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 FOR FORMER HHS OFFICIALS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

MATTHEW M. HOFFMAN
ANDREW KIM
GOODWIN PROCTER LLP
901 New York Ave., N.W.
Washington DC 20001
(202) 346-4000

STEPHEN I. VLADECK
Counsel of Record
4801 Mass. Ave., N.W.
Washington, DC 20016
svladeck@wcl.american.edu
(202) 274-4241

Counsel for Amici Curiae

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INTEREST OF *AMICI CURIAE*

Amici curiae listed in the Appendix are former senior officials of the Department of Health and Human Services ("HHS") or its predecessor, the Department of Health, Education, and Welfare ("HEW").[1] Each of the *amici* exercised direct control over the administration of Medicaid, provided legal counsel about Medicaid's implementation, or advised the Secretary of HHS or HEW on Medicaid policy.[2] *Amici* hold different views about various aspects of the Medicaid Act and its enforcement,[3] but we come together in this case to respond to the brief filed by the United States as *amicus curiae* in support of petitioners (hereinafter "Gov't Br."). As the Government acknowledges, this Court has entertained nonstatutory injunctive claims based on preemption in certain circumstances, whether grounded in the Supremacy

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[1] The parties' blanket consents to the filing of *amici curiae* briefs are on file with the Clerk. No counsel for a party authored any part of this brief; no party or party's counsel made a monetary contribution intended to fund the preparation or submission of this brief; and no person other than *amici curiae* or their counsel made a monetary contribution to the brief's preparation or submission.

[2] HEW was bifurcated into the Department of Education and the Department of Health and Human Services in 1979. The Centers for Medicare and Medicaid Services ("CMS")—the HHS agency that administers Medicaid—was known as the Health Care Financing Administration ("HCFA") from its inception in 1977 until 2001. References to these agencies in this brief reflect their name at the relevant time.

[3] Although there is no single "Medicaid Act," this Court has often used that term to refer collectively to the Medicaid program's statutory provisions. See, *e.g.*, *Wos* v. *E.M.A. ex rel. Johnson*, 133 S. Ct. 1391, 1399 (2013). For ease of reference, *amici* will follow that practice here.

Clause, general equitable jurisprudence, or other legal principles. Gov't Br. 16–21. The Government assumes that such causes of action are properly available in a variety of circumstances "to vindicate the supremacy of federal law," *id.* at 21, but argues that no such cause of action should be recognized to permit Medicaid providers to enforce the "equal access" provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A) (hereinafter "Section 30(A)"). In the collective experience of *amici*, the arguments advanced by the Government in this case are at odds with HHS's longstanding administrative practice and understanding of the Medicaid Act. Furthermore, if the Court were to adopt the Government's cramped view, it would seriously undermine enforcement of one of Medicaid's most fundamental provisions. *Amici* therefore urge the Court to affirm the judgment below.

STATEMENT

A. Medicaid's Statutory Framework

"Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder* v. *Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). As part of this arrangement, a participating state submits to HHS a detailed "plan for medical assistance," which describes the intricacies of how a Medicaid program is to be administered in that state and how the proposed program will comply with the terms of the Act. *Ibid.*; see also 42 U.S.C. § 1396a(a); 42 C.F.R. § 430.10. In exchange, that state receives reimbursement from the federal government for a substantial

portion of the costs of administering the plan. See 42 U.S.C. § 1396d(b); 42 C.F.R. § 433.10(b).

The Medicaid Act requires a state plan to comply with numerous substantive requirements. The Secretary of HHS and her designees determine compliance in the first instance by deciding whether to approve the plan (or any amendments thereto).[4] Once the plan has been approved, however, the Secretary's options for ensuring continued compliance are limited. The Secretary can initiate a compliance proceeding and withhold funding.[5] But that creates a risk that individuals who depend upon Medicaid will be denied service. Thus, compliance proceedings are a drastic remedy that the agency rarely pursues. Instead, as discussed below, HHS has historically relied on private enforcement as a central means of ensuring compliance with various Medicaid provisions.

B. The Equal Access Mandate

One of Medicaid's most important requirements is the "equal access" mandate, which requires state plans to be designed—and payment levels set—to ensure that Medicaid beneficiaries have access to the same type of care and quality enjoyed by the general population. This mandate is currently codified as Section 30(A), which provides that a state Medicaid 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

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[4] 42 U.S.C. §§ 1316(a)-(b); 42 U.S.C. § 1396a(b); 42 C.F.R. § 430.10.

[5] 42 U.S.C. § 1396c; 42 C.F.R. § 430.35.

> 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).

Although Section 30(A) was not enacted in this form until 1989, the basic principle of equal access has been implicit in the statutory scheme since Medicaid's inception and was recognized by HEW in the early days of the program. As originally enacted in 1965, the Medicaid Act provided that medical assistance provided under a state plan "shall not be less in amount, duration, or scope than the medical or remedial care and services made available to individuals not receiving aid or assistance under any such plan." Social Security Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 345. That principle began taking a more tangible form in 1966, when HEW included the prototype for what became Section 30(A) in its Public Assistance Administration Handbook.[6] In 1971, HEW issued a regulation requiring state plans to "[p]rovide that fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent that these are available to the general population." 45 C.F.R. § 250.30(a)(5)

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[6] See *DeGregorio* v. *O'Bannon*, 500 F. Supp. 541, 549 n.13 (E.D. Pa. 1980).

(1972). And in 1978, HEW reinforced the equal access regulation by issuing a self-governing rule requiring adequate reimbursement for providers. See 43 Fed. Reg. 45,176, 45,258 (Sept. 29, 1978).[7]

Congress ultimately codified the equal access provision in 1989. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a), 103 Stat. 2106, 2260. It did so in light of the fear that physicians would not participate as Medicaid providers unless reimbursement rates were at least somewhat on par with the rates charged by non-Medicaid providers in a geographic area. See H.R. Rep. No. 101-247, 101st Cong., 1st Sess. 390 (1989).[8] Though the wording of the provision differed slightly from its regulatory predecessors, the promise remained the same: Medicaid beneficiaries would have a statutory right to the same type of care and quality enjoyed by the general population—a right that would be vindicated by requiring adequate reimbursement levels for providers.

SUMMARY OF ARGUMENT

Since the early days of the Medicaid program, federal courts have recognized that providers may sue to ensure that state Medicaid plans conform to the requirements of federal law. Congress intended for such enforcement, and HHS has understood—and come to rely upon—its existence.

In *Wilder* v. *Virginia Hospital Ass'n*, 496 U.S. 498 (1990), the Court relied on this past practice and understanding in holding that a former provision of the

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[7] This rule is still in force. See 42 C.F.R. § 447.204.

[8] See also Abigail R. Moncrieff, Comment, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. Chi. L. Rev. 673, 686 (2006).

Medicaid Act similar in structure to Section 30(A) could be enforced under 42 U.S.C. § 1983. Although the issue here is whether a nonstatutory right of action under the Supremacy Cause should be recognized to enforce Section 30(A) (as opposed to a § 1983 action), the reasoning of *Wilder* is still instructive. Applying *Wilder*'s reasoning to the equal access provision reveals Section 30(A) imposes a mandate on states that, if violated in a manner that causes injury to providers and beneficiaries, can be enforced through the Supremacy Clause.

Not only has HHS historically understood and accepted that the Medicaid Act is privately enforceable, it has come to rely on that fact. Every aspect of the Department's administration of the Medicaid program—from its regulations to its annual budget—is premised on the understanding that private parties will shoulder much of the enforcement burden. CMS lacks the logistical and financial resources necessary to be the exclusive enforcer of the equal access mandate, and it is highly unlikely to receive the necessary resources in the future. Moreover, exclusive enforcement conflicts with the agency's regulatory priorities. Given that the Department's focus has always been to promote cost-savings and efficiency, charging HHS with the sole responsibility of ensuring the quality of care and availability of access—factors that *increase* the program's costs—makes little sense as a matter of practice or policy.

The Government also suggests Section 30(A) cannot be judicially administered because its standards are too vague and ambiguous. That argument is belied by the body of Section 30(A) caselaw. Judges have competently interpreted the provision for decades and will continue to do so, particularly if a state

challenges the Secretary's decision to reject a plan for violating Section 30(A)—the very approach the Government argues for in lieu of private enforcement. Nor does private enforcement endanger HHS's expert role in administering Medicaid; should a court's interpretation of an ambiguous term in Section 30(A) conflict with the agency's, HHS will always prevail.

Finally, there is little merit to the Government's suggestion that the Medicaid Act's status as a Spending Clause statute militates against provider enforcement. Although Spending Clause laws are somewhat analogous to contracts, that does not mean only contractual principles are to be applied in interpreting such laws. And even under traditional principles of contract law, beneficiaries and providers can hardly be called "incidental" beneficiaries of the Medicaid Act.

ARGUMENT

I. Congressional Intent, This Court's Caselaw, and Historical Practice Support the Conclusion That Section 30(A) Is Privately Enforceable

The Government argues that this Court has never squarely decided if a nonstatutory cause of action for equitable relief based on preemption should be available, yet acknowledges that the Court has entertained such claims in a variety of contexts. Gov't Br. 15–21. It then proceeds on the assumption that "a nonstatutory cause of action is properly available to vindicate the supremacy of federal law in certain . . . circumstances." *Id.* at 21. The Government therefore implicitly concedes that there are cases in which private parties may seek equitable relief on preemption grounds despite the absence of a specific statutory

cause of action (such as enforcement under 42 U.S.C. § 1983). It simply contends there is no cognizable private right of action to enforce Section 30(A).

Amici agree that a nonstatutory equitable cause of action to enforce the primacy of federal law—whether "rooted in general equitable jurisprudence, . . . the Supremacy Clause, or otherwise"—should be available in some circumstances.[9] Gov't Br. 21. Private enforcement of key provisions of the Medicaid Act is—and has long been understood to be—one of those circumstances.

Indeed, there is a long history of providers suing in federal court to ensure that state plans conform to the Medicaid Act's requirements. This Court recognized that history in *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), holding that "it is clear . . . Congress intended that health care providers be able to sue in federal court for injunctive relief" to enforce provisions of the Medicaid Act that affect provider reimbursement. *Id.* at 516. As the Court observed, citing numerous examples, provider suits were legion in the 1970s. *Id.* at 516 & n.14.

The provider actions cited in *Wilder* were brought prior to *Maine* v. *Thiboutot*, 448 U.S. 1 (1980), which held that § 1983 could be used to remedy violations of federal statutory rights (as well as constitutional rights). See *id.* at 5–6. As a result, these early provider suits were not brought under § 1983, but relied

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[9] *Amici* agree that the Medicaid Act does not provide an express cause of action nor one that can be implied in accordance with *Cort* v. *Ash*, 422 U.S. 66 (1975). As discussed below, however, the Act confers clearly discernible *rights* that may be vindicated through various causes of action, such as § 1983, the Supremacy Clause, or other nonstatutory equitable vehicles.

on a variety of other theories. See *St. Mary's Hosp. of E. St. Louis, Inc.* v. *Ogilvie*, 496 F.2d 1324, 1325 (7th Cir. 1974) (noting the suit was filed "under Title XIX of the Social Security Act"); *Catholic Med. Ctr. of Brooklyn & Queens, Inc.* v. *Rockefeller*, 430 F.2d 1297, 1298 (2d Cir. 1970) (assuming, without deciding, that the Supremacy Clause is the proper vehicle for a provider challenge).

The legislative history of various amendments to the Medicaid Act over the years shows that Congress understood and expected that providers would be able to compel state compliance by enforcing federal law. One example comes from the history of a 1975 statute abrogating Eleventh Amendment immunity for states implementing Medicaid. See H.R. Rep. No. 94-1122, 94th Cong., 2d Sess. 3 (1976). Prior to the abrogation provision's enactment, states would unilaterally delay payments to providers and freeze rates without HEW approval. *Id.* at 4. HEW was slow to react. *Ibid.* Congress recognized that, in these circumstances, "providers could sue the State to enjoin action" but had no recourse for obtaining retrospective damages. *Ibid.* It therefore passed a provision "requiring States to consent to be sued in the Federal courts on issues relating to the payment of reasonable cost." *Ibid.* These money-damages suits, however, became cumbersome and hindered the efficiency of state programs. *Ibid.* So Congress repealed the abrogation in 1976, disallowing further claims for monetary relief. But it deliberately kept intact provider suits for injunctive relief. *Id.* at 7 (statement of Marjorie Lynch, Undersecretary of HEW) ("[P]roviders can continue, of course, to institute suit for injunctive relief in State or Federal courts, as necessary.").

Four years after the abrogation provision's repeal, Congress enacted the Boren Amendment, which required state plans to provide for rates that the states found to be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." *Wilder*, 496 U.S. at 501–502 (citation and internal quotation marks omitted). In doing so, Congress expressed its intent for judicial review to continue to serve as a backstop for Medicaid enforcement, despite the Secretary's own authority. See H.R. Rep. No. 97-158, 97th Cong., 1st Sess. 301 (1981) ("Of course, in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action.").[10] Congress repealed the Amendment in 1997. But the legislative history of the repeal reflected an understanding that this action would not affect private enforcement of other Medicaid provisions such as Section 30(A). See *Welfare and Medicaid Reform: Hearings Before the S. Comm. on Fin.*, 104th Cong., 2d Sess. 131 (1996) (statement of the Honorable Donna Shalala, Secretary of HHS) (noting the repeal of the Boren Amendment "does not undermine beneficiaries' ability to enforce their Federal guarantee to coverage and benefits").

In 1994, the Court amended the Social Security Act ("SSA")—of which the Medicaid Act is a part—in response to this Court's decision in *Suter* v. *Artist M.*,

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[10] *See also* Edward Alan Miller, *Federal Administrative and Judicial Oversight of Medicaid: Policy Legacies and Tandem Institutions Under the Boren Amendment*, 38 Publius 315, 321–326 (2008) (summarizing widespread judicial enforcement of the Boren Amendment).

503 U.S. 347 (1992). *Suter* held that the "reasonable efforts" requirement imposed on state adoption plans by the Child Welfare Act of 1980 did not confer rights that could be enforced through § 1983. *Id.* at 364. Congress responded by enacting 42 U.S.C. § 1320a-2, which provides that, "[i]n an action brought to enforce a provision of the [SSA], such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan." The statute further specified that it was "not intended to limit or expand the grounds *for determining the availability of private actions to enforce State plan requirements* other than by overturning any such grounds applied in *Suter* . . . but not applied in prior Supreme Court decisions respecting such enforceability." *Ibid.* (emphasis added). Contrary to the Government's argument, Gov't Br. 29–30, this language makes clear that Congress did not intend to disturb the status quo, which—as discussed above—unquestionably recognized the availability of private actions to enforce Medicaid provisions.[11]

Although *Wilder* addressed whether the Boren Amendment was enforceable under § 1983, rather than through a nonstatutory action under the Supremacy Clause, its reasoning is nonetheless instructive in demonstrating why providers are proper parties to bring the instant action. *Wilder*'s reasoning

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[11] The only door that § 1320a-2 kept shut was one that the *Suter* Court had closed: the Child Welfare Act's "reasonable efforts" provision would continue to provide no privately enforceable federal right. 42 U.S.C. § 1320a-2 ("[T]his section is not intended to alter the holding in [*Suter*] that [the "reasonable efforts" provision] is not enforceable in a private right of action.").

also shows that Section 30(A) accords rights for providers to vindicate through the Supremacy Clause. The Boren Amendment was structurally similar to the current Section 30(A) in that it imposed requirements on payment levels to providers. That structure yielded a part procedural, part substantive right: a right to "the adoption of reimbursement rates that are reasonable and adequate to meet the costs of an efficiently and economically operated facility that provides care to Medicaid patients." *Wilder*, 496 U.S. at 510; see *ibid.* ("The right is not merely a procedural one that rates be accompanied by findings and assurances (however perfunctory) of reasonableness and adequacy; rather the Act provides a substantive right to reasonable and adequate rates as well."). Like the Boren Amendment, the equal access mandate (1) creates a part procedural, part substantive right—*i.e.*, the right to equal access and the procedures to safeguard that access; (2) gives states a large amount of discretion; (3) has the Secretary play a role in oversight; and (4) contains broad, discrete factors for states, the Secretary, and the judiciary to balance in determining whether a plan provides "equal access."

Because of these structural similarities, myriad courts (including the First, Third, Fifth, and Eighth Circuits) held that Section 30(A) could be enforced under § 1983 in the wake of *Wilder*.[12] Following *Gon-*

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[12] See, *e.g.*, *Pa. Pharmacists Ass'n* v. *Houstoun*, 283 F.3d 531 (3d Cir. 2002) (en banc) (Alito, J.); *Evergreen Presbyterian Ministries, Inc.* v. *Hood*, 235 F.3d 908 (2000), *overruled by Equal Access for El Paso, Inc.* v. *Hawkins*, 509 F.3d 697 (5th Cir. 2007); *Visiting Nurse Ass'n of N. Shore, Inc.* v. *Bullen*, 93 F.3d 997 (1996), *overruled on other grounds by Long Term Care*

zaga University v. *Doe*, 536 U.S. 273 (2002), courts have divided on whether § 1983 is an appropriate vehicle for enforcement of Section 30(A). The Eighth Circuit has held that § 1983 remains an appropriate vehicle,[13] while the First, Fifth, Sixth, and Ninth Circuits have held that § 1983 is not available as an enforcement tool because of *Gonzaga*.[14] But the Ninth Circuit properly held in this case that even if § 1983 is not a proper enforcement vehicle, such a holding does not preclude private enforcement through appropriate nonstatutory causes of action, like those employed in the cases discussed in *Wilder*. Pet. App. 2–3; see also *Indep. Living Ctr. of S. Cal.* v.

Pharmacy Alliance v. *Ferguson*, 362 F.3d 50 (1st Cir. 2004); *Ark. Med. Soc'y, Inc.* v. *Reynolds*, 6 F.3d 519 (8th Cir. 1993).

[13] See *Pediatric Specialty Care, Inc.* v. *Ark. Dep't of Human Servs.*, 443 F.3d 1005 (8th Cir. 2006), *judgment vacated in part on other grounds by Selig* v. *Pediatric Specialty Care, Inc.*, 551 U.S. 1142 (2007).

[14] See, *e.g.*, *Mandy R.* v. *Owens*, 464 F.3d 1139 (10th Cir. 2006); *Westside Mothers* v. *Olszewski*, 454 F.3d 532 (6th Cir. 2006); *Sanchez* v. *Johnson*, 416 F.3d 1051 (9th Cir. 2005); *Long Term Care Pharmacy Alliance* v. *Ferguson*, 362 F.3d 50 (1st Cir. 2004). These courts treated *Wilder* as anomalous, misperceiving the decision as addressing a one-off provision requiring "States to pay an 'objective' monetary entitlement to individual health care providers," *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 280 (2002), a description in considerable tension with *Wilder* itself. *Wilder*, 496 U.S. at 510. Cf. *Mandy R.*, 464 F.3d at 1148 (describing *Gonzaga*'s treatment of *Wilder* as a recharacterization of the right in question). To the circuits finding no right under § 1983, *Gonzaga* has been viewed as license to disregard past precedent. *Long Term Care*, 362 F.3d at 59 ("If *Gonzaga* had existed prior to *Bullen*, the panel could not have come to the same result. Whether *Gonzaga* is a tidal shift or merely a shift in emphasis, we are obligated to respect it, and it controls this case.").

Maxwell-Jolly, 572 F.3d 644, 653–654 (9th Cir. 2009) (discussing the continued vitality of Supremacy Clause actions to enforce Section 30(A), even in light of Ninth Circuit caselaw barring enforcement through § 1983), *vacated and remanded sub. nom. Douglas* v. *Indep. Living Ctr. of S. Cal.*, 132 S. Ct. 1204 (2012). The long history of private enforcement and Congress's repeated indications that it expected such enforcement strongly suggest that, at a minimum, a direct action under the Supremacy Clause should be available to enforce the equal access mandate.

II. Because HHS Has Presumed Private Enforcement of the Medicaid Act, the Agency Cannot Realistically Enforce the Act Alone

Unsurprisingly, beneficiaries and providers have consistently relied on the presumption that the equal access provision can be privately enforced. But so too has HHS. Every aspect of the enforcement scheme—starting with the regulations the Department promulgates down to the annual budget for Medicaid administration—is shaped around the understanding that private parties will shoulder much of the enforcement burden. Not only is the Government's suggestion that Congress intended Section 30(A) to be exclusively enforced by HHS logistically unfeasible, it is belied by the limited regulatory scheme currently in place.

A. HHS's Scant Administrative Resources For Implementing the Medicaid Program Reflect the Department's Understanding That Its Enforcement Role Is Limited

HHS has fewer than 500 employees devoted to administering over $300 billion in federal funds for 56 state-level Medicaid programs.[15] Out of necessity, most of HHS's employees are tasked with bookkeeping and routine management of Medicaid funds at the state level. Few are responsible for the review of state plans and plan amendments for Section 30(A) compliance.

HHS cannot afford to be the exclusive enforcer of the equal access mandate. As of the most recent fiscal year, CMS has $156 million to administer Medicaid—a $304-billion program in which 20% of Americans are enrolled. Centers for Medicare & Medicaid Services, *Financial Report: Fiscal Year 2014*, at 6, 60 (2014) ("*FY 2014 CMS Report*"). In other words, CMS has less than $2.44 per beneficiary to coordinate with 56 states and territories in implementing and overseeing a complex scheme of benefits. And while the Medicaid program receives hundreds of billions of dollars each year, the vast majority of that money is committed to funding services—i.e., "mandatory" spending that cannot be used for administrative costs, which fall under the category of "discretionary" spending and must therefore be appropriated on an annual basis by Congress.

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[15] All 50 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands administer a Medicaid program.

But even if HHS sought to increase such appropriations, expanding CMS's administrative budget would be no easy task. CMS must annually compete with nine other agencies—including agencies far more likely to be the subject of congressional munificence such as the Centers for Disease Control, the Food and Drug Administration, and the National Institutes of Health—for a limited pool of discretionary funds.

Moreover, recent events suggest HHS is highly unlikely to increase CMS's administrative budget for more robust enforcement of Section 30(A). Since this Court's decision in *Douglas* v. *Independent Living Center*, 132 S. Ct. 1204 (2012), 27 states and the District of Columbia have voluntarily expanded their Medicaid programs pursuant to the Affordable Care Act. That expansion, in turn, increased federal Medicaid outlays by $40 billion. Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2014 to 2024*, at 10 (Aug. 2014). But despite the sharp spike in costs and total number of covered beneficiaries, CMS's administrative budget went *down* by $11 million compared to the previous fiscal year. See *FY 2014 CMS Report*, *supra*, at 61 (listing the fiscal year 2013 Medicaid administrative budget as $167 million).

And even if HHS suddenly shifted gears and directed its sparse resources to ensuring equal access, those resources would yield poor dividends. The Government gives the misleading impression that HHS uses its extensive expertise to carefully comb through the substance of a state's proposed plan or plan amendment to assess the level of access. Gov't Br. 24. The reality is that the review process is "cursory at best . . . limited to whether the 'documenta-

tion submitted by the State Medicaid Agency complies with procedural requirements,'" *Amisub (PSL), Inc.* v. *Colo. Dep't of Soc. Servs.*, 879 F.2d 789, 794 (10th Cir. 1989), partly owing to the fact that the Department has limited resources.

Manpower aside, HHS's enforcement mechanisms are either ineffective or rarely used. The plan approval process, for instance, is of questionable value in the rate reduction context. Though states are not to implement rate reductions before CMS has an opportunity to formally accept or reject a plan amendment, some do so anyway because the cuts do not require additional federal funds. See, *e.g.*, *Cmty. Pharmacies of Ind., Inc.* v. *Ind. Family & Soc. Servs. Admin.*, 816 F. Supp. 2d 570, 577 (S.D. Ind. 2011) (rejecting providers' suggestion that Indiana needed to wait for plan approval before implementing a rate reduction).[16] In any event, HHS is generally reluctant to pursue a compliance action while a state's plan amendment is pending approval. Instead, it attempts to preserve the status quo by deferring any payments required under the amendment until the approval process is complete. *Id.* at 578.

There is good cause for this reluctance. The "stick" of withholding funds that accompanies a compliance action ultimately does not punish the state, but the very people the Medicaid Act is meant to benefit. See

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[16] See Julia Bienstock, Note, *Administrative Oversight of State Medicaid Payment Policies: Giving Teeth to the Equal Access Provision*, 39 Fordham Urb. L.J. 805, 831 (2012) (concluding that the plan approval process is not an "effective tool[] for ensuring state compliance with the equal access provision . . . because states do not require additional federal matching dollars when they decrease rates").

Pennhurst State Sch. & Hosp. v. *Halderman*, 451 U.S. 1, 52 (1981) (White, J., dissenting) (explaining a reluctance to declare that an agency's ability to withhold funds necessarily forecloses a private right of action, as "a funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act").[17] And once a compliance action is initiated, the Secretary has no choice but to withhold. See 42 U.S.C. § 1396c ("[T]he Secretary *shall* notify such State agency that further payments will not be made to the State . . . ." (emphasis added)). Therefore, a compliance action is an effective enforcement mechanism only in theory. In practice, a state's non-compliance creates a damned-if-you-do, damned-if-you-don't scenario where the withholding of state funds will lead to depriving the poor of essential medical assistance.[18] As this Court explained in *National Federation of Independent Business* v. *Sebelius*, 132 S. Ct. 2566 (2012), the Secretary's ability to

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[17] See Brian J. Dunne, Comment, *Enforcement of the Medicaid Act Under 42 USC § 1983 after* Gonzaga University v. Doe: *The "Dispassionate Lens" Examined*, 74 U. Chi. L. Rev. 991, 994–995 (2007) (explaining the "general reluctance by federal agencies to police states by withholding program funding" as applied to CMS and Medicaid). Cf. *Arthur C. Logan Mem'l Hosp.* v. *Toia*, 441 F. Supp. 26, 27 (S.D.N.Y. 1977) ("The Secretary can withhold payment or he can negotiate with a State. He cannot compel compliance.").

[18] See Br. of the United States as *Amicus Curiae* at 13 n.11, *Exeter Mem'l Hosp. Ass'n* v. *Belshe*, 943 F. Supp. 1239 (E.D. Cal. 1996) (No. 96-693) ("A compliance action, which results in the withholding of [federal funds], has a potentially detrimental effect on Medicaid recipients and providers. If HCFA were to withhold [funds] pursuant to a compliance action, recipients may well be deprived of medical assistance because the State may no longer be able to provide certain services.").

withhold all of a state's Medicaid funding is akin to a "gun to the head," in light of its essential role in the "intricate statutory and administrative regimes [developed by the states] over the course of many decades to implement their objectives under existing Medicaid." *Id.* at 2604.

B. HHS's Priorities Conflict With the Government's Position That the Department Should Be Solely Responsible for Enforcing the Entire Equal Access Mandate

HHS has historically viewed only one half of the equal access mandate as within its charge: the promotion of "economy" and "efficiency." The Department carries out these twin belt-tightening objectives by enforcing regulations such as the upper payment limit, "a Medicaid payment ceiling based on expenses that would be allowed under Medicare payment rules." *Minnesota* v. *CMS*, 495 F.3d 991, 994 (8th Cir. 2007); see also *Alaska Dep't of Health & Soc. Servs.* v. *CMS*, 424 F.3d 931, 935 (9th Cir. 2005) (explaining that "[Section] 30(A) has been the principal statutory authority for a series of upper payment limit [] regulations that cap state reimbursement rates to promote economy and efficiency" (citation and internal quotation marks omitted)). What follows is a plan approval process where "CMS often withholds approval of [state plan amendments] that seek to increase reimbursement rates in violation of Section 30(A) and the [upper payment limit],"[19] but

[19] Bienstock, *supra* note 16, at 832.

does nothing to block state efforts to *reduce* reimbursement rates.[20]

In the rare instance where HHS does intervene in a state's attempt to lower reimbursement rates, the Department's process of addressing its concerns is an informal one.[21] Indeed, a proposed rule interpreting Section 30(A) shows HHS not only tolerates state cost-cutting efforts, but encourages them to the point where the Department will not stand in the way of the states. Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342, 26,343 (May 6, 2011) ("Achieving best value has been a key strategy for some States that have attempted to reduce costs in the Medicaid program. . . . We do not intend to impair States' ability to pursue that goal."). The rule also illustrates HHS's *lack* of interest in the equal access mandate's other requirements—namely, "quality of care" and sufficiency of access. Though the rule provides a framework for evaluating these criteria, that framework gives states considerable leeway and is part of a state's *self-conducted* access review. *Id.* at 26,345.[22]

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[20] Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. Davis L. Rev. 413, 462 (2008).

[21] Br. of the Sec'y of Health & Human Servs. as *Amicus Curiae* at 12, *Clark* v. *Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990) (No. 87-1700) ("HHS regional officials have sought to monitor and promote access through informal processes, principally by raising the issue of the adequacy of rates in meetings and correspondence with state authorities.").

[22] See also 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, 837–838 (2012) (explaining that "the most impactful decisions

The current and proposed regulations implementing the equal access mandate only further evince HHS's understanding that it is not the exclusive (or even primary) safeguard for ensuring every aspect of the mandate. HHS's limited enforcement resources and its budget are accordingly rooted in—and reflective of—that understanding, rendering exclusive enforcement entirely unfeasible. The Government's position would therefore eviscerate one of the Medicaid Act's central mandates.

III. The Government's Other Arguments Are Without Merit

A. The Equal Access Provision Is Judicially Administrable

The Government also argues against private enforcement of Section 30(A) on the ground that its standards are too vague and ambiguous to be judicially enforced. This Court rejected a similar contention in *Wilder*, and it should likewise reject the Government's argument here.

First, this Court has already concluded judges are competent at weighing broad factors nearly identical to the ones in Section 30(A). In *Wilder*, the Court observed the Boren Amendment required evaluation of four criteria: two objective, two subjective. "Efficiency" and "economy" were considered parts of an "objective benchmark" integral to the ratemaking analysis. See 496 U.S. at 519. "Reasonableness" and "adequacy" were subjective considerations that gave the

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with respect to the quality of the rate-setting process . . . are all left to state discretion" and that the "guidance and discussion" provided by the proposed rule are "merely advisory").

states "substantial discretion in choosing among reasonable methods of calculating rates." *Id.* at 519–520. Despite the general nature of the terms used to set forth these criteria, the Court found review of such qualities to be "well within the competence of the Judiciary." *Id.* at 520.

Section 30(A) presents a similar combination of objective and subjective components. The terms used by Section 30(A) are no more "vague and amorphous" than the ones found judicially administrable by the *Wilder* Court. "Efficiency" and "economy" are objective touchstones, as they were in the Boren Amendment. Judges can refer to HHS's established standards for discerning whether a plan is efficient and economical. See*, e.g.*, 42 C.F.R. § 447.272(b).

The statute also allows for subjective considerations subject to state discretion, e.g., the relative "quality of care" and the rate levels that would "enlist" a sufficient number of providers. And again, judges can follow whatever standards HHS selects for determining whether a state plan meets these criteria. Cf. 76 Fed. Reg. at 26,344 (proposing a "three-part framework for analyzing access to care which . . . considers: (1) Enrollee needs; (2) the availability of care and providers; and (3) utilization of services."

Second, the weight of Section 30(A) caselaw proves judges can competently decide whether the provi-

sion's terms have been satisfied.[23] The existence of *any* meaningful body of caselaw undercuts the Government's argument.

Indeed, in the immediate wake of the equal access mandate's enactment, HHS not only acquiesced to judicial administration of Section 30(A), it actively participated in the process. See, *e.g., Clark* v. *Kizer*, 758 F. Supp. 572, 576 (E.D. Cal. 1990) (describing the "multi-factor approach for measuring compliance with the equal access regulation" proposed by HHS in an amicus brief), *rev'd and remanded on other grounds sub nom. Clark* v. *Coye*, No. 92-15131, 1992 WL 140278 (9th Cir. June 23, 1992). The Government, of course, is free to change its mind and contend that judicial administration of Section 30(A) is impossible. But the about-face is an untenable one, especially because the Government's position presupposes an uptick in litigation in which states challenge plan denials (or compliance proceedings) grounded in a violation of Section 30(A). The Government is, in essence, arguing that judges cannot "decide questions of compliance with Section 30(A)," because "different evidentiary records . . . [will] re-

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[23] See *Rite Aid of Pa., Inc.* v. *Houstoun*, 171 F.3d 842, 853–856 (3d Cir. 1999) (declaring a Pennsylvania plan to be arbitrary and capricious for giving "some of the section 30(A) factors more attention than others"); *Fla. Pharmacy Ass'n* v. *Cook*, 17 F. Supp. 2d 1293, 1301 (N.D. Fla. 1998) (determining there was a right to "enough providers" but the record did not evince a violation); *Stephens* v. *Childers*, No. 94-75, 1994 WL 761466, at *8 (E.D. Ky. Nov. 4, 1994) (enjoining a state plan because "[t]he defendants failed to assess the level of care available to the insured population"); *Ohio Hosp. Ass'n* v. *Ohio Dep't of Human Servs.*, 579 N.E.2d 695, 699 (Ohio 1991) (invalidating a state Medicaid law because "it [did] not meet the requirements of the Medicaid statute").

sult[] in different factual findings," Gov't Br. 25, though they have competently done so for decades, see, *e.g.*, *Christ the King Manor, Inc.* v. *Sec'y of U.S. Dep't of Health & Human Servs.*, 730 F.3d 291, 309–314 (3d Cir. 2013) (concluding HHS approval of a state plan was arbitrary and capricious because it failed to consider "quality of care"), and would continue to do so in the state appeals the Government's position would likely provoke.

It may well be true that a provider suing to enforce the equal access provision bears a heavy burden of proof. After all, HHS's enforcement framework gives states some leeway in making judgment calls about access. It is possible that a provider will prevail only in cases where there are "extreme disparities in access for Medicaid beneficiaries." 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, 825 (2012) (citing *Clark*, 758 F. Supp. at 580). But there is a world of difference between a case that is difficult to prove because the applicable framework sets a high bar, and one that is impossible to prove because there is no discernible framework at all. Cases addressing Section 30(A) clearly fall into the former category.

Finally, the Government errs by viewing private rights of action and agency oversight as competing, and not complementary, modes of enforcement. The "predictive and policy judgments" made by HHS in its "expert role" are doubtless deserving of deference. *See* Gov't Br. 14. Private enforcement of Section 30(A), however, does not mean this deference is abandoned or otherwise jeopardized. Courts *must* defer to HHS's reasonable interpretation of how to

discern "equal access," as with any other ambiguous language within the Medicaid Act.[24] HHS's role of applying its expertise and policy judgments is not compromised when judges follow the guideposts the Department erects.[25] See, *e.g.*, 42 C.F.R. § 447.253 (implementing Section 30(A)). And if courts interpret Section 30(A) before HHS has had an opportunity to weigh in, the Department is not bound by these prior judicial pronouncements. Cf. *Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 982–983 (2005) ("Only a judicial precedent holding that the statute unambiguously forecloses the agency's interpretation, and therefore contains no gap for the agency to fill, displaces a conflicting agency construction."). In no way is the agency's expert role endangered by allowing for private enforcement.

For many federally administered programs, the agency *should* be the exclusive enforcer of the statutory and regulatory scheme; uniformity is key to "avoid[ing] the comparative risk of inconsistent interpretations and misincentives that can arise out of an occasional inappropriate application of the statute in a private action for damages." *Gonzaga*, 536 U.S. at 292 (Breyer, J., concurring). But Medicaid is dif-

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[24] See, *e.g.*, *Pharm. Research & Mfrs. of Am.* v. *Thompson*, 362 F.3d 817, 821–822 (D.C. Cir. 2004); *West Virginia* v. *Thompson*, 475 F.3d 204, 212–213 (4th Cir. 2007); *Harris* v. *Olszewski*, 442 F.3d 456, 466–467 (6th Cir. 2006); *S.D. ex rel. Dickson* v. *Hood*, 391 F.3d 581, 595–596 (5th Cir. 2004).

[25] Given HHS's limited resources and its mission to promote efficiency and economy in state Medicaid programs, it is highly unlikely that HHS will promulgate regulations specifically defining the quality-of-care and sufficient-providers aspects of Section 30(A). See *supra* part II.

ferent. It is not a statutory scheme of single administration. Congress intended some discord when it rejected a single, harmonious federal system in favor of a patchwork of 56 different programs. Cf. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2629–2630 (Ginsburg, J., concurring in part and dissenting in part) ("Rather than authorizing a federal agency to administer a uniform national health-care system for the poor, Congress offered States the opportunity to tailor Medicaid grants to their particular needs, so long as they remain within bounds set by federal law."). As HHS has long understood, an essential part of what threads that patchwork together is the needle of private enforcement.

B. The Spending Clause Does Not Bar Private Enforcement of the Medicaid Act

Because the Medicaid Act is a Spending Clause law, the Government cryptically advances the analogy that Medicaid beneficiaries and providers are like incidental third-party beneficiaries to a contract, with no right to enforce the contract's terms. Gov't Br. 22. But that analogy does not hold up.

While this Court has held that Spending Clause legislation operates "*much* in the nature of a contract," *Pennhurst*, 451 U.S. at 17 (majority opinion) (emphasis added), that simply means states may agree to do things in exchange for federal funds that Congress could not compel them to do directly. This does not mean, however, that a Spending Clause law *is* a contract or that contract law principles should be unflinchingly applied to the interpretation of such laws. See *Westside Mothers v. Haveman*, 289 F.3d 852, 858 (6th Cir. 2002).

And in any event, contract law principles *support* provider enforcement of the equal access provision. It is untenable for the Government to say that providers are merely *incidental* beneficiaries, much like a bystander who benefits from a stroke of good fortune. See Restatement (Second) of Contracts § 302 cmt. e, illus. 16 (1981). The entire Medicaid framework is meant to address the needs of recipients and providers. Section 30(A) "evince[s] a congressional concern for preserving financial incentives to providers—by ensuring adequate reimbursement payment levels." *Visiting Nurse Ass'n of N. Shore, Inc.* v. *Bullen*, 93 F.3d 997, 1004 (1996), *overruled on other grounds by Long Term Care Pharmacy Alliance* v. *Ferguson*, 362 F.3d 50 (1st Cir. 2004). Therefore, even under contractual principles, providers are intended beneficiaries who should accordingly be able to enforce the Medicaid Act's terms—especially in actions, such as this one, seeking injunctive relief.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

MATTHEW M. HOFFMAN
ANDREW KIM*
GOODWIN PROCTER LLP
901 New York Ave., N.W.
Washington, DC 20001
(202) 346-4000

STEPHEN I. VLADECK
Counsel of Record
4801 Mass Ave., N.W.
Washington, DC 20016
svladeck@wcl.american.edu
(202) 274-4241

Counsel for Amici Curiae

December 23, 2014

* Admitted only in California. Application to the D.C. Bar is pending; practice supervised by Matthew M. Hoffman.

APPENDIX

List of *Amici Curiae*, Former HEW/HHS Officials

JODIE Z. BERNSTEIN
General Counsel, HEW (1979-1981)

HON. JOSEPH A. CALIFANO, JR.
Secretary, HEW (1977-1979)

RICHARD COTTON, PH.D.
Deputy Executive Secretary, HEW (1977-1978);
Executive Secretary, HEW (1978-1980)

PETER EDELMAN
Counselor to the Secretary, HHS (1993-1995);
Assistant Secretary for Planning and Evaluation, HHS (1995-1996)

JUDITH M. FEDER
Principal Deputy Assistant Secretary for Planning and Evaluation, HHS (1993-1995)

MICHAEL HASH
Deputy Administrator, HCFA (1998-2000);
Acting Administrator, HCFA (2000);
Director, HHS Office of Health Reform (2011-2014)

NAN D. HUNTER
Deputy General Counsel, HHS (1993-1996)

RENÉE M. LANDERS
Acting Deputy General Counsel, HHS (1996);
Deputy General Counsel, HHS (1996-1997)

KAREN POLLITZ
Deputy Assistant Secretary for Health Legislation, HHS (1993-1997);
Director, Office of Consumer Support, Center for Consumer Information and Insurance Oversight, CMS (2010-2011)

HARRIETT S. RABB
General Counsel, HHS (1993-2001)

DAVID SATCHER, M.D., PH.D.
U.S. Surgeon General (1998-2002);
Assistant Secretary for Health, HHS (1998-2001)

HON. DONNA E. SHALALA
Secretary, HHS (1993-2001)

HELEN L. SMITS, M.D.
Deputy Administrator, HCFA (1993-1996);
Chief Medical Officer, HCFA (1993-1996)

BRUCE C. VLADECK, PH.D.
Administrator, HCFA (1993-1997)

TIMOTHY M. WESTMORELAND
Director of Center for Medicaid and State Operations, HCFA (1999-2001)