No. 09-958

In the Supreme Court of the United States

DAVID MAXWELL-JOLLY, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA, PETITIONER

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., ET AL.

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

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

Under 42 U.S.C. 1396a(a)(30)(A), a State's plan for medical assistance under the Medicaid Act must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary * * * to assure that payments are consistent with efficiency, economy, and quality of care and are 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 questions presented are:

1. Whether Section 1396a(a)(30)(A) requires States to rely on "responsible cost studies" in setting Medicaid reimbursement rates or otherwise to consider efficiency, economy, quality of care, and access to care before reducing Medicaid reimbursement rates.

2. Whether the Supremacy Clause provides a cause of action to Medicaid providers or beneficiaries who assert that state law conflicts with the requirements of Section 1396a(a)(30)(A).

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This brief is submitted in response to the Court's order inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

1. The Medicaid program established in 1965 by Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, is a cooperative federal-state program to provide medical care to needy individuals. *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Atkins* v. *Rivera*, 477 U.S. 154, 156 (1986). State participation in Medicaid is voluntary, but those States that elect to participate must comply with requirements imposed by the Medicaid Act and by the Secre-

tary of Health and Human Services (HHS) in her administration of the Act. See 42 U.S.C. 1396a; *Wilder*, 496 U.S. at 502; *Rivera*, 477 U.S. at 157. Within those basic limits, however, each State enjoys great flexibility in designing and administering its own program.

To qualify for federal funds, participating States must submit to the Secretary, and receive approval of, "a plan for medical assistance" detailing the nature and scope of the State's Medicaid program. 42 U.S.C. 1396a(a); 42 C.F.R. 430.10; *Wilder*, 496 U.S. at 502. Among other requirements, a State's plan must

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are 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.

42 U.S.C. 1396a(a)(30)(A).

2. On February 16, 2008, the California Legislature passed Assembly Bill 5 (AB 5), which added Sections 14105.19 and 14166.245 to the California Welfare and Institutions Code. Section 14105.19 reduced by ten percent payments under California's Medicaid plan (Medi-Cal) to physicians, dentists, pharmacies, adult health care centers, clinics, health systems, and other providers. Section 14166.245 similarly reduced payments for inpatient services provided by acute care hospitals not under contract with the State (non-contract hospitals). Both rate reductions were scheduled to take effect on July 1, 2008. Pet. App. 4.

3. On April 22, 2008, respondents, a group of pharmacies, health care providers, senior citizens' groups, and individual Medi-Cal beneficiaries, filed a petition in state court seeking a writ of mandamus or injunction to prevent petitioner from implementing AB 5. Pet. App. 3, 4-5. As relevant here, respondents alleged that the ten-percent rate reductions are inconsistent with the requirements of Section 1396a(a)(30)(A) and are therefore preempted under the Supremacy Clause. *Id.* at 5.

a. Petitioner removed the suit to federal court, and respondents moved for a preliminary injunction, which the district court denied. Pet. App. 5-6. Following circuit precedent, the district court explained that Section 1396a(a)(30)(A) does not confer individual rights enforceable under 42 U.S.C. 1983, see *Sanchez* v. *Johnson*, 416 F.3d 1051 (9th Cir. 2005), and held that respondents did not have an implied right of action to pursue their preemption claim under the Supremacy Clause. No. 08-3315, 2008 WL 4298223, at *3-*5 (C.D. Cal. June 25, 2008). The court reasoned that preemption claims had been permitted only in three circumstances: (1) "where the plaintiff claims that a state law requires him to act in violation of federal law"; (2) "where the plaintiff contends that his conduct will be restricted by a state law that is preempted by federal law"; and (3) "where state law interferes with federally created rights." *Id.* at *4. Because in its view none of those circumstances was present here, the court declined to grant a preliminary injunction. *Id.* at *5.

The court of appeals reversed. Pet. App. 58-93. The court explained that "[t]he Supreme Court has repeatedly entertained claims for injunctive relief based on federal preemption, without requiring that the standards for bringing suit under [Section] 1983 be met, and without intimating that such claims must fit into one of three categories or 'cir-

cumstances' in order to be cognizable." *Id.* at 68. The court continued: "For more than a century, federal courts have entertained suits seeking to enjoin state officials from implementing state legislation allegedly preempted by federal law." *Id.* at 83. Seeing "no reason to depart from the general rule in this case, or in this category of cases," the court held "that a party may seek injunctive relief under the Supremacy Clause regardless of whether the federal statute at issue confers any substantive rights on would-be plaintiffs." *Ibid.* This Court denied certiorari. 129 S. Ct. 2828 (2009).

b. On remand, the district court granted a preliminary injunction in relevant part. Pet. App. 94-124. Applying the Ninth Circuit's decision in *Orthopaedic Hospital* v. *Belshe*, 103 F.3d 1491 (1997), cert. denied, 522 U.S. 1044 (1998), the district court explained that, in modifying reimbursement rates, a State "must consider efficiency, economy, quality of care, and equality of access, as well as the effect of providers' costs on those relevant statutory factors." Pet. App. 106. Because in its view the California Legislature had not considered any of the "relevant factors" in enacting AB 5, the court concluded that respondents were likely to succeed on the merits of their claim, and it enjoined petitioner from enforcing the ten-percent reduction in payments to physicians, dentists, pharmacies, adult day health care centers, clinics, health systems, and other providers. *Id.* at 123. The court later clarified that its injunction applied only prospectively, to payments made for services provided on or after the date on which the preliminary injunction was entered. *Id.* at 126, 128-129 n.1.

On July 9, 2009, the court of appeals affirmed the district court's order granting a preliminary injunction, but reversed the subsequent order granting only prospective relief. Pet. App. 1-38, 54-57. The court affirmed the contin-

uing vitality of *Orthopaedic Hospital*, *id.* at 15-24, and concluded that petitioner "failed to 'rely on responsible cost studies, its own and others,' * * * in determining the effect of the rate cuts mandated by AB 5 on the statutory factors of efficiency, economy, quality, and access to care before implementing those cuts." *Id.* at 3-4 (quoting *Orthopaedic Hosp.*, 103 F.3d at 1496); *id.* at 11. The court of appeals also cited three alternative grounds for affirmance. First, the court concluded that AB 5 conflicted with Section 1396a(a)(30)(A) because "the only reason for imposing the cuts was California's current fiscal emergency." *Id.* at 20. Second, the court determined that, even under "relax[ed] procedural requirements," petitioner's "failure to study the effect of the rate reduction in any meaningful way would still lead [the court] to enjoin implementation of AB 5." *Id.* at 21-22. Third, the court suggested that, even under a purely "substantive" standard, "the ten percent rate reduction might still conflict with the quality of care and access provisions of [Section] 30(A)" because it had "apparently forced at least some providers to stop treating Medi-Cal beneficiaries." *Id.* at 23. The court then determined that petitioner "lacked sovereign immunity against retroactive orders" and that "the district court's * * * order should have applied retroactively" to all services provided after the rate cuts went into effect on July 1, 2008. *Id.* at 36-37.[1]

c. Several months later, petitioner moved to vacate the court of appeals' decision on the ground that the district court's preliminary injunction had become moot on appeal due to a change in California law. Pet. App. 43. Specifically, on September 30, 2008, California passed Assembly Bill 1183 (AB 1183), providing that the rate reductions es-

[1] Petitioner does not challenge the retroactive-payments holding. Pet. 11 n.4.

tablished in AB 5 would expire on February 28, 2009. *Id.* at 44. AB 1183 replaced the prior ten-percent rate reductions with a one-percent reduction, except that it applied a five-percent reduction to adult day health centers, pharmacies, and hospital-based nursing-facility and subacute-care services, and continued to impose a ten-percent reduction for inpatient services provided by certain non-contract hospitals. *Id.* at 44, 189.[2] The court of appeals denied petitioner's motion, concluding that the retroactive application of the district court's order was a "damages award [which] ensured that both parties retained an interest in the case despite the passage of AB 1183." *Id.* at 47.

4. In September 2008, while this litigation was pending, the State submitted a State Plan Amendment (SPA) to HHS for most of the rate reductions encompassed in AB 5 and AB 1183. Pet. App. 187-210. Upon HHS's request, petitioner split that submission into four separate SPAs, which were submitted on October 29, 2008. Pet. at 9 n.3, *Maxwell-Jolly* v. *California Pharms. Ass'n*, No. 09-1158

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[2] Some of the revised rate reductions enacted by AB 1183 were challenged and ultimately the subject of preliminary injunctions entered in separate suits now pending before this Court in *Maxwell-Jolly* v. *California Pharmacists Ass'n*, No. 09-1158 (filed Mar. 24, 2010). That petition also involves a case challenging Senate Bill 6 (SB 6), which would reduce the cap on the State's maximum contribution to wages and benefits paid by counties to In-Home Supportive Services. The California Legislature recently passed a superseding bill (AB 1612) that delays implementation of SB 6 until July 2012 and requires a court to validate the reduction prior to implementation. Additionally, a separate petition, *Maxwell-Jolly* v. *Santa Rosa Memorial Hospital*, No. 10-283 (filed Aug. 25, 2010), involves a court of appeals' decision upholding a preliminary injunction barring the reimbursement rates imposed by AB 5 for inpatient services provided by non-contract hospitals. Both petitions raise the same questions presented and, unless otherwise noted, the arguments set forth below apply to all three petitions.

(filed Mar. 24, 2010) (*Cal Pharm*). On December 31, 2008, petitioner submitted a fifth SPA encompassing the AB 1183 reductions for inpatient services provided by non-contract hospitals. *Ibid.* On December 24, 2008, HHS requested additional information on the SPA at issue in this petition, explaining that, as submitted, it was "inadequate and does not provide sufficient information to understand the reimbursement methodology," and asking the State to explain "[w]hat impact, if any, does this proposed [amendment] have on access to providers providing these non-institutional services in California?" Sacramento Clinics Br. in Opp. App. 8a-9a.

The requested information was not forthcoming. On November 18, 2010, HHS disapproved all five relevant SPAs. The disapproval letter explains that HHS could not approve the amendments because "California has not demonstrated that they would meet the conditions set out in" Section 1396a(a)(30)(A), specifically the requirement that State plans assure that "payments [to providers] . . . are sufficient to enlist enough providers so that care and services are available under the [State's Medicaid] plan [to recipients] at least to the extent that such care and services are available to the general population in the geographic area." App., *infra*, 2a (brackets in original) (quoting 42 U.S.C. 1396a(a)(30)(A)).

The State requested reconsideration of the disapproval (App., *infra*, 5a-7a), which triggers a formal administrative hearing process. See pp. 20-21, *infra*.

DISCUSSION

The court of appeals erred in affirming its prior reading of Section 1396a(a)(30)(A) as imposing on States an obligation to consider cost studies to ensure that payment rates bear a reasonable relationship to providers' costs. But the

court of appeals' decision also rested on alternative grounds that raise nuanced questions regarding the scope of Section 1396a(a)(30)(A). Review of these issues is not warranted at this time. The ten-percent rate reduction enjoined by the court of appeals expired in February 2009; the Secretary recently disapproved the operative State plan amendment and a formal administrative hearing will now be conducted; and HHS has committed to conducting a rulemaking proceeding over the next year that will result in an authoritative interpretation of Section 1396a(a)(30)(A). The Secretary's rulemaking may well resolve the disagreement among the circuits on these issues, making this Court's review unnecessary. The question whether a private right of action could properly be recognized directly under the Supremacy Clause in this context may also be informed by the Secretary's assessment of what obligations Section 1396a(a)(30)(A) actually imposes on States. There is, moreover, no conflict among the courts of appeals on the cause-of-action issue. The Court therefore should deny the petition for a writ of certiorari.

1. a. In *Orthopaedic Hospital* v. *Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998), the court of appeals construed Section 1396a(a)(30)(A) to require a State to set reimbursement rates that "bear a reasonable relationship" to provider costs, and to consider "responsible cost studies" to establish such rates. The court of appeals reaffirmed that interpretation here, and held that petitioner violated Section 1396a(a)(30)(A) "as interpreted in *Orthopaedic Hospital*" by failing to consider provider costs or examine cost studies before implementing the ten-percent rate reduction embodied in AB 5. Pet. App. 3-4, 11-20, 24; cf. Pet. App. at 36, 80, *Cal Pharm*, *supra*; Pet. App. at 2, *Maxwell-Jolly* v. *Santa Rosa Mem. Hosp.*, No. 10-283 (filed Aug. 25, 2010) (*Santa Rosa*). We agree

with petitioner that this aspect of the court's decision was in error.

As the government's amicus brief at the petition stage in *Orthopaedic Hospital* explained, that interpretation misreads Section 1396a(a)(30)(A) and frustrates Congress's purpose of giving States wide discretion to set Medicaid payments that are consistent with efficiency, economy, and access to quality care. Gov't Br. at 7-9, *Orthopaedic Hosp.*, *supra* (No. 96-1742). There is no general mandate under Medicaid to reimburse providers for all or substantially all of their costs, and Section 1396a(a)(30)(A) does not set forth any requirement that a State consider cost studies in setting payment rates. In contrast to the Boren Amendment to the Medicaid Act (42 U.S.C. 1396a(a)(13)(A) (1988)), which was at issue in *Wilder* v. *Virginia Hospital Ass'n*, 496 U.S. 498 (1990), but has since been repealed, the focus of Section 1396a(a)(30)(A) is on the availability of services rather than meeting providers' costs.[3] To be sure, reimbursement levels affect provider participation rates. But there is no requirement that Medicaid assume all or substantially all of the costs incurred by providers in order to ensure reasonable access to quality care.

As petitioner explains (Pet. 27), the Ninth Circuit stands alone among the courts of appeals in requiring States to adopt a particular cost-based methodology to set Medicaid

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[3] The Boren Amendment required States to make payments based on rates that "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" providing inpatient hospital, skilled nursing, and other institutional services. 42 U.S.C. 1396a(a)(13)(A) (1988). In the Balanced Budget Act of 1997, Congress repealed the Boren Amendment and replaced it with a more limited requirement that States provide for public notice-and-comment participation in their ratemaking processes for such institutional services. Pub. L. No. 105-33, § 4711, 111 Stat. 507.

payment rates. See *Methodist Hosps., Inc.* v. *Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) ("Nothing in the language of [Section] 1396a(a)(30), or any implementing regulation, requires a state to conduct studies in advance of every modification."); pp. 10-11, *infra*.

b. The court of appeals, however, did not rely solely on its erroneous decision in *Orthopaedic Hospital*. Instead, the court set forth three alternative grounds that, it held, would also justify affirming the district court's preliminary injunction: (i) the Medi-Cal rate reduction was based solely on budgetary concerns; (ii) the State failed to study the effect of the rate reduction in a meaningful way; and (iii) even under a substantive standard, "the ten percent rate reduction might still conflict with the quality of care and access provisions * * * as the cuts have apparently forced at least some providers to stop treating Medi-Cal beneficiaries." Pet. App. 20-23; cf. Pet. App. at 20, 33, *Cal Pharm*, *supra*.

These alternative grounds raise additional questions concerning the proper interpretation of Section 1396a(a)(30)(A), and implicate nuanced disagreements among the courts of appeals. For example, the Seventh Circuit has held that Section 1396a(a)(30)(A) requires States to produce a substantive result but does not impose any procedural requirements. See *Methodist Hosps., Inc.*, 91 F.3d at 1030; see also *Evergreen Presbyterian Ministries, Inc.* v. *Hood*, 235 F.3d 908, 933 n.33 (5th Cir. 2000), overruled on other grounds by *Equal Access for El Paso, Inc.* v. *Hawkins*, 509 F.3d 697 (5th Cir. 2007), cert. denied, 129 S. Ct. 34 (2008). The Third Circuit agrees that "[S]ection 30(A) mandates only substantive compliance" with the statutory factors and "does not specify a particular process for a state agency to follow in establishing rates." *Rite Aid, Inc.* v. *Houstoun*, 171 F.3d 842, 851-852 (1999).

The Third Circuit, however, has declined to "go as far as" the Seventh Circuit, instead examining whether the State acted "arbitrarily and capriciously" and noting that "budgetary considerations" cannot be "the sole basis for a rate revision." *Id.* at 851-852, 854-856. The Eighth Circuit has held that Section 1396a(a)(30)(A) "mandates consideration of the specified factors * * * ; however, it does not require the State to utilize any prescribed method of analyzing and considering said factors." *Minnesota Homecare Ass'n* v. *Gomez*, 108 F.3d 917, 918 (1997) (per curiam) (citation omitted); see *Arkansas Med. Soc'y* v. *Reynolds*, 6 F.3d 519, 530-531 (8th Cir. 1993) (holding that State must consider statutory factors and that "budgetary considerations" cannot be the "conclusive factor").

c. Review of the disagreement among the courts of appeals as to the proper interpretation of Section 1396a(a)(30)(A), however, is not warranted at this time.

HHS has informed this Office that it is initiating a rulemaking process to furnish an authoritative interpretation of Section 1396a(a)(30)(A), and a notice to that effect will be published as part of HHS's formal regulatory agenda in the near future. Specifically, HHS is committed to promulgating a notice of proposed rulemaking in April 2011 and a final rule by December 2011. HHS is the agency charged with reviewing state plans for medical assistance, and ensuring that they comply with the Medicaid Act, including Section 1396a(a)(30)(A). 42 U.S.C. 1396a(b). The nature and extent of the obligations imposed on States under Section 1396a(a)(30)(A) are best suited for expert agency consideration in the first instance. The agency's interpretation will be entitled to deference under *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. 837 (1984), and may well resolve any conflict among the courts of appeals, rendering review by this Court unnecessary.

Moreover, the ten-percent rate reduction at issue here expired in February 2009, and the Secretary recently disapproved the SPA seeking approval of that reduction. In its disapproval letter, the Secretary explained that "California has not demonstrated that it would meet the conditions set out in" Section 1396a(a)(30)(A). App., *infra*, 2a. That decision renders this case a particularly inappropriate vehicle for review because, if sustained on reconsideration, it provides a distinct reason—separate from the court's preliminary injunction—why petitioner cannot retroactively implement the now-expired ten-percent rate reduction.[4]

2. Petitioner also asks this Court to consider whether Medicaid providers and beneficiaries can maintain a cause of action directly under the Supremacy Clause to challenge state Medicaid reimbursement rates as inconsistent with Section 1396a(a)(30)(A). This Court's review of that question is not warranted at this time.

a. After this Court's decision in *Gonzaga University* v. *Doe*, 536 U.S. 273 (2002), nearly every court of appeals to consider the issue has held that neither providers nor beneficiaries have a cause of action under 42 U.S.C. 1983 to enforce Section 1396a(a)(30)(A) because that provision does not create rights enforceable under Section 1983. See *Equal Access for El Paso*, 509 F.3d at 703; *Mandy R.* v. *Owens*, 464 F.3d 1139, 1147 (10th Cir. 2006), cert. denied, 549 U.S. 1305 (2007); *Westside Mothers* v. *Olszewski*, 454 F.3d 532, 542-543 (6th Cir. 2006); *New York Ass'n of Homes & Servs. for the Aging, Inc.* v. *DeBuono*, 444 F.3d 147, 148

[4] Although the rate reductions imposed by AB 1183 and at issue in the *Cal Pharm* petition have not expired, that petition is also a poor vehicle for review because those SPAs were disapproved by HHS as well. App., *infra*, 1a-2a. The same is true of the rate reduction at issue in *Santa Rosa*. *Ibid.*

(2d Cir. 2006) (per curiam) (providers only); *Sanchez* v. *Johnson*, 416 F.3d 1051, 1058-1062 (9th Cir. 2005); *Long Term Care Pharm. Alliance* v. *Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004) (providers only). But see *Pediatric Specialty Care, Inc.* v. *Arkansas Dep't of Human Servs.*, 443 F.3d 1005, 1016 (8th Cir. 2006) (declining to reconsider precedent holding that Section 1396a(a)(30)(A) is enforceable by providers and beneficiaries through Section 1983), cert. granted, judgment vacated in part, 551 U.S. 1142 (2007).

Respondents, however, did not rely on Section 1983 for their cause of action, but instead contended that petitioner should be enjoined from implementing the Medi-Cal rate reduction because AB 5 was preempted by Section 1396a(a)(30)(A). Agreeing with that contention, the court of appeals "join[ed] several other circuits in holding that a party may seek injunctive relief under the Supremacy Clause regardless of whether the federal statute at issue confers any substantive rights on would-be plaintiffs." Pet. App. 83.

At its broadest level of generality, the question petitioner raises is whether or when, in the absence of a statutory cause of action, a private party can seek equitable relief in a cause of action directly under the Supremacy Clause against state officials responsible for implementing a state law allegedly preempted by federal law. At its most specific, the question is whether Medicaid providers or beneficiaries can bring such a cause of action to enjoin rate reductions that allegedly violate the terms of Section 1396a(a)(30)(A).[5]

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[5] It is not clear that this case squarely raises the question, since respondents filed this action in state court as a petition for a writ of mandamus under state law. A California intermediate appellate court has held that Medi-Cal reimbursement rates can be challenged as violating Section 1396a(a)(30)(A) through state mandamus. See *California*

b. This Court has never squarely decided if or when a cause of action for equitable relief should be recognized directly under the Supremacy Clause without reliance on 42 U.S.C. 1983 or some other federal statutory cause of action. This Court has held that "[a] plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute, which, by virtue of the Supremacy Clause of the Constitution, must prevail, * * * presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve." *Shaw* v. *Delta Air Lines*, 463 U.S. 85, 96 n.14 (1983). But the question at issue in *Shaw*, of subject matter jurisdiction, is analytically distinct from the question whether a plaintiff has a private right of action directly under the Supremacy Clause to seek injunctive relief from a state law that allegedly conflicts with federal law. See *Verizon Md., Inc.* v. *Public Serv. Comm'n*, 535 U.S. 635, 642-643 (2002) ("It is firmly established in our cases that the absence of a valid (as opposed to arguable) cause of action does not implicate subject-matter jurisdiction, *i.e.*, the courts' statutory or constitutional *power* to adjudicate the case.") (quoting *Steel Co.* v. *Citizens for Better Env't*, 523 U.S. 83, 89 (1998)).[6]

Hosp. Ass'n v. *Maxwell-Jolly*, 115 Cal. Rptr. 3d 572 (Ct. App. 2010), petition for review denied, No. S186829 (Cal. Nov. 23, 2010). Thus, respondents may have a cognizable state law cause of action whether or not a right of action should be recognized directly under the Supremacy Clause. Even if state law furnishes a cause of action, there would then be a further question whether Section 1396a(a)(30)(A) may be invoked by private parties as a matter of federal law, but neither petitioner nor the courts below focused on that distinct inquiry. The other pending petitions were brought in federal court directly under the Supremacy Clause and do not assert any state law cause of action.

[6] In *Free Enterprise Fund* v. *Public Co. Accounting Oversight Board*, 130 S. Ct. 3138 (2010), the Court rejected the government's con-

The Court has, however, often decided preemption claims on their merits in cases brought in federal court, perhaps implicitly assuming that a cause of action exists under the Supremacy Clause in at least some circumstances. See, *e.g.*, *Rowe* v. *New Hampshire Motor Transp. Ass'n*, 552 U.S. 364 (2008); *Watters* v. *Wachovia*, 550 U.S. 1 (2007); *Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268 (2006); *Bates* v. *Dow Agrosciences*, 544 U.S. 431 (2005); *Engine Mfrs. Ass'n* v. *South Coast Air Quality*, 541 U.S. 246 (2004); *PhRMA* v. *Walsh*, 538 U.S. 644 (2003) (plurality opinion). Some Members of this Court have raised doubts about the existence of such a cause of action in certain contexts. See *PhRMA*, 538 U.S. at 683 (Thomas, J., concurring) (noting "serious questions as to whether third parties may sue to enforce Spending Clause legislation—through preemption or otherwise"). Others have expressly affirmed the existence of such a cause of action to prevent enforcement against plaintiffs of allegedly preempted state laws. See *Golden State Transit Corp.* v. *City of L.A.*, 493 U.S. 103, 119 (1989) (Kennedy, J., dissenting) (plaintiffs may prevent enforcement of an allegedly preempted state statute "by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes," because "[t]hese statutes do not limit jurisdiction to those who can show the

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tention that there was no implied right of action directly under the Constitution to challenge federal governmental action under the Appointments Clause and separation-of-power principles. See *id.* at 3151 n.2 (quoting *Correctional Servs. Corp.* v. *Malesko*, 534 U.S. 61, 74 (2001) (Equitable relief "has long been recognized as the proper means for preventing entities from acting unconstitutionally."")). In *Free Enterprise Fund*, 130 S. Ct. at 3155-3157, and *Malesko*, 534 U.S. at 73, however, the constitutional provisions sought to be enforced themselves protected individual rights and liberties.

deprivation of a right, privilege, or immunity secured by federal law within the meaning of [Section] 1983") (citing 28 U.S.C. 1331, 2201, 2202).

Consistent with the apparent assumption underlying this Court's cases, those courts of appeals that have considered the question whether a plaintiff may bring an action in federal court to enjoin a state law that is allegedly preempted by a federal statute, if the federal statute itself does not confer any private right enforceable under 42 U.S.C. 1983, have generally agreed that the answer is yes. The Second Circuit has acknowledged the "potential anomaly of rejecting a private right of action to enforce a statute while allowing a claim under the Supremacy Clause that the statute preempts a local regulation," but explained that "[a] claim under the Supremacy Clause that a federal law preempts a state regulation is distinct from a claim for enforcement of that federal law." *Western Air Lines, Inc.* v. *Port Auth.*, 817 F.2d 222, 225 (1987), cert. denied, 485 U.S. 1006 (1988); see *Air Transp. Ass'n of Am., Inc.* v. *Cuomo*, 520 F.3d 218 (2d Cir. 2008). Other courts have held likewise. See *Lankford* v. *Sherman*, 451 F.3d 496, 509 (8th Cir. 2006); *Planned Parenthood* v. *Sanchez*, 403 F.3d 324, 333-335 (5th Cir. 2005); *Qwest Corp.* v. *City of Santa Fe*, 380 F.3d 1258, 1266 (10th Cir. 2004); cf. *Puerto Rico Tel. Co.* v. *Municipality of Guayanilla*, 450 F.3d 9, 15 (1st Cir. 2006) (finding "no need to resolve" whether federal statute provided private cause of action because case was brought "under the Supremacy Clause").

Despite petitioner's contention (Pet. 22-23), *Legal Environmental Assistance Foundation, Inc.* v. *Pegues*, 904 F.2d 640 (11th Cir. 1990), is not to the contrary. The Eleventh Circuit declined to recognize a cause of action under the Supremacy Clause because the plaintiff was seeking "to review the [EPA] Administrator's erroneous interpretation

of federal law in a proceeding against the state agency." *Id.* at 644. The court concluded that, where the statute provides another means to challenge the Administrator's actions, a plaintiff could not "bootstrap a statutory claim that should be asserted against the Administrator into a constitutional claim." *Ibid.* Petitioner also relies on Judge McConnell's dissenting opinion in *Wilderness Society* v. *Kane County*, 581 F.3d 1198 (10th Cir. 2009). The Tenth Circuit granted rehearing en banc in that case on February 5, 2010, 595 F.3d 1119, and no decision has issued.

c. Petitioner acknowledges (Pet. 24-25; Reply Br. 5-6) that this Court appears to assume the existence of a Supremacy Clause cause of action in cases in which regulated parties have sought to prevent enforcement of allegedly preempted state laws against them. Petitioner argues, however, that this case is different because Medicaid providers and beneficiaries are not regulated by the allegedly preempted state law.

Petitioner relies on Judge McConnell's dissenting opinion in *Wilderness Society*, which noted that, in certain other cases in which courts have entertained private preemption claims, the "plaintiffs were raising preemption as a *defense*." 581 F.3d at 1233; see *ibid.* ("When threatened with the enforcement of a state or local law that has been preempted, the target can of course raise a preemption defense in the form of a suit for injunctive or declaratory relief."). In contrast, petitioner maintains, respondents here (Medicaid providers and beneficiaries) are not regulated by AB 5 and do not seek to assert an immunity defense by way of a suit for an injunction. But while most of the preemption cases decided by this Court that originated in federal court were in fact cases in which the plaintiff was regulated by the challenged state law and could have raised a preemption defense in any enforcement action for non-

compliance, see, *e.g.*, *Rowe*, 552 U.S. at 637-369 (state law regulating plaintiff motor carriers' delivery of tobacco); *Watters*, 550 U.S. at 8-9 (state law imposing registration and inspection requirements on plaintiff national bank),[7] not all of this Court's cases necessarily fit that description, see, *e.g.*, *Crosby* v. *National Foreign Trade Council*, 530 U.S. 363 (2000) (state law restricting authority of state agencies to purchase goods or services from companies doing business with Burma). And because this Court has not squarely decided if or when a cause of action should be recognized directly under the Supremacy Clause, the Court's cases have not addressed the question whether a Supremacy Clause cause of action would be available only to those plaintiffs who seek to raise preemption as a defense.

Petitioner also relies (Pet. 18, 24-25; Reply Br. 5-6) on the fact that the Medicaid Act is Spending Clause legislation, under which the allegedly preemptive terms of federal law often operate as conditions on the granting of federal funds rather than freestanding regulatory or rights-conferring measures. Section 1396a(a)(30)(A), for example, makes no explicit mention of private rights but rather requires that state Medicaid plans have reasonable methods and procedures in place to operate their programs in a manner that ensures a certain level of access to services by beneficiaries as a general matter. If a State fails to comply with the obligations it has agreed to undertake under the Medicaid Act, the Secretary may terminate federal funding, or, as demonstrated in this case, disapprove a plan amendment as non-compliant. In deciding whether to ap-

[7] The Declaratory Judgment Act, 28 U.S.C. 2201, was intended to permit actions in federal court in anticipation of suits that might have been brought by the opposing party. See *Perez* v. *Ledesma*, 401 U.S. 82, 111-113 (1971).

prove state plans or plan amendments under Section 1396a(a)(30)(A), the Secretary must balance the financial interests of the States and the Medicaid program (efficiency and economy) with the welfare interests of beneficiaries (quality care and equal access to care).

Petitioner argues that, in the Spending Clause context, the "'federal interest in assuring the supremacy of th[e] law'" is "advanced only by limiting enforcement to * * * agency review and the potential withholding of funding." Reply Br. 6-7 (citation omitted; brackets in original). As a general matter, that argument overlooks the important role private parties can and often do play in vindicating federal law. A system that relies solely on agency review may often be less effective in ensuring the supremacy of federal law than a system of agency review supplemented by private enforcement. And those programs in which the drastic measure of withholding all or a major portion of federal funding is the only available remedy would be generally less effective than a system that also permits awards of injunctive relief in private actions in appropriate circumstances. See, *e.g.*, *Cannon* v. *University of Chi.*, 441 U.S. 677, 705 (1979). To the extent a private party's claim rests on an interpretation of a federal statute that is inconsistent with the agency's own interpretation, the latter interpretation, if reasonable, will control. See *National Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 983 (2005).

To be sure, the considerations petitioner raises are ones that counsel caution in recognizing a cause of action directly under the Supremacy Clause to challenge state laws allegedly preempted by provisions of a federal statute such as the Medicaid Act that do not confer private rights enforceable under 42 U.S.C. 1983. This Court's review, however, is not warranted at this time to decide whether or

in what circumstances such a cause of action should be recognized, either generally or specifically under Section 1396a(a)(30)(A). HHS has committed to conducting a rulemaking process that will result in an authoritative interpretation of Section 1396a(a)(30)(A) in the coming year. The threshold question whether respondents have a cognizable cause of action implied directly under the Supremacy Clause to enforce particular provisions of Section 1396a(a)(30)(A) may be informed by the proper interpretation of that Section. The rulemaking may include a determination whether Section 1396a(a)(30)(A) protects interests of providers at all following repeal of the Boren Amendment (note 3, *supra*); what procedural or substantive requirements the statute imposes on States with respect to beneficiaries; and how the various provisions of Section 1396a(a)(30)(A) and other Medicaid requirements interact. Insofar as the question petitioner raises implicates concerns about the standards applicable under Section 1396a(a)(30)(A), Pet. 16, the outcome of the rulemaking process may affect the appropriate analysis.

Moreover, no other court of appeals has decided whether a state plan provision can be challenged as preempted by Section 1396a(a)(30)(A) in a cause of action implied directly under the Supremacy Clause. And critically, as discussed above, the ten-percent rate reduction has since expired and the Secretary recently disapproved the plan amendments at issue in this case and others now pending before this Court. The State has requested reconsideration of those disapprovals, which institutes a formal hearing process in HHS on the State's proposed plan amendments. 42 C.F.R. 430.18, 430.60 *et seq.* Under HHS regulations, interested individuals or groups may be permitted to participate in that administrative proceeding, 42 C.F.R. 430.76, and the State may petition for judicial review in the court

of appeals of an adverse decision by HHS, 42 C.F.R. 430.38, 430.102(c); 42 U.S.C. 1316(a)(3). Because this case and the two related petitions involve preliminary injunctions and thus are in an interlocutory posture, the courts below will have an opportunity in any further proceedings to consider developments in this administrative hearing process, as well as the upcoming rulemaking.

For these reasons as well, review by this Court is not warranted at this time.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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Attorneys

DECEMBER 2010

APPENDIX A

[LOGO OMITTED]

DEPARTMENT OF HEALTH & HUMAN SERVICES | Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

[Nov. 18, 2010]

Mr. Toby Douglas, Chief Deputy Director
Health Care Programs
Department of Health Care Services
1501 Capitol Avenue, 6th Floor
MS 0002
Sacramento, CA 95814

Dear Mr. Douglas:

I am responding to your request for approval of the following California Medicaid State plan amendments (SPAs) which propose to reduce the reimbursement rates for certain services furnished under the approved State plan:

- TN 08-009A — Reduction in reimbursement for non-contracting hospitals (submitted on September 29, 2008);
- TN 08-009B-1 — Reduction in reimbursement for various outpatient services (submitted on September 29, 2008);
- TN 08-009B-2 — Reduction in reimbursement for prescription drugs (submitted on September 29, 2008);

TN 08-009D — Reduction in reimbursement for certain nursing facility services (submitted on September 29, 2008); and

TN 08-019 — Additional limitations on certain non-contracting hospitals (submitted on December 31, 2008).

The Centers for Medicare & Medicaid Services (CMS) is unable to approve these SPAs because California has not demonstrated that it would meet the conditions set out in section 1902(a)(30)(A) of the Social Security Act (Act). This action does not prevent the State from submitting other rate related SPAs in the future; please let us know if you would like to discuss how California might proceed, if it decides to do so.

Section 1902(a)(30)(A) of the Act requires that State plans assure that "payments [to providers] . . . are sufficient to enlist enough providers so that care and services are available under the [State's Medicaid] plan [to recipients] at least to the extent that such care and services are available to the general population in the geographic area."

When the SPAs were initially submitted, the State did not provide information concerning the impact of the proposed reimbursement reductions on beneficiary access to services, even though available national data indicate that this may be an issue for California. In the Requests for Additional Information (RAI) for SPAs TN 08-009A, TN 08-009B-1, TN 08-009D, (sent to the State in December 2008), and 08-019 (sent to the State in March, 2009), CMS requested information about beneficiary access to services; but California has not respond-

ed. Additionally, CMS is concerned that, given the time that has elapsed since these SPAs were submitted, the cumulative effect of a retroactively effective approval of these reimbursement reductions would only serve to exacerbate access concerns. As indicated in the guidance on the SPA review process in our January 2, 2001, Letter to State Medicaid Directors, CMS may initiate disapproval action if information responding to an RAI is not received within 90 days after the request.

Because considerably more time has elapsed since the issuance of the RAI, we are disapproving the SPAs.

For these reasons, and after consulting with the Secretary as required by Federal regulations at 42 CFR 430.15(c)(2), I am disapproving these SPAs.

If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth in Federal regulations at 42 CFR section 430.18. Your request for reconsideration may be sent to:

Ms. Cynthia Hentz
CMS, Center for Medicaid, CHIP and Survey & Certification
7500 Security Boulevard, Mailstop S2-25-22
Baltimore, Maryland 21244-1850

If you have any questions, or wish to discuss this determination further, please contact:

Ms. Gloria Nagle, Associate Regional Administrator
CMS Region IX, Division of Medicaid and Children's Health
Department of Health and Human Services
90 7th Street, #5-300 (5W)
San Francisco, California 94103-6706

Sincerely,

/s/ DONALD M. BERWICK, M.D.
DONALD M. BERWICK, M.D.

APPENDIX B

[LOGO OMITTED] [SEAL OMITTED]

DAVID MAXWELL-JOLLY
Director

ARNOLD SCHWARZENEGGER
Governor

State of California-Health and Human Services Agency

Department of Health Care Services

November 18, 2010

Ms. Cynthia Hentz
CMS, Center for Medicaid, CHIP and Survey & Certification
7500 Security Boulevard, Mailstop S2-25-22
Baltimore, Maryland 21244-1850

Re: Request for Reconsideration Regarding Disapproval of State Plan Amendments

Dear Ms. Hentz:

Pursuant Title 42, Code of Federal Regulations, section (42 CFR §) 430.18, this letter constitutes the California Department of Health Care Services' (DHCS) Request for Reconsideration of the Disapproval of State Plan Amendments (SPA) dated November 18, 2010, regarding SPA Numbers TN 08-009A, TN 08-009B-1, TN 08-009B-2, TN 08-090D and TN 08-019.

While 42 CFR § 430.18 does not require a statement of reasons be included in a Request, DHCS believes that the issues to be reconsidered should include, but are not limited to; (1) whether DHCS responded appropriately to CMS' Requests for Additional Information (RAI); (2) whether the disapproval should have been issued prior to discussions with DHCS regarding issues as mandated by 42 CFR § 430.14; (3) whether there is regulatory support for disapproval based upon lapse of time; (4) whether DHCS demonstrated compliance with section 1902(a)(30)(A) of the Social Security Act; and (5) whether the data referenced by CMS in its disapproval is valid and/or indicates access to services within California would be negatively impacted by approval or implementation of the SPAs.

Please direct all correspondence relating to this matter to:

Derek E. Backus
Senior Staff Counsel
Office of Legal Services MS 0010
Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413
Direct Line: (916) 440-7816
Fax: (916) 440-7711

Thank you for your consideration of this matter.

Sincerely,

/s/ TOBY DOUGLAS
TOBY DOUGLAS
Chief Deputy Director
Department of Health Care Services

cc: Gloria Nagle,
Associate Regional Administrator, CMS Region IX
Division of Medicaid and Children's Health
Department of Health and Human Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707