No. 14-15

In the Supreme Court of the United States

RICHARD ARMSTRONG, *et al.*,
Petitioners,

v.

EXCEPTIONAL CHILD CENTER, INC., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

Brief of *Amici Curiae* National Health Law Program, AARP, Service Employees International Union, National Legal Aid and Defender Association, Sargent Shriver National Center on Poverty Law, National Disability Rights Network, DisAbility Rights Idaho, Center for Medicare Advocacy, National Senior Citizens Law Center, First Focus, National Center for Youth Law, National Center for Law and Economic Justice, National Housing Law Project, National Women's Law Center, Planned Parenthood Federation of America, National Family Planning & Reproductive Health Association, National Latina Institute for Reproductive Health, Asian Americans Advancing Justice - Los Angeles, Southern Poverty Law Center in Support of Respondents

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INTEREST OF THE AMICI

Amici are organizations committed to serving the needs of low-income persons, including older Americans, individuals with disabilities, children, and women of child-bearing age. *Amici*'s work involves promoting public awareness of the disproportionate need for health care and barriers to care experienced by these populations and advocating for their interests and legal rights. It is in this last capacity that *amici* submit this Brief, asking the Court to affirm the decision below.[1]

The **National Health Law Program** is a 40-year-old public interest law organization that engages in education, litigation and policy analysis to advance access to quality health care and protect the legal rights of low-income and underserved people. **AARP** is a nonprofit, nonpartisan organization with a membership that strengthens communities and fights for the issues that matter most to families such as health care, employment, income security, retirement planning, affordable utilities and protection from financial abuse. AARP supports access to and expansion of quality health care through publicly administered health insurance programs, including Medicaid, an essential safety net program that provides coverage to people who would otherwise be denied health care. To further that end, Medicaid

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[1] No counsel for a party authored this brief in whole or in part or made a monetary contribution to fund the preparation or submission of this brief. No persons other than the *amici*, their members or their counsel made such a monetary contribution. The parties consented to the filing of this brief.

recipients' access to the courts to challenge the denial of Medicaid services is critical.

The **Service Employees International Union** (SEIU) is the nation's largest health care union, with more than half of its 2.1 million members in the health care field. SEIU is concerned about the ability of individuals to enforce Medicaid because it provides vital insurance coverage for millions of Americans, including SEIU members and their families.

The **National Legal Aid and Defender Association** is the largest organization in the United States dedicated solely to securing equal justice for the disadvantaged in the civil and criminal justice systems. NLADA members represent thousands of families in need of adequate health care and access to the courts. The **Sargent Shriver National Center on Poverty Law** advances laws and policies that improve quality of life and opportunity for people living in poverty. The Shriver Center has worked for many years on behalf of its clients to ensure access to Medicaid, quality health care for eligible people, and access to the courts to enforce their rights.

The **National Disability Rights Network** (NDRN) is the non-profit membership association of protection and advocacy (P&A) agencies that are located in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Territories. For 30 years, P&As have worked with children and adults with disabilities who depend on Medicaid-funded services and supports to enable them to live in the community rather than in institutions. **DisAbility Rights Idaho** (DRI) is a non-profit corporation providing legal and other advocacy assistance to Idahoans with disabilities. DRI has the

responsibility to provide advocacy services to Idahoans with developmental disabilities including legal representation. DRI has been representing people with disabilities in Medicaid appeals for over 35 years. DRI is vitally concerned with the Idaho Medicaid system and its services for people with disabilities.

Founded in 1986, **the Center for Medicare Advocacy** is a non-profit public interest law organization that represents older and disabled people throughout the United States. The Center works to advance fair access to Medicare, Medicaid and quality health care through individual representation, education, policy analysis, administrative advocacy, and litigation. The **National Senior Citizens Law Center** (NSCLC) is a non-profit organization that advocates nationwide to promote the independence and well-being of low-income older persons and people with disabilities. For more than 40 years, NSCLC has served these populations through litigation, administrative advocacy, legislative advocacy, and assistance to attorneys in legal aid programs. NSCLC works to ensure access to the federal courts to enforce safety net and civil rights statutes, particularly the Medicaid Act, a critical source of health insurance for millions of older persons and people with disabilities.

First Focus is a bipartisan advocacy organization that is committed to making children and families a priority in federal policy and budget decisions. In all of its work, First Focus strives to ensure that every child in America has access to the high quality, comprehensive, affordable health care they need to grow up to become healthy and productive adults. The **National Center for Youth Law** (NCYL) is a private,

non-profit organization that uses the law to help children in need nationwide. For more than 40 years, NCYL has worked to protect the rights of low-income children and to ensure that they have the resources, support, and opportunities they need for healthy and productive lives. NCYL provides representation to children and youth in cases that have a broad impact. NCYL also engages in legislative and administrative advocacy to provide children a voice in policy decisions that affect their lives.

Founded in 1965, the **National Center for Law and Economic Justice** is a national law office that advocates on behalf of low-income individuals to assure their access to Medicaid and other safety net benefits. NCLEJ's work with low-income community groups and individuals confirms that Medicaid is critical to the ability of low-income people to receive health care. The **National Housing Law Project** is a charitable nonprofit corporation established in 1968 whose mission is to use the law to advance housing justice for low-income people by increasing, preserving and improving the supply of decent, affordable housing; by expanding and enforcing tenants' and homeowners' rights; and by increasing housing opportunities for people protected by fair housing laws.

The **National Women's Law Center** is a nonprofit legal advocacy organization dedicated to the advancement and protection of women's legal rights since its inception in 1972. NWLC's work includes advocating for health coverage for low-income women of all ages through the Medicaid program. NWLC joins this Brief in this capacity. **Planned Parenthood Federation of America** (PPFA) is the nation's largest

and most trusted voluntary reproductive health care organization. PPFA's 66 affiliates operate approximately 700 health care centers nationwide. In addition to providing reproductive health care, PPFA and its affiliates are among the nation's most active and widely recognized advocates for increased access to comprehensive reproductive health services and education. PPFA is committed to promoting and preserving full reproductive choice for all people and to providing access to high quality, confidential, reproductive health services. The **National Family Planning & Reproductive Health Association** (NFPRHA) is a national membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, underinsured, and uninsured women and men. NFPRHA's members operate or fund a network of nearly 5,000 safety-net health centers and service sites that provide high-quality family planning and other preventive health services to millions of individuals in all 50 states and the District of Columbia. The mission of the **National Latina Institute for Reproductive Health** (NLIRH) is to ensure the fundamental human right to reproductive health and justice for Latinas, their families and their communities through public education, community mobilization and policy advocacy. NLIRH is the nation's only reproductive health policy and advocacy organization working on behalf of the reproductive health and justice of the nation's 26 million Latina women. **Asian Americans Advancing Justice - Los Angeles** (Advancing Justice - LA), formerly the Asian Pacific American Legal Center, is the nation's largest legal and civil rights organization for Asian Americans, Native Hawaiians, and Pacific Islanders. Advancing Justice - LA serves

more than 15,000 individuals every year, including low-income Medicaid beneficiaries. Advancing Justice – LA has a long history of representing vulnerable members of our communities in federal courts on a broad range of issues, including health care and public benefits.

The **Southern Poverty Law Center** (SPLC), based in Montgomery, Alabama, is a non-profit organization founded in 1971 to advance and protect the rights of minorities, the poor, and victims of injustice in significant civil rights and social justice matters. SPLC particularly seeks to address the unique systematic barriers faced by people living in or on the edge of poverty in the Deep South, particularly when state laws, regulations, and procedures are preempted by federal law. Access to health care is an issue of fundamental significance to the populations we seek to serve, and that access is enabled in part by the enforceability of federal health care laws through the Supremacy Clause.

SUMMARY OF ARGUMENT

The history and purpose of the Medicaid Act illustrate the need for private enforcement when states' violations of the Medicaid Act are harming program beneficiaries. This Court has long recognized the right of program beneficiaries and health care providers to enforce the Supremacy Clause and enjoin state laws that are inconsistent with provisions of the Medicaid Act and other Social Security Act titles. The statutory scheme of the Medicaid Act does not preclude private enforcement, and Congress has enacted legislation to preserve private enforcement of the Social Security Act by program beneficiaries. The federal government has

repeatedly taken the position that private enforcement should complement federal agency remedies.

ARGUMENT

I. THE HISTORY AND PURPOSE OF MEDICAID SHOW THE NEED FOR PRIVATE ENFORCEMENT.

Millions of Americans depend on their states' Medicaid programs operating pursuant to the Constitution and as Congress intended. Over the 50-year history of the Medicaid Act, private enforcement has consistently been the primary means of halting ongoing state violations of federal law and realizing Medicaid's promises and protections.

Title XIX of the Social Security Act established Medicaid in 1965. *See* 42 U.S.C. §§ 1396-1396w-5. Cooperatively funded by the federal and state governments, Medicaid is designed to provide low-income people who meet the program's eligibility requirements with health insurance that will allow them to obtain care and services from the private health care sector, including hospitals, doctors, pharmacies, nursing facilities, and home health care agencies. *See* Rand E. Rosenblatt et al., *Law and the American Health Care System* 415 (1997). Congress' "very clear ... intent [was] that the medical and remedial care and services made available to recipients under Title XIX be of high quality and in no way inferior to that enjoyed by the rest of the population." *Id.* at 416, *quoting* U.S. Dep't of Health, Educ., & Welfare, *Handbook of Public Assistance Administration* § D-5140.

Before Medicaid was enacted, low-income, uninsured people only could obtain health services through a patchwork of programs, such as hospital charity care and local programs for the poor. This system provided uneven coverage from state to state and within states. The Medicaid Act was intended to change this by providing for a uniform and statewide medical insurance program, while allowing for some variation among states. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 266 (July 30, 1965). Designed for people with disabilities and the limited finances of low-income people, Medicaid was tailored to cover a fuller range of necessary health and support services not then typically covered by private insurance. Medicaid's purpose is to help enrolled individuals to "attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1.

Over 68 million Americans—more than one in every five—depend on Medicaid or the much smaller Children's Health Insurance Program (CHIP) for their health care at some point during the year. *See* Dep't of Health & Human Servs., *Medicaid & CHIP: October 2014 Monthly Applications, Eligibility Determinations and Enrollment Report* 2 (Dec. 18, 2014) [hereinafter *Medicaid & CHIP Enrollment Report*], http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/october-2014-enrollment-report.pdf; Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Moving Forward* 1-2 (June 2014), http://files.kff.org/attachment/the-medicaid-program-at-a-glance-update-fact-sheet (reporting over 66 million Americans enrolled in Medicaid). While most enrollees live in working

families, Medicaid includes newborns, children, pregnant women, individuals with physical and intellectual disabilities and mental illnesses, and poor elderly and disabled Medicare beneficiaries.

Medicaid is the largest source of health insurance for children in the United States. In 2013, over 45 million children (more than one in three children), including about one million children in foster care, obtained coverage for medical, dental and developmental screening and treatment through Medicaid or CHIP. *See* Dep't of Health & Human Servs., *2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP* 1 (Nov. 2014), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf. Of the more than 98 million U.S. women between the ages of 15 and 44, 12 percent rely upon Medicaid for services, including breast and cervical cancer screening and treatment, testing and treatment for sexually transmitted diseases, and pregnancy-related care. See Kaiser Family Found., *Women's Health Insurance Coverage* (Nov. 6, 2013), http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/.

Medicaid covers approximately 9.3 million non-elderly individuals, including 1.5 million children, with severe physical and/or mental disabilities (*e.g.*, cerebral palsy, Down Syndrome, autism). Medicaid also covers more than 9 million Medicare beneficiaries (one in every five), based on low income. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid: A Primer* 1, 9 (Mar. 2013) [hereinafter *Medicaid Primer*], http://kaiserfamilyfoundation.files.wordpress.com/20

10/06/7334-05.pdf. These so-called "dually eligible" beneficiaries account for only 15 percent of Medicaid enrollees but 38 percent of Medicaid spending. *Id*. Medicaid is the largest single purchaser of long-term care services for the elderly and non-elderly people with disabilities in the United States. More than six of every ten nursing facility residents are covered by Medicaid, and Medicaid covers about 40 percent of the total long term care expenditures in the United States. *Id.* at 1, 4.

Effective January 1, 2014, a Medicaid provision extends eligibility to nonelderly, nondisabled, childless adults with incomes below 133 percent of the federal poverty level. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). As of October 2014, 26 states and the District of Columbia had implemented the expansion. In these states, Medicaid and CHIP enrollment rose by more than 24 percent compared to the 2013 baseline period, whereas enrollment rose by seven percent in states that have not expanded their Medicaid programs to childless adults. *See Medicaid & CHIP Enrollment Report, supra*, at 3.

Over its 50-year history, the Medicaid Act has played a pivotal role in the arrangement of and funding for health services. Implementation of the Act has resulted in dramatic improvements in health insurance coverage and health status of covered populations. It has reduced the numbers of uninsured, helped provide near-universal protection against communicable childhood diseases, played a major role in reducing infant mortality rates, and provided a critical life line to individuals with chronic and disabling conditions. *See*, *e.g.*, *Medicaid Primer, supra*, at 1-2. Medicaid is a

cornerstone of the nation's health care system for low-income Americans.

Medicaid is an entitlement program. Accordingly, "all individuals" who meet the eligibility requirements are entitled to receive a federally established set of benefits with "reasonable promptness." *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(8). *See Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981) ("An individual is entitled to Medicaid if he fulfills the criteria established by the State in which he lives."). The federal and participating state governments have a legal obligation to pay for and administer medical assistance needed by program beneficiaries in compliance with the requirements of the Medicaid Act and implementing regulations. *Id.* Thus, Medicaid coverage responds as emerging populations and economic needs arise, including rising unemployment, loss of private health care coverage, disasters (for example, providing short-term benefits for 350,000 New Yorkers following the 9/11 terrorist attacks), increasing disability rates, and an aging society. *See Medicaid Primer, supra*, at 6.

Entitlement to Medicaid triggers legal rights, including the right to enforce certain statutory requirements that are placed on the states. It is this entitlement that makes Medicaid insurance and that assures individuals that coverage will be there when care is needed. Since the beginning of the Medicaid program, beneficiaries have been able to make their entitlement real by bringing *Ex parte Young* actions for prospective injunctive relief against state officials who

are engaged in ongoing violations of federal law. *See* Section II, *infra.* These cases have been based not only on 42 U.S.C. § 1983 but also on the Supremacy Clause.

II. THIS COURT HAS CONSISTENTLY ALLOWED PROGRAM BENEFICIARIES TO ENJOIN STATE LAWS THAT ARE INVALID UNDER THE SUPREMACY CLAUSE, AND CONGRESS HAS RECOGNIZED THIS RIGHT.

From the very beginning, on numerous occasions dating from the early 1970s, this Court has recognized that beneficiaries of Social Security Act programs can bring preemption actions to enjoin state laws that conflict with federal law and are, thus, "invalid under the Supremacy Clause." *Townsend v. Swank*, 404 U.S. 282, 285 (1971). In *Bennett v. Arkansas*, 485 U.S. 395, 397 (1988) (per curium), the Court held that a state statute that conflicted with the Social Security Act was preempted by operation of the Supremacy Clause. The Court noted that the Social Security Act "unambiguously rules out any attempt to attach Social Security benefits," while the Arkansas statute at issue in the case "just as unambiguously allows the State to attach those benefits." *Id.* at 397. The Court held that "this amounts to a 'conflict' under the Supremacy Clause—a conflict the State cannot win." *Id.*; *see Blum v. Bacon*, 457 U.S. 132, 138 (1982) (holding state welfare regulations that conflicted with regulations promulgated pursuant to the Social Security Act "are invalid under the Supremacy Clause"); *N.Y. State Dep't of Social Servs. v. Dublino*, 413 U.S. 405, 423 n.29 (1973) (applying preemption analysis but finding no inconsistency, noting that "[c]onflicts [in Social

Security Act programs], to merit judicial rather than cooperative federal-state resolution, should be of substance and not merely trivial or insubstantial. But if there is a conflict of substance as to eligibility provisions, the federal law of course must control."); *Carleson v. Remillard*, 406 U.S. 598, 604 (1972) (holding that a California regulation excluding a parent's absence because of military service from the definition of "continued absence" from home conflicted with Social Security Act AFDC eligibility provisions and was invalid under the Supremacy Clause); *see also Ark. Dept. of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006) (assuming preemption cause of action without discussion). *See also PhRMA v. Walsh*, 538 U.S. 644 (2003) (plurality opinion) (deciding merits of preemption claim brought by provider organization); *Dalton v. Little Rock Family Planning Services*, 516 U.S. 474, 478 (1996) (applying Supremacy Clause in provider case and remanding for entry of injunction to extent state constitution conflicted with Medicaid Act).

In 1994, Congress amended the Social Security Act in two sections to make it clear that private causes of action are available to program beneficiaries. *See* 42 U.S.C. §§ 1320a-2, 1320a-10. Those amendments overruled parts of *Suter v. Artist M.*, 503 U.S. 347 (1992). They also affirmed the clear understanding of Congress that program beneficiaries would maintain access to the courts on the grounds that were recognized by this Court prior to 1992, the year *Suter* was decided. *See* H.R. Conf. Rep. No. 761, 103d Cong., 2d Sess., at 926 (1994), reprinted in 1994 U.S.C.C.A.N. 2901, 3257 ("The intent of this provision is to assure that individuals who have been injured by a State's failure to comply with the Federal mandate of the State

plan titles of the Social Security Act are able to seek redress in the federal courts to the extent that they were able to prior to the decision in *Suter v. Artist M*."). The Supremacy Clause cause of action was recognized well before *Suter*, and sections 1320a-2 and 1320a-10 clearly mean that Congress intends preemption actions under the Supremacy Clause to live on as a means of preventing state officials from acting contrary to the requirements of the Social Security Act. Moreover, private enforcement of Social Security Act provisions must be considered in context with these congressional amendments, not simply the Court's observation in other contexts that "[i]n legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981) (assessing provision of spending clause enactment that was not part of the Social Security Act); *see also Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002) (same).

The petitioners voice concern that a litigation floodgate will be produced if plaintiffs are able to enjoin state laws that are invalid under the Supremacy Clause. However, this ignores the decades long history of Medicaid enforcement by federal courts through the use of prospective injunctions tailored to end the harm caused by a state's ongoing violation of federal law. In a line of cases dating back more than 40 years, each of the circuit courts of appeals have used Supremacy Clause analysis to determine the validity of state Medicaid laws without dire consequences coming to pass. *See, e.g.*, *PhRMA v. Concannon*, 249 F.3d 66, 75

(1st Cir. 2001) (considering whether state statute conflicted with Medicaid so as to be invalid under Supremacy Clause); *Concourse Rehab. & Nursing Ctr., Inc. v. Whalen*, 249 F.3d 136, 146 (2d Cir. 2001); *Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170, 178 (3d Cir. 1995) ("The Supremacy Clause requires invalidation of any state constitutional or statutory provision that conflicts with federal law … and compels compliance by participants in Title XIX federal aid programs with federal law and regulations."); *Randall v. Lukhard*, 709 F.2d 257 (4th Cir. 1983), *aff'd in part en banc*, 729 F.2d 966 (4th Cir. 1984) (finding that a Virginia rule was invalid because it conflicted with a provision of the Medicaid Act); *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 331 (5th Cir. 2005) ("[I]t is well-established that the federal courts have jurisdiction under 28 U.S.C. § 1331 over a preemption claim seeking injunctive and declaratory relief."); *Planned Parenthood Affiliates of Mich. v. Engler*, 73 F.3d 634, 637 (6th Cir. 1996) (because Michigan law "conflicts with the program requirements of Medicaid, it must be held invalid under the Supremacy Clause"); *Zbaraz v. Quern*, 596 F.2d 196, 202 (7th Cir. 1979) (remanding with instructions to enjoin enforcement of state law to the extent it conflicted with Medicaid); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006) (granting recipients' request to enjoin Medicaid service cutback, holding "preemption claims are analyzed under a different test than section 1983 claims, affording plaintiffs an alternative theory for relief when state law conflicts with a federal statute or regulation"); *Lewis v. Hegstrom*, 767 F.2d 1371, 1375 (9th Cir. 1985) (applying "settled proposition that state regulations which are inconsistent with federal [Medicaid] law are

invalid under the Supremacy Clause"); *Hern v. Beye*, 57 F.3d 906, 906 (10th Cir. 1995) (affirming injunction prohibiting enforcement of state law "to the extent it conflicts with federal Medicaid law"); *Planned Parenthood Fed'n v. Heckler*, 712 F.2d 650, 663-64 (D.C. Cir. 1983) ("It is elementary that under the Supremacy Clause of the Constitution states are not permitted to establish eligibility standards for federal assistance programs that conflict with the existing federal statutory or regulatory scheme.").

III. THE MEDICAID ACT'S STATUTORY SCHEME IS CONSISTENT WITH THE NEED FOR PRIVATE ENFORCEMENT OF THE SUPREMACY CLAUSE TO PREVENT STATE MEDICAID OFFICIALS FROM ACTING CONTRARY TO FEDERAL LAW.

In its brief supporting the petitioners, the United States argues that allowing Medicaid providers access to the courts is inconsistent with Medicaid's "statutory scheme" vesting enforcement authority in the Department of Health and Human Services (DHHS). Brief for the United States as Amicus Curiae Supporting Petitioners at *10-11 Armstrong v. Exceptional Child Ctr. et al. (Nov. 2014) (No. 14-15) [hereinafter U.S. Exceptional Child Ctr. Brief 2014]. This argument conflicts with Supreme Court precedent and the expressed opinion of Congress and ignores DHHS's limited enforcement authority.

A statutory enforcement scheme either substitutes for private enforcement or it does not. In *Wilder*, this Court has held that the Medicaid Act does not contain a statutory scheme that replaces private enforcement. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 521-22

(1990); s*ee generally City of Rancho Palo Verdes v. Abrams*, 544 U.S. 113, 121-22 (2005) (listing Medicaid as a statute whose private judicial enforcement is not foreclosed based on a statutory enforcement scheme). When Congress amended the Social Security Act in 1994, it expressed its intent that private enforcement of the Social Security Act be determined according to the grounds applied in this Court's decisions prior to 1992. *See* 42 U.S.C. §§ 1320a-2, 1320a-10.

To be sure, Medicaid's statutory scheme includes a provision authorizing the Secretary of DHHS to enforce federal Medicaid law: 42 U.S.C. § 1396c authorizes the Secretary to terminate federal funding to states whose plans are not in compliance with the Act. Termination of federal funding to states is a draconian remedy, one that DHHS has rarely used over the 50-year history of Medicaid. As noted by the United States when it opposed certiorari when the issue before the Court was first raised in 2011: "[P]rograms in which the drastic measure of withholding all or a major portion of federal funding if the only available remedy would be generally less effective than a system that also permits awards of injunctive relief in private actions." Brief for the United States as Amicus Curiae Opposing Certiorari at *19, Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., 572 F.3d 644 (9th Cir. 2009) on petition for cert. December 2010.[2] *See also Va. Office for Prot. & Advocacy v.*

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[2] As evidence that DHHS is "committed to ensuring that" Medicaid beneficiaries have meaningful access to covered services, the United States cites a regulation proposed by DHHS more than four years ago when the similar case, *Douglas v. Independent Living Center of Southern California*, Nos. 09-958, 09-1158, 10-283, was pending before the Court. U.S. Exceptional Child Ctr. Brief at *10

Stewart, 131 S. Ct. 1632, 1639 n. 3 (2011) ("The fact that the Federal Government can exercise oversight of a federal spending program and even withhold or withdraw funds—which are the chief statutory features respondents point to—does not demonstrate that Congress has displayed an intent not to provide the more complete and more immediate relief that would otherwise be available under *Ex parte Young*.") (citation omitted)).

Despite the position taken here, the United States has elsewhere recognized that private enforcement complements the Secretary's oversight. This complementary role exists whether the particular statutory provision is enforceable through the Supremacy Clause or through section 1983. For example, in May 2011, Indiana enacted a statute that barred certain entities that perform abortions from participating in Medicaid. Medicaid-participating providers who were barred from providing services and Medicaid recipients who lost access to care filed suit in federal court arguing that the state law was preempted by a specific Medicaid Act provision and also that they had a federal right under 42 U.S.C. § 1983 to enforce the provision. The United States filed an amicus brief

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(citing Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342 (May 6, 2011)). The proposed regulation does not contain an enforcement scheme that would render the need for private enforcement unnecessary. And while issuance of a final regulation will hopefully provide guidance that states will follow, thereby decreasing noncompliance with the statutory requirement of rates sufficient to assure equal access, the regulation does not remove the necessity of private enforcement in situations where recalcitrant states continue to ignore the statutory mandate.

urging the court to enjoin implementation of the Indiana law. *See* Statement of Interest of the United States at *21-22, Planned Parenthood of Indiana, Inc. v. Commissioner of the Ind. State Dep't of Health, June 16, 2011 (S.D. Ind. No. 1:11-cv-00630-TWP-DKL). According to the United States, the recipients' and providers' request for injunctive relief was "particularly necessary" because "Indiana has expressed its view that operating a 'non-compliant program' is a 'lawful option for the State under the [Medicaid] statute,' so long as the State is willing to 'risk that the Secretary will turn off the funding spigot." *Id.* at *21-22; *see also, e.g.*, Brief for the United States as Amicus Curiae Supporting Respondents at *30, Blessing v. Freestone, 520 U.S. 329 (1997) (No. 95-1441) (arguing that private enforcement is "an important complement to the Secretary's necessarily macroscopic oversight of the State, by assuring that States carry out the specific duties" of the Social Security Act and arguing that federal-state cooperative program of the Social Security Act does not contain a statutory scheme that precludes private enforcement); Brief for the United States as Amicus Curiae Opposing Certiorari at *19, Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., 572 F.3d 644 (9th Cir. 2009) on petition for cert. December 2010 at *19 (No. 09-958) (arguing that limiting enforcement to agency review and withholding of funding "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."). *Cf. Chisholm v. Hood*, 110 F. Supp. 2d 499 (E.D. La. 2000) (ordering State to cover physical and related therapy services for Medicaid-eligible children six years

after CMS had informed the State that the Act required coverage of these services).

Nor do the private parties have another adequate remedy, despite some suggestions to the contrary. *See PhRMA*, 538 U.S. at 675 (Scalia, J., concurring). In *PhRMA*, Justice Scalia suggested that the plaintiffs only remedy for a violation of the Medicaid Act is to ask the Secretary to terminate federal funding and thereafter file an Administrative Procedure Act action if they are dissatisfied with the outcome. *Id.* at 675 (citing 5 U.S.C. § 706(2)(A)). However, there is no such administrative and appeal process for Medicaid beneficiaries to seek termination of federal funds scheme, *see* 42 U.S.C. § 1316 (citing § 1396c). Federal regulation allows a state to obtain administrative and judicial review when it is dissatisfied with the denial of a state plan amendment or federal withhold of funding. *See* 42 C.F.R. §§ 430.30-430.104. Only CMS and the state are automatic parties to the administrative hearing, *id.* at § 430.76, and only the state has a right to judicial review, *id.* at § 430.38. The regulation permits individuals to petition the federal agency for permission to participate in the hearing, but participation is within the discretion of the presiding officer at the hearing. *Id.* at § 430.76. The ability of a recipient or provider to seek permission to participate in a state's hearing before the Department is not a statutory scheme that displaces private enforcement. *See Rosado v. Wyman*, 397 U.S. 397, 406 (1970) (refusing to attach significance to the fact that HEW (predecessor to DHHS) was engaged in a study of the issues before the Court or to impose an "exhaustion of administrative remedies" requirement, noting that under the regulations recipients could not "have

obtained an administrative ruling since HEW has no procedures whereby welfare recipients may trigger and participate in the Department's review of state welfare programs."); *Almenzares v. Wyman*, 453 F.2d 1075, 1087 (2d Cir. 1971) (finding administrative petition scheme inadequate because of the "inability of welfare recipients to trigger such a proceeding, along with the natural reluctance of HEW to embark on a course that could lead to withdrawal of federal aid"); *Ariz. Dep't of Pub. Welf. v. Dep't of Health, Educ. & Welf.*, 449 F.2d 456. 464, n.9 (9th Cir. 1971) (finding courts without jurisdiction to hear petitions from welfare recipients because § 1361 limits review to petitions from states and suggesting recipients bring direct declaratory action in district court finding such a remedy "preferable to a judgment ordering the cessation of the flow of federal [welfare] funds"). *See also Wilder*, 496 U.S. at 514 n.12 (acknowledging position of United States that there is no remedy under the APA because the decision to accept a state's assurance is entrusted to agency discretion); *id.* at 521-22 (rejecting argument that an action against the Secretary under the APA forecloses private enforcement).

IV. PRIVATE ENFORCEMENT OF MEDICAID ACT PROVISIONS PURSUANT TO 42 U.S.C. § 1983 IS NOT AT ISSUE HERE.

Gonzaga Univ. v. Doe, 536 U.S. 273 (2002), clarified that private enforcement under 42 U.S.C. § 1983 is limited to federal statutes that create federal rights because they exhibit unambiguous congressional intent to benefit the individual plaintiff. The enforcement test under § 1983 is well-established, and § 1983 is not at issue here. As of December 2014, all of the federal

circuit courts of appeals, with the exception of the D.C. Circuit, have reviewed at least one § 1983 Medicaid case since *Gonzaga* was decided. Consistent with this Court's instruction, the courts have decided enforceability on a provision-by-provision basis. *See Blessing v. Freestone*, 520 U.S. 329, 342 (1997) ("Only when the complaint is broken down into manageable analytic bites can a court ascertain whether each separate claim satisfies the various criteria we have set forth for determining whether a federal statute creates rights."). Forty-one cases, reviewing the enforceability of 23 different Medicaid Act provisions, have been decided by courts of appeals since *Gonzaga*. There are no splits among the circuits.[3] *See* National Health Law Program, *Update on Private Enforcement of the Medicaid Act* (Oct. 2014), http://www.healthlaw.org/publications/browse-all-publications/Issue-brief-medicaid-supremacy-clause#.VIC2VsmRKng.

CONCLUSION

For the foregoing reasons, *Amici Curiae* respectfully request the Court to affirm the judgment of the circuit court.

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[3] Unlike other appellate courts, in a decision post-dating *Gonzaga*, the Eighth Circuit allowed enforcement of 42 U.S.C. § 1396a(a)(30)(A) in a law-of-the-case decision that was vacated on other grounds. *Pediatric Specialty Care v. Ark. Dep't of Human Servs.*, 443 F.3d 1015 (8th Cir. 2006), *vacated on other grounds Selig v. Pediatric Specialty Care*, 551 U.S. 1142 (2007). *See Minn. Pharm Ass'n v. Pawlenty*, 690 F. Supp. 2d 809, 820-21 (D. Minn. 2010).

Respectfully submitted,

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