No. 14-15

IN THE

Supreme Court of the United States

RICHARD ARMSTRONG, *et al.*,

Petitioners,

v.

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

Respondents.

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

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, AMERICAN DENTAL ASSOCIATION, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AND CALIFORNIA MEDICAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

Amici are among the most prominent medical and dental professional associations in the United States.[1] Collectively, the members of *amici* provide medical and dental services to millions of Medicaid patients. *Amici* are profoundly interested in this case because the States' failure to comply with the Medicaid Act's "equal access" provision has a well-documented, negative impact on patient care. Restricting the availability of a judicial remedy would leave Congress's mandate of "equal access" an empty promise.

The American Medical Association ("AMA"), through its House of Delegates, enables substantially all physicians and medical students in the United States to participate through their State or specialty medical societies in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.

The American Dental Association ("ADA") is the world's largest professional association of

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[1] Pursuant to Rule 37.3(a), all parties have filed letters with the Clerk granting blanket consent to the filing of amicus briefs. In accordance with Rule 37.6, *amici* state that no counsel for any party has authored this brief in whole or in part. The Litigation Center of the AMA has provided funding for this brief. No other person or entity has made any monetary contribution to the preparation or submission of this brief.

dentists. The ADA is committed to the public's oral health, and to the ethics, science, and professional advancement of dentistry. On behalf of its more than 155,000 members, the ADA is vitally concerned with access-to-care issues and serves as a principal advocate on issues affecting oral health.

The American Academy of Pediatrics ("AAP") represents 62,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists. Its mission is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. AAP is the largest professional association of pediatricians in the world.

The American Congress of Obstetricians and Gynecologists ("ACOG") represents more than 50,000 obstetricians and gynecologists and residents in obstetrics and gynecology. ACOG is dedicated to the advancement of women's health care and to establishing and maintaining the highest possible standards of practice. ACOG also promotes policy positions on issues affecting the specialty of obstetrics and gynecology and supports quality health care for every woman throughout her life.

The American Academy of Family Physicians ("AAFP"), headquartered in Leawood, Kansas, is the national association of family doctors. Founded in 1947 as a not-for-profit corporation, its members are physicians and medical students from all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and the Uniformed Services of the

United States. As part of its mission, the AAFP seeks to improve the health of patients, families, and communities by serving the needs of members and their patients with professionalism and dignity and by advocating for public health.

The American College of Emergency Physicians ("ACEP") is a non-profit, voluntary professional and educational society of over 32,000 emergency physicians practicing in the United States and other countries. ACEP fosters the highest quality of emergency medical care through: the education of emergency physicians, other health care professionals, and the public; the promotion of research; the development and promotion of public health and safety initiatives; and the provision of leadership in the development of health care policy.

The California Medical Association ("CMA") is a not-for-profit professional association for physicians with nearly 40,000 members. CMA physician members practice medicine in all specialties and modes of practice throughout California, including participating in the Medi-Cal program. CMA encourages physician participation in government health care programs, such as Medi-Cal, in order to ensure that all Californians have adequate access to medically necessary health care services. For more than 150 years, CMA has promoted the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession.

SUMMARY OF ARGUMENT

Federal jurisdiction under the Supremacy Clause to entertain suits in equity to enjoin inconsistent State laws has been recognized numerous times by this Court. This principle has never been (and should not now be) limited to "anticipatory defenses" to State enforcement actions. Respondents thoroughly set forth these arguments and the long line of authority supporting them. There is no need to reiterate those arguments, which create a compelling legal rationale for affirmance. Instead, *amici* focus on the important role of private actions to enforce the supremacy of federal law, including Section 30(A)'s equal-access mandate and other sections of the Medicaid Act, and urge this Court to refrain from deciding issues that are not briefed or presented for decision here.

* * *

Codified in Section 30(A) of the Medicaid Act, the "equal access" provision requires that States choosing to accept federal Medicaid funds must set provider reimbursement rates that are, *inter alia*, "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). In enacting this provision, Congress recognized that, "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). And, without

participating providers, Medicaid patients will inevitably receive inferior and unequal access to health care, contrary to the intent of Congress and the overriding purpose of the Medicaid Act.

Despite Congress's mandate, "equal access" has been largely illusory for millions of America's most vulnerable citizens. Motivated largely by budgetary concerns, some States have reduced reimbursement rates without even considering the effect it would have on access to care. These rates often fall below providers' average cost to deliver the service. It is therefore unsurprising that federal courts, medical researchers, and governmental bodies have found a gap between access to health care for those with Medicaid, as compared to those with private insurance and Medicare.

Every day in their own practices, members of the *amici* observe this reality and witness the human suffering caused by the States' non-compliance. As one court has aptly summarized:

> This case is about people—children and adults who are sick, poor, and vulnerable—for whom life, in the memorable words of poet Langston Hughes, "ain't been no crystal stair." It is written in the dry and bloodless language of "the law"—statistics, acronyms of agencies and bureaucratic entities, Supreme Court case names and quotes, official governmental reports, periodicity tables, etc. But let

> there be no forgetting the real people to whom this dry and bloodless language gives voice: anxious, working parents who are too poor to obtain medications or heart catheter procedures or lead poisoning screens for their children . . . , elderly persons suffering from chronic conditions like diabetes and heart disease who require constant monitoring and medical attention. Behind every "fact" found herein is a human face and the reality of being poor in the richest nation on earth.

Salazar v. District of Columbia, 954 F. Supp. 278, 281 (D.D.C. 1996).

Nearly twenty-five years of history demonstrates that private actions are indispensable to enforcing Section 30(A). Recognizing that State reductions to reimbursement rates may represent the difference between life and death, Medicaid beneficiaries and providers have long relied on private lawsuits to remedy States' non-compliance with the equal-access mandate. While these lawsuits, brought pursuant to the Supremacy Clause and 42 U.S.C. § 1983, require a great deal of time and resources, they have succeeded in bridging the access gap. As explained below, private enforcement has achieved significant progress in entire States, resulting in increased reimbursement rates, greater provider participation, and ultimately improved access to care. This success has come in the form of injunctive relief, consent decrees, settlement

agreements, and political action spurred by the litigation. Whatever the form of relief, private enforcement has saved lives and improved the health of those who need it most, including low-income children and people with disabilities.

By contrast, the federal government's administrative enforcement tool—a revocation of funding—is extreme and would devastate rather than benefit the individuals whom Medicaid was designed to protect. In fact, the federal government has rarely, if ever, cut funding to a State for violating the equal-access mandate. States know that federal enforcement is a paper tiger. And Petitioners now candidly express the view that, despite Section 30(A)'s mandatory language, it "does not obligate the State to do *anything*." Pet. Br. 52 (emphasis in original). Thus, absent private enforcement, Congress's promise of equal access will go unfulfilled.

Accordingly, *amici* urge this Court to affirm the decision below and re-affirm the long-recognized existence of a Supremacy Clause cause of action. This case presents a single question under the Supremacy Clause, and the Court should resist the suggestion at places in Petitioners' and certain *amici*'s argument to go beyond that question and decide other issues.

ARGUMENT

A. The Medicaid Act, Children's Health Care, and the Promise of "Equal Access"

"The Medicaid program was established in 1965 in Title XIX of the [Social Security] Act for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Schweiker v. Hogan*, 457 U.S. 569, 571 (1982) (citation omitted). States participating in Medicaid must have a plan for medical assistance approved by the Secretary of Health and Human Services ("HHS") that "provide[s] coverage for the 'categorically needy' and, at the State's option, may also cover the 'medically needy.'" *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 650–51 (2003) ("*PhRMA*") (footnotes omitted). Thus, the central purpose of the Medicaid program is to "furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

From early on, the President and Congress placed special emphasis on health care for low-income children. In 1967, Congress amended the Medicaid Act to impose a mandatory children's health care program—now known as Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT")—upon every State choosing to accept federal Title XIX funds. See Pub. L. No. 90–248, 81 Stat. 821. The children's health amendments were enacted amid growing concerns about the unavailability of pediatric health care and

correlative effects on education. In a "Special Message to Congress," President Lyndon B. Johnson explained:

> Recent studies confirm what we have long suspected. In education, in health, in all of human development, the early years are the critical years. Ignorance, ill health, personality disorder—these are disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation. Our nation must rid itself of this bitter inheritance. Our goal must be clear—to give every child the chance to fulfill his promise.[2]

Unfortunately, many of the problems identified by President Johnson in 1967 persisted. As a result, Congress amended the Act in 1989 and "imposed a mandatory duty upon participating states to provide EPSDT-eligible children with all the health care, services, treatments and other measures described in § 1396d(a) of the Act, when necessary to correct or ameliorate health problems discovered by screening, regardless of whether the applicable state plan covers such services." *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 589–90 (5th Cir. 2004); see 42 U.S.C. § 1396d(r)(5).

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[2] http://www.presidency.ucsb.edu/ws/index.php?pid=28438.

That same legislation also mandated access to "care and services . . . under the [Medicaid] 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). This "equal-access" mandate lies at the heart of the Medicaid regime, for it was designed to help effectuate Medicaid's overriding purpose of eliminating "dual-track" medical care. See Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 Am. J.L. & Med. 191, 195–98 (1995). But it could accomplish that purpose only if beneficiaries, including low-income children, actually received the care for which they were eligible.

To provide such access, Congress recognized the need to ensure provider participation. Congress "heard testimony that Medicaid participation of physicians generally, and obstetricians and pediatricians in particular, [was] inadequate" because of low reimbursement rates, and the accompanying House Report found that such rates were an "important factor" in a physician's decision whether to accept Medicaid patients. H.R. Rep. No. 101–247, at 389–90 (1989). The Report observed that, "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program." *Id.* at 390. Congress codified this common-sense correlation between rates, provider participation, and equal access to care in Section 30(A), requiring States to set rates that 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).

B. The Access Gap Between Congressional Promise and State Implementation

Despite Congress's mandate, equal access remains elusive for many Medicaid beneficiaries. Reimbursement rates lag behind private insurance and Medicare; participating providers remain sparse in many areas of the country; and access to health care services remains unequal. The consequences can be fatal.

"Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it makes an unavoidable target." Sack & Pear, *States Consider Medicaid Cuts as Use Grows*, N.Y. Times, Feb. 19, 2010. In 2012, 32 States reduced and/or froze Medicaid rates, and 23 did so in 2013. See Nat'l Governors Ass'n & Nat'l Ass'n of State Budget Officers, *The Fiscal Survey of States: An Update on State Fiscal Conditions* 58 (2012 & 2013). Medicaid rates for primary care physicians and dentists thus remain a fraction of private insurance and Medicare. See, *e.g.*, Nasseh, et al., *A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services* 4–5 (Am. Dental Ass'n 2014); Zuckerman & Goin, *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013?: Evidence from a 2012 Survey of Medicaid Physician Fees* 5–7 (Urban Inst. 2012). In some instances, rates "are not even

adequate to meet overhead expenses," *Clark v. Kizer*, 758 F. Supp. 572, 577 (E.D. Cal. 1990), aff'd in relevant part sub nom. *Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992) (unpublished), effectively requiring providers to pay out of pocket to treat Medicaid patients, a fanciful proposition.

Indeed, reimbursement rates are just as important to physician participation today as they were twenty-five years ago. In 2011, the Government Accountability Office ("GAO") estimated that, of the providers who elected not to participate in Medicaid and the related Children's Health Insurance Program ("CHIP"), 95% were influenced by low reimbursement rates. U.S. Gov't Accountability Office, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, GAO–11–624, at 18 (2011); see also Kaiser Comm'n on Medicaid & the Uninsured, *Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians* 9 (2011) (89% of primary care physicians cited inadequate reimbursement as a reason for accepting only some or no new Medicaid patients).

"Empirical studies confirm that doctors avoid treating Medicaid patients when Medicaid rates are lower than Medicare and private insurance rates." Watson, at 197. And because States often cut rates for purely budgetary reasons, they often do so without even considering the impact they will have on access to care. See, *e.g.*, App. 4 to Pet. for Cert.; *Indep. Living Ctr. of So. Cal., Inc. v. Maxwell-Jolly*,

572 F.3d 644, 655–56 (9th Cir. 2009), vacated and remanded on other grounds sub nom. *Douglas v. Indep. Living Ctr. of So. Cal., Inc.*, 132 S. Ct. 1204 (2012); *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 529–31 (8th Cir. 1993); *Amisub (PSL), Inc. v. State of Colo. Dep't of Social Servs.*, 879 F.2d 789, 799–801 (10th Cir. 1989). Predictably, the result is that access to health care is inferior for many Medicaid recipients when compared to that enjoyed by those with private insurance and/or Medicare. Studies have documented this phenomenon across various medical fields.[3]

Government reports tell the same story. In 2008, the GAO found that "children in Medicaid were almost twice as likely to have untreated tooth decay" as those with private insurance, with only

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[3] See, *e.g.*, Rhodes, et al., *Primary Care Access for New Patients on the Eve of Health Care Reform*, 174 JAMA Internal Med. 861 (2014); Iobst, et al., *National Access to Care for Children with Fractures*, 33 J. Pediatric Orthopaedics 587 (2013); Bisgaier, et al., *Disparities in Child Access to Emergency Care for Acute Oral Injury*, 127 Pediatrics e1428 (2011); Bisgaier & Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance*, 364 New Eng. J. Med. 2324 (2011); Decker, *Medicaid Payment Levels to Dentists and Access to Dental Care Among Children and Adolescents*, 306 JAMA 187 (2011); Skaggs, et al., *Access to Orthopedic Care for Children with Medicaid Versus Private Insurance: Results of a National Survey*, 26 J. Pediatric Orthopaedics 400 (2006); Med. Access Study Group, *Access of Medicaid Recipients to Outpatient Care*, 330 New Eng. J. Med. 1426 (1994).

one in three such children receiving any dental care at all. *Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay*, GAO–08–1121, at 4 (2008). In 2011, the GAO found that about 80% of physicians accepted privately-insured children as new patients, while less than 50% accepted children enrolled in Medicaid and CHIP. 2011 GAO Report, *supra*, at 10. It further estimated that 84% of participating physicians experienced difficulty in referring Medicaid and CHIP children to specialists, compared with only 26% for privately-insured children. *Id.* at 20. In November 2013, the GAO reiterated that, "for most services, access to care for" children enrolled in Medicaid and CHIP is "lower than that of the privately insured, particularly for dental care." *Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance*, GAO–14–40, at 27–28 (2013). And, recently, an HHS investigation spanning 32 States revealed "that Medicaid managed care enrollees may not be able to make appointments with as many as half of the providers listed by their plans." Dep't of Health & Human Servs., Office of Inspector Gen., *Access to Care: Provider Availability in Medicaid Managed Care* 5, 8 (2014).[4]

The lack of provider participation and resultant unequal access can be deadly. For example, in 2007, a 12-year old Medicaid recipient

[4] http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

named Deamonte Driver died from a brain infection caused by untreated tooth decay. Otto, *For Want of a Dentist*, Wash. Post, Feb. 28, 2007. "A routine, $80 tooth extraction might have saved him." *Ibid.* But his mother was unable to find a Medicaid-participating dentist to provide preventive care for Deamonte and his brother, who had six rotted teeth. *Ibid.* "By the time Deamonte's own aching tooth got any attention, the bacteria from the abscess had spread to his brain." *Ibid.* After two operations, and more than six weeks of hospital care (costing more than $250,000), he died. *Ibid.*

C. Private Litigation Has Successfully Narrowed the Access Gap

To compel compliance with the supremacy of federal law, beneficiaries and providers have repeatedly turned to the courts. These actions have successfully remedied equal-access violations and spurred significant improvement in provider participation and access to care. Two exemplar cases, which proceeded to a full trial on the merits, vividly illustrate the indispensable role of private enforcement.

1. *Memisovski*

The *Memisovski* case was a class action brought on behalf of all Medicaid-eligible children in Cook County, Illinois, among the most populous counties in the United States. *Memisovski ex rel. Memisovski v. Maram*, 2004 WL 1878332 (N.D. Ill. Aug. 23, 2004). By the time of trial, approximately

600,000 Cook County children were on Medicaid. *Id.* at *11. After the trial, the court ruled in the plaintiffs' favor, issuing extensive findings of fact and conclusions of law. See *id.* at *11–56.

The findings chronicle both statistical and anecdotal evidence of a Medicaid system that often provided no health care at all, let alone "equal access." The court determined that most physicians in Cook County either did not see Medicaid-enrolled children at all, or significantly limited their Medicaid practices. See *id.* at *17. This lack of providers had a predictable negative effect on patient care. For instance, the court found that approximately 90% of Medicaid-enrolled children in Cook County had never received a vision examination, 80% had never received a hearing examination, and 75% had never received a dental examination. *Id.* at *30. The court relied upon expert analysis showing that approximately one-third of the pediatric Medicaid population had never received "any preventive health care at all." *Id.* at *23.

"[M]any of the physicians testified that Medicaid children frequently use the emergency room as a source of primary care because they simply have nowhere else to go." *Id.* at *44. A pediatric emergency room doctor testified that Medicaid-enrolled children with asthma, gastroenteritis, flu, and diabetes "frequently presented [at the emergency room] with more aggravated or serious symptoms . . . as a result of lack of primary care." *Ibid.* The head of one Chicago

emergency room testified that Medicaid patients frequently arrived with "conditions that privately-insured patients do not typically have and which reflect a lack of primary care, including untreated bone fractures or advanced asthmatic conditions." *Ibid.*

The court also relied on the testimony of Medicaid recipients, such as Yesinia Rodriguez. Ms. Rodriguez testified concerning the extraordinary difficulty she had in locating a physician who would accept Medicaid. When she called the Illinois hotline for a physician referral, she was given the names of approximately ten different doctors, all of whom practiced more than thirty miles away and *none* of whom accepted Medicaid. *Id.* at *18. When she called again, she was given contact information for twenty more doctors. *Ibid.* Once again, however, *not one* of those doctors accepted Medicaid. *Ibid.*

The court's findings concerning Illinois' Medicaid payment rates explained why access to needed care was inadequate. Indeed, the defendants admitted that Medicaid rates were low, unattractive, and set without any consideration of the effect on access. *Id.* at *45. The court found that Medicaid rates in Illinois were approximately 50% of Medicare rates and that "[a] pediatrician practice relying solely on Medicaid beneficiaries maximum reimbursements could not survive since Medicaid pays nearly 10% less than the median practice costs." *Id.* at *12–13. In summarizing the overwhelming evidence put on by the plaintiffs, the court stated:

> Testimony showed that Medicaid-enrolled children face conditions such as longer waiting times for care, a more limited population of providers willing to provide care, and multiple trips to the doctor for services which could be addressed in one visit. All in all, the doctors painted a picture of Medicaid-enrolled patients being afforded a significantly lesser degree of access to care than that enjoyed by privately-insured children.

Id. at *43 (internal citations omitted).

The court ultimately entered a consent decree, requiring the State to "provide plaintiffs with (i) Equal Access to pediatric care and services and (ii) EPSDT Services." Case No. 1:92–cv–1982, Doc. 422 at 9 ¶ 4 (filed N.D. Ill. Nov. 18, 2005). The decree effectively reformed the State's primary-care system and turned around Medicaid in Illinois. Indeed, a study revealed that, in the years following the decree, the number of beneficiaries "grew considerably," hospital and emergency room visits declined, savings increased while costs decreased, and "[q]uality [of care] improved for nearly all metrics." Phillips, Jr., et al., *Cost, Utilization, and Quality of Care: An Evaluation of Illinois' Medicaid Primary Care Case Management Program*, 12 Annals of Family Med. 408, 408, 411–12 (2014).

2. *OKAAP*

As in *Memisovski*, the plaintiffs in *OKAAP* were successful in proving wholesale violations of the equal-access mandate, and the district court issued detailed findings of fact evincing non-compliant and badly broken Medicaid programs. *Okla. Chapter of the Am. Academy of Pediatrics ("OKAAP") v. Fogarty*, 366 F. Supp. 2d 1050 (N.D. Okla. 2005). The court's findings and conclusions meticulously set out the Oklahoma defendants' continuing, serious, and knowing failures to assure that eligible children received health care services required by the Medicaid Act.

> The testimony from providers and parents of class members alike was that recipients have great difficulty accessing needed health care services in Oklahoma. As plaintiffs established, the lack of physician participation in Medicaid forces class members either to wait for unreasonable periods of time to receive needed care or to travel long distances to find Medicaid participating providers, putting these children at *risk of harm* ***or even death***.
>
> The testimony at trial also demonstrated that providers are widely opting out of the Medicaid program or restricting their Medicaid caseloads.

> *Finally, defendants admitted at trial that reimbursement rates are inadequate and that the equal access provision is being violated.*

Id. at 1107 (emphases added; internal numbering omitted).

The evidence in the case was extensive. For instance, the court found that one young Medicaid patient died while awaiting a delayed airway surgery. *Id.* at 1100. At the time of the class-certification hearing, one named plaintiff "had been unable to secure a medically necessary prosthetic shoe insert to replace her amputated foot." *Id.* at 1088. The primary care physician of another named plaintiff had attempted, without success, for approximately three years to find *any* Medicaid-participating facility to perform a necessary diagnostic sleep study. *lbid.*

The court found generally that Medicaid "recipients in Oklahoma often experience long delays in obtaining appointments for provision of medically necessary care." *Id.* at 1079. Access to neurological care was of particular concern. Pediatric Medicaid patients in Oklahoma City with seizure disorders were forced to "wait *around a year* to be seen by a pediatric neurologist." *Id.* at 1067 (emphasis added). "Some of these patients ha[d] poorly controlled seizures," and, as the court found, "without the prompt care of a neurologist, the seizures will have a negative impact on school performance, development, behavior, and the overall

medical well-being of these children." *Ibid.* (quotation marks omitted). The court noted the chilling account of one parent who "testified that she had to drive her daughter for four hours to see a pediatric neurologist, and her daughter experienced a severe seizure en route." *Ibid.*

Office-based ear, nose, and throat ("ENT") specialists in Oklahoma simply refused to treat children on Medicaid. *Id.* at 1067–68. "The lack of Medicaid participation by private practice ENT specialists ha[d] created almost a crisis situation" at one medical center. *Id.* at 1068 (quotation marks omitted). A pediatric thoracic surgeon in Tulsa described access to orthopedists accepting Medicaid as "extremely poor." *Id.* at 1069. The court noted the testimony of another Tulsa pediatrician regarding "a six-week ordeal his office encountered attempting, without success, to secure an orthopedic consult for a four-year-old girl with a fractured toe." *Ibid.*

Statistical and anecdotal evidence alike showed significant disparities in access to care. Only 34% of Oklahoma's pediatricians participated fully in the Medicaid program, while 69% of Oklahoma's pediatricians accepted all new privately-insured patients. *Id.* at 1063. The many physicians who testified at trial corroborated these statistics. A pediatric neurologist, who had ceased accepting new Medicaid patients, testified that "children on Medicaid [did] not have the same access to neurological services provided to children with private insurance because of low or nonexistent Medicaid reimbursement." *Id.* at 1067. Another

pediatrician testified that, while access to ENT specialists was extremely poor for Medicaid patients, "children with private insurance ha[d] no problems accessing ENT services." *Id.* at 1068.

Consistent with the 2011 GAO Report, the court found that "[a]pproximately ninety-three percent (93.2%) of Oklahoma's pediatricians report[ed] that low reimbursement [was] a very important reason why they would limit their participation in the Medicaid program." *Id.* at 1075. "From 1995 through December 31, 2003, provider reimbursement under Oklahoma's Medicaid fee-for-service schedule never exceeded 72% of Medicare." *Id.* at 1059. By contrast, "[u]nder commercial plans, Oklahoma physicians were reimbursed at rates of 130% to 180% of Medicare." *Id.* at 1060. As the Chief Executive Officer of Oklahoma's Medicaid agency candidly admitted, Oklahoma's Medicaid physician reimbursement rates "are low, were low, and that this is a factor that makes it difficult to recruit physicians." *Id.* at 1075 (citation omitted).

In response to the lawsuit, the State increased reimbursement rates to 100% of Medicare rates. *Medicaid Ruling Reversed*, Tulsa World, Jan. 4, 2007, at A1. While the Tenth Circuit later reversed,[5] the State decided that it would

[5] The court of appeals reversed on purely legal grounds—partly on a basis later overruled by Congress, see *Leonard v. Mackereth*, 2014 WL 512456, at *6–7 (E.D. Pa. Feb. 10, 2014) (discussing 2010 amendment to 42 U.S.C. § 1396d(a))—and did *not* challenge the district court's

nonetheless maintain those increased reimbursement rates. *Ibid.* Thus, the litigation effectively resulted in increased rates, and, in turn, increased access to care for children in Oklahoma. Indeed, from the commencement of the litigation in 2001 to 2011, EPSDT screening ratios increased from 56% to 74%, EPSDT participant ratios increased from 40% to 55%, and the number of eligible children receiving any dental services increased from approximately 69,000 to approximately 258,000. See Annual EPSDT Participation Report: Form CMS-416 73–74 (2001); *id.* at 106–07 (2011).[6]

* * *

These success stories serve only as examples. In addition to awarding relief after full trials, courts have repeatedly awarded preliminary injunctive relief to stave off Medicaid rate cuts. See, *e.g.*, *Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010), vacated and remanded on other grounds sub nom. *Douglas*, 132 S. Ct. 1204 (2012); *Long Term Care Pharmacy Alliance v. Ferguson,* 260 F. Supp. 2d 282 (D. Mass. 2003), vacated and remanded on other grounds, 362 F.3d 50 (1st Cir. 2004); *Ark. Med. Soc'y, Inc. v. Reynolds,* 834 F. Supp.

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underlying findings of fact. See *OKAAP*, 472 F.3d 1208, 1214–15 (10th Cir. 2007).

[6] Reports available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

1097, 1101–05 (E.D. Ark. 1992). The availability of such injunctive relief is vital, for, once the rate reductions go into effect, access to care can be significantly curtailed. See, *e.g.*, *Maxwell-Jolly*, 572 F.3d at 656–57 ("some medical providers have refused to treat Medi-Cal recipients since the ten percent rate reduction was implemented").

Private lawsuits have also produced settlements significantly improving access to care. For example, a 2008 agreement settling a Connecticut lawsuit increased dental reimbursement rates, generating a dramatic increase in provider participation and access. Ct. Health Found., *Impact of Increased Dental Reimbursement Rates on HUSKY A-Insured Children: 2006–2011* (Feb. 2013).[7] A study comparing conditions before and after the settlement found that: "[p]rivate dentist participation in the Medicaid program more than doubled;" continuously-enrolled children with at least one dental visit per year grew from 46% to 69.5%, surpassing even the rate of children with private insurance; "[t]he increase in utilization occurred across all three major services types," namely diagnostic, preventive, and treatment; and "utilization rates . . . increased in 167 of 169 of Connecticut's cities and towns," with 158 towns experiencing double-digit increases. *Id.* at 3–5.

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[7] http://www.cthealth.org/wp-content/uploads/2013/02/impact-of-increased-dental-reimbursement-rates.pdf.

Improvement in provider participation and access to care would not have occurred absent private enforcement. The "federal government lacks the financial, legal, logistical, and practical wherewithal comprehensively to enforce § 30(A) against the states." *Douglas*, Br. Former HHS Officials as *Amici Curiae,* 2011 WL 3706105, at *4, 27, (filed Aug. 5, 2011); see Donenberg, Note, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 Yale L.J. 1498, 1501–02 (2008). Indeed, the only enforcement tool available to the Secretary of HHS—revocation of a State's federal funding, 42 U.S.C. § 1396c—is the administrative equivalent of a nuclear bomb. "[A] funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act." *Pennhurst State Sch. & Hosp. v. Halderman,* 451 U.S. 1, 52 (1981) (White J., dissenting in part). Were the Secretary to revoke funding of a State's Medicaid program for non-compliance with Section 30(A), recipients would lose health coverage altogether, turning a crisis into a catastrophe. States know that this "remedy is so destructive to the underlying aid program that it is rarely, if ever, invoked." Donenberg, at 1502 (citation omitted).

The facts in *Douglas* illustrate the limitations of HHS enforcement. There, California implemented rate cuts before even submitting State plan amendments ("SPAs") to HHS's Centers for Medicaid & Medicaid Services ("CMS") for approval, notwithstanding well-established circuit precedent requiring the States to "submit . . . and obtain

approval *before* implementing any material change in a plan." *Arc of Cal. v. Douglas*, 757 F.3d 975, 984 n.4 (9th Cir. 2014). California later submitted SPAs but continued implementing the cuts while the SPAs were pending, even after CMS informed California that it could not approve the SPAs without additional information regarding compliance with Section 30(A). And, most revealing, California continued to implement the cuts even after CMS denied the SPAs for non-compliance with the equal-access provision, which did not occur until over two years after the cuts were originally implemented.[8] The only cuts that the State did not unilaterally implement throughout this period were those that had been enjoined as a result of private litigation. See *Douglas*, Br. Am. Health Care Ass'n, et al. as *Amici Curiae*, 2011 WL 3488988, at *19–20 (filed Aug. 5, 2011); *Douglas*, Br. Intervenor Resp. in No. 09–958 & Cal. Pharmacists Resp. in No. 09–1158, 2011 WL 3288335, at *4–7, (filed July 29, 2011);

[8] Contrary to the suggestion of one of Petitioners' *amici*, see Cal. HHS Br. 11, CMS denied the SPAs not because of the court's injunction, but rather "because California ha[d] not demonstrated that it would meet the conditions set out in section 1902(a)(30)(A)." *Douglas*, U.S. Cert. Amicus Br. in No. 09–958 2a (filed Dec. 3, 2010). Indeed, California refused to provide the requested information despite being given almost two years to do so. As a secondary "concern", CMS noted that, even if California had demonstrated compliance, such late approval would have created retroactive liability for providers; but that concern arose only because of the length of delay caused by California's own non-cooperation. See *id.* at 3a.

Douglas, U.S. Cert. Amicus Br. in No. 09–958, 2010 WL 4959708, at *2–7, 1a–4a (filed Dec. 3, 2010).

Not only does this episode illustrate the limitations of HHS enforcement, but it confirms that private enforcement serves as a critical complement to federal administrative action. In *Douglas*, private enforcement enjoined certain rate cuts that California initially did not submit for approval to CMS, that CMS later denied for lack of information from California regarding compliance with Section 30(A), and that California implemented for more than three years before receiving very limited approval from CMS.[9] Moreover, in this case, CMS did approve Idaho's new rate-setting methodology, but private enforcement was still necessary to complement HHS enforcement because Idaho never implemented its new rate-setting methodology. See Resp. Br. 2–3 & n.1. Thus, private enforcement offers a more nuanced, flexible remedy of declaratory and injunctive relief capable of bringing State programs into compliance with federal law. And Congress has clearly expressed its intent that

[9] One of Petitioners' *amici* suggests that private litigation interferes with HHS enforcement because, when CMS finally granted limited approval to certain SPAs in *Douglas*, it required California to give up all but three months' worth of claims for retroactive recoupment. See Cal. HHS Br. 10–11. But California voluntarily withdrew its request for approval for several years in which rate reductions had been enjoined. See *Douglas*, Letter from U.S. (filed Oct. 28, 2011). And, as noted above, the delay in the administrative process was attributable solely to California's refusal to timely provide information to CMS.

private enforcement play this vital role, codifying that, "[i]n an action brought to enforce a provision of this chapter [*i.e.*, the Social Security Act], such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan." 42 U.S.C. § 1320a–2 (1994).

Absent private enforcement, the grievous deficiencies within the Medicaid programs in Illinois, Oklahoma, and other States would have never been addressed. Thus, private enforcement is crucial to ensure equal access and effectuate the core purpose of the Medicaid Act.

D. To Avoid Disturbing the Indispensable Role of Private Enforcement, the Court Should Decide Only the Question Presented

The question presented here is whether "the Supremacy Clause gives Medicaid providers a private right of action to enforce [Section 30(A)] against a state where Congress chose not to create enforceable rights under that statute." Pet. for Cert. i. The Court should answer that question affirmatively for the reasons and long line of decisions set forth in Respondents' brief.

In resolving that question, the Court should also reject the at least implicit invitations of Petitioners and certain *amici* to decide other issues of statutory interpretation, such as whether Section

30(A) is enforceable through Section 1983, and whether Section 30(A) confers rights on recipients (as opposed to providers).

1. The Court Should Refrain From Deciding Whether Section (30)(A) Confers Rights Enforceable Through Section 1983

The plaintiffs brought this action pursuant to the Supremacy Clause, not Section 1983. That is unsurprising: Ninth Circuit precedent permitted the former, but not the latter. See *Indep. Living Ctr. of So. Cal. v. Shewry*, 543 F.3d 1050, 1065 (2008); *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (2005). Given that legal and factual backdrop, the unavailability of a Section 1983 action was taken as a given for purposes of this litigation. The issue was never contested by the parties, and the lower courts had no occasion to consider it. Opining on the issue here would therefore run afoul of this Court's general rule against considering issues not litigated or considered below. See *Taylor v. Freeland & Kronz*, 503 U.S. 638, 645–46 (1992). Nor has the issue been fully briefed in this Court; to the contrary, it has received only scant treatment by Petitioners and their *amici*. See Pet. Br. 18 & n.4, 22–23; U.S. Br. 11–14.

Accordingly, while this Court may recognize that the question presented assumes that Section 30(A) confers no statutorily enforceable rights, the Court itself should not decide that proposition. The

Chief Justice employed that prudent approach in *Douglas*, which also came to this Court from the Ninth Circuit with the same assumption built into the question presented. See *Douglas v. Indep. Living Ctr.*, 132 S. Ct. 1204, 1212 (2012) (Roberts, C.J., dissenting) ("Thus, *as this case comes to us*, the federal rule is that . . . private parties have no statutory right to sue to enforce" Section 30(A).) (emphasis added). And this Court has previously exercised such restraint with respect to threshold issues that were not fully briefed or properly presented. See, *e.g.*, *Norfolk So. Ry. Co. v. Sorrell*, 549 U.S. 158, 164–65 (2007) ("prefer[ring] not to address" a "significant" issue "anterior" to the question presented because it "has not been fully presented"); *Lebron v. Nat'l R.R. Passenger Corp.*, 513 U.S. 374, 404–05 (1995) (O'Connor, J., dissenting) (discussing examples); see also *Nat'l Aeronautics & Space Admin. v. Nelson*, 562 U.S. 134, 131 S. Ct. 746, 756 n.10 (2011) (deeming it "undesirable for us to decide a matter of this importance in a case in which we do not have the benefit of briefing by the parties"); *Ortiz v. Jordan*, 562 U.S. 180, 131 S. Ct. 884, 894–95 (2011) (Thomas, J., concurring in the judgment) (considering it "unwise" to reach an issue not considered below because it presented "difficult and far-reaching questions").

That is particularly true since any opinion declaring Section 30(A) unenforceable through Section 1983 would "cast serious doubt on longstanding precedent," a "step [this Court] historically take[s] only with the greatest caution

and reticence." *Knox v Serv. Employees Int'l Union, Local 1000*, 132 S. Ct. 2277, 2299 (2012) (Sotomayor, J., concurring in the judgment). Specifically, this Court held in *Wilder* that providers could bring suit under Section 1983 to enforce the Boren Amendment to the Medicaid Act, a rate-reimbursement provision that is indistinguishable from Section 30(A). See 496 U.S. at 501–02, 524. Critically, *Wilder* remains binding precedent. Indeed, this Court re-affirmed it in *Gonzaga University v. Doe*. See 536 U.S. 273, 280–81 (2002).

Petitioners do not mention *Wilder*'s holding at all in their brief, and their *amici* refer only to legislative activity post-dating the case. See U.S. Br. 30 n.11.; Cal. HHS Br. 11–13. They emphasize that Congress repealed the Boren Amendment in 1997. But importantly, Congress declined to take any action on Section 30(A), even though at the time the Boren Amendment repeal was under consideration, Section 30(A) was already the subject of judicial enforcement by providers. See, *e.g.*, *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1495–96 (9th Cir. 1997); *Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 1002–05 (1st Cir. 1996); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996); *Reynolds*, 6 F.3d at 523–28.

Congress's decision to leave Section 30(A) untouched, despite being urged to repeal it, see Resp. Br. 44, takes on greater significance given that Congress also left *Wilder* untouched, but *did* quickly act to overrule in part this Court's very next Section 1983 enforcement decision in *Suter v. Artist M.*, 503

U.S. 347 (1992). See 42 U.S.C. § 1320a–2 (1994). And, in doing so, Congress expressly preserved "the grounds for determining the availability of private actions to enforce State plan requirements . . . applied in prior Supreme Court decisions respecting such enforceability." *Ibid.* Despite effectively re-affirming *Wilder*, Congress's "*Suter* fix" is not mentioned in Petitioners' brief, and the Government discusses it only in the context of the Supremacy Clause issue, see U.S. Br. 29–30.

Congress has amended the Medicaid Act repeatedly in the decades since *Rosado v. Wyman*, 397 U.S. 397 (1970), held that federal courts have authority to enjoin State laws preempted by the Social Security Act's State plan requirements. And Congress has done so without changing the statutory structure to make the administrative remedy exclusive, or otherwise expressing any intent to foreclose the role of the courts. Thus, Congress's action in repealing the Boren amendment without repealing 30(A), along with Congress's enactment of the *Suter* fix, are not only relevant to whether there is an enforceable right under Section 1983, but also show that Congress did not intend to preclude Supremacy Clause actions. See Resp. Br. 42–44.

2. The Court Should Refrain From Opining on the Rights of Recipients and on Provisions Other than Section 30(A)

Because the question presented is expressly limited to both Medicaid providers and Section 30(A), this Court should limit its opinion accordingly. Whether recipients have enforceable rights under Section 30(A) is not "fairly included" in that question. S. Ct. R. 14.1(a). Recipients stand in a different position from providers, and determining whether they have enforceable rights requires an independent legal analysis not appropriate here. See, *e.g.*, *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 538, 541–44 (3d Cir. 2002) (en banc) (Alito, J.) (concluding that Section 30(A) was written to benefit Medicaid recipients, not providers).

And, as Respondents note, this Court has repeatedly held that other provisions of the Medicaid and Social Security Acts are privately enforceable. See, *e.g.*, *PhRMA*, 538 U.S. at 649–50 (Medicaid Act); *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474 (1996) (per curiam) (Medicaid Act as affected by Hyde Amendment); *Rosado*, 397 U.S. at 407, 420 (Social Security Act); see also Resp. Br. 35–37 (citing additional examples). Thus, this Court should limit its opinion to providers with respect to Section 30(A) of the Medicaid Act.

CONCLUSION

For the foregoing reasons, *amici* respectfully request that this Court affirm the decision below.

Respectfully submitted,

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