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 *AMICI CURIAE* FOR THE AMERICAN ASSOCIATION OF PEOPLE WITH DISABILITIES AND TWELVE OTHER ORGANIZATIONS FOR RESPONDENTS

**(Additional *Amici* Listed on Inside Cover)**

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American Association of People with Disabilities
National Alliance on Mental Illness
The Arc of the United States
National Council for Behavioral Health
The National Federation of the Blind
ADAPT
The Autistic Self Advocacy Network
The Quality Trust for Individuals with Disabilities
Disability Rights Education and Defense Fund
Judge David L. Bazelon Center for Mental Health Law
Center for Public Representation
Disability Rights New York
Disability Rights Ohio

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## INTEREST OF *AMICI CURIAE*

*Amici Curiae* are thirteen associations of people with disabilities and public interest groups that advocate for the rights of people with disabilities, including American Association of People with Disabilities, National Alliance on Mental Illness, The Arc of the United States, National Council for Behavioral Health, The National Federation of the Blind, ADAPT, The Autistic Self Advocacy Network, The Quality Trust for Individuals with Disabilities, Disability Rights Education and Defense Fund, Judge David L. Bazelon Center for Mental Health Law, Center for Public Representation, Disability Rights New York, and Disability Rights Ohio.[1] The separate interests of *amici* are set out in Appendix A.

*Amici* submit this brief because private suits with respect to the Medicaid Act – under both section 1983 and the Supremacy Clause – are critical to assure that people with disabilities, particularly those who live in poverty or are elderly, get the health care they need and deserve, and that they have recourse to the federal courts and do not need to depend on an overburdened federal agency to revoke funding when they do not receive such care.

Such necessary Medicaid Act services include the home- and community-based programs serving

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[1] Petitioner and Respondent have consented to the filing of this brief. Counsel for *amici* authored the entire brief. No person or entity other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief.

people with disabilities at issue in this suit – "residential habilitation" services, provided in supported living environments, and designed to help people with intellectual disabilities[2] to live successfully in the community. Pet. App. 16.[3] This Court affirmed in *Olmstead v. L.C.*, 527 U.S. 581, 600, 601 (1999), that requiring people with disabilities to receive care in an institution, rather than in their homes and communities, "severely diminishes" their quality of life, including "family relations, social contacts, work options, economic

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[2] *Amici* use the term "intellectual disability" in place of "mental retardation" except when directly quoting others. Although the latter term appears in some relevant case law, it is offensive to many persons and has been replaced by more sensitive and appropriate terminology. As this Court stated in *Hall v. Florida*: "Previous opinions of this Court have employed the term 'mental retardation.' This opinion uses the term 'intellectual disability' to describe the identical phenomenon … This change in terminology is approved and used in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, one of the basic texts used by psychiatrists and other experts…" 134 S. Ct. 1986, 1990 (2014) (citing Rosa's Law, Pub. L. No. 111-256, 124 Stat. 2643 (2010) (changing entries in the U.S. Code from "mental retardation" to "intellectual disability"); Schalock et al., "The Renaming of *Mental Retardation*: Understanding the Change to the Term *Intellectual Disability,*" 45 Intellectual & Developmental Disabilities 116 (2007); American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 33 (5th ed. 2013)).

[3] Such services include, but are not limited to, skills training, and assistance with decision-making, money management, socialization, mobility, and behavior shaping or management, as well as grooming, bathing, eating, administering

independence, educational advancement, and cultural enrichment" and also "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."

Before the injunction in this case, Idaho had not changed its payment rates for home- and community-based services since 2006, even though the state itself recommended that rates be increased substantially and the federal Center for Medicaid and Medicare Services ("CMS") approved that increase. Pet. App. 18-19; Pet. Opp. 1-2 & n.1. Until providers brought this preemption suit under the Supremacy Clause, payment for such services stayed at the 2006 level. As a result of the suit payments were substantially increased. For 2013, for instance, the state paid $12 million in additional reimbursements under the revised rates. See *Idaho Asks Supreme Court to Take Medicaid Case*, Associated Press (July 3, 2014) *available at* http://www.spokesman.com/stories/2014/jul/03/idaho-asks-supreme-court-to-take-up-medicaid/. That result vividly illustrates why this Court should not reach out to interfere with over 200 years of established law by limiting preemption suits under the Supremacy Clause.

## SUMMARY OF ARGUMENT

Even though this case presents only the issue whether plaintiffs can bring a preemption claim

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medications, meal preparation, laundry, shopping and the like, as well as skills training for family and other caregivers. *Id.*

under *one* Medicaid Act provision, 42 U.S.C.A. § 1396a(a)(30)(A), petitioners suggest that the Medicaid Act as a whole is not enforceable by private plaintiffs at all, under either the Supremacy Clause or 42 U.S.C.A. § 1983. See Pet. Br. 28-29. That is decidedly not so. To the contrary, as detailed in Section I below, section 1983 is still the primary means of enforcing the Medicaid Act. Courts have applied this Court's framework developed in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), and *Blessing v. Freestone,* 520 U.S. 329 (1997), to a variety of other Medicaid Act provisions and permitted section 1983 actions to enforce them.

Accordingly, section 1983 actions are available to enforce provisions of the Medicaid Act that guarantee care to all eligible people on the same terms; guarantee that they will receive such care with "reasonable promptness"; guarantee that they are informed of and permitted to choose feasible non-institutional care; guarantee that they are treated appropriately in nursing homes; and guarantee that if they are under twenty-one they will be assessed regularly and receive care deemed necessary during such assessments. *See* Section I, *infra.* Congress intended to permit section 1983 actions under all these separate provisions, these courts concluded, because they contain the type of individual rights creating language and meet the other requirements this Court's cases set forth,

With respect to the issue actually presented here, a long line of cases from the earliest days of the country's history have permitted private plaintiffs to bring actions to enjoin state statutes, regulations,

policies, or practices when they conflict with a governing federal law under the Supremacy Clause. These cases do not require that plaintiffs establish a separate "private right of action" under the law that governs section 1983 in order to rely on the Constitution for a preemption claim. As respondents' brief explains in detail, under this established law the Ninth Circuit's opinion should be affirmed.

Finally, it makes no difference to this result that this case involves state *inaction* preempted by federal law, rather than the state action presented by the typical preemption case. To the contrary, this Court has recognized before that inaction, as well as action, may be preempted by federal law under the Supremacy Clause. *See Golden State Transit Corp. v. City of Los Angeles,* 475 U.S. 608 (1986) (city's failure to renew franchise license to gain leverage in labor dispute preempted by federal labor law).

## ARGUMENT

### I. Many provisions of the Medicaid Act are enforceable under 42 U.S.C.A. § 1983

This case presents only the question whether a particular provision of the Medicaid Act—42 U.S.C.A. § 1396a(a)(30)(A)—can be privately enforced through a preemption cause of action. But some of petitioners' arguments suggest that the Medicaid Act in general cannot be privately enforced through *any* cause of action, whether arising under the Supremacy Clause or under 42 U.S.C.A. § 1983. See Pet. Br. 28-29.

Respondents' brief describes in detail why the lack of a private right of action under section 1983 does not foreclose a claim under the Supremacy Clause that a state law conflicts with a federal law. Respondents Br. at 21-28, 47-54. As Respondents explain in particular, the lack of a Section 1983 cause of action to enforce 42 U.S.C.A. § 1396a(a)(30)(A) does not bar a basic preemption claim when a state law or action directly conflicts with Section 30(A).

*Amici* believe, however, that it is important for the Court to understand the extent to which section 1983 itself continues to provide an important source of enforcement for a wide variety of Medicaid Act provisions. These claims help ensure that people with disabilities, or those who are poor or elderly, receive the medical care to which the statute entitles them. Such section 1983 claims remain the mainstay of Medicaid enforcement. Some of the numerous Medicaid Act provisions for which private parties may bring a claim under section 1983 include:

**(1) 42 U.S.C.A. § 1396a(a)(10).** Claims by people who did not receive various Medicaid services to which they are entitled under 42 U.S.C.A. § 1396a(a)(10), which requires states to make medical assistance available to "all [eligible] individuals" in the same amount, duration, and scope as other eligible individuals.

Cases so holding include: *Watson v. Weeks,* 436 F.3d 1152, 1155, 1159–62 (9th Cir. 2006), *cert. denied sub nom. Goldberg v. Watson,* 549 U.S. 1032

(2006) (allowing section 1983 claim by a class of elderly patients and people with disabilities that Oregon violated §1396a(a)(10) by reducing nursing home services as part of budget cutting measures); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 181, 182 (3d Cir. 2004) (allowing section 1983 claim by a class of persons with intellectual disabilities seeking access to "intermediate care facilities" after "languish[ing] on waiting lists for years," finding that § 1396a(a)(10), among other provisions, created a private right of action); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1142, 1143 (10th Cir. 2006) (allowing section 1983 claim by a class of hundreds of people with developmental disabilities on waiting lists for residential services under 42 U.S.C.A. § 1396a(a)(10) and other provisions based on other circuit precedent "without deciding" whether such claim was appropriate), *cert. denied*, 549 U.S. 1305 (2007); *Brontrager v. Ind. Fam. & Soc. Servs. Admin.*, 697 F.3d 604 (7th Cir. 2012) (allowing section 1983 claim under 42 U.S.C.A. § 1396a(a)(10) by beneficiary with claim for medically necessary dental services that exceeded state limit of $1,000 for such services), *cert. denied*, 133 S.Ct. 2002 (2013).

**(2) 42 U.S.C.A. § 1396a(a)(8).** Claims by people who did not receive Medicaid services with "reasonable promptness" as required by 42 U.S.C.A. § 1396a(a)(8).

Cases so holding include: *Bryson v. Shumway*, 308 F.3d 79 (1st Cir. 2002) (allowing section 1983 claim by people with acquired brain disorders to the state's failure to fill available slots for home care services rather than

institutionalization); *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007) (allowing section 1983 claim by individual with developmental disabilities, including epilepsy, mild mental retardation, and cerebral palsy, to state's failure to provide her with residential services required by her plan of care), *cert. denied*, 128 S.Ct. 1483 (2008); *Sabree*, 367 F.3d at 181, 182 (allowing section 1983 claim by a class of persons with intellectual disabilities seeking access to "intermediate care facilities" after "languish[ing] on waiting lists for years," finding that §§ 1396a(a)(8), among other provisions, created a private right of action); *Mandy R.*, 464 F.3d at 1142, 1143 (allowing section 1983 claim by a class of hundreds of people with developmental disabilities on waiting lists for residential services under 42 U.S.C.A. § 1396a(a)(8) and other provisions based on other circuit precedent "without deciding" whether such claim was appropriate).[4]

**(3) 42 U.S.C.A. §§ 1396n(c)(2), (d)(2).** Claims by people with disabilities that they were not properly informed of or allowed to choose feasible alternatives to care in an institution, as required by 42 U.S.C.A. §§ 1396n(c)(2), (d)(2).

Cases so holding include: *Ball v. Rodgers*, 492 F.3d 1094, 1107 (9th Cir. 2007) (permitting section 1983 claim by people with physical and

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[4] *Accord Doe 1-13 By & Through Doe, Sr. 1-13 v. Chiles*, 136 F.3d 709, 711 (11th Cir. 1998) (allowing section 1983 claim by people with developmental disabilities who had been on waiting lists for intermediate care facilities for "several years" without receiving services).

developmental disabilities and elderly people that by not hiring or compensating sufficient home-care attendants Arizona did not provide them with a feasible choice for non-institutional care, holding that individuals have "two explicitly-identified rights" under section 1396: "the right to be informed of alternatives to traditional, long-term institutional care," and "the right to *choose* among those alternatives") (emphasis in original).

**(4) 42 U.S.C.A. § 1396a(a)(15).** Claims by people with disabilities who did not receive treatment in intermediate-care facilities as required by 42 U.S.C.A. § 1396a(a)(15). *E.g., Sabree*, 367 F.3d at 181, 182 (allowing section 1983 claim by a class of persons with intellectual disabilities seeking access to "intermediate care facilities" after "languish[ing] on waiting lists for years," finding that 42 U.S.C.A. § 1396d(a)(15), requiring that the state provide intermediate care services, provided for a private cause of action, along with other provisions.

**(5) 42 U.S.C.A. § 1396r.** Claims by people in nursing homes that the state did not provide them with the level of care required by 42 U.S.C.A. § 1396r, which requires among other things that nursing homes must provide care necessary to promote maintenance and quality of life and must undertake assessments and have plans to provide appropriate care to each resident.

Cases so holding include: *Rolland v. Romney*, 318 F.3d 42, 44, 56 (1st Cir. 2003) (allowing section 1983 claim by people with developmental and intellectual disabilities because the state did not

provide them with the "specialized services" necessary to meet their needs in a nursing home setting, as required by 42 U.S.C. § 1396r); *Grammer v. John J. Kane Reg'l Centers-Glen Hazel*, 570 F.3d 520 (3d Cir. 2009) (allowing section 1983 claim by a daughter claiming that the nursing home treating her mother did not provide the care required by 42 U.S.C.A. § 1396r, with the result that the mother developed ulcers, became malnourished and eventually developed sepsis and died), *cert. denied*, 559 U.S. 939 (2010).

**(6) 42 U.S.C.A. § 1396a(bb).** Claims by providers that the state did not pay for required services provided at federally-qualified health centers and rural clinics located in medically-under-served communities, in violation of 42 U.S.C.A. § 1396a(bb).

Cases so holding include: *California Ass'n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1011 (9th Cir. 2013) (permitting section 1983 claim by providers that California improperly eliminated payments to dentists, podiatrists, optometrists, and chiropracters); *Concilio de Salud Integral de Loiza, Inc. v. Perez–Perdomo,* 551 F.3d 10, 17–18 (1st Cir. 2008) (permitting section 1983 claim by providers that Massachusetts had not fulfilled its obligation to make wraparound payments under section 1396a(bb) that were necessary to compensate clinic for difference between amounts due and amounts previously paid); *Pee Dee Health Care, P.A. v. Sanford,* 509 F.3d 204, 210–12 (4th Cir. 2007) (permitting section 1983 claim by providers that South Carolina paid unduly low rates (but finding

specific contract with provider limited the availability of claim)); *Rio Grande Cmty. Health Ctr., Inc. v. Rullan,* 397 F.3d 56, 74–75 & n. 12 (1st Cir. 2005) (permitting section 1983 claim by providers that state failed to make "wraparound" payments required by section 1396a(bb)(5) that were necessary to compensate clinic for difference between amounts due and amounts previously paid and assure continued cash flow).

**(7) 42 U.S.C.A §§ 1396d(4)(B), 1396d(r)(5), 1396d(a).** Claims by beneficiaries that states did not provide medically necessary services for children, as required by Medicaid Act provisions requiring the state to provide "early and periodic screening, diagnosis, and treatment services" for certain persons under age twenty-one (the "EPSDT" mandate, 42 U.S.C.A. §§ 1396a(a)(10)(A), 1396d(4)(B), 1396d(a)) and further requiring the state to reimburse certain services found necessary in such a screening even if the state would not otherwise cover those services (42 U.S.C.A. §§ 1396d(r)(5), 1396d(a) (listing services required to be covered)).

Cases so holding include: *Pediatric Specialty Care, Inc. v. Ark. Dept of Human Servs.,* 293 F.3d 472, 479 (8th Cir. 2002) (permitting section 1983 claim by parents and providers that state was required to provide early intervention day treatment services recommended by a doctor to children with physical and mental disabilities), *later proceeding* 443 F.3d 1005 (8th Cir. 2006) (declining state's request to revisit earlier holding under *Gonzaga*, 563 U.S. at 273 and permitting section 1983 claim

against state employees who manipulated the state's prior approval program to deny children necessary rehabilitative services) *judgment vacated as moot sub nom. Selig v. Pediatric Specialty Care, Inc.,* 551 U.S. 1142 (2007); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 601-07 (5th Cir. 2004) (permitting section 1983 claim by a child with spina bifida that he was not reimbursed for the disposable undergarments necessary to address his incontinence and the resultant sores and infection, with the result that he was homebound and unable to attend school).[5]

**(8) 42 U.S.C.A. §§ 1396r–6 and 1396u–1.** Claims that a state improperly cut off "transitional" Medicaid benefits, which must remain available to families for a year after they lose Medicaid eligibility because of income increases under 42 U.S.C.A. §§ 1396r–6 and 1396u–1.

Cases so holding include: *Rabin v. Wilson-Coker*, 362 F.3d 190, 201 (2d Cir. 2004) (permitting section 1983 claim by families denied transitional services when they lost eligibility because income

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[5] *Accord Collins v. Hamilton,* 349 F.3d 371, 376, n. 8 (7th Cir. 2003) (section 1983 claim; "a state's discretion to exclude services deemed 'medically necessary' ... has been circumscribed by the express mandate of the statute"); *Pittman by Pope v. Sec'y, Fla. Dep't of Health & Rehab. Servs.,* 998 F.2d 887, 892 (11th Cir. 1993) (section 1983 claim; 1989 amendment adding section 1396d(r)(5) took away any discretion state might have had to exclude organ transplants from the treatment available to individuals under twenty-one) *cert. denied sub nom. Agency for Health Care Administration v. Pittman by Pope,* 510 U.S. 1030 (1993).

requirements for Medicaid were lowered rather than a new employment situation).

**(9) 42 U.S.C.A. § 1396a(a)(23).** Claims that a state restricted a patient's freedom of choice to obtain treatment from any qualified provider, as required by 42 U.S.C.A. § 1396a(a)(23). *E.g., Planned Parenthood of Indiana, Inc. v. Comm'r of Indiana State Dep't of Health*, 699 F.3d 962 (7th Cir. 2012) (permitting section 1983 claim that the Indiana law forbidding any state or federal funding to facilities providing abortions restricted low-income women from receiving Medicaid-covered services from providers of their choice), *cert. denied sub nom. Sec'y of Indiana Family & Soc. Servs. Admin. v. Planned Parenthood of Indiana, Inc.*, 133 S.Ct. 2736 (2013) and *cert. denied sub nom. Planned Parenthood of Indiana, Inc. v. Sec'y of Indiana Family & Soc. Servs. Admin.*, 133 S.Ct. 2738 (2013); *Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006) (permitting section 1983 claim that state violated "freedom of choice" statute by requiring a single supplier for certain medical supplies).

**(10) 42 U.S.C.A. § 1396a(a)(3).** Claims by beneficiaries who did not receive an appropriate or timely hearing on requests for Medicaid services as required by 42 U.S.C.A. § 1396a(a)(3).

Cases so holding include: *Gean v. Hattaway*, 330 F.3d 758, 772–73 (6th Cir. 2003) (permitting section 1983 claim by a class of patients based on state's failure to provide a "fair hearing" for denial of medical care under the Medicaid Act); *Shakhnes v. Berlin,* 689 F.3d 244 (2d Cir. 2012) (permitting

section 1983 claim by a class of people who applied for home health care services, were denied, and did not receive a hearing or decision within 90 days), *cert. denied*, 133 S.Ct. 1808 (2013).

**(11) 42 U.S.C.A. § 1396p(d)(4).** Claims that state actions or laws regarding "supplemental needs" or "special needs" trusts – i.e., trusts established pursuant to 42 U.S.C.A. § 1396p(d)(4) for people with severe and chronic or persistent disabilities to help provide for care that Medicaid does not cover – improperly permitted the state to count such trusts as "assets" and accordingly deprived beneficiaries of Medicaid coverage.

Cases so holding include: *Lewis v. Alexander*, 685 F.3d 325, 333-34, 342 (3d Cir. 2012) (permitting section 1983 claim by patients who lost benefits because of Pennsylvania law imposing additional requirements on supplemental or special needs trusts), *cert. denied*, 133 S.Ct. 933 (2013); *Ctr. for Special Needs Trust Admin., Inc. v. Olson*, 676 F.3d 688, 699 (8th Cir. 2012) (permitting section 1983 claim by trustee to state claim for reimbursement from a trust that was mistakenly excluded from a Medicaid beneficiaries' assets).

Those holdings were all issued *after* this Court decided *Suter v. Artist M.*, 503 U.S. 347 (1992), *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), and *Blessing v. Freestone,* 520 U.S. 329 (1997). They considered the factors the Court set out in those cases, and correctly applied them to the particular Medicaid Act provisions at issue, recognizing

implicitly (and sometimes expressly)[6] the substantial differences between those provisions and section 30A. And this Court has repeatedly denied requests to review them on *certiorari*.[7]

Indeed, Congress expressly recognized the continued importance of section 1983 and other private plaintiff suits in its response to the Court's decision in *Suter*, 503 U.S. 347. In *Suter*, the Court held that section 1983 was not available for private suits to enforce the "reasonable efforts" provision of the Adoption Act, another part of the Social Security Act along with the Medicaid Act.

Congress promptly acted to change that result, providing that "[i]n an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its

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[6] *Ball*, 492 F.3d at 1102, 1107-17 (Medicaid Act's free choice provisions (42 U.S.C.A. §§ 1396n(c)(2)(C), (d)(2)(C)) may be enforced through section 1983 cause of action, but equal access provision (42 U.S.C.A. § 1396a(a)(30)(A)) may not); *Mandy R.*, 464 F.3d at 1142 (relying on other Circuits' precedent to permit a section 1983 claim under Medicaid's reasonable promptness and comparability provisions, sections 1396a(a)(8) and 1396a(a)(10), but finding no section 1983 claim permissible under section 1396a(30)(A)).

[7] *See, e.g.*, *Shakhnes*, 689 F.3d at 244, *cert. denied*, 133 S.Ct. 1808 (2013) (regarding section 1396a(a)(3)); *Brontrager*, 697 F.3d at 604, *cert. denied*, 133 S.Ct. 2002 (2013) (regarding section 1396a(a)(10)(A)); *Lewis*, 685 F.3d at 325, *cert. denied*, 133 S.Ct. 933 (2013) (regarding sections 1396a(a)(18), 1396p(d)(4)(C)); *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't. of Health*, 699 F.3d at 962, *cert. denied*, 133 S.Ct. 2736, 2738 (2013) (regarding section 1396a(a)(23)).

inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan." In so doing, it made plain that the law in effect before *Suter* – including both section 1983 law and preemption law under the Supremacy clause – would continue to govern suits under the Medicaid Act. The text of the post-*Suter* statute specifically explained that it did not "intend to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements." 42 U.S.C.A. § 1320a-2; see 42 U.S.C.A. § 1320a-10 (similar). Similarly, the Conference Report explained that "[t]he intent of this provision is to assure that individuals who have been injured by a State's failure to comply with the Federal mandates of the State plan titles of the [SSA] are able to seek redress in the federal courts to the extent they were able to prior to the decision in *Suter v. Artist M.*" H.R. Rep. No. 103-761, at 926 (1994) (Conf. Rep.).

These statements indicate that Congress, acting against a backdrop of the numerous section 1983 and preemption actions that had been permitted in the Medicaid Act context, meant for private plaintiffs to retain the ability to bring such actions. Under Congress' reasoning following *Suter* and under the cases cited above, section 1983 continues to provide important individual protections for people who rely on Medicaid for health care, including the people with disabilities who are members of *amici* organization or whose rights the *amici* organizations represent.

## II. Even When Section 1983 Does Not Provide A Private Right Of Action, Private Plaintiffs May Sue To Enjoin State Laws That Are Preempted By The Medicaid Act

Even when a Medicaid Act provision, unlike the numerous provisions outlined above, does not permit a private right of action under section 1983, Medicaid beneficiaries, providers, and other private parties who are injured by a state law that conflicts with the Medicaid Act have a recourse in federal court. As Respondents' Brief explains in detail, this Court, relying on principles established since the early days of this country, has consistently permitted private plaintiffs injured by a state law, regulation, policy, or practice that conflicts with federal law to seek an injunction under the Supremacy Clause. It has not imported the principles governing whether there is a private right of action under section 1983 into this established analysis. This Court should reject Petitioners' urging that it do so now.

The Supremacy Clause is clear on its face. It says:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the

> Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const. art. VI. The Supremacy Clause does not say that it is purely a choice-of-law rule, as Petitioners assert. It does not say that it can be relied upon only if Congress has separately authorized a statutory private right of action under section 1983. It says federal law governs over state law, full stop.

Consistent with this language, and again as set forth in detail in Respondents' brief, this Court has repeatedly recognized that private plaintiffs may obtain injunctive relief when a state law conflicts with the Medicaid Act and similar Spending Clause provisions *without* requiring a determination that Congress intended to create a statutory private right of action as a prerequisite to such suit.

Just two Terms ago, the Court applied established preemption analysis in a Medicaid Act case without once mentioning, in majority, concurring or dissenting opinion, any necessity for Congress to have intended to create a private right of action under the relevant provision. In *Wos v. E.M.A. ex rel. Johnson*, 133 S.Ct. 1391 (2013), a North Carolina statute provided that the state could collect one-third of a Medicaid claimant's tort recovery. This conflicted with federal Medicaid law in 42 U.S.C.A § 1396p(a)(1), which prohibits a state from collecting any part of a judgment or settlement that is not attributable to medical damages. The majority explained that "Under the Supremacy Clause, '[w]here state and federal law "directly

conflict,'" state law must give way" and affirmed the Fourth Circuit's determination that North Carolina's statute in fact did directly conflict with the Medicaid Act's requirement. *Id.* at 1398.[8] *Accord Ark. Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268 (2006) (holding that state law regarding collection of Medicaid recipient's tort recovery that conflicted with the Medicaid Act's anti-lien provision was preempted, without discussion of any necessity of finding a private right of action).

In a number of other cases, the Court similarly has decided whether a state law is preempted by Medicaid Act or similar Spending Clause provisions while somehow failing to mention that a Congressional intent to create a private right of action is a prerequisite to such suits. *See, e.g., PhRMA v. Walsh*, 538 U.S. 644 (2003) (considering provider claim that federal Medicaid law regarding prescription drug rebates under 42 U.S.C.A § 1396r-8 preempted a Maine law requiring participating providers to provide such rebates with respect to all drugs sold in the state, without considering whether Congress intended a private right of action); *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 478 (1996) (federal law requiring Medicaid funding for abortions in cases of rape and incest preempted state law prohibiting any use of state or federal funds for abortions, without considering whether Congress intended a private right of action); *Bennett*

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[8] The Court mentioned that the original case was brought under section 1983, *id.* at 1396, but that fact was not mentioned again in either majority or dissent.

*v. Arkansas*, 485 U.S. 395, 397 (1988) (*per curiam*) (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," thus creating "a 'conflict' under the Supremacy Clause –a conflict the State cannot win"; no mention of need for private right of action); *Blum v. Bacon*, 457 U.S. 132, 138 (1982) (Social Security Act provision requiring state to provide emergency assistance to beneficiaries preempted state welfare regulations that forbade such assistance when the beneficiary's funds were stolen or lost; no motion of need for private right of action); *Carleson v. Remillard*, 406 U.S. 598, 604 (1972) (Social Security Act eligibility requirements for AFDC, which relied in part on a parent's "continued absence" from home, preempted a California law excluding a parent's absence because of military service; no mention of need for private right of action). *See generally* Respondents Br. 24-25, 35-37.

These cases in the Medicaid Act context are consistent with many others from this Court recognizing that federal courts must vindicate the supremacy of federal law on a claim by a private plaintiff that it conflicts with state law without separately requiring a showing that Congress created a private right of action for those claims. This history is detailed in Respondents' brief, 11-15. It confirms that, as the United States says, the "longstanding judicial practice [that] private parties may bring a suit in federal court to enjoin state regulatory action from which the plaintiffs claim immunity under federal law" "has considerable

historical grounding and appropriately vindicates the supremacy of federal law." United States Br. at 8, 16.

As Respondents explain, (1) the Supremacy Clause has decidedly not been limited to cases which present an "anticipatory defense" to state action, and in any event this case would fit the mold of an anticipatory defense, Respondents Br. 21-28; (2) the Supremacy Clause has long been available to enforce provisions of the Medicaid Act and other Spending Clause statutes, see Respondents Br. 35-37; and (3) there are real and substantial differences between implied rights of action under section 1983 and Supremacy Clause claims based on the Constitution that dictate that the law governing the first should not be imported into the law governing the second, Respondents Br. 47-56. Accordingly, this Court should reject petitioners' effort to confine preemption claims to those that could be brought under Section 1983.

## III. Although This Case Involves A Preemption Challenge To State Inaction Rather Than To An Affirmative State Statute, The Same Principles Apply

This case involves a situation that is arguably more complicated than the typical preemption case. Typically, private plaintiffs in a preemption case contend that a particular state *action* – an affirmative state statute, regulation, policy, or practice – is inconsistent with federal law and thus seek an injunction *forbidding* the State from enforcing the provision. *E.g., Wos*, 133 S.Ct. at 1391

(enjoining North Carolina statute allowing state to collect one-third of a Medicaid claimant's tort recovery as inconsistent with federal law); *Dalton*, 516 U.S. at 478 (enjoining state law precluding use of any federal or state funds for abortions as inconsistent with federal law); *Bennett*, 485 U.S. at 397 (enjoining state attachment of Social Security benefits for children in custody as inconsistent with federal law); *Crosby v. Nat'l Foreign Trade Council,* 530 U.S. 363 (2000) (enjoining Massachusetts statute regarding dealings with Burma as inconsistent with federal foreign policy); *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624 (1973) (enjoining city ordinance that limited flight landing hours as inconsistent with federal law).

Here, at least on this record, the situation is arguably different, as it involves Idaho's *inaction*, rather than action. The allegation is not that Idaho passed a statute or promulgated a regulation that is inconsistent with federal law, but rather that it failed to take action that the respondents contend would be required in order to comply with such law. Pet. App. 21 (case involves Idaho's "failure to amend existing reimbursement rates"); *id.* at 4 n.2. As the trial court noted, "Plaintiffs do not challenge the propriety of a rate change action. Instead, they challenge [Idaho's] inaction, or failure to amend existing reimbursement rates." Pet. App. 21.

Respondents accordingly did not seek an injunction that would forbid enforcement of an Idaho law, but rather an injunction that would require the State to take affirmative action – change its rate

program – in order to comply with federal law. Since the injunction, rates for the home and community based waiver program in Idaho have been revised and increased to follow the previously-rejected recommendations.

The Ninth Circuit expressed "serious doubt over whether [Idaho's] inaction constitutes a 'Thing' in state law that can be preempted under the Supremacy Clause." Pet. App. 4 n. 2. *Accord id.* at 2 (Medicaid provider "has an implied right of action under the Supremacy Clause to seek injunctive relief against the enforcement or implementation of state legislation.") The district court noted, similarly, that "Ninth Circuit cases addressing alleged violations of §30A have involved changes to reimbursement rates or methodologies, not maintenance of existing rates." Pet. App. 21.

Under the cases set out above and in Respondents' brief, however, this is a distinction without a difference. The Medicaid Act provides that that states accepting federal Medicaid finds must set provider reimbursement rates using "such methods and procedures" as necessary to assure, *inter alia*, that payments 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.A. § 1396a(a)(30)(A). As the legislative history notes, "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program." H.R. Rep. No. 101-247, at 390 (1989).

There is, of course, no question of constitutional power here. Congress is free to condition the grant of federal funds on recipient states' agreement to take affirmative governmental action with the money they receive. See *New York v. United States*, 505 U.S. 144, 166-167 (1992). As Part I, *supra*, demonstrates, Congress has done just that in the Medicaid Act. As the many cases cited in Part I illustrate, these state obligations under the Medicaid Act often confer on individual beneficiaries an affirmative right to services—a right they may enforce under Section 1983. And Congress is free to impose affirmative obligations on the recipients of federal funds and to authorize private parties to enforce them through statute-specific rights of action. See, *e.g.*, *Forest Grove Sch. Dist. v. T.A.*, 557 U.S. 230 (2009) (private suit enforcing affirmative right of children with disabilities to receive a "free appropriate public education" under the Individuals with Disabilities Education Act). The only question here is whether private parties can enforce affirmative obligations through preemption suits in instances in which the relevant statute does not confer individual rights enforceable under Section 1983 or another express private cause of action.

This Court should answer that question in the affirmative. Idaho has done exactly what section 30A forbids. It has not provided payments sufficient to ensure that people who need home and community-based services receive them. That it did so through inaction rather than action is immaterial. In at least one case, this Court has held similar state inaction formed a basis for a preemption claim. *See Golden State Transit Corp. v. City of Los Angeles,*

475 U.S. 608, 617 (1986) (city was not permitted to let a taxicab franchise renewal application lapse in order to force taxicab company to resolve a labor dispute; its failure to act was preempted by federal labor law requiring each side "free use of economic weapons"). *Accord Bldg. Trades Employers' Educ. Ass'n v. McGowan*, 311 F.3d 501, 511, 512 (2d Cir. 2002) (state could not fail to act on approving a union's proposed training/apprenticeship program in order to encourage the union not to bring a labor dispute; "we think defendant's refusal to act threatens to skew the collective bargaining process by placing economic pressure on plaintiffs"; "we believe defendant's inaction, rather than its action, is barred by *Garmon* preemption."). Accordingly, that respondents challenge the state's inaction should make no difference to the preemption cause of action analysis.

## CONCLUSION

The Court should affirm the decision of the Ninth Circuit.

Respectfully submitted.

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# APPENDIX

## THE AMICI ORGANIZATIONS

**The American Association of People with Disabilities ("AAPD")** is the Nation's largest cross-disability membership organization, advocating for equal opportunity, economic empowerment, and political participation for persons with disabilities. The organization's more than 100,000 members come from all states and include persons with disabilities and their families, friends and supporters. Founded in 1995 and headquartered in Washington, D.C., AAPD has a strong interest in the full enforcement and implementation of the Medicaid Act, which provides for services vital to people with disabilities.

**The National Alliance for the Mentally Ill ("NAMI")** is the nation's largest grassroots organization dedicated to improving the lives of people with mental illnesses. NAMI has more than 220,000 members and 1,200 state and local affiliates in all 50 states, the District of Columbia, Puerto Rico and Canada. Since its creation in 1979, NAMI's members have worked extensively on a national basis to combat barriers to the recovery of people with mental illness and their full participation in society. NAMI works for full enforcement and implementation of the Medicaid Act, which provides for services vital to people with mental illness.

**The Arc of the United States ("The Arc")** is the nation's largest community-based organization of and for people with intellectual and developmental disabilities. The Arc advocates for the rights and full participation of all children and

adults with intellectual and developmental disabilities. It provides an array of services and support for families and individuals and includes 140,000 members affiliated through 700 state and local chapters across the nation. The Arc is devoted to ensuring the full implementation of the Medicaid Act and its chapters bring litigation enforcing the right of beneficiaries to services under the Act.

**National Council for Behavioral Health ("National Council")** is the voice of America's community mental health and addiction treatment organizations. Together with our 2,200+ member organizations employing 750,000 staff, the National Council serves our nation's most vulnerable citizens, more than eight million adults and children living with mental illnesses and addictions. The National Council is committed to ensuring all Americans have access to comprehensive, high-quality care that affords the opportunity for recovery and full participation in community life. The National Council is committed to full implementation of the Medicaid Act as a critical step toward ensuring that people with mental illness have access to adequate health care.

**The National Federation of the Blind ("NFB")** is the largest membership organization of blind people in the United States. With more than 50,000 members, and affiliates in all fifty states, in the District of Columbia, and in Puerto Rico, and over 700 local chapters in most major cities, the NFB works for the integration of the blind into society on an equal basis. Since its founding in 1948, the NFB

has devoted significant resources toward advocacy, education, research, and development of programs for the blind. The NFB actively engages in litigation on behalf of the blind to address systemic barriers.

**ADAPT** is a national grass-roots community that organizes disability rights activists to engage in nonviolent direct action, including civil disobedience, to assure the civil and human rights of people with disabilities to live in freedom. ADAPT engages in political advocacy and litigation to advance the rights of people with disabilities to community-based services under the Medicaid Act.

**The Autistic Self Advocacy Network ("ASAN")** is a nationwide nonprofit organization run by and for individuals on the autism spectrum. ASAN promotes the interests of autistic adults and children through public policy advocacy, education, research, and cultural outreach activities. Many of ASAN's constituents rely on services provided through federal Spending Clause statutes such as the Medicaid Act.

**The Quality Trust for Individuals with Disabilities ("Quality Trust")**, incorporated in 2001, is an independent, nonprofit advocacy organization dedicated to ensuring that people with disabilities have access to the supports and services they need to live full and meaningful lives in the places and ways they choose. The Quality Trust has supported well over 5,000 people with disabilities, the vast majority of whom are low-income, and trained thousands of people with disabilities, family

members, advocates, attorneys, guardians, providers and health care workers on a wide range of disability policy and practice topics. The Quality Trust supports full implementation and enforcement of the Medicaid Act.

**The Disability Rights Education & Defense Fund ("DREDF")**, based in Berkeley, California, is a national non-profit law and policy center dedicated to advancing and protecting the civil rights of people with disabilities. Founded in 1979 by people with disabilities and parents of children with disabilities, DREDF remains board- and staff-led by members of the community it represents. Recognized for its expertise in the interpretation of federal disability civil rights laws, including the Medicaid Act, DREDF pursues its mission through education, advocacy and law reform efforts.

**The Judge David L. Bazelon Center for Mental Health Law ("Bazelon Center")** is a national public interest organization founded in 1972 to advocate for the rights of individuals with mental disabilities. Through litigation, federal policy advocacy, and public education, the Bazelon Center promotes equal opportunity for individuals with mental disabilities in all aspects of life, including health care, employment, education, housing, and community living. The Bazelon Center actively engages in litigation to enforce beneficiaries' entitlements under the Medicaid Act.

**Center for Public Representation ("CPR")** seeks to improve the quality of lives of people with mental illness and other disabilities through the systemic enforcement of their legal rights while promoting improvements in services for citizens with disabilities. Based in Massachusetts, CPR r is engaged in litigation and advocacy throughout the nation. Through its systemic activities during the past 30 years, CPR has been a major force in promoting improvements in services for citizens with disabilities. CPR has brought numerous cases enforcing the rights of Medicaid beneficiaries to needed community-based services.

**Disability Rights New York ("DRNY")** is the federally-mandated Protection & Advocacy Agency for persons with disabilities in New York. DRNY advocates for the civil and legal rights of New Yorkers with disabilities, including rights under the Medicaid Act.

**Disability Rights Ohio ("DRO")** is the federally-mandated Protection & Advocacy Agency for persons with disabilities in Ohio. DRO advocates for the civil and legal rights of Ohio's citizens with disabilities, including rights under the Medicaid Act.