 869 (7th Cir. 2000), the Seventh Circuit concluded that *de novo* review applies when "[b]oth our jurisdiction * * * and the merits of the appeal turn on" the same statutory interpretation question. *Id.* at 872; *see also Vaca-Tellez* v. *Mukasey*, 540 F.3d 665, 668-669 (7th Cir. 2008).

2. Five circuits hold that *Chevron* deference applies where the same statutory interpretation question decides the lawfulness of the agency's action and the boundary of the court's jurisdiction.

The D.C. Circuit agrees that in most circumstances, *Chevron* deference does not "extend" to an agency's construction of "the scope of the judicial power vested by [a] statute." *Murphy Expl. & Prod. Co.* v. *U.S. Dep't of the Interior*, 252 F.3d 473, 479 (D.C. Cir. 2001) (internal quotation marks omitted). In the decision below, however, the court forged an exception to that rule: It held that *Chevron* deference applies "when, as here, our consideration of the agency's statutory authority merges with our consideration of the applicability of a [judicial] preclusion provision." Pet. App. 18a. Thus, the D.C. Circuit deferred to HHS's interpretation of the phrase "method for controlling * * * volume" in the Medicare statute, even though the meaning of that term determined the court's own jurisdiction. *Id.* at 15a-16a.

The Second Circuit applies *Chevron* deference under similar circumstances. In *Mugalli* v. *Ashcroft*, 258 F.3d 52 (2d Cir. 2001), the petitioner challenged a removal order on the ground that a prior conviction did not qualify as an aggravated felony. *Id.* at 54-55. The Second Circuit acknowledged that it could not "review any final removal order against an alien who is deportable because he was convicted of an aggravated

felony," and that this "jurisdictional inquiry * * * merges with the question on the merits." *Id.* at 54-55 (quoting *Sui* v. *INS*, 250 F.3d 105, 110 (2d Cir. 2001)). The court held that it was nevertheless appropriate to apply *Chevron* deference to the Board of Immigration Appeals's interpretation of the statutes it administers, even though the court's own "jurisdiction depend[ed]" on that interpretation. *Id.* at 55-56, 62; *see also Rodriguez* v. *Barr,* 975 F.3d 188, 192 (2d Cir. 2020) (per curiam) (according *Chevron* deference to the BIA's "far-reaching construction" of the term "aggravated felony"), *petition for cert. filed sub nom. Rodriguez* v. *Wilkinson*, No. 20-6987 (Dec. 7, 2020); *James* v. *Mukasey*, 522 F.3d 250, 253 (2d Cir. 2008) (acknowledging that *Chevron* applies even though "our jurisdiction depends on the definition of a phrase used in the INA").

The Third Circuit also "employ[s] *Chevron* when interpreting immigration statutes that ultimately determine[] [its] jurisdiction." *Valansi* v. *Ashcroft*, 278 F.3d 203, 208 (3d Cir. 2002). In *Valansi*, the petitioner challenged a removal order on the ground that her prior conviction for embezzlement did not qualify as a deportable aggravated felony. *Id.* at 205. The court recognized that its jurisdiction depended on its resolution of the merits of the petitioner's challenge: "If she is right, judicial review is not precluded, and the removal order will be vacated for failing to allege a removable offense. If she is wrong, 8 U.S.C. § 1252(a)(2)(C) deprives us of jurisdiction to inquire any further into the merits, and the removal order will stand." *Id.* at 207. The court declared that, in resolving this jurisdictional issue, it "will give deference to the agency's interpretation of the aggravated felony definition if Congress's intent is unclear," but

acknowledged that there was disagreement among the circuit courts on this point. *Id.* at 208; *see also Core Commc'ns, Inc.* v. *Verizon Pennsylvania, Inc.*, 493 F.3d 333, 342-343 (3d Cir. 2007) (deferring to FCC's interpretation of the Telecommunications Act to hold that "federal court jurisdiction over state commission interpretation and enforcement decisions should be limited to appellate review").[2]

The Eighth Circuit has likewise deferred to an agency's "statutory interpretation concerning the scope of agency authority," even "in the face of [a co-extensive] statutory bar on review." *Key Med. Supply, Inc.* v. *Burwell*, 764 F.3d 955, 962 (8th Cir. 2014). The statute at issue required HHS to implement a competitive bidding system to "control" Medicare costs, prohibiting judicial review over "the establishment of payment amounts," "the awarding of contracts," "the selection of items * * * for competitive acquisition," and "the bidding structure" for contracts. *Id.* at 957-959 (quoting 42 U.S.C. § 1395w-3(b)(11)). A prospective bidder challenged HHS's bidding requirements as outside the scope of the agency's statutory authority. *Id.* at 960. The Eighth Circuit dismissed the challenge for lack of jurisdiction, deferring to the agency on "question[s] of statutory interpretation." *Id.* at 964.

The Eleventh Circuit agrees. In *BellSouth Telecommunications, Inc.* v. *MCImetro Access Transmission Services, Inc.*, 317 F.3d 1270 (11th Cir. 2003), the en banc court analyzed whether 47 U.S.C. § 252(e), which expressly granted "state commissions authority

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[2] The Third Circuit's precedent on this issue "is a matter of some confusion." *Denis* v. *Att'y Gen. of U.S.*, 633 F.3d 201, 207-208 (3d Cir. 2011) (citing a number of cases applying *de novo* review to a jurisdictional question that is intertwined with the merits).

to approve or reject interconnection agreements" between telecommunications companies, also impliedly granted those commissions authority to "interpret[ ] and enforce[ ]" such agreements. *Id.* at 1274. The answer to that statutory interpretation question also determined the "extent of federal [court] jurisdiction," which was limited to reviewing determinations made by state commissions pursuant to their statutory authority. *Id.* at 1273; *see* 47 U.S.C. § 252(e)(6). A fractured Eleventh Circuit majority applied *Chevron* deference to hold that a state commission had "the authority under federal law to interpret and enforce" interconnection agreements *and* "that its determination is subject to review in the federal courts." *BellSouth*, 317 F.3d at 1279. Judge Tjoflat dissented, arguing that *Chevron* deference is not "owed on a question that is ultimately about federal jurisdiction—a matter that is uniquely within the province of the judiciary to decide." *Id.* at 1305 (Tjoflat, J., dissenting).

Similarly, in *Garces* v. *U.S. Attorney General*, 611 F.3d 1337 (11th Cir. 2010), the Eleventh Circuit considered whether the petitioner was subject to removal for committing a drug trafficking offense. *See id.* at 1343. The court held that it lacked "jurisdiction to review a final order of removal against an alien who is removable by reason of" committing a drug trafficking offense, but that the court had jurisdiction to determine whether the petitioner "committed a criminal offense and therefore is removable." *Id.* (internal quotation marks omitted). The court explained that the "upshot of all this is that the jurisdictional question merges into our consideration of the merits." *Id.* The Eleventh Circuit applied *Chevron* deference to that merits question. *See id.* at 1343-44.

Given this deep and enduring split among the circuits on an important question regarding the interpretation of jurisdictional statutes, this Court should grant certiorari.

II. THE DECISION BELOW IS WRONG.

The decision below is wrong, for two reasons.

First, deferring to an *agency*'s interpretation of a statute that determines the *court*'s jurisdiction violates separation of powers. Federal courts "have an independent obligation to determine whether subject-matter jurisdiction exists." *Arbaugh*, 546 U.S. at 514. They must "ask and answer" jurisdictional questions "for [themselves] * * * without respect to the relation of the parties to it." *Steel Co.* v. *Citizens for a Better Env't*, 523 U.S. 83, 94 (1998) (internal quotation marks omitted). This obligation "springs from the nature and limits of the judicial power of the United States and is inflexible and without exception." *Id.* at 94-95 (internal quotation marks and alteration omitted).

Under 42 U.S.C. § 1395*l*(t)(12)(A), the court's jurisdiction ends where the agency's authority begins. *See* Pet. App. 13a, 15a-16a. By deferring to HHS's interpretation of that statute, the D.C. Circuit permitted the agency to set the boundary of the court's power. But a party to litigation "cannot confer jurisdiction; only Congress can do so." *Whitman*, 547 U.S. at 514 (internal quotation marks omitted); *see also* U.S. Const. art. I, § 8; art. III, § 1; *Guerrero-Lasprilla* v. *Barr*, 140 S. Ct. 1062, 1078 (2020) (Thomas, J., dissenting) (noting Congress's "exclusive authority" over federal jurisdiction). Agencies are no exception. It is up to the federal courts, not administrative agencies, to determine their jurisdiction.

Chevron permits executive agencies "to swallow huge amounts of core judicial" power. *Gutierrez-Brizuela* v. *Lynch*, 834 F.3d 1142, 1149 (10th Cir. 2016) (Gorsuch, J., concurring). Members of this Court have questioned its constitutionality for that reason, among others. *See, e.g.*, *Perez* v. *Mortg. Bankers Ass'n*, 575 U.S. 92, 126 (2015) (Thomas, J., concurring) ("When courts refuse even to decide what the best interpretation is under the law, they abandon the judicial check."). But even if the Court accepts *Chevron* deference in some settings, it should reject it here. Article III does not ask whether a court's jurisdiction is "reasonable" under *Chevron*. *See* Pet. App. 28a. It asks whether the court has jurisdiction, period. Federal courts "have no more right to decline the exercise of jurisdiction which is given, than to usurp that which is not given." *Cohens* v. *Virginia*, 19 U.S. (6 Wheat.) 264, 404 (1821). By applying *Chevron* deference when interpreting a jurisdictional statute, the D.C. Circuit impermissibly delegated a core Article III responsibility to an administrative agency.

Second, "*Chevron* deference 'is premised on the theory that a statute's ambiguity constitutes an implicit delegation from Congress to the agency to fill in the statutory gaps.' " *Smith*, 139 S. Ct. at 1778 (quoting *King* v. *Burwell*, 576 U.S. 473, 485 (2015)). "The scope of judicial review," however, is "hardly the kind of question" that "Congress implicitly delegated to an agency." *Id.*

The decision below, and others like it, apply *Chevron* deference because agencies are "generally entitled" to such treatment when interpreting ambiguities in their authorizing statutes. Pet. App. 16a; *see also James*, 522 F.3d at 253 (according *Chevron* deference

because the Immigration and Nationality Act is "a statute that the BIA administers"); *Garces*, 611 F.3d at 1344 (similar). But even broad delegations of legislative authority do not "empower [agencies] to regulate the scope of the judicial power vested by the statute." *Adams Fruit Co.*, 494 U.S. at 650.

Chevron is appropriate only where Congress delegates authority to an agency to interpret "the 'specific provision' and 'particular question' before the court." *City of Arlington* v. *FCC*, 569 U.S. 290, 322-323 (2013) (Roberts, C.J., dissenting) (quoting *Chevron, U.S.A., Inc.* v. *Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984)). Here, Congress did not delegate to HHS "the power to determine the scope of the judicial power vested by" the Medicare statute or "to determine conclusively when its dictates are satisfied." *Smith*, 139 S. Ct. at 1779 (internal quotation marks omitted). "Such an extraordinary delegation of authority cannot be extracted from the statute Congress enacted." *Kucana* v. *Holder*, 558 U.S. 233, 252 (2010). It is neither express nor implied from a statutory provision setting the scope of "judicial review." 42 U.S.C. § 1395*l*(t)(12). The decision below is simply "beyond the *Chevron* pale." *United States* v. *Mead Corp.*, 533 U.S. 218, 234 (2001).

The D.C. Circuit attempted to justify its decision to apply *Chevron* deference by reasoning that *de novo* review "would mean that Congress's decision to enact a preclusion provision operated to enhance judicial scrutiny and restrict the agency's leeway." Pet. App. 18a. But that is precisely the point. There is a "strong presumption that Congress intends judicial review of administrative action." *Bowen*, 476 U.S. at 670; *see also Gutierrez de Martinez* v. *Lamagno*, 515 U.S. 417,

424 (1995). An agency's thumb-on-the-scale interpretation of an ambiguous jurisdictional provision is not the "clear and convincing evidence," *Traynor* v. *Turnage*, 485 U.S. 535, 542 (1988) (internal quotation marks omitted), required to overcome that presumption.

As this Court has explained, "[w]hen a statute is 'reasonably susceptible to divergent interpretation,'" the federal courts should "adopt the reading that accords with traditional understandings and basic principles: that executive determinations generally are subject to judicial review." *Kucana*, 558 U.S. at 251 (quoting *Lamagno*, 515 U.S. at 434). This Court has "consistently applied that interpretive guide," "particularly to questions concerning the preservation of federal-court jurisdiction." *Id.* By making HHS's authority to implement volume-control methods *unreviewable*, Congress indicated that what qualifies as a volume-control method should be narrowly construed and carefully examined—not subject to the preferences of the agency. Applying *de novo* review to that statutory interpretation question best implements congressional intent.

The decision below violates separation of powers, misapplies *Chevron*, and departs from established principles of statutory interpretation. This Court should grant certiorari and reverse.

III. THIS PETITION IS AN IDEAL VEHICLE TO ADDRESS A RECURRING AND IMPORTANT QUESTION.

The question presented is recurring. The Medicare statute alone contains dozens of provisions that determine both the lawfulness of agency action and the

scope of the federal courts' jurisdiction. *See supra* pp. 5-6. Statutes governing immigration, the Transportation Security Administration, the Federal Communications Commission, the Supplemental Nutrition Assistance Program, and state telecommunications commissions include similar provisions. *See supra* pp. 6-7, 18-19. Many of those statutes are frequently litigated in the D.C. Circuit, and future disputes will be governed by the precedent adopted by the court below. In light of "today's vast and varied federal bureaucracy," *City of Arlington*, 569 U.S. at 313 (Roberts, C.J., dissenting) (internal quotation marks omitted), the question whether to defer to an agency's interpretation of a statutory provision that determines the court's jurisdiction will occur time and again. And, indeed, it already has, with notably dissonant results. *See supra* pp. 13-20.

This recurring question has immense legal significance. Petitioners ask the Court to decide whether the Constitution vests power in Congress to set the limits of federal jurisdiction—and in the judiciary to determine if those limits apply in a particular case—or whether administrative agencies may instead determine the boundaries of the courts' authority. Such separation of powers issues are "foundational." *Seila Law LLC* v. *Consumer Fin. Prot. Bureau*, 140 S. Ct. 2183, 2205 (2020); *see also Plaut* v. *Spendthrift Farm, Inc.*, 514 U.S. 211, 217-219 (1995). "Congress' power over federal jurisdiction" must remain "an essential ingredient of separation and equilibration of powers." *Patchak* v. *Zinke*, 138 S. Ct. 897, 907 (2018) (plurality op.) (quoting *Steel Co.*, 523 U.S. at 101). And Article III, not Article II, must define the federal courts' authority. *See Stern* v. *Marshall*, 564 U.S. 462, 482-483

(2011). This Court's intervention is required to uphold those fundamental principles.

The question presented also has a substantial practical impact, further warranting review. "One way or another, Medicare touches the lives of nearly all Americans." *Azar* v. *Allina Health Servs.*, 139 S. Ct. 1804, 1808 (2019). Given the vast scale of the Medicare program, "even seemingly modest modifications to the program can affect the lives of millions." *Id*. The Medicare program "spends about $700 billion annually to provide health insurance for nearly 60 million aged or disabled Americans." *Id.* And HHS administers more than $83 billion annually in Medicare reimbursements through the Outpatient Prospective Payment System. *See* Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 85 Fed. Reg. 85,866, 85,869 (Dec. 29, 2020). Given those stakes, Congress has established an "elaborate statutory scheme," Pet. App. 56a, to set the "amount of payment" for services provided by off-campus PBDs. 42 U.S.C. § 1395*l*(t)(4). HHS completely bypassed that scheme in this case, based solely on its dubious interpretation of a sub-sub-sub provision of the Medicare statute that *does not even mention* reimbursement. Pet. App. 56a-57a; *see also* 42 U.S.C. § 1395*l*(t)(4).

As a result of the Final Rule, hospitals—many of them struggling—will be deprived of over $600 million *annually*, and many off-campus PBDs will be forced to "reduce their services or close completely." Pet. App. 41a. That will be devastating. Off-campus PBDs offer services that may not be otherwise available, particularly in communities with vulnerable populations.

See Hearing with MedPAC to Discuss Hospital Payment Issues, Rural Health Issues, and Beneficiary Access to Care: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means, 114th Cong. 38 (2015) (statement of Am. Hosp. Ass'n). And the Final Rule threatens access to critical healthcare services that provide a safety net for low-income and disabled patients. *See id.*; *see also* Pet. App. 38a n.1.

The decision of the court below, moreover, will embolden HHS to make more drastic cuts to Medicare reimbursement. In addition to the $600 million reduction at issue in this petition, the agency—again citing *Chevron*—simultaneously cut *$1.6 billion* in annual funding for hospitals that serve low-income communities. *Am. Hosp. Ass'n* v. *Azar*, 967 F.3d 818, 835 (2020) (Pillard, J., dissenting in part) (arguing that HHS's position was contrary to clear statutory text and "nullifie[d]" Congress's direct "specifications"). HHS has demonstrated that it will wield *Chevron* deference to re-write the Medicare statute—even where, as here, the federal courts' jurisdiction is at stake.

This case presents an ideal vehicle to resolve this important issue. The question presented was raised and passed on below. *See* Pet. App. 18a-19a. Petitioners disputed below whether *Chevron* applies to jurisdictional statutes. *See* Response Br. for Appellees at 23, 56, *Am. Hosp. Ass'n* v. *Azar,* 964 F.3d 1230 (D.C. Cir. 2020) (No. 19-5352). The D.C. Circuit's decision squarely addressed that question, holding that even though "our consideration of the agency's statutory authority merges with our consideration of the applicability of a preclusion provision," it would "examine that question under the traditional *Chevron* framework." Pet. App. 16a, 18a. And this issue is

dispositive here. The court below nowhere suggested that it would have reached the same result if it had analyzed the jurisdictional statute *de novo*; it held that the statute at issue "does not unambiguously foreclose" HHS from cutting reimbursement as a "method" of volume control. *Compare* Pet. App. 28a, *with Washington Reg'l Medicorp* v. *Burwell*, 813 F.3d 357, 362 (D.C. Cir. 2015) ("[W]e would uphold HHS's interpretation with or without *Chevron* deference because HHS's interpretation is not only reasonable but also the best interpretation of the statute."), *and Competitive Enter. Inst.* v. *U.S. Dep't of Transp.*, 863 F.3d 911, 921 (D.C. Cir. 2017) (Kavanaugh, J., concurring) ("Even without affording *Chevron* deference to the Department's interpretation of the statute, I would still reach the same result in this case.").

And understandably so. Without *Chevron* deference, no court could reasonably countenance HHS's argument that a minor sub-provision of the Medicare statute authorizes the agency to cut reimbursements to hospitals by over $600 million per year—particularly where Congress has addressed the precise policy question at issue and chosen a different outcome. *See supra* p. 9; 42 U.S.C. § 1395*l*(t)(21)(B)(ii). As the District Court stated below, it is "clear[]" that Congress did not intend to grant HHS "unilateral authority to pick and choose what to pay for [off-campus PBD] services." Pet. App. 65a. There is no reason to wait for further percolation. A majority of the circuits has weighed in on the question presented, and the circuit conflict is deep and persistent. This Court's review is warranted.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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