No. 14-15

In The
Supreme Court of the United States

RICHARD ARMSTRONG AND LISA HETTINGER,

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 THE CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY AS AMICUS CURIAE SUPPORTING PETITIONERS

KAMALA D. HARRIS
Attorney General of California
EDWARD C. DUMONT
Solicitor General
KATHLEEN A. KENEALY
Chief Assistant Attorney General
JULIE WENG-GUTIERREZ
Senior Assistant Attorney General
GREGORY D. BROWN*
Deputy Solicitor General
SUSAN M. CARSON
Supervising Deputy Attorney General
JOSHUA N. SONDHEIMER
Deputy Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5461
Gregory.Brown@doj.ca.gov

**Counsel of Record*

QUESTION PRESENTED

Whether the Supremacy Clause gives Medicaid providers a private right of action to seek judicial intervention in the rate-setting process under 42 U.S.C. § 1396a(a)(30)(A) through suits against state officials, when Congress has not created privately enforceable rights under that statute.

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INTEREST OF AMICUS CURIAE[1]

The California Health and Human Services Agency (CHHS) oversees numerous state departments, boards, and offices, including the California Department of Health Care Services (DHCS), which administers the State's Medicaid program, known as Medi-Cal.

The Director of DHCS was the petitioner in *Douglas v. Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204 (2012), in which this Court granted certiorari on essentially the same question presented here, but did not decide the issue because of a change in circumstances after certiorari was granted. *Id.* at 1211. This issue remains exceptionally important to CHHS, DHCS, and other CHHS departments, as the Ninth Circuit continues to adhere to its pre-*Douglas* rule that the Supremacy Clause creates a private right of action to enforce 42 U.S.C. § 1396a(a)(30)(A) (§ 30(A)) against state officials, even though it is undisputed that Congress did not intend § 30(A) to create any privately enforceable rights. Pet. App. 2-3 (citing *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir.

[1] The parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made any monetary contribution intended to fund the preparation or submission of this brief. No person other than amicus curiae, the departments it oversees, and its counsel has made a monetary contribution to this brief's preparation or submission.

2008) (*ILC I*)). DHCS estimates that since *ILC I* was decided in 2008, injunctions based on § 30(A) claims brought under the Supremacy Clause have cost California more than $1.5 billion by precluding DHCS from implementing cost reductions that the federal government determined are perfectly consistent with federal law. DHCS is currently defending against a number of lawsuits raising such claims.

SUMMARY OF ARGUMENT

The Supremacy Clause does not create a private right of action to enforce § 30(A) because Congress designed this complex program to be administered and enforced cooperatively by state officials and the federal Centers for Medicare & Medicaid Services (CMS) – not through individual lawsuits by private parties.[2] CHHS generally agrees with the arguments on that point set forth by petitioners and amici curiae the State of Texas, et al. This brief seeks to elaborate on two points.

1. The Court need not decide the broader question whether the Supremacy Clause can ever create a private right of action, as it is sufficient to decide this case on the narrower ground that the Supremacy

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[2] CMS is a division of the federal Department of Health & Human Services (HHS), and HHS has delegated to CMS the responsibility and authority to administer the Medicaid program. *See*, *e.g.*, 42 C.F.R. § 430.15(b).

Clause does not create a private right of action to enforce federal Spending Clause statutes such as § 30(A) where Congress has not clearly and unambiguously created a privately enforceable right. Federal statutes that invoke Congress's spending power to create cooperative federal-state programs are unique in two key respects.

First, such Spending Clause statutes do not automatically preempt or invalidate allegedly conflicting state laws. They give States a choice between participating in the joint program and receiving federal money, or opting not to participate and forgoing the federal funds related to that particular statute. *See Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 28 (1981). Because States may make a lawful choice not to participate, a State's failure to satisfy a federal funding condition is not necessarily in "conflict" with federal law, and does not invoke preemption in the ordinary sense.

Second, Spending Clause legislation must clearly and unambiguously convey any obligation imposed on States accepting federal funds so that the States can make an informed decision about whether to accept the "contract." Because § 30(A) does not evince any congressional intent to subject States to private lawsuits challenging the adequacy of their rates – indeed, the text, structure, and legislative history of the Medicaid Act indicate that Congress intended to preclude such lawsuits – it is improper to impose such an obligation on unconsenting States.

2. The Court should not create a private right of action to enforce § 30(A) under the Supremacy Clause because to do so would frustrate Congress's intent and impede the state and federal governments' ability to manage States' Medicaid programs. Congress chose to centralize enforcement of the Medicaid Act's complex and often generally-phrased requirements in CMS, the federal agency with subject matter expertise in managing and overseeing the Medicaid program. And Congress intended for the States to work collaboratively with CMS to carry out that program, specifically providing an enforcement mechanism for CMS to withhold or withdraw federal funds from States if it determines that they are not meeting their obligations under the federal statutes. Where disputes arise, the Medicaid Act provides for administrative proceedings at CMS. And aggrieved parties may seek review of CMS's decisions under the Administrative Procedure Act (APA), 5 U.S.C. § 701 et seq.

Private lawsuits challenging the adequacy of Medicaid reimbursements interfere with the ability of CMS and the States to manage this system. DHCS estimates that, since 2008, injunctions under § 30(A) have forced California to pay Medicaid providers more than $1.5 billion in excess payments that both CMS and DHCS have determined are unnecessary to ensure that beneficiaries have access to quality care and services under the Medicaid program. As a legal or practical matter, DHCS will likely never be able to recover from the providers who were overpaid. And these injunctions do not occur in a vacuum, but

instead have affected California's budgeting decisions during a severe fiscal crisis. When DHCS is forced by injunctions to divert more money than the law requires to one particular program, or even to a set of particular providers or services in that program, the State necessarily has less to spend on other important programs and services. This Court has cautioned against such "government by injunction," *Schlesinger v. Reservists Comm. to Stop the War*, 418 U.S. 208, 222 (1974), and it should put an end to the system the court of appeals has created here.

ARGUMENT

THE SUPREMACY CLAUSE DOES NOT CREATE A PRIVATE RIGHT OF ACTION TO ENFORCE § 30(A) WHERE CONGRESS HAS NOT CREATED PRIVATELY ENFORCEABLE RIGHTS UNDER THAT STATUTE

I. The Supremacy Clause Does Not Supply a Cause of Action to Enforce the Terms of Cooperative Federal-State Programs Enacted Pursuant to Congress's Spending Power

This Court need not decide in the present case whether the Supremacy Clause may *ever* provide a private cause of action. This case can be resolved on the narrower ground that the Supremacy Clause does not provide a private cause of action to enforce a Spending Clause statute such as § 30(A) where

Congress chose not to create privately enforceable rights under that statute.

1. Spending Clause legislation of the sort at issue in this case is unique in that it "is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Such legislation cannot be unduly coercive, and must offer the States "a legitimate choice whether to accept the federal conditions in exchange for federal funds." *Nat'l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2602-2603 (2012).

Because of their quasi-contractual nature, such Spending Clause statutes do not "preempt" allegedly conflicting state laws in the ordinary sense. A state law that is preempted by federal law under the Supremacy Clause is "invalid." *Int'l Paper Co. v. Ouellette*, 479 U.S. 481, 491 (1987). But where a State chooses not to participate in a cooperative program created by a Spending Clause statute, that is a lawful choice. The only consequence for the State is that it will not receive the federal funds attached to that federal statute. If a State chooses to participate, then it must of course comply with any condition that Congress validly imposes. But "[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 non-compliance but rather action by the Federal Government to terminate funds to the State." *Pennhurst*, 451 U.S. at 28.

Indeed, the Medicaid Act specifically contemplates that States will not always be in clear compliance with all of the Act's provisions, and provides specific remedies that allow CMS to withhold and, if necessary, terminate funding if it believes a State is not complying. Thus, if she believes a State is failing to comply with any provision of the Medicaid Act, the Secretary of HHS, "after reasonable notice and opportunity for hearing," "shall notify [the appropriate] State agency that further payments will not be made to the State (or, in [her] discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure)," until "the Secretary is satisfied that there will no longer be any such failure to comply." 42 U.S.C. § 1396c; *see also* 42 C.F.R. § 430.35. Medicaid regulations provide for various repayment mechanisms when States are found not to be in compliance, *see* 42 C.F.R. §§ 430.33(c)(3), 430.35(d), 430.42(a), (h)(3), 430.48, and States that disagree with the Secretary's determination may request an administrative hearing, *id.* §§ 430.60 et seq., and ultimately seek judicial review under the APA, 5 U.S.C. § 701 et seq.

2. Using the Supremacy Clause to support private enforcement of this sort of Spending Clause legislation is also inappropriate for another reason: such statutes must clearly apprise States of the obligations they are taking on by accepting federal

funds. "There can, of course, be no knowing acceptance" of a Spending Clause "contract" "if a State is unaware of the conditions or is unable to ascertain what is expected of it." *Pennhurst*, 451 U.S. at 17. By requiring Congress to "speak with a clear voice" and impose any conditions "unambiguously," "we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation." *Id.* Here, neither § 30(A) nor any other Medicaid Act provision puts States on notice that by participating in the Medicaid program they could face private lawsuits brought by providers to challenge the adequacy of their payments – much less preliminary injunctions requiring the State to reimburse providers at higher rates than the State believes are required, under circumstances that make later recoupment effectively impossible, based on judicial construction of the Act's general terms uninformed by the expert judgment of the agency designated by Congress to administer and enforce the Act.

II. The Creation of a Private Right of Action to Enforce § 30(A) Would Frustrate Congress's Intent and Disrupt the State and Federal Governments' Ability to Manage State Medicaid Programs

1. Implying a private cause of action to enforce § 30(A) is inconsistent with the Medicaid Act's statutory framework and, in particular, Congress's decision to centralize enforcement authority in CMS. *See Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 58 (1st Cir. 2004); *Sanchez v. Johnson*, 416 F.3d

1051, 1059-1061 (9th Cir. 2005); *see also Astra USA, Inc. v. Santa Clara County*, 131 S. Ct. 1342, 1349 (2011) (holding that private enforcement of obligations owed by pharmaceutical companies to the federal government under Medicaid's 340B program would undermine Congress's intent for centralized enforcement). Private suits undermine the key benefits of a centralized administrative enforcement scheme: national uniformity, consistency, and predictability in interpretation and administration of federal law. Indeed, States in the Ninth Circuit have been subjected to onerous, judicially created requirements, purportedly under § 30(A), that apply nowhere else in the country and have no textual basis.[3] This is the antithesis of how the system is supposed to work. *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 292 (2002) (Breyer, J., concurring) (contrasting "the expertise, uniformity, wide-spread consultation, and resulting administrative guidance that can accompany agency decisionmaking" with 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").

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[3] For example, in this case the Ninth Circuit appears to have revived, at least to some degree, a procedural requirement that States conduct a certain type of "cost study" before reducing rates. Pet. App. 3-4 (citing *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1499 (9th Cir. 1997)). This atextual interpretation of § 30(A) has been rejected by HHS, every other circuit to consider the question, and a prior Ninth Circuit panel. *See Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1245-1250 (9th Cir. 2013).

In addition, regulation by litigation makes it virtually impossible for States to plan and budget their Medicaid obligations. As the system is supposed to work, the States communicate regularly with CMS, even obtaining guidance memoranda as issues arise.[4] Such communication reduces the likelihood that a State will guess incorrectly how CMS will interpret a Medicaid obligation and face substantial unplanned liabilities as a result. Litigation is far more unpredictable and less informed: DHCS's inability to predict how courts in the Ninth Circuit would misinterpret § 30(A) has cost its Medicaid program, in DHCS's estimate, well over $1.5 billion since 2008 in unanticipated and unnecessary expenses – exactly the result that the Court has explained should be avoided. *Pennhurst*, 451 U.S. at 17 ("[W]e may assume that Congress will not implicitly attempt to impose massive financial obligations on the States."); *see also Schlesinger*, 418 U.S. at 222 (cautioning against "government by injunction").

Private lawsuits also interfere with, and disrupt, CMS's own enforcement procedures. This was vividly demonstrated in *Douglas v. Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204 (2012),

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[4] In addition, providers and beneficiaries can, and often do, participate in the federal approval process, as contemplated by HHS regulations. *See* 42 C.F.R. §§ 430.76, 430.83, 430.86, 430.88; *see also Managed Pharmacy Care*, 716 F.3d at 1242-1243 (discussing the "extensive input" CMS received from providers in considering whether to approve DHCS's state plan amendments).

where the underlying preliminary injunctions materially altered and prejudiced California's ability to obtain CMS approval of its proposed state plan amendments (SPAs). In those cases, CMS initially denied all of California's SPAs citing, *inter alia*, concern about the destabilizing effect on access to services if providers were required to repay funds disbursed pursuant to the pending injunctions. *See* Brief for the United States as Amicus Curiae, App. 3a, *Douglas*, S. Ct. No. 09-958 (filed Dec. 3, 2010) ("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."). When CMS subsequently approved California's SPAs, finding that the proposed rate reductions were in fact consistent with the § 30(A) factors, CMS nonetheless required the State to give up all but approximately three months of its claims for retroactive recoupment, based on concerns that cumulatively approving recoupment for the entire time that the erroneously issued injunctions were in effect could harm providers and beneficiaries. *See* Letter from the United States, *Douglas*, S. Ct. No. 09-958 (filed Oct. 28, 2011); Petitioners' Supplemental Letter Brief, *Douglas*, S. Ct. No. 09-958 (filed Nov. 18, 2011).

2. Congress's belief that the Medicaid Act should not allow private suits challenging the adequacy of Medicaid payments is further demonstrated by its repeal of the Boren Amendment following *Wilder v.*

Virginia Hospital Association, 496 U.S. 498 (1990). In *Wilder*, the Court held that the Boren Amendment conferred a "right" on providers, enforceable under 42 U.S.C. § 1983, to "reimbursement rates that are reasonable and adequate to meet the costs of an efficiently and economically operated facility." *Id.* at 509-510. *Wilder* sparked a nationwide explosion of provider lawsuits challenging the adequacy of state Medicaid rates.[5]

Congress responded by repealing the Boren Amendment in 1997. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507-508 (1997). In so doing, Congress repeatedly expressed its intent to eliminate private lawsuits in order to give the States more flexibility in setting Medicaid rates and to reduce Medicaid costs. A House committee report stated:

> A number of Federal courts have ruled that State systems failed to meet the test of "reasonableness" and some States have had to increase payments to these providers as a result of these judicial interpretations.[¶]. . . . It is the Committee's intention that, following enactment of this Act, *neither this nor*

[5] *See*, *e.g.*, *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306 (2d Cir. 1991); *Erie County Geriatric Ctr. v. Sullivan*, 952 F.2d 71 (3d Cir. 1991); *Temple Univ. v. White*, 941 F.2d 201 (3d Cir. 1991); *Abbeville General Hosp. v. Ramsey*, 3 F.3d 797 (5th Cir. 1993); *Ill. Health Care Ass'n v. Bradley*, 983 F.2d 1460 (7th Cir. 1993); *Kan. Health Care Ass'n, Inc. v. Kan. Dep't of Soc. & Rehab. Servs.*, 31 F.3d 1536 (10th Cir. 1994).

> *any other provision of Section 1902* [of the Social Security Act, i.e., 42 U.S.C. § 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.

H.R. Rep. No. 105-149, at 590-591 (1997) (emphasis added); *see also* 143 Cong. Rec. S6301-02, S6305 (1997) (statement of Sen. Domenici) ("Provide flexibility instead of the rigidity brought on by lawsuits. The Boren amendment should be dead."). The Congressional Budget Office had estimated that Boren's repeal would reduce Medicaid spending by about $1.2 billion from 1998 to 2002 – an estimate that "assumes that reimbursement rates for institutional providers would increase more slowly than if providers could continue to use the threat of Boren suits as leverage against the states." H.R. Rep. No. 105-149, at 625.[6]

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[6] *See also* 143 Cong. Rec. at S6305 (statement of Sen. Gramm) ("The Boren amendment has produced endless lawsuits. States want to negotiate with hospitals and get the best rate they can. Repealing the Boren amendment takes it out of the courts."); 143 Cong. Rec. S6058-04, S6068 (1997) (statement of Sen. Roth) (repeal of Boren Amendment "will take the providers and the States out of the Federal courts and put them back at the contract negotiating table"); 142 Cong. Rec. S5305-05, S5355 (1996) (statement of Sen. Chafee) (repeal "will allow States to establish their own reimbursement rates and free them from much of the litigation that now exists").

3. Private lawsuits to enforce § 30(A) under the Supremacy Clause have improperly disrupted California's ability to manage its $90 billion Medicaid program. Every decision relating to provider payments is potentially subject to private challenges seeking injunctions that mandate additional payments or prohibit reductions based on judicial second-guessing of the State's rate-setting process. DHCS estimates that since *ILC I* was decided in 2008, injunctions issued based on the Ninth Circuit's erroneous interpretation of § 30(A) have cost the State more than $1.5 billion.

In balancing budgets with diminishing resources, state elected officials must carefully consider hundreds of competing demands and priorities. In States like California, budget adjustments are typically a zero-sum process. California is required under its Constitution to balance its budget, *see* Cal. Const. art. IV, § 12(a) & (g), and has limited means of raising revenue. For example, neither taxes nor fees producing general revenue can be raised without a vote of the people or a two-thirds vote of the Legislature. *See* Cal. Const. art. XIIIA, § 3(a). Thus, when injunctions improperly prevent a state agency such as DHCS from implementing appropriate, legally permissible cost reductions in one area, the Legislature often has no choice but to cut the funding of other important programs.

From approximately 2008 to 2012, California faced an unprecedented budget crisis from which it is still recovering. In fiscal year 2011-2012, for example, the State faced a $26.6 billion budget gap, and the Legislature was forced to cut $15 billion from schools, universities, public-safety programs, welfare services, courts, parks, and dozens of other important programs, including Medicaid. Revenue shortfalls in December 2011 triggered an additional $1 billion in further cuts, eliminating funding for school bus transportation, local libraries, and criminal-prosecution grants, and further reducing funding for schools, universities, community colleges, child-care programs, and California's Medicaid in-home supportive services program.

During the recent budget crisis, the Legislature initially looked for ways to reduce Medicaid expenditures without affecting services to beneficiaries. The State identified areas where a sufficient number of providers could absorb a modest payment reduction and still be willing to participate in the Medicaid program. *See*, *e.g.*, *Managed Pharmacy Care*, 716 F.3d at 1242; Cal. Welf. & Inst. Code § 14105.192(a)(2), (m), (o)(1); *id.*, § 14105.19 (2008). When these rate reductions were enjoined by the courts, the State was forced to divert scarce resources from other programs and services – and in some instances, eliminate certain optional Medicaid services to beneficiaries, *see* Cal. Welf. & Inst. Code § 14131.10 – in order to pay higher reimbursements to Medicaid providers.

In nearly every case in which a California rate reduction was initially enjoined based on the Ninth Circuit's unique interpretation of § 30(A), both DHCS and CMS – the state and federal agencies with subject matter expertise in all things Medicaid – ultimately determined that the proposed reductions complied with § 30(A) and would not impair beneficiary access to services. *See*, *e.g.*, *Douglas*, 132 S. Ct. at 1209; *Managed Pharmacy Care*, 716 F.3d at 1243. Yet, as either a legal or a practical matter, there was and likely will be no way for DHCS to recoup the money it was improperly forced to spend.

For all these reasons, recognizing a private right of action under the Supremacy Clause to enforce § 30(A) would frustrate Congress's intent in designing the Medicaid program and improperly disrupt the ability of state and federal administrators to work together to manage the program as it is appropriately implemented in each State.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
EDWARD C. DUMONT
Solicitor General
KATHLEEN A. KENEALY
Chief Assistant
Attorney General
JULIE WENG-GUTIERREZ
Senior Assistant
Attorney General
GREGORY D. BROWN*
Deputy Solicitor General
SUSAN M. CARSON
Supervising Deputy
Attorney General
JOSHUA N. SONDHEIMER
Deputy Attorney General

Attorneys for Amicus Curiae the California Health and Human Services Agency

**Counsel of Record*

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