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Deference to the Federal Agency in Medicaid Cases[1]
National Health Law Program
Fact Sheet
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Introduction

In this fact sheet, we review and discuss court decisions on deference to sub-regulatory agency guidance. In these cases, parties argue whether and to what extent courts should defer to interpretations in, for example, guidance letters from the Centers for Medicare and Medicaid (CMS) services.[2] The question also arises as to whether the approval by CMS of state Medicaid plans should be given deference.

This fact sheet provides background on deference. It also reviews cases dealing with deference and, finally, we analyze some significant recent cases in which courts have explained the basis for their deference decisions.

Background

The Supreme Court has struggled to clarify the standards for according deference to federal agency interpretations of federal statutes. While clear standards have not emerged, in *Chevron U.S.A.. v. Natural Resources Defense Council*,[3] the Court articulated a two-step inquiry for judicial review of administrative interpretations. First, the court must determine whether Congress has spoken to the specific issue. If so, the congressional statement will displace administrative interpretation. However, if Congress has not spoken to the point or if its statements are ambiguous, the court must defer to the administrative interpretation as long as it is "reasonable."[4]

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[2] In 2001, the name of the Health Care Finance Agency (HCFA) was changed to the Centers for Medicare and Medicaid Services (CMS). Court decisions and guidance that pre-date 2001 refer to the agency as HCFA. For the sake of clarity, this fact sheet refers to the agency as CMS.

[3] 467 U.S. 837 (1984).

[4] 467 U.S. at 844-45.

In recent years, the Court has taken steps to narrow *Chevron's* application. In *Christensen v. Harris County*,[5] the Court refused to apply *Chevron* to an agency opinion letter, finding that "[i]nterpretations such as those in opinion letters – like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law – do not warrant *Chevron*-style deference."[6] *Christensen* held these types of agency interpretations are "entitled to respect," but only to the extent they have the power to persuade.[7] This type of deference is called "*Skidmore* deference" based on the 1944 decision in *Skidmore v. Swift & Co.,*[8] which said the weight to be accorded to an administrative interpretation in a particular case "will depend upon the thoroughness evident in its consideration, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control."[9]

In *U.S. v. Mead Corporation*,[10] the Court discussed the circumstances for applying *Chevron* or *Skidmore* deference. At issue in *Mead* was a "tariff ruling letter" authorized by regulation but not subjected to formal rulemaking. Tariff ruling letters also are formally binding only upon the particular entity to whom they are issued. The United States Customs Service argued that the letter at issue was entitled to *Chevron* deference. Rejecting this position, the eight-member majority attempted to clarify the circumstances for applying *Chevron* deference:

> We hold that administrative implementation of a particular statutory provision qualifies for *Chevron* deference when it appears that Congress delegated authority to the agency to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority. Delegation of such authority may be shown in a variety of ways, as by an agency's power to engage in adjudication or notice-and-comment rulemaking, or by some other indication of a comparable congressional intent.[11]

In other words, *Chevron* deference is limited to agency interpretations where "it appears that Congress delegated authority to the agency to make rules carrying the force of law, and that the agency interpretation was promulgated in the exercise of that authority."[12] Applying this standard,

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[5] 529 U.S. 576, 587 (2000).

[6] *Id.* at 587.

[7] *Id.* (quoting *Skidmore v. Swift*, 323 U.S. 134, 140 (1944)).

[8] 323 U.S. 134 (1944).

[9] *Id.* at 140.

[10] 121 S.Ct. 2164 (2001).

[11] *Id*. at 2171.

[12] *Id.*

the Court found no evidence of congressional intent for the agency's tariff ruling letter to carry *Chevron's* "force of law."[13]

The Court then looked to see whether the tariff ruling was entitled to "some deference" under the "practical criteria" of *Skidmore*.[14] In so doing, the majority rejected the position articulated by Justice Scalia in dissent that would have broadened the occasions for *Chevron* deference while eliminating other lesser forms of deference.[15] According to the majority:

> *Chevron* did nothing to eliminate *Skidmore*'s holding that an agency's interpretation may merit some deference whatever its form, given the specialized experience and broader investigations and information available to the agency, and given the value of uniformity at and in its administrative and judicial understandings of what a natural law requires.[16]

Numerous cases, pre-dating *Mead*, accord deference to the federal Medicaid agency's interpretive statements. While some of these cases cite *Chevron* and *Skidmore,* others simply describe the level of deference without citation to the Supreme Court. And, the level of deference varies from case to case.[17]

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[13] *Id*. at 2173-2176.

[14] *Id*. at 2175.

[15] *Id.* at 2177-89.

[16] *Id*. at 2175-76. For an interesting post-*Mead* case, see *Barnhart v. Walton*, 122 S.Ct.1265 (2002), which accorded *Chevron* deference to a Social Security regulation promulgated in response to the very case that was before the Court: "In this case, the interstitial nature of the legal question, the related expertise of the Agency, the importance of the question to administration of the statute, the complexity of that administration, and the careful consideration the agency has given the question over a long period of time all indicate that *Chevron* provides the appropriate legal lens through which to review the legality of the Agency interpretation here at issue." *Id.* at 1272.

[17] For Court of Appeals cases, s*ee K&A Radiologic Tech. Servs. Inc. v. Comm'r of the Dep't of Health of State of New York,* 189 F.3d 273, 282-83 (2d Cir. 1999) (State Medicaid Manual); *Bray v. Dowling*, 25 F.3d 135, 143 (2d Cir. 1994) ("[c]onsistent interpretations by the agencies entrusted with the administration of the Social Security Act are due deferential treatment in the courts.") (citations omitted); *Liegl v. Webb,* 802 F.2d 623, 625-26 (2d Cir. 1986) (discussing the Medical Assistance Manual, which pre-dated the State Medicaid Manual); *Wisconsin Dep't of Health and Social Services v. Bowen,* 797 F.2d 391, 398 (7th Cir. 1986), *cert. dismissed,* 485 U.S. 1017 (1988) (Medicaid Action Transmittal) (finding that Secretary's interpretation is warranted deference if reasonable and permitted by the statute, without citing *Chevron* or *Skidmore*); *Smith v. Miller*, 665 F.2d 172, 179 (7th Cir. 1981) (Medical Assistance Manual) (affording judgment of the agency considerable weight); *Philadelphia Welfare Rights Org. v. Shapp*, 602 F.2d 1114, 1122 (3d Cir. 1979), *cert. denied*, 444 U.S. 1026 (1980) (Medical Assistance Manual); *Stanton v. Bond*, 504 F.2d 1246, 1249 (7th Cir. 1974), *cert. denied*, 420 U.S. 984 (1975); *Compare AMISUB, Inc. v. Colorado Dep't of Social Servs.,* 879 F.2d 789, 798 (10th Cir. 1989) ("state agency's determination of procedural and substantive compliance with federal law is not entitled to the deference afforded a federal agency").

Courts have, in some cases, applied the *Chevron-Mead* deference standard to administrative interpretations of Medicaid provisions. The Supreme Court itself recently cited *Mead,* but offered little other discussion, to give "respectful consideration" to consistent agency interpretation contained in a Regional State Medicaid Letter and proposed regulation.[18] Perhaps not surprisingly, other than the fact that states do not treat these sub-regulatory materials as having the force of law, *Mead* has not imposed significantly more uniformity in this area.

Courts have applied different standards of deference that sometimes depends on the form in which the agency statement comes. As well as issuing regulations, CMS also provides guidance through the *State Medicaid Manual*, a voluminous statement of Medicaid policy and guidance that is periodically updated by the Agency. In addition, CMS periodically issues transmittals and letters to state Medicaid directors ("Dear State Medicaid Director") that contain statements of policy and interpretation. If these policy statements are helpful, advocates may argue in a legal challenge that courts should give them weight. In addition, states submit Medicaid plans that must be approved by CMS before they can take effect.[19] 42 U.S.C. § 1396a(a). And, states can apply for "waivers" of certain Medicaid requirements to offer home and community based services to people at risk of institutionalization. 42 U.S.C. § 1396n. In addition, states may be given approval to create demonstration or pilot projects to advance the purposes of the Medicaid Act. 42 U.S.C. § 1315. CMS must also approve these waiver applications. This approval process is intended to ensure that the state plans and waiver programs comply with federal law. On occasion, however, advocates and beneficiaries have complained that, despite CMS approval, plans and waiver programs contain provisions that in fact do violate the federal law. In these circumstances, advocates may argue that courts should not defer to the suggestion implicit in plan approval that CMS has actually determined that the plans or waivers comply with Medicaid law.

A review of cases decided after *Mead* shows that courts have taken multiple approaches to this issue. For example, in *Indiana Family and Social Services Admin. v. Thompson,* the Seventh

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For District Court cases, *see Salazar v. District of Columbia*, 954 F. Supp. 278, 328-34 (D.D.C. 1996) (State Medicaid Manual) (using the standards established in the Manual without citing *Chevron*); *State of New York Dep't of Social Servs. v. Sullivan*, 811 F. Supp. 964, 975 (S.D.N.Y. 1993) ("[L]aw mandates that we treat with substantial deference the Secretary's [plausible] interpretation of his own regulation."); *Sundberg v. Mansour*, 627 F. Supp. 616, 619-20 (W.D. Mich. 1986) (regional office memorandum) (stating that deference is due the Secretary's interpretation unless plainly erroneous or inconsistent and rejecting the agency interpretation, without citing *Chevron* or *Skidmore*); *Olson v. Reagen*, 631 F. Supp. 154, 157-58 (S.D. Iowa 1986), *aff'd in part, rev'd in part sub nom., Olsen v. Norman,* 830 F.2d 811 (8th Cir. 1987) (same) (according the same level of deference to informal statements of policy as it does regulations, without citing *Chevron*); *Smith v. Vowell*, 379 F. Supp. 139 (W.D. Tex. 1974), *aff'd mem.,* 504 F.2d 759 (5th Cir. 1974) (Medical Assistance Manual) (finding that the administrative requirements expressed in the Manual are to be given full force and effect if consistent with the overriding purpose of the legislation).

[18] *Brumer v. Wisconsin Dep't of Health and Social Services*, 122 U.S. 962 (2001).

[19] For more information on the state plan process, see the April Q & A from NHeLP, "State Medicaid Plans," April 25, 2006.

Circuit accorded *Skidmore* level deference to provisions of the *State Medicaid Manual*.[20] Specifically, that court decided that "less formal" interpretations in agency manuals should receive "more flexible respect" depending on the agency's care, consistency, formality, relative expertness and the position's overall persuasiveness. In *Strand v. Rasmussen*, the Iowa Supreme Court decided that "substantial deference" is due to the agency interpretations contained in the *State Medicaid Manual.* [21] In *Ramey v. Reinertson*, the Tenth Circuit stated that the court must give deference to the *State Medicaid Manual* but only to the extent that it does not conflict with the purpose of the Medicaid Act.[22]

The Second Circuit, in *Rabin v. Wilson-Coker,* has held that Dear State Medicaid Director letters are entitled to "some significant measure of deference."[23] In *Johnson v. Guhl*,[24] a New Jersey district court held that transmittal letters are entitled to "some deference" as long as they are consistent with the plain language and purpose of the statute and with prior administrative views. In *Grey Bear v. N.D. Dep't of Human Services*, the North Dakota Supreme Court has said that a letter to state Medicaid directors will normally receive deference, especially where that interpretation does not contradict statutory language.[25] In contrast, the Sixth Circuit refused to give deference to an opinion letter from CMS in *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrecoverable Trust.*[26] Citing *Mead,* the court made the broad statement that because a letter is not subject to rule making authority and notice and comment, it should not be given deference. Significantly, however the court also held that the letter is inconsistent with the statutory scheme, thus, despite the broad statements in the opinion, the end result is not a departure from previous holdings.

Courts may show more reluctance to defer to letters that are issued in response to specific inquiries. In *Estate of F.K. v. Div. of Med. Assist. & Health Services*[27], the court gave *Skidmore* deference to several letter from CMS based on indications that the agency and director gave thorough consideration to the underlying issue, but refused to defer to a letter responding to a specific inquiry that does not evidence "independent analysis." Indeed, courts may give less deference to a letter that comes in response to a specific inquiry or may represent the view of only one employee. *See, e.g., A.B. v. Division of Medical Assistance and Health Services*, 865 A.2d 791 (N.J. Super. A.D. 2005) (finding that a CMS letter was entitled to "little if any deference because of its guarded wording and because it responded to an inquiry which assumed the

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[20] 286 F.3d 476 (7th Cir. 2002).

[21] 648 N.W.2d 95 (Iowa 2002).

[22] *See,* 268 F.3d 955 (10th Cir. 2001).

[23] 362 F.3d 190, 197 (2d Cir. 2004).

[24] 166 F. Supp. 2d 42 (D.N.J. 2001) (citations omitted).

[25] 2002 N.D. 139 (2002).

[26] 410 F.3d 304 (6th Cir. 2005).

[27] 863 A.2d 1065 (N.J. Super. A.D. 2004).

conclusion that a retail market existed."); *Harris v. Olszewski*, 442 F.3d 456, 471 (6th Cir. 2006) (refusing to defer to a "tentative view" of a single Medicaid program representative at CMS) (discussed *infra*) *S.D. v. Hood,* 391 F.3d 581 (5th Cir. 2004) (refusing to defer to an opinion expressed in an employee e-mail because the individual had no authority to bind the agency) (discussed *infra*).

Advocates should be aware of an issue that can pose serious problems for beneficiaries. In cases in which beneficiaries are challenging a state's Medicaid plan or waiver program, the defendants will often argue that the plan has been approved by CMS and that, accordingly, the decision to approve the plan should be given deference. Several decisions show that courts may give significant deference to plan approval.

In *Visiting Nurses' Ass'n v. Bullen,* a case pre-dating *Mead,* the First Circuit held that a plan approval constituted the "implicit interpretation" of a Medicaid requirement and was therefore to be accorded *Chevron* deference.[28] Similarly, the Eleventh Circuit applied *Chevron* deference to the denial of a state plan amendment.[29] Another pre-*Mead* case, *Perry v. Dowling*[30] holds that federal agency approval of a Medicaid state plan warrants deference under *Chevron*. Post-*Meade,* in *Bryson v. Shumway,* plaintiffs sued defendant state Medicaid officials alleging that the limitation on the number of participants in their home and community based waiver program violated the Medicaid statute.[31] The defendants argued that the fact that CMS had approved its home and community based waiver application indicated that the state had not violated the Medicaid Act and that the court should defer to this approval. While noting that the waiver approval process may not be entitled to *Chevron* deference, the court held it should receive *Skidmore* deference. Finding that the approval of the waiver program was both consistent with the statutory language and with longstanding agency interpretation, the court ruled against the plaintiffs. Finally, the Washington Court of Appeals, ducked the issue in *Gasper v. Dep't Soc. Servs.*[32] The state had argued that CMS' approval of its home and community based waiver program indicated approval of a rule governing reimbursement of providers. The court did not address whether such approval would be accorded deference, finding that there was no evidence that CMS was aware of the particular rule because it was not described in the waiver application.

Recent Cases

Several important decisions have been issued by federal courts of appeal in the past year. In two cases, deference was beneficial to the plaintiffs because CMS' guidance supported their claims. The opposite was true in the other two cases – both from the Sixth Circuit. Advocates should be aware of these decisions and the opportunities and hazards that they present.

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[28] 93 F.3d 997 (1st Cir. 1996).

[29] 8 F.3d 1565, 1572-73 (11th Cir. 1993).

[30] 95 F.3d 231 (2d Cir. 1996).

[31] 308 F.3d 79 (1st Cir. 2002).

[32] 132 Wn. App. 42 (2006).

Lankford v. Sherman[33]

The plaintiffs in *Lankford* filed suit to challenge a Missouri regulation governing the coverage of durable medical equipment, supplies and appliance (DME). The regulation eliminated coverage of many items of DME for Medicaid recipients who are aged or disabled, but not blind. The regulation became effective September 1, 2005. It provides that Medicaid recipients who are blind or pregnant are still entitled to the full scope of coverage. In contrast, adult Medicaid recipients who are not blind or pregnant can no longer receive coverage for many important items of DME including artificial larynxes, CPAPs, BiPAP, and IPPB machines; nebulizers; suction pumps; apnea monitors; or wheelchair accessories or scooters – regardless of whether their health care providers determined that these devices were medically necessary. The state would grant exceptions from the rule only if an individual was completely confined to his home, required skilled nursing services or fell under other very narrow exceptions. Moreover, it could not be used to obtain items restricted by state law.

Plaintiffs argued, among other things, that Missouri's regulation was in conflict with CMS' general guidance on the coverage of DME. Moreover, plaintiffs noted, CMS specifically instructed the state Medicaid agency that its exception policy was not in compliance with federal requirements.

The court agreed with the plaintiffs and ruled that the Missouri regulation conflicted with federal Medicaid law. First, it held that the "homebound" requirement violated federal law. In so ruling, it relied in part upon a 2000 Dear State Medicaid Director letter from CMS stating that homebound requirements are improper.[34] In addition, the court noted that "CMS has directly told Missouri that its 'homebound requirement . . . is out of compliance with CMS policy,'" citing to an email and a letter from two different CMS employees. Second, the court held that the exceptions process provided for obtaining non-covered items of DME was inadequate, relying in part upon a 1998 letter from the Director of CMS. This letter instructed states that DME policies must include a meaningful procedure for requesting non-covered items or it would be inconsistent with the reasonable standards requirement. "Because the DME regulation restricts available DME and plaintiffs have no other procedure to obtain it, the regulation . . . appears unreasonable under directives from both CMS and this court." *Id.* at *44. The court did not cite *Chevron, Skidmore* or *Mead.*

It is important to advocates were advocating with CMS behind the scenes as this litigation proceeded. While it is impossible to be sure, there is a distinct possibility that this advocacy helped to shape the very helpful communications regarding home health and medical equipment.

S.D. v. Hood

In this case, the Louisiana Medicaid agency refused to cover incontinence supplies under its program. An administrative appeal of the agency's denial found its way to federal court. The district court ruled in favor of the plaintiff and the Fifth Circuit affirmed that decision.

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[33] 451 F.3d 496 (8th Cir. 2006).

[34] CMS, Dear State Medicaid Director (July 25, 2000).

The court deferred to definitions in CMS' regulation under *Chevron*. In addition, the court held that the fact that CMS had approved of other states' Medicaid plans that provided for coverage of incontinence supplies was also entitled to *Chevron* deference. "The agency's review and determination definitively indicates whether it interprets a state plan or amendment to be in conformity with the statute." The court also took into account the fact that the State Medicaid Manual also indicates that incontinence supplies should be covered. It did not, however, apply *Chevron* deference, but stated that "relatively informal" CMS interpretations . . . are entitled to respectful consideration . . ."

Harris v. Olszewski

The plaintiffs in these consolidated cases argued that Michigan's single source contract for purchase of "medical devices" violates Medicaid's freedom of choice provision. The plaintiffs argued that incontinence products are not medical devices. Although the court held that the Medicaid provision conferred an enforceable right, it reversed the district court's grant of summary judgment. It held that it was permissible for the state to treat incontinence supplies as medical devices.

The court based its holding in part on several items. First, it cited a 1997 letter from CMS stating that incontinence supplies qualified as medical devices. *Id.* at 467. The court also applied *Chevron* deference to the fact that CMS approved the related state plan amendment. This amendment contained a certification from the state Medicaid agency that the single-source contract for incontinence supplies complied with statutory and regulatory requirements for the single source contract. The Court stated that

> When HHS accepted [the] certification, it was required to find that the amendment satisfied all statutory requirements . . including that the department's single-source contract for incontinence products complied with [the Medicaid Act]. In carrying out that responsibility, HHS was exercising Congress' 'express delegation of specific interpretive authority, *U.S. v. Mead Corp*., [citation omitted] and accordingly the agency's approval is entitled to *Chevron* deference.

Id. The court further noted that deference to the agency position is "particularly appropriate in the context of a complex and highly technical regulatory program like Medicaid." *Id.* at 468 [citations omitted]. It also rejected the plaintiffs' argument that *Chevron* deference because the approval of the amendment had not been made subject to notice and comment or formal adjudication.

Rosen v. Goetz, 410 F.3d 919 (6th Cir. 2005).

Tennessee's Medicaid agency instituted new procedures for disenrolling beneficiaries from the program. Plaintiffs challenged the procedures. The court reversed the district court's determination that these procedures were illegal. The court did not cite *Chevron, Mead* or *Skidmore,* but simply stated that CMS' actions supporting defendants were entitled to "substantial deference." It reasoned that CMS had reviewed and expressly approved the state's disenrollment procedures, thus conveying that they complied with Medicaid law. The State Medicaid Manual also "expressly embrac[ed]" this interpretation of the law. Finally, the court deferred to CMS'

statements in an *amicus* brief filed in the case, stating that the procedures complied with Medicaid regulations.

Conclusion

Despite the Supreme Court's purported intent to clarify this area with its decision in *Mead,* there appears to be no more consistency in the application of deference than there was before the decision. A few things are clear, however. Based on the decisions in this area, advocates face an uphill battle when CMS approves of a state plan or waiver. To the extent possible, advocates should work to stay informed about proposed states' plans and engage in advocacy designed to persuade CMS not to approve problematic plan provisions. Of course, this is more easily said than done in the current political climate. In addition, advocates should do their best to show that CMS did not specifically approve of a particular aspect of the plan, as the plaintiffs did in *Gasper*. Also, advocates are sure to be better off when they take positions that have been supported by CMS in writing. NHeLP has been collecting Dear State Medicaid Letters and other transmittals for years – many of which have proved helpful to advocates in litigation and administrative. Advocates should check with NHeLP for possible support.