APA Deference After *Independent Living Center*: Why Informal Adjudicatory Action Needs a Hard Look

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HEALTH care advocates, providers, and Medicaid beneficiaries have
been on a rollercoaster ride ever since the Supreme Court's decision
to grant certiorari in the case of Douglas v. Independent Living Center of
Southern California, Inc.2 The Court granted cert on the question of whether
Medicaid providers and beneficiaries could sue in federal court to challenge
cuts to California's Medi-Cal reimbursement rates. Medi-Cal is the Medicaid
program in California. The plaintiffs alleged that the rate cuts violated federal
access and quality protections in the rate-setting provisions of the Medicaid Act
(the "Act").3 In light of studies documenting provider shortages for Medi-Cal
patients, providers and beneficiaries worried that the rate cuts would exacerbate
access problems by causing more providers to leave the Medi-Cal program
or to refuse to treat Medi-Cal patients. Plaintiffs also pointed to problems in
the rate-setting process because of the State's failure to consider statutorily
required factors prior to proposing the new rates.

The Medicaid Act does not create an express cause of action for such
challenges, so plaintiffs have used the Supremacy Clause to try to prevent cuts
by arguing that the rates conflict with, and thus are preempted by, federal law.
This strategy has been successful among lower courts, so many feared that
the Supreme Court's decision to grant certiorari on this procedural question
signaled its willingness to eliminate this avenue for challenging cuts in federal
court.4 Despite the significant rights at stake and the attention received from

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1204 (2012).
3 Id. at 1207-08.
4 See infra Part I.B.
numerous interested parties who filed amicus briefs, the Court ultimately did not answer the question presented. In a 5-4 opinion, the Supreme Court decided that the question should be remanded to the Ninth Circuit due to "changed circumstances." The changed circumstances to which the Court referred were subsequent approvals of the state's payment cuts by the federal agency charged with Medicaid oversight, the Centers for Medicaid and Medicare Services (CMS). At the time the suit was originally brought, the state legislature had enacted the cuts, but they had not yet been approved by CMS. The Court noted that this federal approval may change the procedural question because federal agency action is subject to judicial review under the Administrative Procedure Act (APA). Plaintiffs' right to seek judicial review under the APA was viewed as relevant to question of whether they should also be able to sue under the Supremacy Clause.

The Court's decision to reframe and remand the question has generated confusion, with parties on both sides of the dispute offering different interpretations of Independent Living Center. Providers, beneficiaries, and advocates viewed the decision as a win because, by not deciding the question, the Supreme Court effectively preserved plaintiffs' rights to challenge state cuts in federal court using the Supremacy Clause. On the other hand, the Court's explanation contained dicta speculating that CMS approval would make it harder to challenge the cuts. Citing Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., the majority noted that courts ordinarily apply deference when reviewing agency action under the APA. California officials quickly seized on this dicta, interpreting it as a message to lower courts to defer to CMS and labeling Independent Living Center a win for states. Given the strong financial incentives shared by states and the federal government in cutting Medicaid costs, states view CMS as an important ally, and after Independent Living Center, they expect CMS approval to shield them from federal court scrutiny.

Because Independent Living Center's discussion about deference was merely dicta, its import is uncertain. But the way this dicta is being interpreted is a cause for concern. Last year, in Managed Pharmacy Care v. Sebelius, the Ninth Circuit invoked Independent Living Center in applying a very deferential standard to uphold a new round of Medi-Cal rate cuts approved by CMS. The Ninth
Circuit reversed the district court's injunctions, and it ignored much of the evidence that led the district court to find California's rate-setting process and CMS's approval arbitrary and capricious. Managed Pharmacy Care represents a stark divergence from the robust judicial review that the Ninth Circuit had historically applied to state Medicaid cuts.

Most of the coverage about these cases has focused on the implications for health care access, and health care advocates are justifiably concerned about what a more deferential approach by courts could mean for Medicaid access going forward. Judicial review has been an essential protection and last resort for providers and beneficiaries challenging illegal state cuts. Medicaid reimbursement has always been an easy target for state officials looking for a quick fix for budgetary problems, which means they often cut rates without any consideration of the impact such cuts will have on access and quality, as required by federal law. This latest dispute in California deserves special attention because the Ninth Circuit has historically been the most protective of Medicaid patients and providers in these challenges, and it has been particularly active in defining federal rate-setting requirements. Thus the Ninth Circuit's recent shift to a more deferential approach does not portend well for Medicaid access suits in California or nationwide. In fact, as this Article was in the editing stages, the Ninth Circuit rejected a request to rehear Managed Pharmacy Care en banc, the Supreme Court denied an appeal by providers, and current challenges to Medi-Cal payment cuts seemed to be losing steam.

This Article, however, focuses on the administrative law implications of Independent Living Center, as interpreted by the Ninth Circuit in Managed Pharmacy Care. I suggest that this interpretation is troubling from a broader administrative law perspective because of the unquestioned deference it seems to endorse for informal adjudicatory actions, like an agency's approval of state Medicaid financing decisions. The amount of deference courts should give to agency action is a perpetually challenging question in administrative law, and much of the scholarly debate about deference has focused on rulemaking and formal adjudication. The APA sets forth certain procedural requirements for

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10 See infra Part III.
12 See generally, Brietta R. Clark, Medicaid Access, Rate Setting and Payment Suits: How the Obama Administration Is Undermining Its Own Health Reform Goals, 55 How. L.J. 771 (2012) [hereinafter Clark, Medicaid Access] (reviewing the role of courts, states, and federal regulators in Medicaid payment suits brought over several decades).
13 Managed Pharmacy Care v. Sebelius, 716 F.3d 1235 (9th Cir. 2013).
rulemaking and formal adjudication that further transparency, accountability,
and participatory principles, all of which are viewed as central to achieving
administrative legitimacy and thus justifying judicial deference.

But a vast amount of agency action falls into the category of informal
adjudication, and the question of how much deference this kind of action
should receive is a more difficult one. The issue of deference for CMS approval
of state rate cuts is a perfect example. CMS approval is not subject to the APA
procedural requirements governing rulemaking or formal adjudication; nor are
there comparable procedural safeguards in the Medicaid Act. Indeed, like other
informal adjudicatory action, federal regulatory approval of state Medicaid rates
has historically lacked the legal and de facto indicia of formality, transparency,
and deliberation, which are characteristic of the kind of agency action that
typically gets deference. Unfortunately, the scholarly debate and jurisprudence
about deference for informal adjudication is not as developed or coherent as
for rulemaking and formal adjudication. This is, in part, because it is difficult
to generalize about the varied forms of agency action that fall within this vast
category of informal adjudication.

Nonetheless, a number of Supreme Court cases have limited or qualified
Chevron deference and provided important guidance for courts in determining
how much deference should be given to informal agency action. Existing
administrative law principles do provide a coherent framework for evaluating
informal adjudicatory action, making clear that courts need to take a hard
look at an agency's decision-making process before granting deference. And
the deference question in the Medicaid payment cases provides a timely
opportunity to explore this doctrine and highlight its importance generally.
This Article contrasts the different approaches taken by the district court and
Ninth Circuit in Managed Pharmacy Care, in order to show why deference
for informal adjudicatory action should not be presumed simply because an
agency acts pursuant to an official grant of authority. Rather, an approach
that scrutinizes the specific circumstances of the agency's action to determine
whether it satisfies the criteria justifying deference—like the district court's
analysis described in greater detail in Part III—is more faithful to deference
doctrine and does a better job of promoting administrative legitimacy.

Part I of this Article describes the procedural and substantive questions
initially presented to the Supreme Court in Independent Living Center. The
Court only granted certiorari on the procedural issue, but in its explanation
for why it was remanding the case, the Court's dicta speculating about how the
substantive question would be resolved appears to have significantly impacted
the outcome of these claims. Part I provides historical context for understanding
both issues, highlighting the federal regulatory neglect that has shaped the
procedural and substantive arguments in Medicaid payment disputes generally,
and in particular, the initial challenges in California that ultimately reached the
Supreme Court in Independent Living Center.
Part II describes Independent Living Center and explores its dicta about deference in greater detail. This Part also does what the Court in Independent Living Center failed to do—situate its comments about the APA and Chevron deference within the broader context of administrative law doctrine that has further defined and limited the application of deference in ways particularly relevant to the informal adjudicatory context. For example, the Supreme Court in Skidmore v. Swift & Co.16 and United States v. Mead Corp.17 addressed the issue of how much weight, if any, should be given to agency action that was not subject to the procedural safeguards of rulemaking or formal adjudication under the APA, identifying several factors courts should consider in making this determination.18 They also treated deference as occurring along a spectrum, in which the amount of deference due is based on the character and circumstances of the agency action. And in Motor Vehicle Manufacturers Ass'n of the United States v. State Farm Mutual Automobile Insurance Co., the Court affirmed the importance of judicial review to ensure reasoned decision-making as a check on agency discretion.19

Some have criticized deference doctrine as incoherent, but the Court's jurisprudence has been animated by long-standing and widely shared concerns about administrative legitimacy. Administrative action is viewed as legitimate when an agency follows procedures to ensure meaningful participation by those impacted by its action, engages in reasoned deliberation by officials based on relevant expertise and data, is transparent about its reasons for action or inaction, and applies the law consistently. These principles are reflected in the factors identified by the Supreme Court as relevant for determining whether deference is warranted.

Part III critiques the Ninth Circuit's interpretation of Independent Living Center dicta in Managed Pharmacy Care, in light of this more comprehensive understanding of deference doctrine. On the one hand, there is a long history of states' blatant disregard for federal law in the face of federal regulatory neglect, and such neglect demands close judicial scrutiny. On the other hand, the Obama administration has been far more active with respect to federal rate-setting requirements, which would seem to suggest that some deference is warranted.

18 Skidmore was decided in 1944, prior to passage of the APA, and it considered what weight should be given by courts to the "rulings, interpretations, and opinions" of an Administrator that did not have the power to make legal findings of fact or determine violations of law. 323 U.S. at 137–138. Skidmore announced several factors relevant to determining how much weight, if any, the interpretations should receive. In 2001, the Mead Court affirmed Skidmore. 533 U.S. at 211. Mead held that a Customs ruling letter did not deserve Chevron deference because it was not issued pursuant to the agency's power to engage in adjudication, notice–and-comment rulemaking, or by some other indication of comparable congressional intent, but that it deserved some respect based on the Skidmore factors. Id.
But are these recent developments evidence of the kind of reasoned decision-making and exercise of agency expertise that justifies *Chevron* deference? The Ninth Circuit’s cursory explanation for deference to CMS approval does not provide a satisfactory answer to this question because it fails to consider the *Mead/Skidmore* factors relevant to assessing the legitimacy of administrative action. This stands in stark contrast to the district court’s more probing deference analysis, which revealed how CMS’s informal approval of Medi-Cal rates failed to satisfy the *Mead/Skidmore* factors. The district court highlighted CMS’s inconsistent and unexplained interpretations of federal rate-setting requirements, as well as instances of irrational or unsupported conclusions about the data, which undermined claims of deference and illustrated why courts should take a hard look at such action.

Part IV delves more deeply into the theory of administrative legitimacy and judicial review animating the Ninth Circuit’s deferential approach and heavy reliance on *Independent Living Center*. The Ninth Circuit criticized the district court for “delving into the minutiae” of Medicaid and second-guessing CMS policy, instead of viewing the analysis as the kind of hard look review that ensures reasoned decision-making. The Ninth Circuit clearly viewed the district court as engaging in judicial overreach, but did not provide a coherent explanation for why. Part IV considers three possible explanations for the Ninth Circuit’s approach in light of the tension between the court’s role as an external check on administrative legitimacy, and concerns about judicial overreach and policy making. Ultimately, however, it concludes that the district court’s approach strikes the right balance. The result of the district court’s injunctions would not have been to make the final policy decision, but rather to require greater explanation and more deliberation, which should, in turn, promote agency legitimacy and result in better decision-making. This function of judicial review is particularly important in programs like Medicaid that delegate tremendous power to regulators to act without the kind of safeguards that promote administrative legitimacy from within.

I. MEDICAID PAYMENT CHALLENGES: WHAT EVERYONE THOUGHT WAS AT STAKE IN *INDEPENDENT LIVING CENTER*

Around the country, states struggle to balance their budgets, in part by making deep cuts to health and other benefits programs for low-income residents. One area that continues to be vulnerable is the Medicaid program—the joint federal–state public health insurance program that provides health care for the very poor. The cuts have sparked policy debates between state officials insisting that such cuts are necessary to get their fiscal houses in order and patients’ advocates who criticize states for trying to balance the budget on the backs of our most vulnerable citizens.20

One of the most common places we see Medicaid cuts is in rate setting for physicians, hospitals, and other health care providers. There is already a shortage of providers, and cuts threaten to drive even more providers out of the Medicaid program, further jeopardizing access for Medicaid beneficiaries. These payment cuts have sparked fierce legal battles in federal court. Patients and health care providers around the country have brought suits challenging these payment reductions on the ground that they violate health care access and quality protections in federal law. These suits raise important substantive and procedural legal issues. The substantive question is whether state rate cuts violate Medicaid rate-setting requirements. The procedural issue concerns whether patients and providers have a right to challenge such violations in court. The Supreme Court in Independent Living Center only granted certiorari on the second question, but the Court’s decision seems to have important implications for the first one as well.

A. The Substantive Question: Determining Whether Rates Violate Medicaid Rate-Setting Requirements

Medicaid program administration, including rate setting, is delegated to states, but subject to federal oversight. Although states are given a great deal of discretion to choose rate-setting methodology and set provider reimbursement rates, the Medicaid Act establishes certain constraints on this discretion. A key provision of the Act, commonly referred to as “§ 30(A),” requires that Medicaid payments be “consistent with efficiency, economy, and quality of care, and . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” The first two factors—economy and efficiency—are typically understood to reflect federal concerns about payments being too high. The second two factors—quality and sufficiency of providers (also commonly referred to as the Equal Access Provision)—are understood to reflect concerns about payments being too low. Section 30(A), especially the Equal Access Provision, is the primary basis for lawsuits challenging payment cuts.

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21 Id. at 805–28.
23 Id. (emphasis added).
24 See Sara Rosenbaum, Cal. HealthCare Found., Medicaid Payment Rate Lawsuits: Evolving Court Views Mean Uncertain Future for Medi-Cal 8-II (2009), http://www.chcf.org/-/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalProvider-RateLitigation.pdf (discussing the evolution of payment suits and the shift in legal theories after the demise of private challenges under Section 1983). Other provisions in the Medicaid Act have been used to challenge rate cuts with varying success. For example, the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A) (1982) (current version at 42 U.S.C. § 1396a(a)(13)(A) (2012)), which required rates for hospitals and nursing facilities to be “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities,” was an effective tool for chal-
Apart from these factors, the Act does not give much guidance about what the state rate-setting process requires; it simply requires a state to submit a state plan amendment (SPA) to the federal regulatory agency charged with oversight, CMS, when it wants to propose a change in rates or rate-setting methodology. The Medicaid Act requires states to make assurances of § 30(A) compliance in the SPA, but the statute does not explicitly require states to make findings to this effect. The regulations governing payments for in-patient hospital services and long-term care facility services provide more guidance in that they explicitly require states to find that rates "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities," but this does not apply to payments for other Medicaid services. Medicaid regulations also require states to submit the new payment rates by provider type, to note whether the change reflects an increase or decrease in rates, and to make projections about the short-term and long-term effects of the new rates on the availability of services. But neither the statute nor the regulations explicitly require a state to submit its findings or the underlying data it used to set rates and determine § 30(A) compliance to CMS; nor do they require CMS to review these findings or data. In fact, the law provides for default SPA approval if CMS fails to act within a certain time, which has not been uncommon. CMS has authority to promulgate regulations to establish clearer guidance about what § 30(A) requires states to do as part of the rate-setting process, such as the kind of data states must consider, but it has not provided such guidance for proposed rate cuts. It has only provided more
specific procedural requirements in the case of rate increases.\textsuperscript{31}

In the midst of this regulatory void, federal courts have been primarily responsible for defining and enforcing § 30(A) obligations. A comprehensive review of Medicaid payment suits since the 1970s shows that most circuits consider rate cuts that are proposed solely in response to a state's budgetary needs and without any consideration of § 30(A) requirements to be clearly illegal, and courts have typically invalidated such cuts.\textsuperscript{32} Nonetheless, it is common for states to cut rates in this manner, and this is what California did in its initial attempts to cut Medi-Cal rates in the \textit{Independent Living Center} case.\textsuperscript{33} Federal courts have had to intervene because, even in these egregious cases, federal regulators typically fail to deny the SPA or to even investigate the state's § 30(A) assurances.\textsuperscript{34}

The harder cases are where cuts are not so blatantly illegal—that is, where states have undertaken some kind of review prior to setting rates. In these cases, there has been greater variation in the level of scrutiny applied by courts to ensure § 30(A) compliance.\textsuperscript{35} Courts have found this task more challenging because of the statutory ambiguity concerning the rate-setting process and the amount of discretion given to states and federal regulators in the Medicaid Act. The Act makes clear that rate setting requires balancing multiple goals and considerations, and the Medicaid program encourages state flexibility and experimentation in deciding how best to achieve those goals. Prior to its recent decision in \textit{Managed Pharmacy Care}, the Ninth Circuit had been the most active Circuit in protecting providers' and beneficiaries' § 30(A) rights against states. It was the only Circuit willing to read specific procedural requirements into § 30(A), interpreting it as requiring states to set rates based on current provider cost studies.\textsuperscript{36} And it was willing to closely review a state's rate-setting process for defects that would undermine the state's conclusions about § 30(A) compliance.\textsuperscript{37}

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\item[\textsuperscript{31}] Id. in 219,
\item[\textsuperscript{32}] \textit{see} Clark, Medicaid Access, supna note 12, at 805–11.
\item[\textsuperscript{33}] \textit{See} Indep. Living Ctr. of Southern California, Inc. v. Maxwell–Jolly, 572 F.3d 644, 655–56 (9th Cir. 2009) ("In this case, the record supports the district court's conclusion that 'the only reason for imposing the cuts was California's current fiscal emergency.' ... Thus, ... the State's decision to reduce Medi–Cal reimbursement rates based solely on state budgetary concerns violated federal law.", vacated sub nom. Douglas v. Indep. Living Ctr. of Southern California, Inc., 132 S. Ct. 1204 (2011).
\item[\textsuperscript{34}] Clark, Medicaid Access, supra note 12, at 805–11.
\item[\textsuperscript{35}] Id. at 829–30.
\item[\textsuperscript{36}] Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1500 (9th Cir. 1997) (holding that states could not make good faith and rational assurances of § 30(A) compliance without a study of provider costs). For further discussion, see infra Part III.A.
\item[\textsuperscript{37}] Clark v. Kizer, 758 F. Supp. 572, 575–80 (E.D. Cal. 1990) (holding that Medicaid payment
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Although other federal courts have enjoined state cuts for violating the Medicaid Act, most have not been as active in their scrutiny of states' rate-setting processes. Some courts have been willing to provide some level of review to ensure § 30(A) compliance, but ultimately were very deferential to states.\textsuperscript{38} Other courts have been hesitant to second-guess a state's rate-setting process, but have left the door open for plaintiffs to prove that the rates were so low that they would adversely impact access and quality in ways that violated § 30(A) guarantees.\textsuperscript{39} And at least one court held that the lack of clear requirements in § 30(A) essentially rendered it unenforceable in the courts.\textsuperscript{40}

It is not clear why the Supreme Court did not grant certiorari on the substantive issue of § 30(A) compliance, which would have given the Court the opportunity to address this variation among lower courts. It could be because CMS urged against it, as it was in the process of studying the issue and beginning the rulemaking process, which would finally give the states and courts long-needed guidance. It could also be that there was no compelling reason to do so because the rate cuts that were originally challenged in \textit{Independent Living Center} were the kind of egregious violation of federal law that presented an easy case for almost all federal courts. Although the Supreme Court chose not to take up this substantive issue, it indirectly returned to it when it reframed the procedural question presented to the Ninth Circuit on remand.

\textbf{B. The Procedural Question: Whether Plaintiffs Can Use the Supremacy Clause to Challenge Medicaid Cuts in Federal Court}

States have long complained about Medicaid payment suits, claiming that they interfere with states' difficult job of managing their own budgets and undermine the discretion they have been delegated under the Medicaid Act. States' first line of defense has been to attack plaintiffs' right to bring these suits in the first place. As noted in the Introduction, the \textit{Independent Living Center} plaintiffs, like plaintiffs in other states, successfully used the Supremacy Clause to get the cuts preliminarily enjoined by the district court and affirmed by the Ninth Circuit. In the appeal to the Supreme Court, California officials challenged whether Medicaid providers and beneficiaries could bring a private right of action under the Supremacy Clause to challenge state rate cuts as inconsistent with—and thus preempted by—§ 30(A).\textsuperscript{41}

\footnotesize{\textsuperscript{38} Clark, \textit{Medicaid Access}, supra note 12, at 805–811.}
\footnotesize{\textsuperscript{39} Id.}
\footnotesize{\textsuperscript{40} Id.}
\footnotesize{\textsuperscript{41} Douglas v. Indep. Living Ctr. of Southern California, Inc., 132 S. Ct. 1204, 1207–08 (2012).}
By granting certiorari on this procedural question, the Supreme Court renewed a recurring dispute about the right of private individuals to enforce Medicaid spending conditions on the rate-setting process. Because the Medicaid Act does not create an express private action for this, providers and beneficiaries have had to use other legal tools to bring these challenges in federal court. Beginning in the 1970s, patients and providers used a federal civil rights statute, known as § 1983, to enforce various Medicaid rate-setting requirements. Section 1983 provides a cause of action for "the deprivation of any rights, privileges, or immunities secured by the Constitution and laws" of the United States. States' initial attacks on plaintiffs' rights to bring these suits were unsuccessful in lower courts, and in 1990 the Supreme Court in *Wilder v. Virginia Hospital Ass'n* affirmed this implied right of action. *Wilder* insisted that such suits were a critical enforcement tool for providers and beneficiaries because of the lack of federal regulatory oversight which allowed states to ignore federal law. Even Congress has affirmed the importance of this private right of action at various times—through explicit legislative action and statements, as well as by its failure to amend the Medicaid Act to prevent such suits. This affirmation occurred despite concerns expressed by some legislators that such suits made it difficult for states to cut costs and effectively administer their Medicaid programs. Nonetheless, twelve years after *Wilder*, the Supreme Court in *Gonzaga University v. Doe* revisited § 1983 and severely narrowed its scope. Although *Gonzaga* did not involve a private challenge to Medicaid rates, almost every federal court that considered how *Gonzaga* applied to such challenges held that § 1983 could no longer be used.

42 See *Rosenbaum*, supra note 24, at 8–11.
43 *Clark, Medicaid Access*, supra note 12, at 802–05.
45 *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 525–28 (1990) (affirming that § 1983 could be used by private plaintiffs to challenge state Medicaid rates that violate federal law; in this case the rates violated the Boren Amendment, a provision similar to § 30(A)).
46 *Id.* at 507–08, 516–19.
47 See *id.* at 521–22; see also H.R. Rep. No. 94–1122, at 4 (1976), reprinted in 1976 U.S.C.C.A.N. 5649, 5649–51; 121 Cong. Rec. 42,359 (1975) (statement of Sen. Robert Taft Jr.) (illustrating that Congress has not always acted consistently, and it has taken actions that seemed to weaken some limits on state discretion, such as repealing the explicit "findings" requirements for state rate-setting for hospital and skilled nursing services in the Boren Amendment). Despite some legislators' concerns about how such provisions have been used to halt or slow state rate cuts, there has never been enough support to repeal § 30(A), which applies broadly to the rate-setting process for all Medicaid services. For further discussion, see *Clark, Medicaid Access*, supra note 12, at 802–03.
48 *Clark, Medicaid Access*, supra note 12, at 802.
In response to losing § 1983 as a vehicle for Medicaid payment challenges, plaintiffs offered a new legal theory for their private cause of action: the Supremacy Clause. The Supremacy Clause provides that where federal and state law conflict, federal law trumps. In the Medicaid payment cases, plaintiffs alleged that state cuts that violated § 30(A) must be invalidated because they conflict with the goals and express requirements of federal law.

States, on the other hand, have argued that the Supremacy Clause is not a legitimate tool for enforcing Medicaid rate-setting requirements. They have emphasized that the Supremacy Clause has been used to defend against state law or action that would require a person to do something that conflicted with or violated federal law, and they have tried to distinguish this from the way providers and beneficiaries have used it in payment challenges. According to states, the Supremacy Clause should not be a vehicle for affirmatively challenging a state's reimbursement rates because providers voluntarily participate in the Medicaid program. In addition, they have said that allowing such suits would create an end-run around Gonzaga and upset the regulatory structure contemplated in the Medicaid Act, which expressly delegates authority to approve or deny state SPAs to the Secretary of Health and Human Services (HHS). Thus, states argue that enforcement of rate-setting program requirements should be vested solely in CMS, the division of HHS tasked with SPA oversight.

The states' arguments have been largely unsuccessful in the lower courts, and for years, providers and beneficiaries have been using the Supremacy Clause. This is one reason many believed that the Supreme Court's grant of certiorari foreshadowed the elimination of this avenue for judicial review; the other reason was speculation that the conservative majority would jump at the chance to remove battles over state health care financing decisions from the federal courts, continuing a trend that had limited private plaintiffs' access to federal court.

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51 U.S. Const. art. VI, cl. 2 ("This Constitution, and the Laws of the United States which shall be made ... under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby ... ").

52 Id.

53 See Rosenbaum, supra note 24, at 1, 9–11.


55 See id. at *27–28.

56 See, e.g., Indep. Living Ctr. of Southern California, Inc. v. Maxwell-Jolly, 572 F.3d 644, 652–54 (9th Cir. 2009), vacated sub nom. Douglas v. Indep. Living Ctr. of Southern California, Inc., 132 S. Ct. 1204 (2012). The Court's failure to grant certiorari on the substantive question likely exacerbated this fear because the elimination of plaintiffs' right to challenge cuts in federal court would have made the substantive question of § 30(A) compliance effectively moot.

57 Indep. Living Ctr., 132 S. Ct. at 1213–1214 (Roberts, C.J., dissenting, joined by Scalia, Thomas, & Alito, JJ.) (criticizing the majority for not deciding the question presented and stating that the Supremacy Clause should not be used to challenge state rate cuts regardless of CMS approval).
number of amicus briefs were filed. Predictably, patient advocates and provider organizations weighed in on the side of the plaintiffs, while states supported California. Less predictable, however, was the divergence in positions taken by former regulatory officials and the Obama administration.

The federal government sided with California, with the acting Solicitor General filing an amicus brief urging the Supreme Court to hold that Medicaid providers and beneficiaries do not have a legal right to sue in federal court to prevent illegal state cuts. The Obama administration argued that it should be up to CMS to determine and enforce § 30(A) compliance. In asserting its position, the Obama administration did not rely on any firm legal precedent. Rather, the crux of its position was that state violations of Medicaid program requirements are different from the kind of other conflicts with federal law that the Supremacy Clause has been used to prevent. Most of the government's brief was devoted to justifying this difference.

The brief highlighted the fact that Medicaid is a cooperative program and argued that program requirements like the Equal Access Provision look more like contract conditions between the federal government and states than the kind of clear and specific statutory right that is enforceable by beneficiaries and providers. Second, the Obama administration argued that CMS enforcement would create better and fairer results because it has the requisite expertise that courts do not have, especially given the complexity of the Medicaid statute and the multiple and potentially conflicting goals of access, quality, economy, and efficiency that states must balance. Finally, the government claimed that allowing federal courts to determine these issues was unfair because of the inconsistency that results from different circuits’ interpretations of federal law.

The essence of CMS's argument was that it was better equipped for the job than courts.

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61 Id.

62 Id.


64 Id. at *11, *31-32.

65 Id. at *32.
But the briefs by former U.S. Health and Human Services officials and members of Congress presented a far different picture of CMS—not as an effective regulator of Medicaid access protections, but as an understaffed and ineffective agency that has lacked the political will and capability to provide meaningful review of rate cuts. This picture is consistent with the regulatory void I have described elsewhere: the agency's failure to define and enforce federal access protections; regulators' uneven focus on SPAs that would potentially increase rates, but not on those proposing cuts; and an utter lack of any judgment or expertise in agency determinations about whether SPAs comply with § 30(A). While there has been some variation in judicial oversight of this issue, any inconsistency has been due primarily to CMS's failure to issue regulatory guidance for states and the courts.

In sum, in both the procedural question taken up by the Court and the substantive question lurking in the background, CMS's regulatory role has been critical to both sides' arguments. Essentially, CMS and the states argued that courts should trust CMS to enforce the law. But the plaintiffs, health care advocates, and former regulators pointed to past regulatory failures to show that such trust was not warranted and to highlight the importance of robust judicial review. The federal regulatory oversight of rate setting contemplated by the Act has simply not been reflected in CMS's action on the ground, at least not until recently.

II. Independent Living Center's (In)Decision Due to "Changed Circumstances"

As noted in the Introduction, the Supreme Court never answered the question on which it granted certiorari—whether patients and providers could challenge Medicaid rate cuts in federal court using the Supremacy Clause. By refusing to answer the question, Independent Living Center effectively preserved plaintiffs' right to do this, at least where there has been no federal approval of the cuts. In a 5–4 decision, the Court reframed the question and remanded it back to the Ninth Circuit due to "changed circumstances"—namely, that CMS approved the proposed rates as consistent with federal law while litigation was pending.


67 Clark, Medicaid Access, supra note 12, at 829–32 (describing the federal regulatory void that has existed for years in the case of SPA approvals when rate cuts have been proposed).

68 Indep. Living Ctr., 132 S. Ct. at 1207-08.
Notably, the process by which CMS approved these rates did not look like the kind of rubber stamping or regulatory inaction described in Part I, which has made judicial intervention so compelling in § 30(A) challenges. Rather, CMS seems to have played an active regulatory role: it inquired about the findings upon which California based its § 30(A) assurances; it refused to approve the rates initially due to access concerns; it required state officials to produce more information; and there appeared to be a good deal of interaction between state and federal regulatory officials concerning access. Indeed, CMS’s actions in this case seemed to reflect a commitment by the Obama administration to greater regulatory oversight of Medicaid access generally.

The Court’s decision to remand the case in light of CMS’s approval of the cuts makes clear that CMS’s regulatory role is relevant to the question on remand, but the Court’s brief explanation raises more questions than it provides answers about what this impact will be. In dicta, the Court suggests that federal agency action might impact judicial review procedurally, by creating a preferred avenue for seeking review in the courts, and substantively, by requiring courts to apply a greater level of deference. The Court’s dicta fails to go beyond mere speculation, however, because these issues were not briefed.

This Part explores the Independent Living Center Court’s sparse reasoning about why agency action should matter in theory and highlights what is missing from the opinion that would be necessary to determine whether deference should apply to CMS approval of SPAs specifically. This Part also provides greater context for the Court’s administrative law jurisprudence on deference—context that is particularly important for evaluating the level of deference due to informal adjudicatory actions like SPA approvals. Parts III and IV will use this more developed theory of deference to critique the Ninth Circuit’s recent application of Independent Living Center in Managed Pharmacy Care and to consider the troubling implications for informal adjudicatory action more generally.

69 Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1242–1243 (9th Cir. 2013).

70 Since 2008, CMS has performed more searching inquiries into § 30(A) assurances before approving requests for rate cuts. See Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342, 26,348 (May 6, 2011) (to be codified at 42 C.F.R. pt. 447) (describing the administration’s recent oversight activities). And in 2011, CMS proposed regulatory guidance for § 30(A) compliance. Id. Although not yet finalized, the proposed rule makes clear that states can no longer ignore § 30(A) requirements and suggests a framework for states’ § 30(A) access reviews. Id.
A. Independent Living Center Dicta: Why Federal Agency Action Might Matter

The new question presented by a majority of the Court was whether federal approval of the cuts “may require respondents now to proceed by seeking review of the agency determination under the [APA] rather than in an action against California under the Supremacy Clause.”71 The majority explained why it thought CMS approval had changed the posture of the case:

For one thing, the APA would likely permit respondents to obtain an authoritative judicial determination of the merits of their legal claim. The [APA] provides for judicial review of final agency action. It permits any person adversely affected or aggrieved by agency action to obtain judicial review of the lawfulness of that action. And it requires a reviewing court to set aside agency action found to be “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.”72

There is nothing radical or controversial about the Court’s observations. The first part focuses on the fact that agency action may make the Supremacy Clause unnecessary because the APA expressly provides for judicial review of federal agency action. Recall that many plaintiffs historically have challenged cuts that states were attempting to implement prior to, or in the absence of, federal regulatory action. The Supremacy Clause was necessary to protect plaintiffs against state violations occurring in this federal regulatory void. The last sentence simply highlights the arbitrary and capricious standard applied to agency action and mentioned in the APA. In fact, this statement about of the relevance of the APA in defining the availability and scope of judicial review of federal action is consistent with how lower courts had previously treated suits challenging federally-approved SPAs under the APA.

The troubling part of the opinion comes in the Court’s speculation about the potential problems that could result if plaintiffs were left with a choice between the Supremacy Clause or the APA. One problem is that the Court’s concern is based on speculation about how the APA standard would be applied in these cases, and that this standard would be more deferential than the standard used by federal courts in Supremacy Clause challenges. The Court began by noting that although CMS approval “does not change the underlying

71 Indep. Living Ctr., 132 S. Ct. at 1230 (citation omitted).
72 Id. (citations omitted) (quoting 5 U.S.C. § 706(2)(A) (2012)).
substantive question” about whether California’s cuts comply with federal law, “it may change the answer.” It then went on to explain why it thought this was so:

[R]espondents’ basic challenge now presents the kind of legal question that ordinarily calls for APA review. The Medicaid Act commits to the federal agency the power to administer a federal program. And here the agency has acted under this grant of authority. That decision carries weight. After all, the agency is comparatively expert in the statute’s subject matter. And the language of the particular provision at issue here is broad and general, suggesting that the agency’s expertise is relevant in determining its application.73

The Court’s concern only makes sense if lower courts apply different standards of review to payment challenges under a Supremacy Clause and APA analysis. And as evidence of this possibility, the Court noted that the Ninth Circuit initially “declined to give weight to the Federal Government’s interpretation” of § 30(A) in determining whether the rate cut violated federal law, but that “ordinarily review of agency action requires courts to apply certain standards of deference to agency decision making” under the APA.74 In describing this standard, the Court cited to Chevron, which has been characterized by some as effecting a revolution that demanded greater deference by courts to agency action.75 The Court also relied on National Cable & Telecommunications Ass’n v. BrandX Internet Services76 (BrandX), which held that courts should defer to agency interpretations of ambiguous statutes, even when they conflict with that court’s own prior judicial interpretations.

The question of how much deference, if any, should be given to CMS’s interpretations and determination of § 30(A) compliance in SPA approvals is considered in greater detail in Parts III and IV. The important point for now is that this issue was not briefed. Because the issue was not briefed, the Court’s speculation about whether courts would apply different standards for an APA versus Supremacy Clause claim was wrong, at least based on prior cases. Moreover, the Court did not consider key Supreme Court cases, which have limited or complicated the question of deference, especially in informal adjudicatory action. Finally, the majority’s speculation that CMS approvals

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73 Id.
74 Id. The Ninth Circuit had long interpreted § 30(A) to require states to perform provider cost studies before setting rates, and the state’s failure to do this was one reason the Ninth Circuit had affirmed the district court’s injunctions prior to Douglas. During the litigation, CMS offered a different interpretation of § 30(A), as not requiring cost studies. However, this interpretation was not the result of rulemaking or formal adjudication, and was inconsistent with CMS’s prior interpretation. See discussion infra Part III.
would satisfy the requirements for *Chevron* deference was not based on any inquiry into the specific facts or circumstances surrounding CMS action in this case. Consequently, the Court's dicta about whether *Chevron* deference should apply should not be viewed as controlling without a more fact-specific inquiry into the circumstances and context of that action. In fact, the Court acknowledged as much when it qualified its own speculation by noting that there may be reasons why a court should not apply these ordinary standards of deference.

Nonetheless, California and federal officials have seized on the Court's dicta about *Chevron* deference for SPA approvals in asserting that *Independent Living Center* was a win for states and viewing it as a message to lower courts to defer to CMS. And even more concerning is that the Ninth Circuit seems to have adopted this view. But this ignores the explicit disclaimers made by the Court, and more importantly, fails to consider the deference question within the textured deference doctrine that has developed through other seminal administrative law cases, like *Skidmore*, *Mead*, and *State Farm*. Indeed, what some perceive to be a simple yes or no question about whether *Chevron* deference should apply actually requires a more nuanced analysis of the principles and limits of APA deference, its application to informal agency adjudication, and the proper role of courts in mediating disputes arising out of programs that are complex, interstitial, and more evolutionary than static. Determining deference in such cases requires more work by courts to be sure; but the next section explains why this is necessary for ensuring administrative legitimacy.

### B. Administrative Legitimacy and Judicial Review

Judicial review is central to ensuring the legitimacy of the administrative state. Administrative agencies, especially in the modern administrative state, have been delegated a great deal of power to create and enforce regulation that touches almost every aspect of our lives. In this modern state, Congress enacts legislation that leaves a number of policy-making gaps to be filled by agencies through their rulemaking and adjudicatory functions. There has been great concern about Congress delegating so much power to define law to a body

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77 Id.
78 *Indep. Living Ctr.*, 132 S. Ct. at 1210.
that is not accountable to the public in the way that legislators are, as well as concern about vesting so much power to adjudicate and resolve disputes outside of the traditional protections of Article III courts. Much of the focus in administrative law scholarship has been on how judicial review furthers administrative legitimacy by ensuring that agencies act according to statutory commands, and that their discretion is exercised in a deliberate, consistent, and fair manner.

The APA addresses these concerns in a couple of ways. It creates procedural requirements for agency rulemaking and formal adjudications, which enhance administrative legitimacy from within. Public notice and the opportunity for comment, documentation of agency findings, and hearing procedures ensure public participation and transparency of agency reasons for action, which, in turn, promote accountability and fairness. Such requirements produce a more deliberative process and thorough vetting of agency decisions, which arguably promotes better policy making. Finally, these requirements facilitate the production of information that enables meaningful judicial review of challenged actions.

The APA also expressly provides for judicial review of agency action and notes the bases on which agency action must be set aside. Specifically, the APA requires agency action to be set aside if it violates statutory or constitutional commands, or if the action is arbitrary, capricious, an abuse of discretion, or otherwise inconsistent with the law. Unless statutorily exempted from review, this standard of review applies to all kinds of agency action, including the vast array of actions that fall within the informal adjudication category and are not subject to the APA procedural requirements described above. Judicial review serves as an external check on agency legitimacy: in the case of rulemaking and formal adjudication, it helps to ensure that agencies comply with the APA procedures that enhance agency decision-making; and in all cases, judicial review helps guard against abuse of power and arbitrariness.

The idea of deference to agencies can only be understood properly with reference to this fundamental concern about the misuse of agency discretion. Courts have interpreted the APA as requiring deference to administrative agencies under certain conditions: given their expertise and accountability to the executive, agencies are in a better position than courts to fill in legislative

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82 See, e.g., 5 U.S.C. § 553 (2012) (procedures governing notice and comment rulemaking); §§ 553(c), 554, 556–557 (listing procedural requirements for formal rulemaking and adjudication).
85 Id. § 706(a)(A)–(C).
gaps that involve value judgments and the balancing of policy goals. Lower courts should not use judicial review to substitute their own policy judgments for that of an agency's; judicial overreach is problematic because it undermines the principles of accountability and administrative expertise that justify congressional delegation to the agency in the first place. On the other hand, the APA makes clear that when an agency fails to act consistently with statutory goals or in a reasoned way, this deference will be lost. Defining the line between improper judicial overreach and proper judicial check on agency abuse is particularly challenging when statutory commands are vague, the action involved requires legal and policy determinations, and the decision-making process is not subject to the kinds of internal procedures described above as enhancing agency legitimacy.

The Supreme Court's administrative law doctrine should be understood as providing guidance to lower courts faced with this challenge. The Court has established two important principles that limit Chevron deference and should guide courts' interpretation of Independent Living Center dicta in the case of SPA approvals. One is the reasoned decision-making requirement. The other is the view of deference as occurring along a spectrum, where the weight given depends on the character and circumstances of the challenged agency action.

1. Reasoned Decision-Making.—In reviewing agency action, courts demand that agencies provide a reasonable basis for their decisions—that is, the agency must demonstrate that it has considered relevant factors and can articulate a rational connection between the evidence considered and its conclusion. This kind of review came to be known as "hard look" review in the 1970s and 1980s, and it was developed by the Supreme Court to address concerns about agencies' increasing use of informal actions to make legal and policy decisions with significant implications. For example, in 1971 in Citizens to Preserve Overton Park, Inc. v. Volpe, the Court applied hard look review to an informal agency decision to authorize federal funds for construction of a highway through a

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89 See Lisa Schultz Bressman, Procedures as Politics in Administrative Law, 107 COLUM. L. Rev. 1749, 1753 (2007) (using legal scholarship and political theory to offer an account of seminal administrative law cases as interested in producing acceptable rules for agency decision-making to enhance administrative legitimacy).
public park.\textsuperscript{91} Although the governing statutes did not require the Secretary of the Department of Transportation to make formal findings justifying the decision, the Court remanded the case to the District Court for a closer review of the Secretary's decisions.\textsuperscript{92} The Court explained that a more searching inquiry into the Secretary's reasons was necessary in order to determine whether the Secretary's decision was consistent with the law.\textsuperscript{93}

This hard look review was applied to agency rulemaking a decade later in \textit{State Farm}. In \textit{State Farm}, the Court explained, and arguably expanded, the kind of inquiry courts should make:\textsuperscript{94}

\begin{quote}
'The scope of review under the "arbitrary and capricious" standard is narrow and a court is not to substitute its judgment for that of the agency. Nevertheless, the agency must examine the relevant data and articulate a satisfactory explanation for its action including a "rational connection between the facts found and the choice made." In reviewing that explanation, we must "consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment."

Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.\textsuperscript{95}
\end{quote}

The reasoned decision-making requirement enables a court to determine whether the criteria for deference have been met by focusing on \textit{how} an agency made its decision and whether it can justify its decision, not whether it made the \textit{right} one.

The fact that an act requires some agency discretion cannot be used as a shield from judicial review. In cases where discretion could be used to disguise arbitrariness or abuse, it is even more important for courts to take a hard look at an agency's decision-making process to ensure that it is not arbitrary, capricious, or otherwise inconsistent with the law. For example, in \textit{State Farm},\textsuperscript{96} and then later in \textit{Massachusetts v. EPA},\textsuperscript{97} the Court found an agency's rescission of a rule and its failure to promulgate a rule, respectively, to be arbitrary and capricious, despite the inherently discretionary character of the decisions. In each case, the

\begin{itemize}
\item \textsuperscript{91} Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971).
\item \textsuperscript{92} \textit{Id.} at 415 (noting that although the Secretary's decision is not subject to APA rulemaking or formal adjudication requirements, the court must engage in a "substantial inquiry" and a "thorough, probing, in-depth review" of the record of agency action).
\item \textsuperscript{93} \textit{Id.} at 409–410 (holding that the statute clearly limited the Secretary's authority to authorize such funding, and that on remand the Secretary would need to show that there was no feasible or prudent alternative to the use of such land and that the plan made provisions for minimizing harm to the park).
\item \textsuperscript{94} See \textit{Jordan}, \textit{supra} note 90, at 398–340.
\item \textsuperscript{96} \textit{Id.} at 30–31.
\item \textsuperscript{97} \textit{Massachusetts v. EPA}, 549 U.S. 497, 527–35 (2007).
\end{itemize}
agency exercised its discretion in ways that seemed at odds with the statute's goals, and it failed to produce findings or offer expertise that justified its choice.98

The result of hard look review is not to substitute the Court's own judgment for the agency's in terms of the ultimate policy decision; rather, when agency action is invalidated in such cases, it means that the agency must gather more meaningful and relevant data to justify its conclusions, do a better job of vetting and explaining its reasons for the action it has taken, or both.99 This focus on reasoned decision-making enhances administrative legitimacy by "reinforc[ing] administrative law values of participation, deliberation, and transparency, which guard against arbitrariness and foster accountability."100 And while some legal scholars have criticized courts' application of this requirement as slowing or impeding administrative progress, others have argued that this has enhanced the quality of agency decision-making.101

98 See State Farm, 463 U.S. at 48 ("Given the effectiveness ascribed to airbag technology by the agency, the mandate of the Safety Act to achieve traffic safety would suggest that the logical response to the faults of detachable seatbelts would be to require the installation of airbags. At the very least this alternative way of achieving the objectives of the Act should have been addressed and adequate reasons given for its abandonment."); Massachusetts v. EPA, 549 U.S. at 532-33 (citations omitted) (internal quotation marks omitted) ("While the statute does condition the exercise of EPA's authority on its formation of a 'judgment,' that judgment must relate to whether an air pollutant . . . may reasonably be anticipated to endanger public health or welfare. Put another way, the use of the word 'judgment' is not a roving license to ignore the statutory text. It is but a direction to exercise discretion within defined statutory limits.").

99 See, e.g., Jordan, supra note 90, at 396, 439 (arguing that a hard look review does not impede agency rulemaking and noting, based on one study, that agencies whose rules were initially invalidated as arbitrary and capricious were able to successfully implement the same policy about 80 percent of the time).

100 Hammond & Markell, supra note 80, at 316 ("[T]hese principles are consistent with the literature on procedural justice, which evaluates the legitimacy of decision-making procedures based on norms of voice, respect, neutrality, and trust. Overall, these principles legitimize by affirming citizenship, reinforcing fidelity to statute, and furthering democratic norms.") (citations omitted). A reasoned decision-making requirement is also consistent with theories of administrative legitimacy that depend on a civic republican view of agency action. See, e.g., Mark Seidenfeld, A Syncopated Chevron: Emphasizing Reasoned Decisionmaking in Reviewing Agency Interpretations of Statutes, 73 Tex. L. Rev. 83, 127-30 (1994) (arguing for a political model of agency decision-making that views agencies as a means of fostering public deliberation about government policy choices and suggesting that courts should scrutinize the reasonableness of agencies' statutory interpretation more carefully); Shapiro et al., supra note 83, at 484-85 (arguing that in the case of rulemaking, the role of judicial review is to turn it into more of a civic republican process). At the time this was written, Chevron was understood as a significant shift in how courts would defer to agency interpretations, but this was before Chevron was qualified by Mead, especially regarding informal agency actions.

101 See, e.g., Mark Seidenfeld, Cognitive Loafing, Social Conformity, and Judicial Review of Agency Rulemaking, 87 Cornell L. Rev. 486, 490 (2002) (discussing these objections and offering a modest defense of judicial review). Seidenfeld asserts that "the psychology of individual decisionmaking biases and group decisionmaking dynamics suggests that judicial review does improve the overall quality of rules." Id. He qualifies this, however, by noting that his article only addresses arbitrary and capricious review of agency legislative rules and not judicial review of issues of law, such as interpretations of statutes. Id.
2. *Informal Adjudication.*—The scholarly literature on the role of judicial review as a check on administrative legitimacy has primarily focused on rulemaking and formal adjudication. In these instances, judicial review and APA procedural requirements work nicely together to enhance administrative legitimacy by ensuring that specific APA procedures are followed and applied in an unbiased, transparent, and meaningful way. Agency action that falls into the broader category of informal adjudication, however, is largely unregulated by the APA. From a doctrinal standpoint it is more difficult to generalize about how such action should be treated because of the wide variety of action that falls into this category and the vast discretion left to agencies with respect to how they make decisions. Nonetheless, the Court's current deference doctrine provides guiding principles.

Although *Chevron* is widely cited for the proposition that agency interpretations of ambiguous statutes should get deference, the Court in *Mead* made clear that not all agency interpretations are equal in this regard. *Mead* identified particular indicia or characteristics of agency action that are

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102 See 5 U.S.C. § 551(6)–(7) (2012) (defining "order" to mean "the whole or a part of a final disposition, whether affirmative, negative, injunctive, or declaratory in form, of an agency in a matter other than rule making but including licensing") (defining "adjudication" as an "agency process for the formulation of an order"); see also Edward Rubin, *It's Time To Make the Administrative Procedure Act Administrative*, 89 CORNELL L. REV. 95, 124–126 (2003) (footnote omitted) ("Considering some of the administrative actions that are neither rulemaking nor formal adjudication illustrates the problem. One of the most distinctive and important aspects of administration is strategic planning, the process by which an agency decides how it will allocate its human, legal and physical resources in the future to achieve its goals. . . . Another important category of decisions . . . involves policy implementation. Even in a situation where the agency is ultimately required to engage in formal adjudication, many of its crucial decisions lie outside the adjudicatory framework. . . . It is notable that the APA was drafted with regulatory agencies in mind and that scholarship and teaching in administrative law have focused almost entirely upon such agencies. They are, of course, enormously important, but their staff members constitute a small fraction of federal employees, and their expenditures represent a correspondingly small proportion of the federal budget. Most administrators work for, and most of the money is spent by, agencies that deliver services, generally through institutions. . . . Nearly all the activities involved in the operation of these institutions—all the planning, budgeting, training, supervision, and actual implementation—presumably fall into the category of informal adjudication . . . . Clearly, therefore, the APA offers few conceptual resources for controlling the manner in which these institutions carry out their functions and interact with the public.").

103 Id. at 126 ("Judicial interpretation has not closed this lacuna in the APA. . . . [T]he APA simply provided no foothold, no conceptual framework, for imposing requirements on most actions that lay beyond the ambit of rulemaking and formal adjudication.").

104 See, e.g., Seidenfeld, *A Synoplated Chevron*, supra note 100, 87–103 (describing the scholarly debate about the significance of *Chevron*).
relevant to the question of how much deference, if any, is deserved. An important one is the formality of the action:

We have recognized a very good indicator of delegation meriting Chevron treatment in express congressional authorizations to engage in the process of rulemaking or adjudication that produces regulations or rulings for which deference is claimed. It is fair to assume generally that Congress contemplates administrative action with the effect of law when it provides for a relatively formal administrative procedure tending to foster the fairness and deliberation that should underlie a pronouncement of such force. Thus, the overwhelming number of our cases applying Chevron deference have reviewed the fruits of notice-and-comment rulemaking or formal adjudication.

This emphasis on formality is consistent with the Court's concerns about administrative legitimacy and the fact that the APA procedures in rulemaking and formal adjudication help ensure this legitimacy from within. But the Medicaid SPA approval process does not fall into either category; in fact there are almost no regulatory procedural safeguards in the case of SPA approvals, and certainly no requirements that ensure public participation and vetting of CMS's reasons for approving cuts. At least when a SPA is denied, states have the right to seek an administrative hearing, triggering the formal adjudicatory procedures required under the APA; but providers and beneficiaries do not have a comparable right in the case of SPA approvals. As noted in Part I, implementing regulations require states to submit assurances of § 30(A) compliance to HHS when they submit a state plan amendment. But neither the statute nor Medicaid regulations explicitly note what findings states must make to support their SPA assurances, require states to submit any findings or evidence of support to the federal government as part of the SPA, or require the federal agency to review any findings or support for the states' assurances. In fact, the regular practice, at least prior to the Obama administration, was for the Secretary to rely on states' assurances without requesting underlying documentation.

Perhaps more important than CMS's decision to approve cuts in a given case is the fact that the SPA approval process requires CMS to fill in crucial statutory gaps without the benefit of rulemaking or formal hearing protections, which are designed to facilitate a thorough vetting of its statutory interpretations and to ensure agency consistency of those interpretations over time. CMS's decision that a SPA complies with, or violates, § 30(A) depends on its interpretation of what § 30(A) requires states to do in order to ensure the sufficiency of rates and to demonstrate equal access. Yet, until 2011, CMS had failed to use its rulemaking authority to articulate and justify its interpretation of the law. Indeed, the number of comments received by CMS when it finally did propose regulations reflected considerable concern that CMS's approach would not adequately enforce § 30(A) protections.

106 Id. at 229–30 (emphasis added) (footnote omitted) (citations omitted).
107 See Clark, Medicaid Access, supra note 12, at 800–01.
108 Id. at 801.
While formality is important, Mead does make clear that the absence of formality is not determinative. The Court views the question of deference as a matter of degree, where the amount of deference warranted may depend on a number of factors:

The fair measure of deference to an agency administering its own statute has been understood to vary with circumstances, and courts have looked to the degree of the agency's care, its consistency, formality, and relative expertness, and to the persuasiveness of the agency's position. [An] approach [which] has produced a spectrum of judicial responses, from great respect at one end, to near indifference at the other.109

Thus, in contrast to the way the question of deference was discussed in Independent Living Center, the Mead Court notes that deference is not necessarily a simple yes or no question, but that the degree of weight accorded to agency action varies based on the context and circumstances surrounding agency action.110 According to Mead, even if an action does not warrant Chevron deference, it may still get some degree of respect under Skidmore, a Supreme Court decision addressing the weight accorded to agency action prior to Chevron.111 In Skidmore, the Court held that the degree of weight "will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control."112

This inquiry into the circumstances of CMS's approval to determine whether it deserves some weight under Mead and Skidmore is missing from Independent Living Center. The Court, in its dicta referring to Chevron deference, acknowledged that "it may be that not all of the considerations that may bear upon the proper resolution of the issue have been presented."113 The Mead and Skidmore factors are precisely the kinds of considerations that the Court likely had in mind, and which are explored in greater depth in the next Part.

III. THE NINTH CIRCUIT'S INTERPRETATION OF INDEPENDENT LIVING CENTER

The challenges reviewed in Independent Living Center represent only a fraction of the lawsuits brought in recent years to halt state cuts in California based on federal law. Because of the preliminary injunctions repeatedly granted by district courts and affirmed by the Ninth Circuit prior to Independent Living Center, California legislators have made multiple attempts to cut rates. As described further below, the latest round of cuts was challenged in a group of cases decided by a California district court in December 2011 and January 2012,
and the cases were consolidated and ultimately heard by the Ninth Circuit in *Managed Pharmacy Care*.

Providers and beneficiaries brought four suits challenging these more recent cuts in federal court: *California Medical Ass’n v. Douglas,*(n4) *California Hospital Ass’n v. Douglas,*(n5) *California Medical Transportation Ass’n v. Douglas,* and *Managed Pharmacy Care v. Sebelius* — referred to collectively as the “Post–ILC Medicaid Payment Cases.”(n6) The cuts challenged in *Managed Pharmacy Care* were almost identical to the ones challenged in *Independent Living Center* in that they targeted a diverse group of providers, including providers of skilled nursing, physician, clinic, dental, emergency medical transportation, durable medical equipment and supply, and pharmaceutical services.(n7) But the process through which these latest cuts were effected looked very different. These latest cuts were enacted as part of Assembly Bill (AB 97), which contained language expressly acknowledging California’s § 30(A) obligations and conditioning the proposed cuts on § 30(A) compliance.(n8)

The Director of the California Department of Health Care Services (DHCS), Toby Douglas, was authorized to make this determination and, pursuant to this authorization, the Director caused DHCS officials to undertake an access review as part of its rate-setting process before resubmitting its SPA to CMS. CMS also took an uncharacteristically active role in reviewing California’s SPA and requesting additional information from which to assess California’s assurances of § 30(A) compliance.(n9)

On the surface, at least, California and

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(n7) ILC is the abbreviation for the *Independent Living Center* case.

(n8) Managed Pharmacy Care, 716 F.3d 1235.

(n9) Managed Pharmacy Care, 716 F.3d at 1243.

(n10) Assemb. B. 97, 2011–12 Gen. Assemb., Reg. Sess. (Cal. 2011) (emphasis added) (focusing on finding places to cut only “where reimbursement levels are higher than required under the standard provided in [§ 30(A)] and can be reduced in accordance with federal law”). The statute authorized the Director to identify such opportunities for legal reductions and specifically prohibited the Director from implementing rate reductions unless and until the Director (i) determined that the reductions would comply with applicable federal Medicaid requirements and (2) were approved by CMS.

(n11) See Letter from Donald Berwick, Administrator, Ctrs. for Medicare & Medicaid Servs., U.S. Dept of Health and Human Servs., to Toby Douglas, Dir. of Health Care Programs, Cal. Dept of Health Care Servs. (Oct. 27, 2011) (submitting two SPAs for CMS approval). CMS did not approve right away; it issued a letter to DHSC requesting additional information concerning the impact of the proposed rate reduction on access. In response, DHSC submitted access studies and plans for monitoring access. CMS ultimately approved the SPAs in “succinct” letters noting the “the data CMS reviewed, the monitoring plan, and [CMS’s] consideration of stakeholder input” as evidence of § 30(A) compliance. The letter went on to note that “the State was able to provide metrics that adequately demonstrated beneficiary access” including the: (i) “Total number of providers
CMS officials appeared to take their federal obligations seriously. But after the review, state officials concluded that a 10% across-the-board payment reduction—the same reduction originally attempted by the state without any process—would comply with federal law. CMS approved the cuts over provider and beneficiary objections.

In each case, the California district court preliminarily enjoined the cuts despite CMS approval. While there were some differences in the opinions based on the specific services impacted in each case, the underlying reasoning was essentially the same: the state violated federal law by failing to do credible studies of provider costs to determine whether the proposed rates were consistent with economy and efficiency per § 30(A) (the “provider cost issue”); and the state’s access review was fundamentally flawed and thus could not accurately evaluate the potential impact of rates on equal access or quality guarantees in § 30(A) (the “access review issue”). In light of these defects, the district court refused to defer to CMS’s approval of the cuts, finding it arbitrary and capacious.

California and federal officials appealed the district court’s decisions to the Ninth Circuit, and last year, the Ninth Circuit overturned the decisions and vacated the injunctions in Managed Pharmacy Care v. Sebelius. The Ninth Circuit relied heavily on Independent Living Center in applying Chevron deference to CMS’s approval. In light of the original question presented to, and remanded by, the Independent Living Center court, it is important to note that although plaintiffs brought challenges to the cuts using the Supremacy Clause and the APA, the district court’s substantive analysis focused on the APA. The district court noted briefly in the opinion that the Supremacy Clause may also provide plaintiffs a basis for challenge, but deferred back to its APA analysis for the likely outcome of that challenge. There was nothing in the district court’s opinion to suggest that the Supremacy Clause might provide a less deferential standard of review than the APA or that the choice of claim would change the outcome. Both the district court and the Ninth Circuit agreed that the APA governed the dispute, but they disagreed on whether the SPA approvals satisfied the APA conditions for deference.

by type and geographic location and participating Medi-Cal providers by type and geographic area; (2) “Total number of Medi-Cal beneficiaries by eligibility type,” (3) “[u]tilization of services by eligibility type over time,” and (4) “Analysis of benchmark service utilization where available.” Id.


123 See, e.g., id. at 1131–32.

124 Managed Pharmacy Care, 716 F.3d 1235.

125 Id. at 1246–47.

126 See, e.g., Cal. Med. Ass’n, 848 F. Supp. 2d at 1126 (APA claim addressed at p. 1127; Supremacy Clause basis for action addressed briefly at pp. 1126–27); see also Indep. Living Ctr. of Southern California, Inc. v. Maxwell-Jolly, 572 F.3d 644, 656 (9th Cir. 2009) (describing how “reviewing courts typically subject state rate-making to something akin to ‘arbitrary and capricious’ review”), vacated sub nom. Douglas v. Indep. Living Ctr. of Southern California, Inc., 132 S. Ct. 1204 (2012).
A. Provider Cost Issue & Deference for Statutory Interpretation

The first issue implicating the deference question involved the parties’ dispute about whether § 30(A) required states to perform provider cost studies before setting rates. Recall that § 30(A) requires states to set rates that are consistent with economy, efficiency, and equal access to quality care, and SPAs must include state assurances to federal regulators that rates comply with this provision. Because federal regulators have not promulgated rules to define this obligation, federal courts have been forced to interpret this provision in determining whether state rate-setting methodology violates federal law. As noted in Part I, the Ninth Circuit did this in Orthopaedic Hospital.127 In Orthopaedic Hospital, the court found that in order to demonstrate compliance with § 30(A)’s substantive guarantees, state officials had to be able to demonstrate a reasonable nexus between the rates and § 30(A) factors, which it could not do without cost data.128 Based on Orthopaedic Hospital, rate cuts had previously been invalidated because of a state’s failure to do such studies, so the plaintiffs in the Post-ILC Medicaid Payment Cases relied on Orthopaedic Hospital to show that provider cost was a relevant factor that states must consider. According to plaintiffs, the state’s failure to perform such studies made CMS’s approval arbitrary and capricious under State Farm.129

In justifying SPA approval, CMS relied on a contrary interpretation of § 30(A)—that cost studies are not required. CMS argued that its interpretation was entitled to deference under Chevron because the statute was ambiguous and CMS was delegated the authority to fill in this gap in the SPA approval process.130 If CMS’s interpretation was entitled to Chevron deference, then under Brand X, CMS’s interpretation should control despite the Ninth Circuit’s contrary interpretation in Orthopaedic Hospital.131 Thus the question of deference turned on whether the statute was ambiguous, and if so, whether CMS’s interpretation in the SPA was the kind of action that warranted deference.132

There did not seem to be any significant dispute about the statute’s ambiguity, nor that the complexity and interstitial nature of the Medicaid Act made it the kind of program in which Congress explicitly and implicitly delegated great

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127 Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1496 (9th Cir. 1997) ("[T]he Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.... The Department cannot know that it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services. It stands to reason that the payments for hospital outpatient services must bear a reasonable relationship to the costs of providing quality care incurred by efficiently and economically operated hospitals.").

128 Id.

129 See, e.g., Cal. Med. Ass'n, 848 F. Supp. at 30 (indicating that consideration of an agency’s reliance on responsible cost studies is a relevant factor).

130 Id. at 1128–30.


132 Id. at 980–81.
discretion to CMS to fill in the gaps. But the problem with the Ninth Circuit's decision was that it did not look beyond this general character of the Medicaid program and federal regulators' discretion. It ignored or dismissed too easily many of the facts discussed in greater detail by the district court, which showed that the *Mead/Skidmore* factors supporting deference—formality, agency care and thoroughness in its consideration, consistency, and persuasiveness—were not satisfied.

One glaring concern was the lack of formality in the process through which CMS approved the rate cuts and asserted its interpretation of § 30(A).\(^3\) CMS's interpretation was not the product of rulemaking or formal adjudication and thus did not go through a thorough vetting process in which evidence or arguments were considered and challenged by the interested parties most impacted by this interpretation: providers and beneficiaries. CMS's interpretation appeared briefly in a succinct letter to California officials announcing approval of the SPA, which the district court found troubling:

> Besides the fact that no explanation is given for not requiring cost studies other than the statement that CMS 'believe[s] the appropriate focus is on access,' this statement by CMS suggests that its position regarding cost studies is not necessarily settled.\(^3\)

CMS's lack of explanation was also problematic because it was aware that § 30(A) had previously been interpreted in *Orthopaedic Hospital* as requiring such studies, so, at a minimum, CMS should have explained why it believed that provider cost should no longer be viewed as a requirement. CMS relied on *Brand X*'s holding that a court's interpretation does not trump an agency's subsequent interpretation of an ambiguous statute. But a court's longstanding interpretation of a statute in the absence of regulatory rulemaking may still help define the relevant statutory factors that an agency must consider in the absence of any reasoned justification for not doing so. CMS's conclusory letter simply did not evidence the degree of care, thoroughness of consideration, or reasoning against which a court could examine the persuasiveness or validity of its decision—indicia required to achieve even a lower level of respect under *Skidmore*, let alone the greater deference under *Chevron*.

The persuasiveness or validity of its interpretation was further undermined by the inconsistency in CMS's position. In 2004, CMS explicitly embraced and relied upon *Orthopaedic Hospital's* interpretation of § 30(A) when it rejected a SPA proposed by Alaska officials that CMS believed would increase rates.

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133 The Ninth Circuit rejected the plaintiffs' argument that a SPA denial should be treated as less deserving of *Chevron* deference simply because it does not afford interested parties the same opportunity to challenge the approval in a formal administrative process. Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1247 (9th Cir. 2013) ("There does not appear to be any logical reason why Congress would delegate to the Secretary the discretion to decide that a proposed SPA violates § 30(A), but choose to withhold from her that same discretion if she decides the SPA complies with § 30(A). The nature of her authority is the same in both instances.").

It denied the SPA, citing Alaska’s failure to justify the rate increases with cost studies as required by Orthopaedic Hospital: “the requirements of [§ 30(A)] are . . . not so flexible as to allow the [State] to ignore the costs of providing services.” *135 This interpretation, adopted for purposes of denying Alaska’s proposed rate changes, was subject to more formal hearing procedures and ultimately an appeal in federal court. Yet, in the letter accompanying California’s SPA approval, CMS provided no explanation for its changed position or for why § 30(A) was applied differently in Alaska and California.

One of the benefits of deferring to agency action cited by courts and scholars is consistency, and courts have repeatedly identified consistency as an important criterion relevant to deference. If this criterion is absent, it raises the concern that the agency is acting in an arbitrary manner, which undermines the argument for deference and makes judicial review even more important. Only by taking a hard look at such agency action can courts ensure fair and consistent treatment of those impacted by the law—whether the interested party is someone directly subject to the regulation or is a member of the group that the law is supposed to protect.

On appeal, however, the Ninth Circuit applied *Chevron* deference to CMS’s interpretation. It began by invoking Independent Living Center’s speculation that *Chevron* deference would apply to SPA approvals, though briefly acknowledging that this issue was not actually decided. It said it would “afford ‘considered dicta from the Supreme Court . . . a weight that is greater than ordinary judicial dicta as prophecy of what that Court might hold.” *136* And it justified this reliance, in part, on CMS’s role in Medicaid program administration:

> Arguably, the Supreme Court has already concluded that SPA approvals meet the *Chevron/Mead* standard by stating that “[t]he Medicaid Act commits to the federal agency the power to administer a federal program. And here the agency has acted under this grant of authority [by approving a SPA]. That decision carries weight.” *137*

The Ninth Circuit did not weigh this against the lack of formality surrounding the SPA approval process and CMS’s interpretive authority. The court relied on *Mead* for the principle that formality is not a prerequisite for *Chevron* deference, but it did not address the *Mead/Skidmore* factors relevant to determining deference. It also failed to acknowledge *Mead*'s characterization of deference as occurring along a spectrum, which implicitly requires a closer look at the persuasiveness and validity of the agency’s decision in order to determine how much weight, if any, agency action deserves. *138* The Ninth Circuit simply

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*136* Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1246 (9th Cir. 2013) (citing United States v. Montero-Camargo, 208 F.3d 1122, 1132 n.17 (9th Cir. 2000) (en banc)).

*137* *Id.* at 1246 (alteration in original) (quoting Douglas v. Indep. Living Ctr. of Southern California, Inc., 132 S. Ct. 1204, 1210 (2012)).

*138* *Mead,* 533 U.S. at 228–31.
presumed deference based on CMS's official authority and the complex nature of Medicaid, ignoring Mead and Skidmore.

Instead, the Ninth Circuit relied on a different case, Barnhart v. Walton. Quoting Barnhart, the Ninth Circuit highlighted the following factors as supporting Chevron deference: "the interstitial nature of the legal question, the related expertise of the [a]gency, the importance of the question to administration of the statute, the complexity of that administration, and the careful consideration the [a]gency has given the question over a long period of time." The problem is that four of these five factors are so general as to be almost meaningless as a guide for courts trying to determine deference in any given case. They essentially do nothing more than reiterate the basic characteristics common to most modern administrative programs.

The last factor, "careful consideration the [a]gency has given the question over a long period of time," is the only one which requires the court to look closely at the context and circumstances of the particular agency action, but this factor was not applied by the Ninth Circuit in a meaningful way. The court offered a generic observation that “[t]he executive branch has been giving careful consideration to the ins and outs of the program since its inception, and the agency is the expert in all things Medicaid." But it did not consider the relevant regulatory context for Medicaid SPA approvals specifically, nor did it consider other evidence adduced by the district court that revealed a lack of careful consideration by CMS in these cases.

Essentially, the Ninth Circuit’s application of Chevron deference was based on two salient characteristics: the character of the program as technical and complex, and the “official” character of the act—that is, the express congressional authorization for CMS to approve SPAs as an essential aspect of Medicaid administration. But this approach reflects an overly simplistic understanding of deference. The Mead Court affirmed Skidmore as a more practical and reliable guide for courts on the deference question than conclusions about whether a particular agency action is "authoritative" or "official." And it is clear that the Mead/Skidmore factors demand a more nuanced inquiry into whether deference is warranted than the one performed by the Ninth Circuit.

Justice Scalia dissented in Mead because he disagreed with this more nuanced approach. He characterized Mead as "an avulsive change in judicial review of federal administrative action" that weakened the presumption of deference in certain cases, forcing courts to engage in a more active inquiry about whether such deference is warranted. Thus both the Mead majority and Justice Scalia’s

140 Managed Pharmacy Care, 716 F.3d at 1247 (alteration in original) (quoting Barnhart, 535 U.S. at 222).
141 Id. at 1248 (emphasis added).
142 Id. at 1248.
143 Id. at 235–39.
144 Id. at 239 (Scalia, J., dissenting).
dissent recognize Mead as complicating the question of deference. Yet the Ninth Circuit’s application of Chevron deference, based merely on CMS’s grant of authority and without looking closely at context and circumstances of how that authority was exercised, looks remarkably like Justice Scalia’s preferred approach—the one expressly rejected by the Mead majority.\textsuperscript{145}

\section*{B. Access Review and Reasoned Decision-Making}

The statutory interpretation issue discussed above was easy to address in a certain respect because it focused the APA analysis on a specific factor—cost studies—that if required would have made SPA approval a clear violation of the law and thus invalid. The more challenging claim by plaintiffs was that the state’s access review was so defective that it could not support the state’s assurances of § 30(A) compliance, making CMS approval arbitrary and capricious. Based on the Ninth Circuit’s refusal to look too closely at the statutory interpretation question about cost studies—a question that falls squarely within the purview of judicial review—it should not be surprising that the Ninth Circuit appeared even more reluctant to engage plaintiffs’ challenges to the access review. Despite the fact that plaintiffs identified several defects in the review, which the district court considered in detail, this is the shortest section in the Ninth Circuit’s opinion. The court largely reiterated its earlier conclusions about the deference due to SPA approvals, and it justified deference based on a cursory consideration of the SPA approval process.

As mentioned earlier, California officials collected and reviewed data to determine whether this latest round of cuts complied with § 30(A) equal access and quality requirements.\textsuperscript{146} It then re-submitted its SPA proposing essentially the same rate cuts and the required assurance about § 30(A) compliance.\textsuperscript{147} CMS initially requested additional information from state officials based on access concerns, but it ultimately approved the cuts.\textsuperscript{148}

\textsuperscript{145} Id. at 237–38 (majority opinion) (emphasis added) (citations omitted) (“Our respective choices are repeated today. Justice [Scalia] would pose the question of deference as an either-or choice. On his view that Chevron rendered Skidmore anachronistic, when courts owe any deference it is Chevron deference that they owe. Whether courts do owe deference in a given case turns, for him, on whether the agency action (if reasonable) is ‘authoritative.’ The character of the authoritative derives, in turn, not from breadth of delegation or the agency’s procedure in implementing it, but is defined as the ‘official’ position of an agency and may ultimately be a function of administrative persistence alone. [But] [t]he Court . . . said nothing in Chevron to eliminate Skidmore’s recognition of various justifications for deference depending on statutory circumstances and agency action . . . We think, in sum, that Justice [Scalia’s] efforts to simplify ultimately run afoul of Congress’s indications that different statutes present different reasons for considering respect for the exercise of administrative authority or deference to it.”).

\textsuperscript{146} Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1242 (9th Cir. 2013).

\textsuperscript{147} Id. at 1241–43.

\textsuperscript{148} Id.
Although there is no legislation or rule mandating a particular rate-setting methodology, a framework for measuring Medicaid access has been recommended by the Medicaid and CHIP Payment and Access Commission (MACPAC) in a 2011 report,149 and by CMS in its 2011 proposed rule on § 30(A) compliance.150 This framework established three categories for measuring access: the level of physician participation, beneficiary need, and patient utilization. It also included examples of the kind of criteria and data that could be used to assess each category.151 The proposed rule says that § 30(A) requires some kind of access review, and that the data used should reflect the reality of access on the ground.152 But the rule also makes clear that the MACPAC criteria are not mandatory, and it repeatedly affirms the importance of state flexibility and experimentation in designing the rate-setting process.153

In the Post–ILC Medicaid Payment Cases, the plaintiffs alleged numerous defects in the state’s process that made the review so fundamentally flawed that it could not yield meaningful data from which to assess § 30(A) compliance. While there was some variation in the evidence offered due to the specific cuts challenged in each case, the plaintiffs’ claims can be fairly summarized as identifying three essential defects:

According to plaintiffs, the Director’s access analyses failed to include
[1] a meaningful comparison of the Medi-Cal population to the general population,
[2] any analysis of access on a local geographic level [and] based on the actual healthcare needs of the Medi-Cal population, or
[3] any attempt to project the rate reduction’s impact on access to quality services.154

The first criticism relates to the comparative nature of § 30(A) obligations: rates must be sufficient to ensure that Medicaid beneficiaries have access to services to the extent available to those in the general population. Plaintiffs alleged that the state failed to present benchmark data that could be used to compare Medicaid beneficiaries’ access to those in the private market; without this data, neither the state nor CMS could meaningfully compare access.155

The second criticism boiled down to the claim that the state’s data created a distorted picture of access. By failing to consider beneficiaries’ pattern of utilization, according to their actual health care needs and with regard

151 Id. at 26,344–45.
152 Id. at 26,354, 26,359.
154 See, e.g., id.
to practically relevant geographic groupings, the data would not present an accurate picture of the reality of access on the ground.\textsuperscript{156} Plaintiffs provided specific examples of how the state’s methodology created a distorted picture of access in each case, but one example of this kind of defect occurred in analyzing access to physician services. Plaintiffs alleged that state officials determined the number of participating Medi-Cal providers by counting the number of physicians who had submitted at least one claim to Medi-Cal per year, but that they did not gather information about how many of these physicians treated Medi-Cal beneficiaries regularly and what kinds of services they were willing to provide the beneficiaries in light of their needs.\textsuperscript{157} Relying on submissions of one Medicaid claim per year as evidence of a physician’s availability creates unrealistic and overly optimistic assumptions about physicians’ ability or willingness to meet beneficiaries’ health needs throughout the year, as demonstrated by numerous surveys documenting providers’ refusal to accept new Medi-Cal patients.\textsuperscript{158}

The third criticism—the state’s failure to make projections about the impact of rate cuts—reflected plaintiffs’ concerns that the state was ignoring the explicit obligations of § 30(A) for states to ensure rate sufficiency prospectively. The state seemed to rely too heavily on a monitoring plan that would detect access and quality problems only after they arise.\textsuperscript{159} Such a retroactive plan is particularly troublesome because the harm that can occur—such as delays in access and loss of services—may be irremediable. After careful consideration of the plaintiffs’ allegations, the district court agreed that CMS could not demonstrate a rational relationship between the data and its conclusion of § 30(A) compliance, making approval arbitrary and capricious.\textsuperscript{160}

The Ninth Circuit only briefly addressed these claims in its opinion. Rather than address the district court’s findings, it treated them dismissively. In fact, it criticized the district court for “delv[ing] into the minutiae of the Secretary’s approval, picking apart DHCS’s research and finding potential flaws—an inappropriate exercise when reviewing agency action under the APA.”\textsuperscript{161} The Ninth Circuit performed only a cursory review of the process noting the “[h]undreds of pages of analysis submitted by DHCS,” the interaction between state and federal officials, and the fact that CMS seemed to consider

\textsuperscript{156} Id. at 1132, 1135.
\textsuperscript{157} Id. at 1133–34.
\textsuperscript{158} See Clark, Medicaid Access, supra note 12, at 785–88.
\textsuperscript{159} Cal. Med. Ass’n, 848 F. Supp. 2d at 1132.
\textsuperscript{160} Id.
\textsuperscript{162} Managed Pharmacy Care, 716 F.3d at 1143.
\textsuperscript{163} Id. at 1251.
some “stakeholder input.” The Ninth Circuit also seemed to accept CMS’s conclusions at face value: it found CMS’s references to § 30(A) obligations and MACPAC categories in the short approval letter to be sufficient evidence that CMS considered the relevant statutory factors, without any inquiry into whether its conclusions were rationally based on the data collected.

IV. REINTERPRETING INDEPENDENT LIVING CENTER

From Parts II and III, it should be clear that the Ninth Circuit’s decision to apply Chevron deference was not the only plausible interpretation of Independent Living Center. Both the district court and the Ninth Circuit considered the most recent California cuts approved by CMS in light of APA deference doctrine, but came to very different results about whether CMS’s approval warranted deference. The district court found CMS’s approval arbitrary and capricious due to the state’s failure to consider provider cost, CMS’s failure to explain its change in position about why this factor did not need to be considered, and a number of other defects in the access review process that undermined officials’ conclusions about § 30(A) compliance. The Ninth Circuit, on the other hand, refused to look closely at the specific circumstances of the SPA approval. It invoked Independent Living Center in applying Chevron deference to CMS’s statutory interpretation and SPA approval, despite the informal nature of the agency action and the fact that the SPA approval did not satisfy the Mead/ Skidmore factors.

This Part delves more deeply into the theory of administrative legitimacy and judicial review animating the Ninth Circuit’s deferential approach and interpretation of Independent Living Center. Why did the Ninth Circuit criticize the district court for delving into the minutiae of Medicaid and second-guessing CMS, instead of viewing the analysis as a product of the hard look that courts should give agency action to ensure reasoned decision-making? In cases where the nature of the act is informal, statutory constraints are vague, and potential for abuse is significant, how does one distinguish an appropriate judicial check on agency action from improper judicial policymaking and overreach?

This Part considers various theoretical explanations for the Ninth Circuit’s approach, but ultimately concludes that the district court struck the proper balance in this case. The result of the district court’s injunctions would not have been to substitute its own policy judgment, but rather to require greater explanation and a better quality of deliberation, which, in turn, should promote better decision-making. This function of judicial review is particularly important in programs like Medicaid that give tremendous discretion and flexibility to regulators and states, not subject to the APA procedural safeguards.

164 See id. at 1251–52.
165 Id. at 1250.
166 Id. at 1243–44.
167 See id. at 1246.
that promote administrative legitimacy from within. Thus, the district court’s approach illustrates why a more nuanced deference analysis and hard look at informal adjudicatory actions is important for ensuring administrative legitimacy.

A. Agency-Forcing Theory of Judicial Review

At a basic level, the Ninth Circuit’s interpretation of Independent Living Center could be seen as consistent with an agency-forcing theory of judicial review, as developed by Catherine Sharkey. Sharkey has used this theory to analyze the outcome of the procedural question in Independent Living Center, but the theory is also useful for trying to understand how the Court’s dicta on the substantive question could be interpreted.

As noted in Part I, there has been a long history of agency neglect and inaction—with SPA’s proposing cuts either getting no review (and being approved by default) or being rubber stamped by federal regulators based on paper assurances of § 30(A) compliance. This pro forma approval of cuts has been encouraged by the failure of federal regulators to use their rulemaking power to provide meaningful guidance in rate setting. Without a clear statutory mandate for agencies to act, courts do not typically have the power to force agencies to do so. Courts’ power primarily comes in the form of invalidating agency action based on the grounds mentioned above. Where the statutes regulating agency action are ambiguous, courts must interpret the statutes in order to help them determine whether an agency’s action complies with or is inconsistent with the law; that is, unless the agency has already filled the gap.

Where such ambiguities exist, agencies can fill in these interpretive gaps. In fact, the assumption is that where ambiguity exists, or some discretion is required, Congress has implicitly delegated this task to the agency due to its expertise and accountability to the executive. Once the agency decides to act, deference is warranted if the agency is in fact using its expertise and discretion within the constraints of the law—that is, not acting arbitrarily or capriciously. Thus, an agency-forcing theory of judicial review views the threat of federal court intervention to fill in these interpretive gaps as necessary when agencies have not acted.

In this light, the Ninth Circuit's interpretation of Independent Living Center seems to make sense. Historically, federal courts have provided the only real protection for providers and beneficiaries against illegal state cuts in the face of federal regulatory inaction, especially regulators’ failure to interpret and define § 30(A) requirements, and their failure to conduct any meaningful review of findings on which state assurances were based. And this was the context in which the payment challenges in Independent Living Center were originally brought. Although the Court did not give a reason for effectively preserving

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the Supremacy Clause avenue in the absence of federal regulatory approval, the issue of regulatory neglect had been prominent in the procedural and substantive aspects of the initial challenge and was likely of significant concern to the majority. If concern about regulatory neglect motivated the majority's decision on the procedural question, then it makes sense that the Court would view CMS's more active oversight and subsequent approval of the SPA as legally relevant to the challenges. Under an agency-forcing theory of judicial review, the agency's actions obviate the need for court intervention.

The problem is that this agency-forcing theory implicitly makes certain assumptions about the quality of the administrative action getting deference, but the Ninth Circuit's interpretation of Independent Living Center does not address this qualitative aspect. For example, should a CMS approval letter issued with no review—essentially a rubber stamp of state assurances—qualify as agency action deserving of deference? The answer to this seems easy: lower courts have previously made clear that such rubber stamping is not the kind of reasoned decision-making demanded by the APA, and thus would not warrant deference. This seems like precisely the kind of consideration the Independent Living Center majority is referring to in noting an exception to the ordinary presumption of deference. Even the Ninth Circuit in its Managed Pharmacy Care decision implicitly rejects such rubber stamping by identifying aspects of the rate-setting process (such as the amount of documentation, quality and quantity of interaction between CMS and state officials, and use of MACPAC categories and § 30(A) factors) that it believed evidenced a rational inquiry.

The harder case is where an agency engages in some kind of process but the process is defective in a way that seems to undermine conclusions about legal compliance. The Medicaid SPA approval process provides a good example of this because of the long history of regulatory neglect of access and quality concerns, evidence of inconsistent interpretations of § 30(A), and structural incentives that encourage CMS to prioritize cost cutting over access and quality protections. These financial incentives have only intensified under health reform as Medicaid coverage expands and the federal government bears primary responsibility for the cost of expansion. In fact, CMS has recommended that states under financial pressure to cut costs look to provider reimbursement.

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169 For example, Sharkey argues that "[f]or preemption challenges . . . courts should apply a 'State Farm with teeth' standard in reviewing the evidence in the agency's regulatory record supporting the conflict between state and federal law." Id. at 10 (footnote omitted). She then suggests that an agency's interpretive views should be subject to Skidmore factors. Id. at 10.

despite studies suggesting that Medicaid is already one of the leanest and most cost-efficient insurance programs around.\footnote{See Leighton Ku & Christine Ferguson, Medicaid Works: A Review of How Public Insurance Protects the Health and Finances of Children and Other Vulnerable Populations 13, 18–19 (2011), available at http://www.firstfocus.net/sites/default/files/MedicaidWorks.pdf (describing Medicaid as "an exceptionally low cost insurance program" that is already very lean and efficient and does not have much room for further cuts).} Finally, California is one of the federal government's key partners in reform—the federal government needs California's cooperation and leadership just as much as California needs the federal government's financial support.

CMS's primary role seems to be as financial partner to the states with a focus on resource allocation, health system planning, and cost containment, as opposed to a neutral regulator whose focus is on enforcing health care access and quality protections. This conflict between CMS's different regulatory roles in Medicaid rate-setting highlights the importance of judicial review as a check on agency discretion or abuse, an idea affirmed by the Supreme Court in \textit{State Farm}:


Sharkey also embraces the role of hard look review, or as she describes it, "\textit{State Farm} with teeth," in her discussion of the role of judicial review on the procedural question.\footnote{See Sharkey, supra note 168 at 10.} The risk that CMS will continue its long pattern of abusing its discretion to ignore access and quality limits in favor of cost cutting goals is particularly great given the lack of internal procedural protections like those required for formal adjudication and rulemaking.

\textbf{B. Supreme Court's Warning to Lower Courts: Misuse It and Lose It}

The Ninth Circuit's interpretation of \textit{Independent Living Center} could also reflect a more subtle, yet critical link between the procedural question about plaintiffs' access to federal court and the Supreme Court's concern about judicial overreach by lower courts on the substantive issue of whether agency action should be respected. Richard Pierce explains this link, as well as the dialogue he perceives between the Supreme Court and lower courts around this issue of judicial review.\footnote{See Pierce, supra note 87, at 1240–43.} Pierce highlights the role that federal courts should play to ensure administrative accountability to the political will of the people.
and believes that judicial overreach undermines this function. To this end, he is concerned about courts using judicial review to mask the improper second-guessing of agency wisdom:

"[T} It is too easy for judges to assume inadvertently a dominant policymaking role through honest efforts to perform any of the . . . difficult tasks for which they bear principal responsibility. The problem of judicial policymaking is acute in judicial review of administrative agencies. Because agencies do not have a direct, step-one relation to the people, judicial review can enhance the principal-agent relationship between the people and agencies by confining agency actions within statutorily-determined boundaries. Yet, the temptation to engage in judicial policymaking disguised as judicial review is great."

According to Pierce, as Congress delegates greater policymaking to agencies, the Supreme Court has had to try to develop a doctrine that guides lower courts as to their appropriate role. He views the Supreme Court’s jurisprudence as an attempt to construct “a democratic model of the administrative state” by “reduc[ing] the power of federal judges to make policy decisions disguised as judicial review of agency policy decisions.”

The most interesting part is his interpretation of the dialogue occurring between the Supreme Court and lower courts around this issue. He worries that to the extent deference doctrine does not effectively prevent overreach, “[t]he Court seems increasingly prone to solve this problem by restricting the classes of cases judges can review.” Pierce argues this is dangerous because of the important role of judicial review in legitimizing agency action, and he offers a cautionary note to lower courts:

[Lower courts should heed] Supreme Court precedents instructing them to defer to politically accountable institutions. . . . [because] unless judges begin to take more seriously the Court’s admonitions concerning their limited role, the Court is likely to continue to select inferior doctrinal solutions that confer on agencies broader discretion than they should enjoy by insulating ever larger categories of agency actions from all judicial review.

Perhaps the Ninth Circuit is viewing Independent Living Center in this light. Certainly the threat of losing federal review of payments is real in light of the demise of § 1983 actions, the Court’s recent grant of certiorari on the Supremacy Clause question, and the fact that four justices were willing to eliminate this right. Moreover, the threat is still there, in light of the majority’s failure to definitively answer the procedural question. Independent Living Center’s reframing of the procedural question in light of its concern

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176 Id. at 1239.
177 Id. at 1242 (footnote omitted).
178 Id. at 1254.
179 Id. at 1243.
180 Id. at 1244.
about the Supremacy Clause being used as end-run around APA deference implicitly links the procedural and substantive questions in a way that seems consistent with Pierce's theory.

But as with the agency-forcing theory, this still begs the question about how closely courts should look at agency action to ensure its legitimacy. To the extent that a court's analysis of CMS approval is performed in the light of increased regulatory activity under the Obama administration (access studies, proposed MACPAC framework, proposed rulemaking, stepped up reviews of SPA submissions, and a willingness to deny or delay rate cuts without more information), a court would likely view CMS as exercising its expertise and discretion in ways that should be respected. This is the perspective the Ninth Circuit seemed to have, which explains why it criticized the district court's analysis as "delving into the minutiae" of Medicaid and viewed its analysis as this kind of overreaching against which the Supreme Court has warned.\(^\text{182}\) On the other hand, if CMS approval is viewed in light of the longer history of regulatory neglect, the increasingly powerful financial motivations of state and federal officials to disregard access and quality concerns in favor of cost-cutting goals, and the informal nature of SPA approvals that lack the internal procedural safeguards necessary for ensuring administrative transparency, participation, and accountability, then one is more likely to view the district court's analysis as the kind of hard look necessary to ensure that administrative discretion has not become a "monster without limits."\(^\text{183}\)

C. Struggling with Judicial Review in a Post-Bureaucratic World

The Ninth Circuit's approach might simply reflect its struggle with how to apply traditional administrative law principles to a more modern conception of administration. William Simon describes how traditional administrative law principles were developed out of an older model of administration.\(^\text{184}\) This model assumes that legislative goals and political choices will and can be codified in clear statutory commands and rules to be implemented by the agency.\(^\text{185}\) Such commands and rules are expected to be easily understandable and consistent over time. Simon describes judicial review under this model as reflecting an "obsessive preoccupation with statutory authori[ty] and . . . rules and rulemaking as . . . rigid constraints on administrative action."\(^\text{186}\) It relies on a command-control model of administration set up primarily to ensure

\(^{182}\) See Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1251 (9th Cir. 2013).
\(^{185}\) See id.
\(^{186}\) Id. at 4.
that officials are following these rigid commands and rules. And while Simon acknowledges that the law based on this model has tolerated some unaccounted—for discretion, the expectation is that expertise will serve as an important constraint on this discretion and judicial review as an important external check to ensure statutory compliance.

The problem is that this traditional model of administrative law cannot effectively address key issues of accountability presented in the more modern administrative state. The modern, or post—bureaucratic, regulatory state relies less on rigid rules or top—down commands that can be easily implemented by an agency; rather, it relies on more flexible, performance—based standards, expected to evolve over time. This evolutionary aspect can be particularly challenging for courts because “implementation [must be understood], not only or even primarily as compliance with previously enacted norms, but as a course of discovery and elaboration.” According to Simon, “[i]f change in bureaucracy is episodic, in post—bureaucratic organization, it is continuous.”

Moreover, the kind of expertise applied in a post—modern bureaucracy may not reflect a static or clear standard or measurement; rather norms and practices develop from the bottom—up, through experimentation and partnerships that hopefully yield information about best practices or models that should be adopted by others. In the modern administrative state, administrative legitimacy is less about compliance with a clear rule and more about the process by which agencies seek to achieve vague and multi—faceted statutory goals. These kinds of administrative programs often depend on tools like written plans and stakeholder participation to enhance transparency, accountability, and participatory values that further administrative legitimacy.

Medicaid, and especially the rate—setting process, is a perfect example of this post—bureaucratic regulatory model. Since its enactment, the Medicaid statute has relied heavily on the states for administration: Medicaid rates and rate—setting methodology are not established at the federal level—rather, the legislation contemplates and encourages states to design their own methodology and propose rates they believe to be consistent with § 30(A) factors as these factors are understood and applied at a local level. For example, California and Arkansas have different health care markets, needs, and challenges that may influence the rates they must pay providers to ensure equal access and quality. Not only does the statute rely on vague standards rather than rigid rules or clear procedural requirements, the statute had been amended a few times to increase state flexibility to experiment with different rate—setting methodologies and to specifically encourage states to experiment with financing systems that require providers to deliver care more cost—efficiently. The assumption is that the best

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187 Id. at 14.
188 Id.
189 See generally id.
190 See Clark, Medicaid Access, supra note 12, at 793–805.
191 Id. at 777–779.
way to accomplish § 30(A) goals is to allow local experimentation that helps us identify promising models for other states and even federal programs. Indeed, this bottom-up approach was explicitly affirmed by CMS in its proposed rule.\textsuperscript{192}

The challenge for courts, according to Simon, is that the command-control, top-down model animates much administrative doctrine, and courts seem more reticent to engage in meaningful judicial review of agency action characteristic of the post-bureaucratic approach. He criticizes existing administrative law doctrine as not effectively dealing with this model:

\begin{quote}
The courts' notion of justiciability seems constrained by the bureaucratic view of organization. They are most ready to intervene in connection with rules, which they tend to understand... as norms... whether promulgated by the legislature of the agency itself. When they encounter more general and provisional norms, they have a harder time conceiving of a plausible role to play. Then they often deny review, saying that there is "no law to apply", or that they cannot risk disrupting coherent administrative practices, or that they should not usurp legislatively conferred discretion. These reasons tend to assume that intervention would take a compliance-type form. The reasons often do not make sense with reference to reasonable-consideration-and-explanation requirements.\textsuperscript{192}
\end{quote}

We see evidence of this struggle with the Ninth Circuit's recurring focus on the vague, complex, and technical nature of rate setting in the Medicaid program. This flexible and evolutionary approach seemed to create an uncertainty that the Ninth Circuit found difficult to navigate. We also see this in the Ninth Circuit's explanation for its willingness to embrace the state monitoring plan as a method of ensuring access and quality despite defects in the prospective analysis.\textsuperscript{194} Section 30(A) factors are not only vague, the court notes, but they depend on inherently uncertain behavioral predictions about how providers will respond to rates.\textsuperscript{195} One gets the sense that the Ninth Circuit threw its hands up at the task of trying to figure out how to exercise meaningful judicial review in the face of such ambiguity, complexity, and uncertainty, without engaging in the inappropriate exercising of policy making.

While this kind of agency action may complicate judicial review a bit, Simon argues that the reasoned decision-making standard provides an effective guiding principle to help courts navigate this challenge:

As illustrated by \textit{State Farm}, the Court can, without guidance from the organic statute, still ascertain that the administrator has exercised discretion on the basis of generally appropriate public norms, that she has considered the legitimate interests and arguments of stakeholders, and that she has sufficiently developed and considered relevant evidence... [M]andating reasonable consideration and explanation encourages the administrator to view her decision in terms of general plans; considering the decision in a broader context is precisely what reasonableness would often entail. And to the extent explanation makes agency practice more transparent, it enhances legislative accountability.\textsuperscript{196}

\begin{flushright}
\textsuperscript{192} \textit{Id.} at 804, 844–45. \\
\textsuperscript{193} Simon, \textit{supra} note 184, at 23. \\
\textsuperscript{194} \textit{See} Managed Pharmacy Care \textit{v.} Sebelius, 716 F.3d 1135, 1249–50 (9th Cir. 2013). \\
\textsuperscript{195} \textit{Id.} \\
\textsuperscript{196} Simon, \textit{supra} note 184, at 24.
\end{flushright}
Contrary to the Ninth Circuit's criticism, it is not necessary to "delv[e] into the minutiae" of Medicaid or second-guess the wisdom of CMS in order to ensure that CMS engaged in reasoned decision-making in the SPA approval process. The district court's concerns were not based on its conclusion that Orthopaedic Hospital had a better approach to rate setting; it was based on CMS's own inconsistencies—inconsistencies which raised fairness concerns because no reasoned explanation was given. It did not require special expertise or a policy judgment to identify the disconnect between the data collected and the state's conclusions: CMS's own MACPAC framework makes clear that the access data must present a realistic picture of access on the ground; § 30(A) makes clear that the state must make some projection about the impact of rates on access; and § 30(A) makes clear that the access requirement is comparative. If the data used by CMS in its review could not be rationally linked to these determinations, this is a serious failure evidencing arbitrary and capricious decision-making that must be rejected by the court.

The result of this kind of review is not a substitution of judgment, but a chance for the court to require the agency to do a better job of explaining its decision. In the case of informal adjudicatory actions like SPA approvals, this may be the only real opportunity to ensure the kind of transparency, reason-giving, and evidence of expertise that enhances accountability and administrative legitimacy. If a court only considers an agency's process and reasoning at a superficial level—for example, whether the officials use "magic language" from § 30(A) and how much paper is generated in the process—and if the court relies on generic observations about the role of agency expertise in program administration broadly, as opposed to looking specifically at whether and how the agency used its expertise in a particular case, then we are right back to the kind of scenario that made judicial review of cuts necessary in the first place—rubber stamping by CMS based on paper assurances of § 30(A) compliance. It is also worth noting that the complex and technical nature of Medicaid rate-setting makes it highly unlikely that courts could use their judicial review powers to substitute their own policy judgment because this is not an issue that presents clear, value-laden options that trigger deep feelings or would powerfully influence judges one way or another.

Conclusion

As health reform implementation brings many more people on to the Medicaid rolls, concerns about provider shortages are becoming more acute. These concerns will grow as fiscally strapped states resort to an easy way to cut costs—reducing Medicaid reimbursement. The Supreme Court's recent dicta about deference for federal approvals of such cuts is already having a troubling
impact on health care policy and administrative legitimacy goals, as illustrated by the Ninth Circuit's recent decision in Managed Pharmacy Care.

The Ninth Circuit invoked Independent Living Center in holding that CMS's approval deserved deference, ignoring important limits on deference developed in Skidmore and Mead and the district court's findings that CMS failed to evidence reasoned decision-making. In addition, the Ninth Circuit held that CMS's interpretation of § 30(A) deserved Chevron deference, despite the fact that the manner in which this interpretation was articulated and applied lacked the legal and de facto indicia of formality, consistency, and deliberation that courts typically use to justify deference.

This Article cautions against this troubling interpretation of Independent Living Center. Decades of regulatory neglect and abuse of discretion by federal and state regulators, as well as the conflict of interest agencies face because of their dual role as payor and regulator, suggest that this problem is not going away. And evidence of increased regulatory activity by the current administration should not make us complacent because regulators continue to exercise power through informal agency decisions not subject to the kind of APA procedural safeguards that govern rulemaking and formal adjudication. Managed Pharmacy Care should serve as a cautionary tale of why action falling into the category of informal adjudication should be subject to a more exacting deference inquiry, and why CMS decisions relating to Medicaid access, in particular, should get a hard look.