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Deference to the Agency Is the Best Policy: The D.C. Circuit Applies *Chevron* in Denying Additional Medicare Reimbursements to Provider Hospitals in *Washington Regional Medicorp*

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DEFERENCE TO THE AGENCY IS THE BEST POLICY: THE D.C. CIRCUIT APPLIES *CHEVRON* IN DENYING ADDITIONAL MEDICARE REIMBURSEMENTS TO PROVIDER HOSPITALS IN *WASHINGTON REGIONAL MEDICORP*

Abstract: On December 29, 2015, in *Washington Regional Medicorp v. Burwell*, the U.S. Court of Appeals for the District of Columbia Circuit held that the Secretary of Health and Human Services ("HHS") correctly interpreted the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") in calculating Medicare reimbursements for a provider hospital based on the capped target amount from the previous year. In agreeing with the Secretary, the D.C. Circuit joined the U.S. Courts of Appeals for the Third and Sixth Circuits in holding that the statute and its implementing regulations supported the Secretary. The U.S. Court of Appeals for the Fifth Circuit, in contrast, has held that the regulations unambiguously compel the contrary conclusion, namely, that the Secretary should base her calculation on a hospital-specific target amount. This Comment argues that the D.C. Circuit's interpretation of TEFRA is the right one. It correctly applies the *Chevron* analysis, deferring to HHS, while also noting that HHS's reading is the best one. In doing so, the D.C. Circuit also fulfills the congressional intent to transfer hospitals from a system of hospital-specific reimbursements to a decidedly more objective system of reimbursements.

INTRODUCTION

Comprising more than one tenth of the federal budget, Medicare is the federally administered program responsible for providing millions of elderly and disabled Americans with health insurance.[1] When provider hospitals treat Medicare patients, they are reimbursed by the Department of Health

[1] *See* 42 U.S.C. § 1395ww (2012) (laying out the mechanics of the Medicare system and describing its general purpose); JULIETTE CUBANSKI & TRICIA NEUMAN, THE HENRY J. KAISER FAMILY FOUND., THE FACTS ON MEDICARE SPENDING AND FINANCING 1 (2016) (noting that Medicare spending constitutes about fifteen percent of the federal budget as of 2015); Eleanor D. Kinney, *In Search of Bureaucratic Justice—Adjudicating Medicare Home Health Benefits in the 1980s*, 42 ADMIN. L. REV. 251, 253 (1990) (detailing the more than thirty million Americans enrolled in Medicare).

and Human Services ("HHS").[2] Hospitals are usually reimbursed according to the Prospective Payment System ("PPS"), through which each hospital receives a fixed amount per year for services rendered to Medicare patients.[3] For many years, psychiatric hospitals constituted an exception to this rule, as they received reimbursements based on their reasonable actual costs.[4] The Tax Equity and Fiscal Responsibility Act ("TEFRA") of 1982 defined the method for calculating the psychiatric hospitals' reimbursement payments.[5]

Not surprisingly, the courts are tasked with the interpretation of this Medicare reimbursement statute.[6] In December 2015, in *Washington Regional Medicorp v. Burwell*, the U.S. Court of Appeals for the District of Columbia Circuit joined the U.S. Courts of Appeals for the Third and Sixth Circuits in holding that the governing statute and its corresponding regulations supported the Secretary's calculation of reimbursement payments.[7] Additionally, the D.C. Circuit suggested that the statute and regulations, even if ambiguous, were entitled to deference in accordance with the U.S. Supreme Court's 1984 decision in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc*.[8] Conversely, the U.S. Court of Appeals for

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[2] *See* 42 U.S.C. § 1395f (instructing the Department for Health and Human Services ("HHS") to make such payments to providers of services, including hospitals); Wash. Reg'l Medicorp v. Burwell (*Wash. Reg'l I*), 72 F. Supp. 3d 159, 160 (D.D.C. 2014), *aff'd*, 813 F.3d 357 (D.C. Cir. 2015) (observing how HHS reimburses hospitals for the services they offer to Medicare patients).

[3] *See* Hardy Wilson Mem'l Hosp. v. Sebelius (*Hardy Wilson II*), 616 F.3d 449, 452 (5th Cir. 2010) (describing the regulatory scheme governing Medicare reimbursements to provider hospitals); Martin F. Grace & Jean M. Mitchell, *Regulation of Health Care Costs: The Implications of the Prospective Payment Reimbursement System*, 2 U. FLA. J.L. & PUB. POL'Y 125, 128 (1989) (describing the Prospective Payment System ("PPS") as the implementation of a more uniform system of hospital reimbursement).

[4] *See* 42 U.S.C. § 1395ww(b)(1) (defining actual costs in terms of the operating costs of a hospital's inpatient services); Mich. Dep't of Cmty. Health v. Sec'y of Health & Human Servs., 496 F. App'x 526, 528, 530 (6th Cir. 2012) (detailing the exclusion of psychiatric hospitals from the PPS during the years 1982 through 2005).

[5] *See* Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, Pub. L. No. 97-248, 96 Stat. 324, 332–33 (codified as amended at 42 U.S.C. § 1395ww) (accounting for, among other things, routine operating costs, ancillary services, and special care unit costs in determining a hospital's operating costs).

[6] *See* Webster v. Luther, 163 U.S. 331, 342 (1896) (declaring that the judiciary is the ultimate arbiter of statutory construction, even when an agency is charged with administering the statute); *Wash. Reg'l I*, 72 F. Supp. 3d at 163 (stating that the judiciary will first use the relevant tools of statutory construction before deferring to an agency's interpretation).

[7] *See* Wash. Reg'l Medicorp v. Burwell (*Wash. Reg'l II*), 813 F.3d 357, 362 (D.C. Cir. 2015) (holding that the Secretary's interpretation squared with the plain meaning of the statute); *Mich. Dep't of Cmty. Health*, 496 F. App'x at 533 (holding that the plain language of the statute supported the Secretary's interpretation); Ancora Psychiatric Hosp. v. Sec'y of U.S. Dep't of Health & Human Servs., 417 F. App'x 171, 175 (3d Cir. 2011) (same).

[8] *See* Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 843 (1984) (requiring deference to the agency when the relevant statute is either silent or ambiguous); *Wash. Reg'l II*, 813 F.3d at 362 (same). In fact, the D.C. Circuit declared it would uphold the Secretary's inter-

the Fifth Circuit, in *Hardy Wilson Memorial Hospital v. Sebelius* decided five years earlier in 2010, held that the regulations in question unambiguously accorded with the hospital's method of calculation.[9]

This Comment argues that the D.C. Circuit reached the correct result by appropriately deferring to the administrative agency as required by *Chevron* and its progeny.[10] This Comment further argues that the holding of the D.C. Circuit is consistent with congressional intent in passing Medicare reimbursement legislation.[11] Part I of this Comment provides an overview of the legislative history surrounding Medicare reimbursements before discussing the factual and procedural history of *Washington Regional Medicorp*.[12] Part II explores the split between the Fifth Circuit and the D.C. Circuit when applying *Chevron* to the Medicare reimbursement statute and regulations.[13] Lastly, Part III argues that the D.C. Circuit correctly held that the hospital was not entitled to higher reimbursement payments just because the statutory caps had expired.[14]

I. A BRIEF HISTORY OF MEDICARE REIMBURSEMENTS AND *WASHINGTON REGIONAL MEDICORP*

The Center for Medicare and Medicaid Services ("CMS") is the component of the HHS responsible for administering the Medicare program.[15] Through the CMS, hospitals are reimbursed for the services they provide to Medicare patients.[16] In the past decade, dispute over the calculation of these reimbursements has resulted in numerous lawsuits.[17] Section A of this Part

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pretation even without *Chevron* deference because that interpretation was "the best interpretation of the statute." *Wash. Reg'l II*, 813 F.3d at 362.

[9] *See Hardy Wilson II*, 616 F.3d at 460 (holding that the regulations clearly compelled the hospital's interpretation because only one part of the regulations had expired at the end of 2002). The Fifth Circuit determined the statute was ambiguous but deferred to the Secretary's interpretation under *Chevron*. *Id.* at 456, 458.

[10] *See infra* notes 88–99 and accompanying text.

[11] *See infra* notes 100–109 and accompanying text.

[12] *See infra* notes 15–56 and accompanying text.

[13] *See infra* notes 57–87 and accompanying text.

[14] *See infra* notes 88–109 and accompanying text.

[15] *See Wash. Reg'l II*, 813 F.3d at 358 (identifying the Center for Medicare and Medicaid Services ("CMS") and its relation to HHS); Sam Halabi, *The Patient Protection and Affordable Care Act of 2010: Rulemaking in the Shadow of Incentive-Based Regulation*, 38 RUTGERS L. REC. 141, 144 (2011), http://lawrecord.com/files/38_Rutgers_L_Rec_141.pdf [https://perma.cc/Q6RZ-9H9X] (noting the oversight role CMS exercises with respect to Medicare and Medicaid).

[16] *See Wash. Reg'l II*, 813 F.3d at 358 (explaining the role of CMS); CTR. FOR MEDICARE & MEDICAID SERVS., ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM 4 (2016) (identifying how CMS determines the amounts of reimbursement payments to which provider hospitals are entitled).

[17] *See, e.g.*, *Wash. Reg'l II*, 813 F.3d at 358 (describing a challenge brought by an inpatient psychiatric hospital to the method of calculation that the Secretary of Health and Human Services

traces the development of the Medicare reimbursements through the lens of an evolving federal statutory scheme and its corresponding regulations.[18] Section B of this Part summarizes the U.S. District Court for the District of the District of Columbia's 2014 decision in *Washington Regional Medicorp v. Burwell*, while also discussing the means of interpreting the pertinent statutory scheme and its accompanying regulations.[19]

A. History of Medicare Reimbursements

To combat Medicare's exorbitant hospital expenditures, Congress enacted TEFRA in 1982, directing the Secretary of HHS to draft a legislative proposal for PPS that would distribute a fixed amount to hospitals for total services rendered.[20] In the interim, Congress imposed a system of limits on the annual rate of increase for reimbursements, which was based on a hospital's reasonable costs.[21] Under the interim plan, hospitals were reimbursed for their reasonable costs not exceeding a ceiling based on the hospital's "target amount" for the given year.[22] When the PPS was rolled out in 1983, psychiatric hospitals were excluded.[23] Consequently, psychiatric hospitals continued to receive reimbursements under the interim plan, based on their reasonable actual costs, leading to substantial differences in reimbursement amounts.[24]

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used); *Mich. Dep't of Cmty. Health*, 496 F. App'x at 527 (deciding a case in which psychiatric hospitals sued the Secretary of HHS); *Ancora Psychiatric Hosp.*, 417 F. App'x at 172 (same).

[18] *See infra* notes 20–37 and accompanying text.

[19] *See infra* notes 38–56 and accompanying text.

[20] *See* Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, Pub. L. No. 97-248, 96 Stat. 324, 335 (codified as amended in scattered sections of Title 42) (requiring the Secretary to develop a plan for the transition from a reasonable costs system to a prospective payment system); *see also* S. REP. NO. 97-494, pt. 1, at 24 (1982) (noting that hospital spending outpaced inflation at an extraordinary rate over the previous decade, perhaps because of the shift in funding from private resources to government programs like Medicare and Medicaid).

[21] *See* 42 U.S.C. § 1395ww(b)(1) (2012) (basing reimbursement on a hospital's operating costs, provided that those operating costs are reasonable).

[22] *Id.* § 1395ww(b)(3)(A); *see* Eleanor D. Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L.J. 1, 17 (1987) (observing that payment was originally linked to the amounts that providers charged). For the first year that a hospital reported its costs, this target amount was defined as the "allowable operating costs of inpatient hospital services" for the preceding year, plus an applicable percentage increase. 42 U.S.C. § 1395ww(b)(3)(A)(i). For all subsequent years, the target amount was defined in terms of the target amount for the preceding year, again plus an applicable percentage increase. *Id.* § 1395ww(b)(3)(A)(ii).

[23] *See Wash. Reg'l II*, 813 F.3d at 359 (explaining that Congress decided to exclude certain types of hospitals, including psychiatric hospitals from the PPS). Congress decided to exclude psychiatric hospitals because they tend to serve disproportionate numbers of low-income earners. 42 U.S.C. § 1395ww(a)(1)(D)(2)(B).

[24] *See* H. REP. NO. 105-149, at 1336 (1997) (suggesting that it was misguided to allow the excluded hospitals to receive reimbursements based on their reasonable actual costs, because a flat

In response to this discrepancy, Congress passed the Balanced Budget Act ("BBA") in 1997, which applied to hospitals exempt from the PPS.[25] Under the BBA, target amounts for the years 1998 to 2002 could not exceed the seventy-fifth percentile of target amounts for all hospitals in the same class for the year of 1996.[26] In 1999, Congress passed the Balanced Budget Refinement Act, which directed the Secretary to transition the psychiatric hospitals onto the PPS by 2002.[27] The Secretary failed, however, to incorporate those hospitals until 2005.[28] As a result, the Secretary continued to calculate reimbursements for the years from 2002 to 2005 based on the BBA capped target amounts.[29]

To effectuate the purposes of TEFRA, the Secretary promulgated regulations beginning in 1982.[30] These regulations detailed how a hospital's target amount would be calculated under TEFRA for the first year and all subsequent years until the PPS was implemented.[31] In 1997, following the BBA's passage, the Secretary amended the regulations for hospitals still calculating their target amounts with reference to the 1982 statute so as to incorporate the new cap scheme.[32] Finally, in 2005, HHS amended the regu-

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price would have driven down costs by limiting the amounts of reimbursements available to similarly situated excluded hospitals).

[25] Balanced Budget Act (BBA) of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified at 42 U.S.C. § 1395ww(b)(3)(H)). The statute explicitly identifies psychiatric units as a distinct class of exempt hospitals. 42 U.S.C. § 1395ww(b)(3)(H)(iv)(I).

[26] *See* 42 U.S.C. § 1395ww(b)(3)(H)(ii)(I) (requiring the Secretary to estimate the 1996 seventy-fifth percentile for each class of hospitals).

[27] Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, Pub. L. No. 106-113, 113 Stat. 1501; *see also Mich. Dep't of Cmty. Health*, 496 F. App'x at 529–30 (describing generally the effect of the BBRA on previously exempt hospitals).

[28] *See* TOMMY G. THOMPSON, U.S. DEP'T OF HEALTH & HUMAN SERVS., PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT SERVICES IN PSYCHIATRIC HOSPITALS AND EXEMPT UNITS 24 (2002) (explaining that defining objective patient characteristics with respect to psychiatric hospitals is more challenging than it is for acute care hospitals). Objective patient characteristics help HHS to set a national rate under the PPS, and this rate will then apply across the board to all similarly situated hospitals. *Id.* at 2.

[29] *See Wash. Reg'l II*, 813 F.3d at 360 (explaining that because the capped target amount was much smaller than the target amount based on actual costs, the target amount in 2003 was correspondingly smaller than it would have been had the target amount been based on actual costs); *see also* Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates, 67 Fed. Reg. 49,982, 50,103–04 (Aug. 1, 2002) (to be codified at 42 C.F.R. pt. 413) (clarifying that the target amount for 2003 would be based on the target amount from 2002, notwithstanding the expiration of the statutory caps).

[30] *See* 42 C.F.R. § 413.40(c)(4) (2016) (detailing how to calculate the target amount). These regulations essentially mimicked the language of the federal statute. *Id.*; *Wash. Reg'l II*, 813 F.3d at 359.

[31] *See* 42 C.F.R. § 413.40(c)(4)(i)–(ii) (mirroring the language of the federal statute for the target amount for both the first year and all years thereafter); *see also* 42 U.S.C. § 1395ww(b)(3)(A)(i)–(ii) (providing a definition of the target amount for the first year as well as all subsequent years).

[32] 42 C.F.R. § 413.40(c)(4)(iii). Under paragraph (c)(4)(iii), the hospital's target amount was to be the lower of the amounts described in paragraphs (c)(4)(iii)(A) and (c)(4)(iii)(B). *Id.* Para-

lations, specifying that the provision incorporating the cap scheme only applied from 1998 through 2002, but that the capped target amount from 2002 could still be used to calculate the target amount for 2003.[33] In that same year, HHS moved psychiatric hospitals to the PPS.[34]

Under 42 C.F.R. § 413.40(i), the target amount is essentially equal to actual costs during the first cost reporting period.[35] Then, in accordance with 42 C.F.R. § 413.40(ii), the target amount for all subsequent years is equal to the target amount from the previous year, increased by a certain percentage.[36] Finally, 42 C.F.R. § 413.40(iii) applied during the years 1998 to 2002, forcing a hospital to select the lower of two numbers: the target amount based on actual costs and the target amount as limited by the BBA caps.[37]

B. The District Court Addresses Medicare Reimbursements for the Gap Years in Washington Regional Medicorp v. Burwell

Fayetteville Hospital, a psychiatric facility operated by Washington Regional Medicorp, provided inpatient services to Medicare patients in 2003 and 2004.[38] At first, the fiscal intermediary responsible for calculating the reimbursement payments notified Fayetteville Hospital that it would be reimbursed based on an amount tied to its actual costs, rather than an amount that the BBA caps limited.[39] The intermediary, however, subsequently altered its calculation and informed the hospital that its target amounts would now be calculated using the capped target amount from 2002.[40] Upset with this reduced reimbursement calculation, the hospital appealed to the Provider Re-

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graph (c)(4)(iii)(A) described a hospital-specific amount, whereas paragraph (c)(4)(iii)(B) outlined the BBA cap amount for the years 1998 through 2002. *Id.* § 413.40(c)(4)(iii)(A)–(B).

[33] *See* Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates, 70 Fed. Reg. 47,278, 47,464 (Aug. 12, 2005) (to be codified at 42 C.F.R. pt. 413) (explaining that the Secretary intended for the provision to expire after September 30, 2002, but that the target amount from 2002 would necessarily be used in calculating the target amount for 2003); *see also* 42 C.F.R. § 413.40(c)(4)(iii) (stating that this provision only applies from 1998 through 2002).

[34] *See* Prospective Payment System for Inpatient Psychiatric Facilities, 69 Fed. Reg. 66,922, 66,922–24 (Nov. 15, 2004) (to be codified at 42 C.F.R. pt. 413) (explaining that the move was delayed because of unanticipated complications in developing a PPS for psychiatric hospitals).

[35] 42 C.F.R. § 413.40(c)(4)(i) (tracking the language of 42 U.S.C. § 1395ww(b)(3)(A)).

[36] *Id.* § 413.40(c)(4)(ii) (tracking the language of 42 U.S.C. § 1395ww(b)(3)(A)(ii)).

[37] *Id.* § 413.40(c)(4)(iii) (tracking the language of 42 U.S.C. § 1395ww(b)(3)(H)).

[38] *Wash. Reg'l I*, 72 F. Supp. 3d at 160.

[39] *Id.* at 162. The fiscal intermediary seemed to assume that it should return to calculating the target amount under TEFRA, instead of relying on the target amount from 2002, the last year in which the BBA was in effect. *See id.* A fiscal intermediary is a private contractor whom the HHS hires to administer its Medicare reimbursement program. *Mich. Dep't of Cmty. Health,* 496 F. App'x at 529 n.3.

[40] *Wash. Reg'l I*, 72 F. Supp. 3d at 162.

imbursement Review Board.[41] Following its hearing of the appeal, the Board approved the dispute for expedited judicial review.[42]

Accordingly, Fayetteville filed this action in the U.S. District Court for the District of Columbia challenging the Secretary's interpretation of the BBA.[43] Fayetteville argued that HHS wrongly extended the BBA caps beyond 2002 by basing its 2003 target amount on the capped 2002 target amount.[44] It maintained that HHS should have instead recalculated the hospital-specific target amount for reimbursements for 2003 and 2004.[45]

Relying on the Supreme Court's 1984 decision in *Chevron*, the district court analyzed the statute in two steps.[46] According to *Chevron*, the court first asks if the statute is unambiguous with respect to the specific issue being litigated.[47] If the statute is unambiguous, the court terminates its analysis because it is obligated to enforce the plain meaning of the statute.[48] If, however, there is ambiguity in the statute, the court gives deference to the interpretation of the statute that the agency advanced.[49] It will not overturn the agency's interpretation unless it is arbitrary or otherwise irrational.[50]

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[41] *Id.* The Provider Reimbursement Review Board is the adjudicative body responsible for hearing any initial dispute concerning a hospital's reimbursements. Kathleen A. Carrigan, Comment, *Administrative Law—Jurisdictional Authority of the Provider Reimbursement Review Board*, 10 W. NEW ENG. L. REV. 183, 184 (1988).

[42] *Wash. Reg'l I*, 72 F. Supp. 3d at 162; *see also* 42 U.S.C. § 1395oo(f)(1) (2012) (granting providers the right to obtain judicial review when the Board determines that it has no authority to decide the question of law presented by the appeal).

[43] *Wash. Reg'l II*, 813 F.3d at 360.

[44] *See id.* at 360–61 (arguing that HHS's approach contradicted 42 U.S.C. § 1395(b)(3)(H) that implemented the BBA caps and limited the applicability of those caps to the years 1998 through 2002).

[45] *Id.* Fayetteville also contended that HHS committed a retroactive revision when it amended its regulations in 2005 by adding the language that limited 42 C.F.R. § 413.40(c)(4)(iii) to the years 1998 through 2002. *Id.*

[46] *See Chevron*, 467 U.S. at 842 (explaining that a court must answer two questions when reviewing an agency's interpretation of a statute); *Wash. Regional I*, 72 F. Supp. 3d at 163 (reciting those same two questions).

[47] *Chevron*, 467 U.S. at 842.

[48] *See id.* at 842–43 (suggesting that a statute is unambiguous if its meaning is clear); FEC v. Democratic Senatorial Campaign Comm., 457 U.S. 27, 42–43 (1981) (implying that the court must overturn any administrative interpretation of a statute that conflicts with the plain language of the statute).

[49] *Chevron*, 467 U.S. at 843; *see also* Clark Byse, *Judicial Review of Administrative Interpretation of Statutes: An Analysis of* Chevron*'s Step Two*, 2 ADMIN. L.J. 255, 256 (1988) (reflecting on the novelty of the second step of the analysis and stressing that the interpretation of the statute then becomes an administrative duty, not a judicial one). Justice Stevens, writing for the majority, maintained that the court will not interject its own interpretation of the statute in cases of textual ambiguity. *Chevron*, 467 U.S. at 843.

[50] *Chevron*, 467 U.S. at 844; United States v. Morton, 467 U.S. 822, 834 (1984) (noting that the grounds for reversing an administrative interpretation of an ambiguous statute are generally limited to arbitrariness, irrationality, and capriciousness).

Courts use a different standard to determine when to defer to an agency's interpretation of a regulation.[51] In 1945, in *Bowles v. Seminole Rock & Sand Co.*, the Supreme Court made clear that deference to an agency is owed when one of its regulations is ambiguous.[52] In that situation, the Court will not overturn the agency's interpretation unless it is patently erroneous.[53]

Applying *Chevron*, the district court granted summary judgment in favor of HHS.[54] The court held that the Medicare statute unambiguously supported the Secretary's reading of both the statute and her own regulations.[55] In the alternative, the district court found that the Secretary's reading of the statute and her own regulations was reasonable, and therefore entitled to deference under *Chevron*.[56]

II. CIRCUITS CONFLICT WHEN APPLYING *CHEVRON* IN THE MEDICARE REIMBURSEMENTS CONTEXT

Since the delayed transition of provider hospitals to a Prospective Payment System in 2008, courts have drawn conflicting conclusions about whether the Medicare reimbursement statute and its accompanying regulations are ambiguous as to the method of calculation.[57] *Washington Regional Medicorp v. Burwell*, a 2015 decision of the U.S. Court of Appeals for the District of Columbia Circuit, represents the courts' latest effort to settle this

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[51] *See* Bowles v. Seminole Rock & Sand Co., 325 U.S. 410, 413–14 (1945) (interpreting a maximum price regulation in the wake of World War II).

[52] *See id.* at 414 (deferring to agency expertise when the meaning of the regulation is in doubt).

[53] *See id.* (insisting that the administrative interpretation is paramount when there is no plain meaning of the regulation that is at issue in the case).

[54] *See Wash. Reg'l I*, 72 F. Supp. 3d at 164, 168. Observing the circuit split on the issue, the court declined to accept the analysis of the Fifth Circuit and instead applied the analysis of the Third and Sixth Circuits. *Id.* at 163–64. *Compare Mich. Dep't of Cmty. Health*, 496 F. App'x at 533 (deciding that the statute was unambiguous), *and Ancora Psychiatric Hosp.*, 417 Fed App'x at 175 (same), *with Hardy Wilson II*, 616 F.3d at 460 (ruling that the statute was ambiguous).

[55] *Wash. Reg'l I*, 72 F. Supp. 3d at 165 (reciting the first step under *Chevron* and finding that it was satisfied in this case); *see also Chevron*, 467 U.S. at 842 (holding that the first step in reviewing an agency's interpretation of a statute is deciding whether the statute unambiguously addresses the question raised by the case).

[56] *See Wash. Reg'l I*, 72 F. Supp. 3d at 165. The district court also rejected the claim that HHS's amendment amounted to a retroactive revision. *Id.* at 167. The district court viewed the amendment as a mere clarification of the temporal limits on 42 C.F.R. § 413.40(c)(4)(iii). *Id.* Thus, it was not a substantive change to the regulations. *Id.* at 168. *But see Hardy Wilson II*, 616 F.3d at 461 (holding that the amendment was a substantive change).

[57] *Compare* Chalmette Med. Ctr., Inc., v. U.S. Dep't of Health & Human Servs., No. 08-cv-4027, 2009 WL 2488265, at *1, *5 (E.D. La. Aug. 11, 2009) (holding that the statute unambiguously dictated that the Secretary use the capped amount from 2002 to calculate the target amount for 2003), *with* Ark. State Hosp. v. Leavitt, No. 07-cv-624, 2008 WL 4531714, at *1, *4 (E.D. Ark. Oct. 8, 2008) (holding that the statute was fairly ambiguous as to how target amounts would be calculated after 2002).

issue of statutory interpretation.[58] Before the D.C. Circuit's decision in *Washington Regional*, the U.S. Courts of Appeals for the Third, Fifth, and Sixth Circuits entertained challenges to the Secretary's interpretation of the Medicare reimbursement statute and its guiding regulations.[59] Section A of this Part reviews the Fifth Circuit's 2010 decision in *Hardy Wilson Memorial Hospital v. Sebelius*, which concluded that the regulation unambiguously directed the Secretary to use hospital-specific amounts in calculating reimbursements for 2003 to 2005.[60] Section B of this Part summarizes the outcome in the D.C. Circuit, which diverged from that of the Fifth Circuit.[61]

A. Fifth Circuit: Regulations Unambiguously Support Hospital's Interpretation

In 2010, in *Hardy Wilson Memorial Hospital*, the Fifth Circuit held that the Medicare reimbursement regulations promulgated by the Secretary actually directed her to use hospital-specific target amounts, not capped amounts, in calculating reimbursement payments for provider hospitals.[62] This case concerned five acute care hospitals, all of which contained psychiatric units in their facilities.[63] Their reimbursements for the years 2003, 2004, and 2005 were based on the capped amounts used between 1998 and 2002.[64] Accordingly, they received much lower payments than they would have received if the Secretary had used the hospital-specific target amounts for those years.[65]

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[58] *See* Wash. Reg'l Medicorp v. Burwell (*Wash. Reg'l II*), 813 F.3d 357, 361–62 (D.C. Cir. 2015).

[59] *See* Mich. Dep't of Cmty. Health v. Sec'y of Health & Human Servs., 496 F. App'x 526, 541 (6th Cir. 2012) (holding that statute and regulations unambiguously required the Secretary to use the capped amounts in calculating the target amounts after 2002); Ancora Psychiatric Hosp. v. Sec'y of U.S. Dep't of Health & Human Servs., 417 F. App'x 171, 172 (3d Cir. 2011) (same); Hardy Wilson Mem'l Hosp. v. Sebelius (*Hardy Wilson II*), 616 F.3d 449, 460 (5th Cir. 2010) (holding that regulations plainly commanded the Secretary to use hospital-specific amounts to calculate the target amounts after 2002).

[60] *See infra* notes 62–74 and accompanying text.

[61] *See infra* notes 75–87 and accompanying text.

[62] *See* 616 F.3d at 460–61 (holding that the Secretary's interpretation was not entitled to deference because the regulation was unambiguous); *see also* Antonin Scalia, *Judicial Deference to Administrative Interpretations of Law*, 1989 DUKE L.J. 511, 521 (observing that deference is not triggered when the plain meaning of a text is clear).

[63] *Hardy Wilson II*, 616 F.3d at 452. An acute care hospital is defined as "a short term care hospital in which the average length of patient stay is less than thirty days . . . ." 29 C.F.R. § 103.30(f)(2) (2016). An acute care hospital does not lose its acute care status if it provides psychiatric care. *Id.*

[64] *Hardy Wilson II*, 616 F.3d at 453. The capped amounts were equivalent to the seventy-fifth percentile of the target amount for hospitals in the same class as the plaintiff hospitals. *Id.*

[65] *Id.* In fact, as the table provided by the Fifth Circuit demonstrates, the payments based on the capped amounts were less than half of the payments based on the hospital-specific amounts. *Id.*

The hospitals sought review of the decision in the district court, where the court granted summary judgment in favor of the Secretary.[66]

On appeal, the Fifth Circuit first reasoned that the Medicare reimbursement statute was ambiguous as to how reimbursement payments should be calculated during the gap years of 2003 through 2005.[67] Given this ambiguity, the court then deferred to the Secretary's interpretation in accordance with *Chevron*.[68] From the court's perspective, using the capped amounts to calculate reimbursement payments was not unreasonable because the statute stated that the target amount for each year was to be based on the target amount from the previous year.[69] As a result, the court upheld the Secretary's interpretation because it drew on the statutory language defining the phrase "target amount" for both the first year and all subsequent years.[70]

Moving to the related issue of regulatory interpretation, the Fifth Circuit next held that the Medicare reimbursement regulations unambiguously required the Secretary to use the hospital-specific target amounts when calculating reimbursement payments for 2003 through 2005.[71] At the outset, the court noted that the target amounts mentioned in the two provisions of the initial regulation were subject to the two provisions of the newer regulation implementing the statutory caps.[72] Next, the court observed that only the second provision of this newer regulation had expired at the end of

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[66] *Id.* at 454. The court pointed out that summary judgment was proper both because there was no genuine issue of material fact and because statutory interpretation is a pure question of law. FED. R. CIV. P. 56(a); *see Hardy Wilson II*, 616 F.3d at 454 (applying the summary judgment standard).

[67] *See Hardy Wilson II*, 616 F.3d at 457 (pointing out that the statute was silent on the issue concerning the gap years). The court pointed to the contrasting interpretations that the Secretary and hospitals offered, deeming both interpretations "plausible." *Id.* at 456. Given the availability of two reasonable interpretations of the statute, the court necessarily concluded that the statute was ambiguous. *Id.* at 457; *see also* United States v. Valle, 538 F.3d 341, 345 (5th Cir. 2008) (describing a statute as ambiguous when it admits of two reasonable interpretations).

[68] *Hardy Wilson II*, 616 F.3d at 458; *see also* Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 843 (1984) (explaining that if the statute is silent or ambiguous in regard to the particular issue, the court should defer to the administrative agency's interpretation, provided that the interpretation is based on an acceptable reading of the statute).

[69] 42 U.S.C. § 1395ww(b)(3)(A)(ii) (2012); *Hardy Wilson II*, 616 F.3d at 458. The Fifth Circuit explained that it could not reverse the Secretary's interpretation unless her interpretation was "arbitrary, capricious, or manifestly contrary to the statute." *Hardy Wilson II*, 616 F.3d at 458 (quoting *Chevron*, 467 U.S. at 844).

[70] 42 U.S.C. § 1395ww(b)(3)(A)(i)–(ii); *see Hardy Wilson II*, 616 F.3d at 458 (noting that the Secretary's interpretation logically followed from the text of the statute and was thus a permissible interpretation of said statute).

[71] *See Hardy Wilson II*, 616 F.3d at 460 (holding that the Secretary's interpretation warranted no deference because the regulation was unambiguous).

[72] *See id.* at 459 (highlighting the language in each regulatory provision); 42 C.F.R. § 413.40 (c)(4)(i)–(iii) (2016) (using a preamble to make clear that (c)(4)(i) and (c)(4)(ii) were subject to (c)(4)(iii)).

2002.[73] Because the first provision remained intact, the target amounts for 2003 through 2005 were subject to that provision, meaning that the hospital-specific target amounts should be used to calculate the reimbursement payments for those years, against the Secretary's contention.[74]

B. Deferring to Agency Interpretations in the Statutory and Regulatory Contexts: The D.C. and Sixth Circuits

The D.C. Circuit's later decision in *Washington Regional* contradicted the Fifth Circuit's decision in *Hardy Wilson Memorial Hospital*.[75] Although the D.C. Circuit seemed to agree with the Fifth Circuit as to the statute, it clearly disagreed as to the regulations.[76]

On appeal in *Washington Regional*, the D.C. Circuit reviewed the district court's *Chevron* analysis.[77] The D.C. Circuit affirmed the district court's holding in both respects.[78] It concluded that the plain language of

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[73] *See Hardy Wilson II*, 616 F.3d at 460 (contrasting (c)(4)(iii)(A) and (c)(4)(iii)(B)). As the court clarified, 42 C.F.R. § 413.40(c)(4)(iii)(A) was not restricted to specific years. *Id.* Section 413.40(c)(4)(iii)(B), however, was limited to the years 1998 through 2002. *Id.*; 42 C.F.R. § 413.40 (c)(4)(iii)(B).

[74] *Hardy Wilson II*, 616 F.3d at 460. The court also rejected the Secretary's attempt in 2005 to clarify the time limits by asserting that all of 42 C.F.R. § 413.40(c)(4)(iii) expired on October 1, 2002. *Id.* at 461. The court concluded by chiding the Secretary for imposing a retroactive revision on the regulatory text. *See id.* (quoting Pope v. Shalala, 998 F.2d 473, 486 (7th Cir. 1993)) (maintaining that the Secretary is obligated to abide by her regulations until she changes them).

[75] *See Wash. Reg'l II*, 813 F.3d at 365 (holding in favor of the Secretary of Health and Human Services); *infra* notes 77–80 and accompanying text.

[76] *See Wash. Reg'l II*, 813 F.3d at 364 (rejecting the argument that the regulations unambiguously dictated used of the hospital-specific target amounts after 2002); *infra* notes 81–87 and accompanying text.

[77] *See Wash. Reg'l II*, 813 F.3d at 358 (holding that the Secretary's reading of the controlling statute and regulation was not only reasonable but also the best reading). Fayetteville Hospital raised two main arguments on appeal: (1) the controlling statute and regulations unambiguously directed the Secretary to use the hospital-specific target amount when calculating reimbursements and (2) the Secretary retroactively revised the regulations in contravention of the plain text. *Id.* at 360–61. The law usually does not approve of retroactive rulemaking. *See, e.g.*, Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 208 (1988) (noting the Court's distaste for retroactive revisions).

[78] *Wash. Reg'l II*, 813 F.3d at 363–65. Writing for a unanimous panel, Senior Circuit Judge David Sentelle reasoned that the most straightforward reading of the statute instructed the Secretary to base each year's target amount on the target amount from the previous year. *Id.* at 362–63; *see* 42 U.S.C. § 1395ww(b)(3)(A)(ii) (providing that the target amount for the present year must be based on the target amount from the previous year). Accordingly, the Secretary based the target amount for 2003 on the capped target amount from 2002. *Wash. Reg'l II*, 813 F.3d at 362; *see also Ancora Psychiatric Hosp.*, 417 Fed App'x at 176 (emphasizing the interplay between (b)(3)(H) and (b)(3)(A)(ii)). As to the regulation, Judge Sentelle observed that its language regarding the target amount was similarly straightforward. *See Wash. Reg'l II*, 813 F.3d at 364 (quoting the regulatory language); 42 C.F.R. § 413.40(c)(4)(ii) ("[F]or subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor . . . .").

the statute supported the Secretary's reading.[79] Without deciding the issue of ambiguity, the D.C. Circuit accepted the Secretary's reading because her reading represented a reasonable interpretation of the statute.[80]

Turning to the regulations, the D.C. Circuit deferred to the Secretary's interpretation.[81] The court made clear, however, that even without deference, it would uphold the Secretary's interpretation.[82] In light of its agreement with the Secretary, the D.C. Circuit further reasoned that the amendment presented no retroactivity problem because it only clarified the time limit associated with the BBA caps.[83]

Similarly, in *Michigan Department of Community Health v. Secretary of Health and Human Services* in 2012, the Sixth Circuit rejected the Fifth Circuit's decision in *Hardy Wilson* because using a hospital-specific target amount would subvert Congress's intent by restoring a reimbursement system tied to hospital-specific costs.[84] More relevant to the D.C. Circuit's decision, the Sixth Circuit also held that the Secretary's interpretation of her regulations was acceptable because no other interpretation necessarily followed from the text.[85] Moreover, the Sixth Circuit observed that deference to the Secretary's interpretation of her regulations was especially appropriate in a case implicating Medicare because the program is so detailed and

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[79] *Wash. Reg'l II*, 813 F.3d at 362–63.

[80] *See id.* at 362 ("HHS's interpretation is not only reasonable but also the best interpretation of the statute."). In reaching this conclusion, Judge Sentelle emphasized that deference to a reasonable administrative interpretation is especially appropriate in the Medicare context because of the extreme complexity inherent in the statute. *Id.*; *see also* Methodist Hosp. of Sacramento v. Shalala, 38 F.3d 1225, 1229 (D.C. Cir. 1994) (advising that heightened complexity in the Medicare statute should result in heightened deference by the court).

[81] *See* Auer v. Robbins, 519 U.S. 452, 461 (1997) (stressing the importance of administrative deference in the regulatory context); *Wash. Reg'l II*, 813 F.3d at 363 (rejecting the argument that the regulations compelled the hospital's reading).

[82] *See Wash. Reg'l II*, 813 F.3d at 363 (suggesting that deference was important, but ultimately besides the point, and intimating that the Secretary interpreted the statute correctly).

[83] *Id.* at 364–65; *see also* Ne. Hosp. Corp. v. Sebelius, 657 F.3d 1, 14 (D.C. Cir. 2011) (contrasting a clarification with a substantive change, and explaining that only a substantive change is impermissibly retroactive).

[84] *See* 496 F. App'x at 535–36 (criticizing the Fifth Circuit for its decision to find ambiguity in the statute despite Congress's obvious decision to abandon a system of hospital-specific reimbursements); *Hardy Wilson II*, 616 F.3d at 457 (stating that the statute was ambiguous because neither side could demonstrate a clear congressional intent in the wording of the statute).

[85] *Mich. Dep't of Cmty. Health*, 496 F. App'x at 540. The court explained that the Secretary acted reasonably in relying on 42 C.F.R. § 413.40(c)(4)(ii) to calculate the reimbursements because 42 C.F.R. § 413.40(c)(4)(iii) no longer served a purpose after the statutory caps expired. *Id.* at 540–41; *see also* Progressive Corp. & Subsidiaries v. United States, 970 F.2d 188, 192–93 (6th Cir. 1992) (advising that a regulation should be interpreted in a manner consistent with its statutory predecessor).

intricate.[86] Following this logic, the D.C. Circuit in *Washington Regional* agreed that the Secretary's interpretation, which is owed considerable deference in the regulatory context, was the best one available.[87]

III. THE D.C. CIRCUIT CORRECTLY APPLIED *CHEVRON* AND THUS GAVE EFFECT TO THE UNAMBIGUOUS CONGRESSIONAL INTENT

In 2015, the U.S. Court of Appeals for the District of Columbia Circuit, following the logic of the U.S. Courts of Appeals for the Third and Sixth Circuits, correctly held in *Washington Regional Medicorp v. Burwell* that the Medicare reimbursement statute and regulations supported the Secretary's interpretation.[88] Section A of this Part argues that the D.C. Circuit's decision in *Washington Regional* reflects an appropriately deferential application of *Chevron* analysis.[89] Next, Section B of this Part argues that the holding is also in accord with the congressional intent to transfer hospitals from a system of hospital-specific reimbursements to a more objective system of reimbursements.[90]

A. The Enduring Importance of Agency Deference

First, the D.C. Circuit's conclusion reflects an appropriately deferential application of *Chevron* analysis.[91] For step one, the D.C. Circuit seemed to concede the existence of some ambiguity in the statute with regard to the specific issue of how to calculate Medicare reimbursements.[92] As a result, the D.C. Circuit deferred to the Secretary, deeming her position to be rea-

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[86] *Mich. Dep't of Cmty. Health*, 496 F. App'x at 541; *see also* Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512 (1994) (noting that deference is particularly apt when the program involved in the case is incredibly complex and highly specialized).

[87] *See Wash. Reg'l II*, 813 F.3d at 363 (concluding that the Secretary put forth a better interpretation); *see also* Bowles v. Seminole Rock & Sand Co., 325 U.S. 410, 417 (1945) (determining that the administrative interpretation of a maximum price regulation clarified any possible uncertainty about the meaning of that regulation).

[88] *See* Wash. Reg'l Medicorp v. Burwell (*Wash. Reg'l II*), 813 F.3d 357, 358 (D.C. Cir. 2015); Mich. Dep't of Cmty. Health v. Sec'y of Health & Human Servs., 496 F. App'x 526, 527 (6th Cir. 2012); Ancora Psychiatric Hosp. v. Sec'y of U.S. Dep't of Health & Human Servs., 417 F. App'x 171, 172 (3d Cir. 2011).

[89] *See infra* notes 91–99 and accompanying text.

[90] *See infra* notes 100–109 and accompanying text.

[91] *See Wash. Reg'l II*, 813 F.3d at 363 (holding that the best reading of the statute was the one that the Secretary adopted); *cf.* Walker v. Bain, 257 F.3d 660, 667 (6th Cir. 2001) (noting that, under *Chevron*, the judicial task is over if the court finds a plain and unambiguous meaning in the statute).

[92] *See Wash. Reg'l II*, 813 F.3d at 362 (holding that the most obvious interpretation of the statute, notwithstanding any ambiguity, squared with that of the Secretary); *see also* Scalia, *supra* 62, at 520 (arguing that *Chevron* has meaning only when congressional intent is found to be ambiguous).

sonable.[93] Here, the D.C. Circuit showed that deferring to the agency is oftentimes the court's role, especially when there is at least a colorable argument in favor of textual ambiguity.[94] Rather than abdicate the judicial role, the D.C. Circuit simply recognized the enduring importance of deference to the agency in an increasingly administrative state.[95]

The deference of the D.C. Circuit was still more pronounced in its interpretation of the regulations.[96] The court specifically alluded to the need for heightened deference in the administrative context, especially in light of the complexities of Medicare.[97] It also noted that the Secretary had consistently adhered to her interpretation of the regulations.[98] Accordingly, the D.C. Circuit had little difficulty in deferring to the Secretary's reading of her own regulations.[99]

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[93] *See Wash. Reg'l II*, 813 F.3d at 362 (conflating somewhat the two-step analysis); *Mich. Dep't of Cmty. Health*, 496 F. App'x at 536 (noting that, assuming that ambiguity exists in the statute, the court would still affirm summary judgment on behalf of the Secretary because of her reasonable interpretation).

[94] *See* Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 842–43 (1984) (stressing that the court defers to a reasonable interpretation of the agency if Congress has not spoken to the issue raised by the litigants); *Wash. Reg'l II*, 813 F.3d at 362–63 (concluding that HHS's interpretation was better than the hospital's, while assuming the existence of some ambiguity in the governing statute); Kenneth W. Starr, *Judicial Review in the Post*-Chevron *Era*, 3 YALE J. ON REG. 283, 298 (1986) (arguing that judicial review coincides with the administrative reality under *Chevron*).

[95] *See Wash. Reg'l II*, 813 F.3d at 362 (examining the language of 42 U.S.C. § 1395 ww(b)(3)(A) and 42 U.S.C. § 1395ww(b)(3)(H) in order to determine whether the Secretary's reading had some basis in the statute); *see also* Marbury v. Madison, 5 U.S. (1 Cranch) 137, 177 (1803) ("It is emphatically the province and duty of the judicial department to say what the law is."); Henry P. Monaghan, Marbury *and the Administrative State*, 83 COLUM. L. REV. 1, 27 (1983) (pointing out that, even in administrative cases, a court should still say both what the law means and what it does not mean). *Compare* 42 U.S.C. § 1395ww(b)(3)(A) (2012) (referring to the target amount prior to 1998), *with id.* § 1395ww(b)(3)(H) (defining target amount since 1998 with reference to the BBA caps).

[96] *See Wash. Reg'l II*, 813 F.3d at 363 (referring to Auer v. Robbins, 519 U.S. 452, 462 (1997), a case involving deference to an agency's own regulations); *see also* Bowles v. Seminole Rock & Sand Co., 325 U.S. 410, 414 (1945) (holding that the administrative construction of a regulation is of "controlling weight").

[97] *See Wash. Reg'l II*, 813 F.3d at 362 (quoting Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512 (1994)).

[98] *See id.* at 363–64 (pointing out that the Secretary had always abided by this particular interpretation of the relevant regulations); *cf.* Scalia, *supra* note 62, at 518 (noting that an agency cannot suddenly change its interpretation during, or perhaps because of, litigation).

[99] *See Wash. Reg'l II*, 813 F.3d at 363 ("With or without deference, we conclude that HHS's interpretation is the better one . . . ."); *see also Bowles*, 325 U.S. at 414 (deferring to the agency, unless its interpretation is "plainly erroneous or inconsistent with the regulation").

B. The Secretary's Interpretation of the Statute Best Effectuates Congressional Intent in Amending the Medicare Reimbursement Statute

Additionally, the D.C. Circuit was correct to uphold the Secretary's interpretation of the statute as allowing targets set in accord with the 2002 targets, because that reading best comported with congressional intent.[100] Indeed, the D.C. Circuit reviewed Congress's intent as a way of confirming the Secretary's reading of the statute.[101] In its review, the D.C. Circuit emphasized how Congress repeatedly amended the Medicare reimbursement statute in its effort to inject objectivity into the calculation of reimbursement payments.[102] In 1998, Congress imposed the statutory caps on reimbursement payments for psychiatric hospitals because there was too much of a discrepancy from one hospital to the next.[103] Although these caps were meant to elapse at the end of 2002, Congress never intended to revert to a reimbursement system based on hospital-specific data.[104] Rather, Congress expected for the hospitals to enter the Prospective Payment System at the end of 2002.[105] When the Secretary failed to establish a PPS for psychiatric hospitals by 2002, the statute suggested that the target amount for the current year should continue to be based on the capped target amount from the previous year so as to prevent excessive reimbursement payments.[106]

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[100] *See Wash. Reg'l II*, 813 F.3d at 362–63 (disagreeing with the hospital's argument that the Secretary contradicted congressional intent); *see also* Univ. of Tex. M.D. Anderson Cancer Ctr. v. Sebelius, 650 F.3d 685, 687 (D.C. Cir. 2011) (commenting on Congress's repeated attempts to mitigate the rise in Medicare costs for provider hospitals); Starr, *supra* note 94, at 295 (noting that the court may look to congressional intent in deciphering whether there is a plain meaning of the statutory language).

[101] *See* King v. Burwell, 135 S. Ct. 2480, 2491–92 (2015) (ruling that a provision of the Affordable Care Act was ambiguous precisely because the most literal reading of the statute unavoidably thwarted congressional intent); *Wash. Reg'l II*, 813 F.3d at 363 (remarking on Congress's persistent efforts to control overly expensive treatment that particular hospitals provided).

[102] *See Wash. Reg'l II*, 813 F.3d at 363 (discussing Congress's effort to shift the provider hospitals from a reimbursement system based on actual costs to one guided by more objective and uniform criteria); *see also* 42 U.S.C. § 1395ww(b)(3)(H) (2012) (demonstrating the shift with the implementation of statutory caps beginning in 1998).

[103] *See Wash. Reg'l II*, 813 F.3d at 359 (describing the consequences of excluding psychiatric hospitals from the PPS); H.R. REP. NO. 105-149, at 1336 (identifying the "significant variation" in hospital costs among hospitals exempted from the PPS as a reason for imposing the statutory caps).

[104] *See Wash. Reg'l II*, 813 F.3d at 363 (concluding that there was no evidence Congress desired for the Secretary to revive the method of calculation based on hospitals' actual costs); H.R. REP. NO. 105-149, at 1336 (citing the rapid growth in reimbursement payments to exempt hospitals as a reason to revamp the payment system).

[105] *See Wash. Reg'l II*, 813 F.3d at 360 (noting that the Secretary was unable to start the transition until 2005); THOMPSON, *supra* note 28, at 46 (admitting to Congress that the Secretary would not be able to meet the 2002 deadline).

[106] *See* 42 U.S.C. § 1395ww(b)(3)(A) (basing the target amount for every year after the first year on the target amount from the year prior, thus suggesting that each year acts as a limitation on

Similarly, the D.C. Circuit concluded that the Secretary's understanding of the regulations best fulfilled the congressional intent.[107] Because the Secretary added the provision at issue to implement the statutory caps, it would defy Congress's clearly expressed intent to apply that provision beyond the period lasting from 1998 through 2002.[108] Accordingly, the D.C. Circuit held that the provision did not apply in 2003 or 2004, thereby preventing Fayetteville Hospital from circumventing congressional intent in the calculation of its target amounts for those years.[109]

CONCLUSION

In 2015, in *Washington Regional Medicorp v. Burwell*, the U.S. Court of Appeals for the D.C. Circuit correctly ruled that the Secretary of Health and Human Services calculated Medicare reimbursement payments to provider hospitals in accordance with the terms of the applicable statute and regulations, joining the Third and Sixth Circuits. In correctly holding in favor of the Secretary's interpretation, the D.C. Circuit applied *Chevron* in an appropriately deferential fashion. As a continuing sign of respect in an increasingly administrative state, courts should imitate the approach of the D.C. Circuit. This approach involves a willingness to defer to the agency, provided that the statute and regulations are not absolutely clear. In addition, the method of calculation employed by the Secretary accurately reflects the congressional intent to move hospitals from a system of hospital-specific reimbursements to the Prospective Payment System based on more objective and nationalized characteristics.

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the subsequent year); *Ancora Psychiatric Hosp.*, 417 F. App'x at 176 (describing how the capped target amounts would exert an "echo" effect on the target amounts for subsequent years, but maintaining that this effect was not contrary to congressional intent because Congress wanted to limit psychiatric hospitals' reimbursable costs).

[107] *See* 42 C.F.R. § 413.40(c)(4)(iii) (2016) (limiting use of the capped target amount to the period starting in 1998 and ending in 2002); *see also Wash. Reg'l II*, 813 F.3d at 363 (reasoning that paragraph (c)(4)(iii) was added to the regulations with the intention of implementing the statutory caps).

[108] *See Wash. Reg'l II*, 813 F.3d at 363–64 (holding that paragraph (c)(4)(iii) only applied so long as the statutory caps remained in effect); *Mich. Dep't of Cmty. Health*, 496 F. App'x at 541 (emphasizing that the Secretary had twice declared that paragraph (c)(4)(iii) would expire at the end of 2002); Carlos E. Gonzalez, *Reinterpreting Statutory Interpretation*, 74 N.C. L. REV. 585, 604 (1996) (suggesting that the text of a statute or regulation may provide the best evidence of congressional intent).

[109] *See Wash. Reg'l II*, 813 F.3d at 364 (refusing to apply 42 C.F.R. § 413.40(c)(4)(iii) in calculating target amounts for 2003 and 2004); *cf.* Progressive Corp. & Subsidiaries v. United States, 970 F.2d 188, 192 (6th Cir. 1992) (observing that the district court had erroneously interpreted a regulation so as to conflict with its statute, contravening congressional intent as a result).

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