No. _____

In The
Supreme Court of the United States

RICHARD ARMSTRONG and LISA HETTINGER,

Petitioners,

v.

EXCEPTIONAL CHILD CENTER, INC.; INCLUSION, INC.; TOMORROW'S HOPE SATELLITE SERVICES, INC.; WDB, INC.; and LIVING INDEPENDENTLY FOR EVERYONE, INC.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

To receive federal Medicaid funding, a state must adopt a plan containing "methods and procedures" that will "safeguard against unnecessary utilization" of Medicaid services and "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population. . . ." 42 U.S.C. § 1396a(a)(30)(A). Congress chose not to confer on Medicaid providers any enforceable rights under this statute. The Ninth Circuit in this case, however, held that (a) Medicaid providers could enforce § 1396a(a)(30)(A) directly under the Supremacy Clause; and (b) the State of Idaho's Medicaid reimbursement rates were preempted by that statute because they did not "substantially reimburse providers their costs" and because they remained in place "for purely budgetary reasons."

The questions presented are:

1. Does the Supremacy Clause give Medicaid providers a private right of action to enforce § 1396a(a)(30)(A) against a state where Congress chose not to create enforceable rights under that statute?

2. If Medicaid providers have a private right of action, are a state's Medicaid provider reimbursement rates preempted by § 1396a(a)(30)(A) where they do not bear a reasonable relationship to provider costs and remain in place for budgetary reasons?

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OPINIONS BELOW

This petition seeks review of one opinion of the U.S. Court of Appeals for the Ninth Circuit, which is unreported and reproduced at App. 1. The initial opinion of the U.S. District Court for the District of Idaho is unreported and reproduced at App. 15. The district court's memorandum decision on Petitioners' motion for reconsideration is unreported and reproduced at App. 7. The judgment of the district court is reproduced at App. 5.

JURISDICTION

The court of appeals issued its decision on April 4, 2014. Petitioners invoke this Court's jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. The Supremacy Clause of the United States Constitution provides:

> 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, cl. 2.

2. A provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), provides:

> A State Plan for medical assistance must –
>
> * * *
>
> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. . . .

INTRODUCTION

The questions in this case present the Court with an opportunity to resolve two significant and recurring issues relating to the proper function of the Supremacy Clause and the administration of Medicaid. The circuits do not agree whether or when the Supremacy Clause supplies a private right of action to enforce Medicaid funding conditions against states

in the absence of Congressional intent to create either a right or remedy for their alleged violation. The Ninth Circuit in this case held that the Supremacy Clause supplies a right of action, as have four other circuits. This Court granted *certiorari* in *Douglas v. Independent Living Center, Inc.*, 132 S. Ct. 1204 (2012) ("*Independent Living*") to decide exactly this question. Post-argument procedural events produced a remand, and so the Court did not reach the question. The Chief Justice, joined by three other Justices, dissented, and would have held that the Supremacy Clause does not supply a right of action of its own force where Congress has not created an enforceable right. One circuit and one state high court has taken influence from the Chief Justice's *Independent Living* dissent and held that the Supremacy Clause does not supply right of action. Another circuit, while not reaching the issue, has expressed doubt that the Supremacy Clause provides a private right of action. The Ninth Circuit's decision rests on an erroneous reading of this Court's cases, and review is warranted to resolve this fundamental question about the role of the Supremacy Clause. The importance of resolving this question is only underscored by the Ninth Circuit's erroneous decision on the merits.

The court of appeals held the State of Idaho's provider reimbursement rates preempted by 42 U.S.C. § 1396a(a)(30)(A) ("§ 30(A)") because they did not substantially reimburse provider costs and because they stayed in place solely for budgetary reasons. Review is warranted to undo the Ninth Circuit's

rewrite of this statute. No other circuit has imposed the requirements the Ninth Circuit has. This is for good reason: The Ninth Circuit's interpretation has no basis in the statutory text and it conflicts with the views of the federal agency entrusted with administering the statute. It imposes requirements Congress did not intend (and that the State did not bargain for). And finally, it frustrates Congress' intent by inhibiting states' flexibility to design their programs and by disrupting the federal-state partnership Congress created.

This case presents the opportunity to resolve at last these issues and end the Ninth Circuit's erroneous foray into the administration of Medicaid. The events triggering the remand in *Independent Living* are not capable of occurring here. There is no pending action before the Centers for Medicare and Medicaid Services, the basis for the court of appeals' decision is clear, and the facts are straightforward.

STATEMENT OF THE CASE

1. Medicaid is a cooperative federal-state program that directs federal funding to participating states to provide medical assistance to "families with dependent children . . . [and] aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services. . . ." 42 U.S.C. § 1396-1. States do not have to participate in Medicaid, but if they do, federal funding

is conditioned on compliance with the Medicaid Act and its implementing regulations promulgated by the Secretary of the U.S. Department of Health and Human Services, otherwise known as "HHS." *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

One such condition is that states adopt and submit "plan[s] for medical assistance" to the Centers for Medicare and Medicaid Services ("CMS") for approval. 42 U.S.C. § 1396a(a); *see also* 42 C.F.R. § 430.10. These plans must:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. . . .

42 U.S.C. § 1396a(a)(30)(A).

This Court has said that Congress has given HHS "exceptionally broad authority to prescribe standards for applying certain sections of the Act." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (citation omitted). And within basic, often broadly written requirements, states have substantial flexibility in designing and administering their Medicaid

programs. *See Alexander v. Choate*, 469 U.S. 287, 303 (1985). A state's flexibility is not unchecked, though. Part of the ongoing relationship between the states and CMS includes periodic program reviews by CMS, 42 C.F.R. § 430.32(a), and the HHS Office of Inspector General conducts periodic audits, 42 C.F.R. § 430.33. The state has the opportunity to submit facts in aid of its position or accept and correct violations. *Id.* § 430.33(c).

If CMS believes a state has failed to correct a violation, Congress has given HHS a powerful enforcement mechanism. CMS may initiate a compliance action and withhold federal funds. 42 U.S.C. § 1396c; 42 C.F.R. § 430.35. If, for example, a state's Medicaid expenditures are inconsistent with its state plan, CMS may disallow the expenditure and force the state to repay federal funds. *See id.* §§ 430.33(c)(3), 430.42(a), 430.35(d). The state may request a hearing if it does not like the disallowance, and private parties, like providers, may participate. *Id.* § 430.76. These parties may conduct discovery and offer opinion and expert testimony. *Id.* §§ 430.83, 430.86, 430.88. CMS's decision is subject to judicial review under the Administrative Procedure Act, 5 U.S.C. §§ 701, *et seq*.

2. Medicaid includes a basic bundle of services, but states may receive funding to provide additional services through waivers. Congress authorized the Developmentally Disabled Home and Community Based Services Waiver – known as the "DD Waiver" –

to assist states in funding a variety of non-institutional care options for persons who would be eligible for Medicaid benefits in an institution, but who prefer to live at home or in the community. 42 U.S.C. § 1396n(c)(1); *see also Sanchez v. Johnson*, 416 F.3d 1051, 1054 n.1 (9th Cir. 2005). The services at issue in this case are called "residential habilitation" services. Idaho has had a DD Waiver since 1995 and provides these services through contracted providers.

This case involves Idaho's reimbursement rates for residential habilitation services under the DD Waiver. The challenged rates were increased by the Idaho Department of Health and Welfare, which is the State's Medicaid agency, in 2006. App. 17. The Department does not typically include the reimbursement rates for these services in its state plan or waiver documents. (Nor is it required to. It simply must maintain documentation of those rates and make them available to CMS on request. 42 C.F.R. § 447.203.) Rather, the State's DD Waiver documents identify the methods and procedures the Department follows to set rates. Once the Department establishes rates, it publishes them in a pricing file, which is made available to Medicaid providers through Information Releases and is published on the Department's website. The providers provide the services and then bill the Department, which reimburses them. The Department then draws its allocation of federal Medicaid money quarterly.

Federal and state regulations limit provider participation to those that agree to accept, as payment

in full, the amounts that the state pays them. 42 C.F.R. § 447.15; Idaho Admin. Code § 16.03.09.210.03. State regulations limit provider reimbursement to the lower of the provider's actual charge or the maximum allowable charge as established by the Department. Idaho Admin. Code § 16.03.10.036.02.

In 2005, the Idaho Legislature adopted a new law directing the Department to compile information relating to the cost of care. *See* Idaho Code § 56-118 (2005) (*amended by* 2011 Idaho Sess. Laws 463). App. 18. The statute directed the Department to furnish this information to the Legislature annually as part of its budget request. The statute did not require any changes in rates based on the information it compiled.

In 2006, the Department hired a firm to conduct surveys to implement § 56-118. The firm produced recommended rates based on varying alternative methodologies for various services each year. App. 18. The Department did not implement the rates in the firm's reports, but continued to report the information to the Legislature each year. In 2009, the Department proposed rate increases for the services at issue in this case. App. 19. However, the Department did not receive an appropriation for the increases from the Idaho Legislature, so the Department did not finalize the methodology change or increase the rates. At no time relevant to this case has CMS ever initiated any compliance action or otherwise complained

about the State's rates or its compliance with the DD Waiver.

3. Question Two in this petition concerns the role of provider costs in setting and maintaining reimbursement rates under § 30(A). The Secretary of HHS has not adopted any regulation addressing how states may demonstrate compliance with § 30(A). The Ninth Circuit, however, has given § 30(A) a reading that imposes substantive requirements on states that do not appear in the text of the statute. To explain: In *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998), the court of appeals read § 30(A) to require states to set hospital outpatient reimbursement rates so that they "bear a reasonable relationship" to provider costs, and to "rely on responsible cost studies" before reducing reimbursement rates. 103 F.3d at 1496. Where rates do not "substantially reimburse providers their costs," a state cannot justify the rates with "purely budgetary reasons." *Id.* at 1499 & n.3. Since then, the Ninth Circuit has reaffirmed and expanded these requirements several times in other cases – including the cases vacated by the Court on other grounds in *Independent Living*.

In 2011, HHS issued a proposed rule setting forth a comprehensive and detailed approach to demonstrating compliance with § 30(A). 76 Fed. Reg. 26,342, 26,343 (May 6, 2011). The proposed rule would have implemented a three-part, flexible framework by which states would monitor access to care using

many factors. *Id.* at 26,343-26,346. HHS noted that there was "no consensus among the circuits" about how states comply with § 30(A), and cited the differing approaches taken by the Ninth Circuit in *Orthopaedic Hospital v. Belshe* and the Seventh Circuit in *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996) (which did not require cost studies or other procedural requirements). 76 Fed. Reg. at 26,343. The agency explained that cost is one consideration that affects access, but that there are many others, and that "cost-based studies may not always be informative or necessary." *Id.* at 26,344. It did not propose to require the approach the Ninth Circuit has taken. *See id.*

The rulemaking status is unclear. In the three-plus years since the proposed rule was published in the Federal Register, no final rule has been adopted, and Petitioners have no information that HHS has taken any further steps toward implementing the rule or even that HHS intends to proceed with this rulemaking.

4. Respondents contract with the State to provide services under the DD Waiver. They sued the Department on December 7, 2009. They did not sue the Secretary of HHS or CMS. Respondents claimed that based on the new cost information, the Department's rates were preempted by § 30(A) because they were not consistent with the Ninth Circuit's requirements from *Orthopaedic Hospital v. Belshe*.

On cross-motions for summary judgment, the district court noted that the record "would appear to support" a finding that the then-existing rates were consistent with precisely the things § 30(A) is concerned with: efficiency, economy, and quality of care. App. 22. And there had been no dispute about access to care, either: The parties agreed that services covered by the DD Waiver were readily available to eligible participants and there was no dispute that there were no waiting lists for any Medicaid services in Idaho. The record before the district court and court of appeals contained no evidence that rates were inefficient or uneconomical. Rather, the providers relied solely on the mere existence of new provider cost information to claim that the Department violated § 30(A).

The district court recognized, too, that *Orthopaedic Hospital v. Belshe* and later cases involved rate cuts, not challenges to existing rates. App. 21. Yet, in light of the more recent cost information, the district court ruled that existing rates failed the requirements of *Orthopaedic Hospital v. Belshe*. App. 22. "The Court need not wait for evidence of low quality of care or insufficient access to services before intervention is warranted," it said. App. 22-23. The court granted the providers' motion for summary judgment and issued an injunction requiring that the Department raise its rates to match those proposed in 2009. App. 24.

On appeal, the Ninth Circuit held first that the providers had a private right of action under the Supremacy Clause to challenge Idaho's rates as

preempted by § 30(A). App. 2-3, *quoting Indep. Living Ctr. of S. Cal. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008) ("Under well-established law of the Supreme Court, this court, and the other circuits, a private party may bring suit under the Supremacy Clause to enjoin implementation of state legislation allegedly preempted by federal law."). The court of appeals deemed itself bound by circuit precedent and this Court's precedents "that have recognized a private right of action under the Supremacy Clause." App. 3, *citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983); *Bud Antle, Inc. v. Barbosa*, 45 F.3d 1261, 1269 (9th Cir. 1994).

On the merits, the court held that, under *Orthopaedic Hospital v. Belshe*, because the State's reimbursement rates did not substantially reimburse providers their costs and remained in place for purely budgetary reasons, the district court correctly granted summary judgment to the providers. App. 4.

REASONS FOR GRANTING THE WRIT

I. THIS COURT SHOULD RESOLVE THE CIRCUIT SPLIT AND DECIDE WHETHER THE SUPREMACY CLAUSE GIVES MEDICAID PROVIDERS A PRIVATE RIGHT OF ACTION TO ENFORCE 42 U.S.C. § 1396a(a)(30)(A) AGAINST STATES WHERE CONGRESS HAS CHOSEN NOT TO CREATE ANY ENFORCEABLE RIGHTS.

A. Review is warranted because there is conflict in the circuits about whether and when Medicaid statutes are privately enforceable through the Supremacy Clause in the absence of a Congressionally created right or remedy.

1. This Court granted *certiorari* in *Independent Living* to decide whether Medicaid providers and beneficiaries had a Supremacy Clause right of action to challenge, as preempted by § 30(A), California laws reducing and imposing other limits on the payments that the state made to various Medicaid providers. 132 S. Ct. at 1208. The suit came after California submitted plan amendments to implement payment cuts, but before CMS acted on them. After oral argument in this Court, CMS approved several of the amendments. *Id.* at 1209.

Five to four, this Court held that CMS's decision meant that the plaintiffs may have to seek review of that decision under the federal Administrative Procedure Act rather than pursue an injunction against the state from a federal court under the Supremacy

Clause. *Id.* at 1210. The dissenters would have held that "[w]hen Congress did not intend to provide a private right of action to enforce a statute enacted under the Spending Clause, the Supremacy Clause does not supply one of its own force." *Id.* at 1215 (Roberts, C.J., dissenting).

2. Without clear guidance from this Court, a split has developed in the circuits. One side of the split holds that a Supremacy Clause right of action exists to enforce Medicaid statutes even in the absence of a federal right or remedy. *See Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 819 & n.3 (D.C. Cir. 2004) (suggesting this Court has *sub silentio* endorsed Supremacy Clause right of action); *Lewis v. Alexander*, 685 F.3d 325, 345-46 (3d Cir. 2012) ("Supreme Court precedent establishes that the Supremacy Clause creates an independent right of action where a party alleges preemption of state law by federal law.") (citation omitted); *Planned Parenthood of Houston and Se. Tex. v. Sanchez*, 403 F.3d 324, 332 & n.31 (5th Cir. 2005) (suggesting the Court has "apparently accept[ed]" existence of Supremacy Clause right of action) (footnotes omitted); *Detgen ex rel. Detgen v. Janek*, No. 13-10396, 2014 WL 2013532 (5th Cir. May 16, 2014) (beneficiaries have Supremacy Clause right of action to enforce "reasonable standards" provision of Medicaid, 42 U.S.C. § 1396a(a)(17)); *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006).

The Ninth Circuit in this case made short work of the question, simply citing *Independent Living Center of Southern California v. Shewry* for the idea

that the Supremacy Clause supplies an implied right of action. That case illuminates the court's rationale a bit better. The court there enjoined California's implementation of legislation cutting provider payments by ten percent. 543 F.3d at 1052. The state contended that the suit was foreclosed because the court of appeals had previously held in *Sanchez v. Johnson* that § 30(A) conferred no rights or rights of action under 42 U.S.C. § 1983. That was, to the court, immaterial, because, it wrote, this Court has "repeatedly entertained" preemption cases under the Supremacy Clause without requiring that the plaintiff satisfy § 1983. *Id.* at 1055-56.

3. To this broad view of the Supremacy Clause, the Tenth Circuit recently said, "No." The court held in *Planned Parenthood of Kansas and Mid-Missouri v. Moser*, 747 F.3d 814 (10th Cir. 2014), that the operator of family planning clinics could not challenge as preempted by Title X of the Public Health Service Act a Kansas law limiting what types of providers may receive grants under that state's program. The court relied significantly on the Chief Justice's dissent in *Independent Living* and expressly rejected the rationales espoused by the courts holding that a Supremacy Clause right of action exists even in the absence of Congressionally created rights or remedies. *Id.* at 826-27, 836 n.7.

The court found, too, that permitting private persons to seek injunctions for alleged violations of Title X would substantially interfere with HHS's administration of the program. *Id.* at 824-25, *citing*

Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984). It found Justice Breyer's concurrence in *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002) insightful. 747 F.3d at 825, *citing Gonzaga*, 536 U.S. at 292 (Breyer, J., concurring) (noting Congress may have intended its remedy as exclusive "to achieve the expertise, uniformity, widespread consultation, and resulting administrative guidance" and to "avoid the comparative risk of inconsistent interpretations and misincentives" that may arise from litigation seeking damages under the statute). The flexibility of Medicaid – the "play in the joints" – as the court put it, is an "important, and apparently desirable" feature of Medicaid that private enforcement through the Supremacy Clause would thwart. *Id.*

The Seventh Circuit seems to align with the Tenth Circuit's view, although so far it has not committed itself. Without reaching the issue, the court in *Planned Parenthood of Indiana, Inc. v. Commissioner of Indiana State Department of Health*, 699 F.3d 962 (7th Cir. 2012), explained that the idea of a freestanding right to bring a preemption suit under the Supremacy Clause was "highly doubtful" for the reasons articulated by the Chief Justice in his *Independent Living* dissent. *Id.* at 983.

Finally, one state high court has followed the logic in the Chief Justice's dissent in *Independent Living* and held that where plaintiffs have no private right of action directly to claim a violation of § 30(A), they cannot do so by simply claiming a violation of

the Supremacy Clause. *Boston Med. Ctr. Corp. v. Sec'y of the Exec. Office of Health & Human Servs.*, 974 N.E.2d 1114, 1128 (Mass. 2012).

B. Review is warranted because in holding that the Supremacy Clause supplies a private right of action to enforce 42 U.S.C. § 1396a(a)(30)(A) against states, the Ninth Circuit has disregarded this Court's cases limiting the availability of a private right of action where Congress has not created one.

1. Respondents did not contend, and the Ninth Circuit did not hold, that Medicaid providers had any enforceable rights under the Medicaid Act. Far from it; the Ninth Circuit has held specifically that providers have no such rights. *Sanchez v. Johnson*, 416 F.3d at 1060-61. This does not present an obstacle in the Ninth Circuit, though, because as this case shows, in that circuit the Supremacy Clause provides the right of action to enforce federal law against conflicting state law, even where Congress has not created rights or made a statute privately enforceable. An allegation that a defendant has violated federal law is not enough to sue in federal court. There must be some authorization to seek a remedy, and that authorization must come from Congress: "Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001) (citation omitted); *see also California v. Sierra Club*, 451 U.S. 287, 297 (1981) ("The federal judiciary will not engraft a

remedy on a statute, no matter how salutary, that Congress did not intend to provide."). The absence of a Congressionally created right or remedy is a defect in Respondents' suit that the Ninth Circuit disregarded.

The analytical framework for determining whether a right of action exists under a particular statute or through § 1983 differs somewhat, but the two inquiries share a common characteristic: Congress' intent is "dispositive." *Transamerica Mortg. Advisors, Inc. v. Lewis*, 444 U.S. 11, 24 (1979). The "judicial task," therefore, "is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy." *Alexander v. Sandoval*, 532 U.S. at 286 (citation omitted). This is sensibly grounded in the separation of powers. "In the absence of congressional intent the Judiciary's recognition of an implied private right of action 'necessarily extends its authority to embrace a dispute Congress has not assigned it to resolve.'" *Stoneridge Inv. Partners, LLC v. Scientific-Atlanta, Inc.*, 552 U.S. 148, 164-65 (2008), *quoting Am. Fire & Casualty Co. v. Finn*, 341 U.S. 6, 17 (1951) (citations omitted).

Congress' intent is particularly important in the context of statutes passed pursuant to Congress' spending power. Federal funding provisions are not privately enforceable "unless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to create individually enforceable rights. . . ." *Gonzaga Univ. v. Doe*, 536 U.S. at 280, *quoting Pennhurst*

State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17, 28 & n.21 (1981). The Court has explained that Spending Clause legislation "is much in the nature of a contract," and that the "typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Pennhurst*, 451 U.S. at 17, 28 (citation omitted); *see also Astra USA, Inc. v. Santa Clara County,* 131 S. Ct. 1342, 1345 (2011) (rejecting third-party beneficiary claim to enforce drug-pricing statute; if plaintiff cannot sue under the statute itself, "it would make scant sense to allow them to sue on a form contract implementing the statute, setting out terms identical to those contained in the statute.").

Part of the inquiry in determining whether Congress intended to create an enforceable right focuses on the statute's wording and whether it is "so 'vague and amorphous' that its enforcement would strain judicial competence. . . ." *Gonzaga Univ. v. Doe*, 536 U.S. at 282, *quoting Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997). Section 30(A) requires "methods and procedures" to ensure that "unnecessary utilization" is avoided and that payments are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" to meet the need for care. This language sets forth only "broad and general" terms. *Independent Living*, 132 S. Ct. at 1210. The statute is therefore not well suited to judicial enforcement. *See, e.g., Blessing v. Freestone*,

520 U.S. at 343. Even the Ninth Circuit has held that § 30(A)'s "broad and diffuse" terms have an "aggregate focus, rather than an individual focus that would be evidence of an intent to confer an individually enforceable right." *Sanchez v. Johnson*, 416 F.3d at 1059, 1060. The Ninth Circuit has not explained why § 30(A) is not "amenable to judicial remedy" under § 1983, *id.* at 1060, but fit for judicial remedy under the Supremacy Clause.

By acknowledging that the Medicaid Act creates no enforceable rights, yet permitting the providers' case to proceed directly under the Supremacy Clause anyway, the Ninth Circuit has disregarded Congress' intent and the "careful approach" this Court takes when considering whether Congress intended to create a private right of action. *Stoneridge Inv. Partners, LLC v. Scientific-Atlanta, Inc.,* 552 U.S. at 164. As the Chief Justice wrote in his dissent in *Independent Living*, "to say that there is a federal statutory right enforceable under the Supremacy Clause, when there is no such right under the pertinent statute itself, would effect a complete end-run around this Court's implied right of action and 42 U.S.C. § 1983 jurisprudence." *Independent Living*, 132 S. Ct. at 1213 (Roberts, C.J., dissenting).

The Ninth Circuit's decision is inconsistent with Congress' intent in another way: Private suits to enforce § 30(A) interfere with CMS's administration of Medicaid. Section 30(A) provides a condition of funding. Its terms reflect Congressional intent to allow great flexibility. If a state agrees and complies,

it receives money to fund, in part, the state's Medicaid services. If CMS, in its expert judgment, determines that the state is not satisfying a particular condition, the state has an opportunity to correct or contest CMS's determination. If all of this fails, in the end there is a Congressionally created remedy – CMS takes the money back or refuses to fund the expenditure. The providers' suit in this case, however, did not include CMS. CMS had approved the methods and procedures the Department used and had never complained about the rates, or access, or quality, or efficiency, or economy. So the suit proceeded without the relative expertise of the agency entrusted to administer and enforce the program. Separate litigation inevitably subjects states to requirements beyond what Congress and CMS have established. *See Astra USA*, 131 S. Ct. at 1349. These requirements may not (and in this case, do not, *infra* Section II) comport with what Congress required and the manner in which CMS implements those requirements. The approach embraced by the Ninth Circuit disrupts Congress' plain intent to facilitate centralized administration and the attendant benefits of uniformity, consistency, and predictability. *Independent Living,* 132 S. Ct. at 1210-11.

2. Allowing the providers' case to proceed under the Supremacy Clause to enforce § 30(A) in the absence of Congressional authorization for the suit puts the Supremacy Clause to the wrong use. It is not a "source of any federal rights." *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 613 (1979); *Golden*

State Transit Corp. v. City of Los Angeles, 493 U.S. 103, 107 (1989); *see also Independent Living,* 132 S. Ct. at 1213 (Roberts, C.J., dissenting) (purpose of Supremacy Clause is "to ensure that, in a conflict with state law, whatever Congress says goes."). The Ninth Circuit's holding in this case rests on a reading of this Court's cases that is too broad to support it. *First*, the court of appeals' reliance on *Shaw v. Delta Air Lines* mistakes a right of action for jurisdiction. The footnote the court of appeals cited in this case addressed subject-matter jurisdiction, not the question whether there was a right of action. Federal subject-matter jurisdiction is a different thing than a right of action. Jurisdiction is, of course, jurisdictional; a cause of action is not. *See Verizon Md., Inc. v. Public Serv. Comm'n of Md.*, 535 U.S. 635, 642-43 (2002) ("It is firmly established in our cases that the absence of a valid (as opposed to arguable) cause of action does not implicate subject-matter jurisdiction, *i.e.,* the courts' statutory or constitutional *power* to adjudicate the case."), *quoting Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 89 (1998).

Second, the other cases the court of appeals relied on all arose in a context unlike that present here. *See Independent Living Ctr. of S. Cal. v. Shewry*, 543 F.3d at 1055-56, *citing Ray v. Atl. Richfield Co.*, 435 U.S. 151 (1978) (state statute regulating size, design, and movement of oil tankers in Puget Sound); *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88 (1992) (state law regulating occupational safety and health matters for hazardous-waste site workers);

Pac. Gas & Elec. Co. v. State Energy Res. Comm'n & Dev. Comm'n, 461 U.S. 190 (1983) (state laws limiting construction of nuclear power plants); *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963) (state law prohibiting transportation or sale of avocados within California according to a certain oil content).

Those cases presented state action that interfered with the plaintiffs' conduct that was, by federal law, either permitted or properly free of state regulation. They concerned, in other words, "the preemptive assertion in equity of a defense that would otherwise have been available in the State's enforcement proceedings at law." *Va. Office for Prot. & Advocacy v. Stewart*, 131 S. Ct. 1632, 1642 (Kennedy, J., concurring) (citations omitted). But in this case, like in *Independent Living*, the Medicaid providers are not threatened with any enforcement action; the providers instead seek to enforce a federal statute in a manner that Congress did not authorize. *See Independent Living*, 132 S. Ct. at 1213 (Roberts, C.J., dissenting) (providers' and beneficiaries' challenges to rate cuts are unlike cases where plaintiffs are subject to or threatened with enforcement proceeding as in *Ex parte Young*, 208 U.S. 123 (1908)); *see also Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 675 (2003) (Scalia, J., concurring in the judgment) ("[T]he remedy for the State's failure to comply with the obligations it has agreed to undertake in the Medicaid Act . . . is set forth in the Act itself: termination of funding by the Secretary of the Department of

Health and Human Services. . . .") (citations omitted); *id.* at 683 (Thomas, J., concurring in the judgment) (noting "serious questions as to whether third parties may sue to enforce Spending Clause legislation – through preemption or otherwise") (citation omitted). The Supremacy Clause supplies a rule of decision, not a right of action.

II. THIS COURT SHOULD GRANT REVIEW TO DECIDE WHETHER STATE MEDICAID REIMBURSEMENT RATES MUST BE BASED ON "RESPONSIBLE COST STUDIES" AND "SUBSTANTIALLY REIMBURSE PROVIDERS THEIR COSTS" AND TO DECIDE WHAT ROLE BUDGETARY FACTORS MAY PLAY IN MAINTAINING RATES.

Section 30(A) aims to ensure that in exchange for federal money, states will establish efficient and economical programs under which quality care is available at a reasonable price without enabling unnecessary utilization. The delivery of services in a manner consistent with § 30(A) is driven by myriad demographic, geographic, and economic forces. Thus, the methods and procedures a state uses to achieve that statute's goals are largely left to the states and CMS to work out.

The Ninth Circuit has added a few of its own things to § 30(A)'s basic, broad requirement. With the decision below, the rule in the Ninth Circuit may be stated this way: (1) states are obligated, on an ongoing basis, to ensure that reimbursement rates

bear a reasonable relationship to provider costs; (2) rates must be based on "responsible cost studies" conducted by the state or someone else; and (3) where rates do not substantially reimburse providers their costs, a state may not decline to raise them solely because there is no money to do so. Providers are entitled, under the Ninth Circuit's rule, to an increase in rates so that rates *do* substantially reimburse providers their costs. This is the rule even if HHS did not require a state to conduct cost studies or to establish rates that bear a reasonable relationship to provider costs. It is the rule even if the court finds that that efficiency, economy, access, and quality are satisfied. It is reasonable to think that if there are no issues relating to efficiency, economy, quality, or access, the reimbursement rates are probably about right. But this is the rule nonetheless. *Cf. Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1247-49 (9th Cir. 2013) (deferring to CMS's interpretation of § 30(A) that cost studies were not required in APA challenge to CMS's approval of plan amendment).

1. The Ninth Circuit compounded its error in permitting the case to proceed under the Supremacy Clause by reaffirming and extending a rule on the merits that conflicts with every other circuit to have considered the question. *See Rite-Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999) ("Section 30(A) does not require any 'particular methodology.'"); *Methodist Hosps.,* 91 F.3d at 1030 ("Nothing in the language of § 1396a(a)(30)(A), or any implementing regulation, requires a state to conduct studies in

advance of every modification. It requires each state to produce a *result*, not to employ any particular methodology for getting there."); *Minn. HomeCare Ass'n, Inc. v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) ("The Medicaid Act . . . does not require the State to utilize any prescribed method of analyzing and considering [§ 30(A)'s] factors.").

The Ninth Circuit's decision is also at odds with the view taken by the Solicitor General at the petition stage in both *Orthopaedic Hospital v. Belshe* and *Independent Living*. In each, the Acting Solicitor General wrote that the Ninth Circuit's reading of § 30(A) is wrong: (a) § 30(A) contains no mandate that that Medicaid reimbursement rates cover "all or substantially all of the costs incurred by provider in order to ensure reasonable access to quality care" and (b) the Ninth Circuit's interpretation "frustrates Congress' purpose of giving States wide discretion to set Medicaid payments that are consistent with efficiency, economy, and access to quality care." Br. of United States as *Amicus Curiae, Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., Inc.*, 131 S. Ct. 992 (2011) (No. 09-958), 2010 WL 4959708 at *9; *see* Br. of United States as *Amicus Curiae*, *Belshe v. Orthopaedic Hosp.*, 522 U.S. 1044 (1998) (No. 96-1742), 1997 WL 33561790 at **2-3. At the petition stage in *Independent Living*, the Acting Solicitor General stated that HHS was committed to a final rule by December 2011. 2010 WL 4959708 at *11. He recommended that the Court deny California's petition, in part for this reason, explaining that "[t]he nature and extent of the obligations imposed on States under Section

1396a(a)(30)(A) are best suited for expert agency consideration in the first instance." *Id.* Yet, no rule has been finalized, and so meanwhile, the Ninth Circuit's erroneous interpretation of the statute continues to drive numerous § 30(A) lawsuits and unnecessarily add significant administrative and financial obstacles to states' Medicaid programs.

2. Not only is the Ninth Circuit's decision inconsistent with three other circuits and with HHS, but the decision cannot square with the plain meaning of § 30(A). This Court has said "time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there." *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (citation omitted); *see also id.* ("When the statutory language is plain, the sole function of the courts – at least where the disposition required by the text is not absurd – is to enforce it according to its terms") (citations and internal quotations omitted). The Ninth Circuit's decision fails on that score. Section 30(A) does not require cost studies to be conducted or considered when rates are set. It does not limit the role budgetary considerations may play when rates are set (or, as in this case, when a state decides *not* to raise rates). And it does not require rates to substantially reimburse providers their costs or bear a reasonable relationship to those costs. It surely does not require that rates be raised whenever there is some information that costs for a particular class of provider might have, in the aggregate, gone up.

Congress knows how to require that payments cover provider costs. One example is the Boren Amendment from 1988. That amendment to 42 U.S.C. § 1396a(a)(13)(A) required states to reimburse inpatient hospital, skilled nursing, and other institutional services providers with rates that were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502-503 (1990). The Boren Amendment has long since been repealed, 1997 Pub. L. No. 105-33, § 4711, 111 Stat. 507, but the fact that Congress chose in places to require states to cover costs and did not choose to do so in other places suggests the Ninth Circuit's rule conflicts with Congress' intent. *See Field v. Mans*, 516 U.S. 59, 67 (1995).

The Ninth Circuit's decision also imposes on states funding conditions that Congress did not intend and to which states never agreed. This cannot be reconciled with this Court's precedents. Spending Clause legislation "is much in the nature of a contract," and "[t]he legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Pennhurst*, 451 U.S. at 17 (citations omitted). The substantive requirements the Ninth Circuit has imposed, which must be met regardless of whether the statute's actual goals are achieved, conflict with this Court's clear view that "if Congress intends to impose a condition on the grant

of federal moneys, it must do so unambiguously." *Id.* (citations omitted).

3. The Ninth Circuit's rule frustrates Congress' goal of allowing states great flexibility in designing and administering their Medicaid programs in cooperation with HHS. It establishes the federal courts as a second regulatory body, whose requirements states must meet, even if CMS has not imposed those requirements. The Ninth Circuit's rule is inflexible, elevating provider costs above end goals of efficiency, economy, and access to quality care. In this regard, a scheme that reimburses provider costs may perpetuate inefficiencies. So a state may establish rates to comply with *Orthopaedic Hospital v. Belshe* only to have CMS deny a plan or waiver amendment or initiate a compliance action because in its judgment those rates will not achieve compliance with § 30(A). States may be forced to choose which penalty they want to risk: an injunction, or a loss of funding. This scenario "threaten[s] to defeat the uniformity that Congress intended by centralizing administration of the federal program in the agency and to make superfluous or to undermine traditional APA review." *Independent Living*, 132 S. Ct. at 1211.

The possibility of federal courts imposing obligations on states that are inconsistent with a state's agreement with CMS is made more likely by the Ninth Circuit's unpredictable approach to § 30(A). *Orthopaedic Hospital v. Belshe* involved rate reductions to hospitals, which are mandatory cost reporters. 42 C.F.R. § 447.253(f), (g). Residential habilitation

providers are not mandatory cost reporters, and so may not track costs in a reliable manner. Following *Orthopaedic Hospital v. Belshe*, the Ninth Circuit expanded the requirements to more (and presumably all) providers, and added further requirements. *See, e.g.*, *Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010); *Dominguez v. Schwarzenegger*, 596 F.3d 1087 (9th Cir. 2010), *both vacated on other grounds sub nom. Douglas v. Indep. Living Ctr.* This case represents yet another erroneous expansion of the rule.

Even as it has expanded the requirements, the Ninth Circuit has not provided clear guidance to states about how to satisfy them. If budgetary concerns cannot be the sole factor in determining rates, what role can budgets play? Since the rule applies not just to rate reductions, but also to existing rates, how often must states conduct studies to make sure their existing rates substantially reimburse providers their costs? What does "substantially reimburse" mean? What is a "responsible" cost study? What level of statistical validity is required? What must the cost study include? Only the Ninth Circuit knows, and these answers will come only through unnecessary and expensive litigation that does not assure that the statute's ends are met.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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July 2, 2014

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

EXCEPTIONAL CHILD CENTER, INC.; INCLUSION, INC.; TOMORROW'S HOPE SATELLITE SERVICES, INC.; WDB, INC.; LIVING INDEPENDENTLY FOR EVERYONE, INC., Plaintiffs-Appellees, v. RICHARD ARMSTRONG; LESLIE CLEMENT, Defendants-Appellants.	No. 12-35382 D.C. No. 1:09-cv-00634-BLW MEMORANDUM* (Filed Apr. 4, 2014)

Appeal from the United States District Court
for the District of Idaho B. Lynn Winmill,
Chief District Judge, Presiding

Argued and Submitted December 2, 2013
Seattle, Washington

* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

Before: TALLMAN and BEA, Circuit Judges, and MURPHY, District Judge.**

Defendants-Appellants Richard Armstrong, the Director of Idaho's Department of Health and Welfare ("IDHW"), and Leslie Clement, an IDHW Deputy Director and former IDHW Division of Medicaid Administrator (collectively, "the Directors"), appeal the district court's grant of summary judgment in favor of Plaintiffs-Appellees, a group of agencies providing supported living services to Medicaid-eligible individuals in Idaho (collectively "the Providers"). We have jurisdiction under 28 U.S.C. § 1291, and we affirm.

We review a district court's grant of summary judgment and its rulings on matters of statutory interpretation de novo. *See Newton-Nations v. Betlach,* 660 F.3d 370, 378 (9th Cir. 2011). Summary judgment is appropriate where the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law. *See* Fed. R. Civ. P. 56(a).

The Providers have an implied right of action under the Supremacy Clause to seek injunctive relief against the enforcement or implementation of state legislation. *See Indep. Living Ctr. of S. Cal. v. Shewry,*

** The Honorable Stephen Joseph Murphy, III, United States District Judge for the Eastern District of Michigan, sitting by designation.

543 F.3d 1050, 1065 (9th Cir. 2008) ("Under well-established law of the Supreme Court, this court, and the other circuits, a private party may bring suit under the Supremacy Clause to enjoin implementation of state legislation allegedly preempted by federal law.").

Although the dissenting justices in *Douglas v. Independent Living Center of Southern California, Inc.,* 132 S. Ct. 1204, 1212 (2012) (Roberts, J., dissenting), would have held otherwise, we remain bound by the prior holdings of the Supreme Court, and of our court, that have recognized a private right of action under the Supremacy Clause. *See Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 96 n.14 (1983); *Bud Antle, Inc. v. Barbosa,* 45 F.3d 1261, 1269 (9th Cir. 1994).

Section 30(A) of the Medicaid Act requires that state Medicaid plans contain procedures to ensure that reimbursement rates for healthcare providers "are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" to meet the need for care and services in the geographic area. 42 U.S.C. § 1396a(a)(30)(A). We have interpreted Section 30(A) to require that reimbursement rates bear a reasonable relationship to provider costs.[1] *Orthopaedic Hosp. v. Belshe,* 103 F.3d 1491,

[1] The Directors call on us to abandon the requirements of *Orthopaedic Hospital.* Nonetheless, "[w]e are bound by circuit precedent unless there has been a substantial change in relevant circumstances, or a subsequent en Banc or Supreme Court decision that is clearly irreconcilable with our prior holding." *See United States v. Vasquez-Ramos,* 531 F.3d 987, 991 (9th Cir.

(Continued on following page)

1499 (9th Cir. 1997). Where rates fail to "substantially reimburse providers their costs," there must be some justification other than "purely budgetary reasons." *Id.* at 1499, 1499 n.3.

The Directors conducted yearly cost studies between 2006 and 2009, developed a new rate setting methodology, and recommended substantial increases in reimbursement rates for supported living services based on the cost study results. The Stipulated Facts provide that the Directors did not implement the proposed rate changes because the Idaho legislature did not appropriate the necessary funds. Because the reimbursement rates at issue fail to "substantially reimburse providers their costs," and because the Directors concede that the 2006 rates remained in place for "purely budgetary reasons," the district court did not err in granting summary judgment to the Providers.[2]

AFFIRMED.

2008) (internal citations omitted). Neither circumstance is present here.

[2] We express serious doubt over whether the Directors' inaction constitutes a "Thing" in state law that can be preempted under the Supremacy Clause. However, the Directors failed to make this argument to the district court and they did not raise the issue in their briefing to our court. Therefore, we deem the issue waived. *See Smith v. Marsh,* 194 F.3d 1045, 1052 (9th Cir. 1999) ("[A]n appellate court will not consider issues not properly raised before the district court. Furthermore, on appeal, arguments not raised by a party in its opening brief are deemed waived.").

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

INCLUSION, INC.; EXCEPTIONAL CHILD CENTER, INC.; LIVING INDEPENDENTLY FOR EVERYONE, INC.; TOMORROW'S HOPE SATELLITE SERVICES, INC.; WDB, INC., Plaintiffs, v. RICHARD ARMSTRONG, and LESLIE CLEMENT, in their official capacities, Defendants.	Case No. 1:09-cv-00634-BLW **JUDGMENT**

In accordance with the Memorandum Decision and Order (Dkt. 39) entered on December 12, 2011,

IT IS ORDERED, ADJUDGED AND DECREED THAT

1. Judgment is entered for Plaintiffs. The relative rights and obligations of the parties are as set out in that Memorandum Decision and Order (Dkt. 39).

2. Defendants shall implement immediately the reimbursement rates for Supported Living Residential Habilitation Services, as set out in and consistent

with that Memorandum Decision and Order (Dkt. 39).

3. The clerk is directed to close this case.

DATED: April 12, 2012

[SEAL] /s/ B. Lynn Winmill
B. Lynn Winmill
Chief Judge
United States District Court

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

INCLUSION, INC.; EXCEPTIONAL CHILD CENTER, INC.; LIVING INDEPENDENTLY FOR EVERYONE, INC.; TOMORROW'S HOPE SATELLITE SERVICES, INC.; WDB, INC., Plaintiffs, v. RICHARD ARMSTRONG, and LESLIE CLEMENT, in their official capacities, Defendants.	Case No. 1:09-cv-00634-BLW **MEMORANDUM DECISION AND ORDER**

Before the Court is Defendants' Motion for Reconsideration (Dkt. 40), Plaintiffs' Motion for Entry of Judgment (Dkt. 43) and Plaintiffs' Motion to Expedite (Dkt. 44). Having considered the parties' briefing and being familiar with the record, the Court will deny reconsideration and enter judgment, thus rendering moot the Motion to Expedite.

BACKGROUND

Plaintiffs are five Idaho corporations providing "residential habilitation" services to Medicaid eligible individuals in supported living settings in the state of

Idaho. *Stip. Facts,* Dkt. 28 at 2-3. Residential habilitation services help Medicaid participants to reside in the community by providing skills training, assistance with decision-making, socialization, mobility, and activities of daily living (e.g. eating, bathing). *Id.* Defendants are Richard Armstrong – Director of Idaho's Department of Health and Welfare (IDHW), and Leslie Clement – an IDHW Deputy Director and former IDHW Division of Medicaid Administrator. *Id.* at 2.

Plaintiffs filed this action seeking to enjoin changes to IDHW's reimbursement rates for service providers – such as Plaintiffs – arguing that the proposed rate changes violated state and federal law. The parties agreed the matter could be decided on stipulated facts, without need for a trial. After reviewing the Stipulated Facts and considering the parties' arguments, this Court granted summary judgment to Plaintiffs and against Defendants. *Memorandum Decision & Order,* Dkt. 39. Defendants now seek reconsideration of that decision, and Plaintiffs move for entry of judgment.

LEGAL STANDARD

A motion to reconsider an interlocutory ruling requires an analysis of two important principles: (1) error must be corrected, and (2) judicial efficiency demands forward progress. The former principle has led courts to hold that a denial of a motion to dismiss or for summary judgment may be reconsidered at any

time before final judgment. *Preaseau v. Prudential Insurance Co.,* 591 F.2d 74, 79-80 (9th Cir. 1979). While even an interlocutory decision becomes the "law of the case," it is not necessarily carved in stone.

Justice Oliver Wendell Holmes concluded that the "law of the case" doctrine "merely expresses the practice of courts generally to refuse to reopen what has been decided, not a limit to their power." *Messinger v. Anderson,* 225 U.S. 436, 444 (1912). "The only sensible thing for a trial court to do is to set itself right as soon as possible when convinced that the law of the case is erroneous. There is no need to await reversal." *In re Airport Car Rental Antitrust Litigation*, 521 F.Supp. 568, 572 (N.D.Cal. 1981) (Schwartzer, J.). However, the need to be right must co-exist with the need for forward progress. A court's opinions "are not intended as mere first drafts, subject to revision and reconsideration at a litigant's pleasure." *Quaker Alloy Casting Co. v. Gulfco Indus., Inc*., 123 F.R.D. 282, 288 (N.D.Ill.1988).

Reconsideration of a court's prior ruling under Federal Rule of Civil Procedure 59(e) is appropriate "if (1) the district court is presented with newly discovered evidence, (2) the district court committed clear error or made an initial decision that was manifestly unjust, or (3) there is an intervening change in controlling law." *S.E.C. v. Platforms Wireless Intl Corp.,* 617 F.3d 1072, 1100 (9th Cir. 2010) (citation omitted). Defendants here seek reconsideration under all three bases.

ANALYSIS

1. New Evidence

Defendants first argue that the Court should reconsider its decision based on newly discovered evidence: two errors in the parties' Stipulations of Fact, discovered after the stipulations were submitted to the Court; and previously unavailable data regarding bids by service providers for an emergency placement services contract. According to Defendants, the number of participants receiving supported living services, as stipulated by the parties, reflects a clerical error, and should have been much lower.[1] Defendants state that the stipulated rate for intense support services – $496.56 – is also incorrect, and should have been $413.82. *Pugatch Dec.,* Dkt. 40-3 ¶ 4. Defendants do not discuss how either error warrants reconsideration, except to note that the Court's decision "rests in part on" the incorrect data. *Def. Br.,* Dkt. 40-1 at 4. Defendants further argue that bids for an emergency placement services contract, unavailable before December 2011, also support reconsideration.

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[1] The Stipulated Facts note "[t]here are 6,202 participants receiving supported living services;" although no year is cited, the next sentence provides, "[a]s of the end of calendar year 2010 Plaintiffs submitted claims for supported living services for the following number of participants. . . ." *Stip. Facts,* Dkt. 28 at 7. Defendants now assert that there were 717 participants using supported living services as of September 30, 2011. *Pugatch Dec.,* Dkt. 40-3 ¶ 3.

The Court finds that the proffered new evidence fails to support reconsideration for three reasons. First, the errors in the parties' stipulated facts are not new; Defendants have not shown, nor do they argue, that the evidence was unavailable or could not have been discovered at the time the parties submitted stipulated facts to the Court. *Cf Lainez-Ortiz v. INS,* 96 F.3d 393, 400 (9th Cir. 1996) (requiring newly discovered evidence to have been previously unavailable, in order to warrant reopening proceedings). As to the bids for the emergency placement services contract, the Court finds such evidence immaterial to the costs and reimbursement rates for residential habilitation service providers.

Second, although Defendants cite a declaration from Sheila Pugatch (IDHW's Principal Financial Specialist), to support that the two stipulations are in error, there is no indication that Plaintiffs agree. Absent further proceedings or a stipulation by Plaintiffs, Defendants' "new evidence" is simply an unresolved issue of fact.[2]

Third, even if the parties had stipulated to the evidence now offered by Defendants, the Court's decision would be no different. It is undisputed that reimbursement rates for the relevant service providers

[2] Defendants ask that the stipulated facts be corrected in the record, but such request is properly the subject of a separate motion to which Plaintiffs would be entitled to respond. The Court here will address the request for reconsideration only.

have remained unchanged since 2006. *Stip. Facts,* Dkt. 28 at 6. It is also undisputed that between 2006 and 2009, provider cost studies were done at the IDHW's request. *Id.* Most significantly, the parties agree that the rates have not been changed because the state legislature failed to appropriate funds to pay for the increases suggested by the cost studies. *Id.* The Court granted summary judgment to Plaintiffs because, as shown by these agreed facts, the current reimbursement rates fail to take into account actual provider costs.

The corrected number of participants would have no effect on the Court's analysis. The corrected figure for intense support services, although lower than the stipulated figure, is still well above – and thus unaccounted for in – the current rate. The Court will therefore deny reconsideration on the basis of newly discovered evidence.

2. Clear Error

Defendants' second basis for reconsideration is that the Court clearly erred in its analysis of *Orthopaedic Hospital v. Belshe,* 103 F.3d 1491 (9th Cir. 1997). Defendants' arguments are little more than an effort to take a second bite at the apple. Defendants attempt to distinguish *Belshe* – all but ignored in Defendants' summary judgment briefing – on its facts. The Court thoroughly examined and discussed *Belshe* in rendering its decision for Plaintiffs. The Court stands by that analysis now. Defendants having

failed to show clear error, the Court will deny reconsideration on that basis.

3. Change In Controlling Law

Defendants asked the Court to delay judgment until after the Supreme Court issued its decision in *Douglas v. Indep. Living Ctr.,* ___ S.Ct. ___, 2012 WL 555204 (2012). That case was decided on February 22, 2012, thus the request to postpone judgment is moot. As Plaintiffs correctly observe, the Supreme Court's decision in *Douglas* did not alter *Belshe,* or this Court's decision here. Given the procedural posture in *Douglas,* the Supreme Court remanded to the Ninth Circuit to address whether a plaintiff may bring a Supremacy Clause challenge where the allegedly non-compliant state law has been approved by the federal Centers for Medicare & Medicaid Services. The action before this Court does not challenge a state statute, let alone a state statute approved by the designated federal agency. Instead, it challenges the IDHW's compliance with state and federal law. There being no relevant change in controlling law, the Court will deny reconsideration on that basis as well.

4. Entry of Judgment

The Supreme Court having decided *Douglas,* there is no basis to delay entry of judgment here. Plaintiffs submitted a proposed judgment. Other than to request that the Court delay entry, Defendants

have not objected nor otherwise responded with an alternate proposal. The Court finds Plaintiffs' proposed form appropriate and in accordance with the Court's Memorandum Decision and Order (Dkt. 39), and will thus enter judgment consistent with Plaintiffs' proposal, to be filed concurrently herewith.

ORDER

IT IS ORDERED THAT:

1. Defendants' Motion for Reconsideration (Dkt. 40) is DENIED.

2. Plaintiffs' Motion for Entry of Judgment (Dkt. 43) is GRANTED. Judgment will be entered separately.

3. Plaintiffs' Motion to Expedite (Dkt. 44) is DENIED as MOOT.

DATED: April 12, 2012

[SEAL] /s/ B. Lynn Winmill
B. Lynn Winmill
Chief Judge
United States District Court

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

INCLUSION, INC.; EXCEPTIONAL CHILD CENTER, INC.; LIVING INDEPENDENTLY FOR EVERYONE, INC.; TOMORROW'S HOPE SATELLITE SERVICES, INC.; WDB, INC., Plaintiffs, v. RICHARD ARMSTRONG, and LESLIE CLEMENT, in their official capacities, Defendants.	Case No. 1:09-cv-00634-BLW **MEMORANDUM DECISION AND ORDER**

Before the Court are cross Motions for Summary Judgment by Plaintiffs (Dkt. 29) and Defendants (Dkt. 30). As memorialized in Docket Entry Order 27, the parties agreed that this case can be resolved on stipulated facts in lieu of a bench trial. The parties submitted Stipulated Facts (Dkt. 28) and briefing, and the Court heard oral argument on October 31, 2011. Having fully considered the parties' written and oral arguments, and being familiar with the record, including stipulated facts, the Court will grant summary judgment as to Plaintiffs, and deny summary as to Defendants, as more fully expressed below.

BACKGROUND

Plaintiffs are five Idaho corporations providing "residential habilitation" services to Medicaid eligible individuals in supported living settings in the state of Idaho. *Stip. Facts* at 2-3, Dkt. 28. Residential habilitation describes an array of services designed and provided to assist Medicaid participants in residing successfully in the community. *Id.* at 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 medications, meal preparation, laundry, shopping and the like. *Id.* Services may also include skills training for family and non-family caregivers for participants. *Id.*

Defendants are Richard Armstrong – Director of Idaho's Department of Health and Welfare (IDHW), and Leslie Clement – an IDHW Deputy Director and former IDHW Division of Medicaid Administrator. *Id.* at 2. Clement has had the responsibility of administering and operating Idaho's Medicaid program under the direction and supervision of Armstrong at all times relevant to this case. *Id.*

Medicaid is a cooperative federal-state program that directs federal funding to participating states to provide medical assistance to "families with dependent children, . . . [and] aged, blind and disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."

42 U.S.C. § 1396-1; *Stip. Facts* at 2. States that choose to participate in the Medicaid program – including Idaho – must comply with the requirements of the Medicaid Act, which includes development of a state plan. 42 U.S.C. § 1396a(a). The state plan must be approved by the Federal Center for Medicaid and Medicare Services (CMS). 42 C.F.R. § 430.10.

In 1981, Congress passed amendment § 1915(c) "in response to . . . studies showing that many persons residing in Medicaid-funded institutions would be capable of living at home or in the community if additional support services were available." *Sanchez v. Johnson,* 416 F.3d 1051, 1054 (9th Cir. 2005). Under the amendment, CMS can waive certain Medicaid Act requirements where a state demonstrates that the cost of caring for an individual in a home and community based program would be less than or equal to the cost of providing institutional care. *Id.* Idaho has been approved by CMS for three waiver programs, including the Developmentally Disabled Home and Community Based Services Waiver (DD Waiver). *Stip. Facts* at 2. The services provided by Plaintiffs in this case are pursuant to Idaho's DD Waiver. *Id.* at 3.

Effective October 1, 2004, the IDHW established reimbursement rates for two separate levels of care – "high support," and "intense support." *Id.* On July 1, 2006, based on onsite observations and a survey of residential habilitation agencies, those rates (see table below) increased slightly. *Id.*

In 2005, Idaho's Legislature passed Idaho Code § 56-118, requiring the IDHW to "implement a methodology for reviewing and determining reimbursement rates" for Medicaid services that incorporates providers' actual costs of providing services. I.C. § 56-118(1), (2). In response, the IDHW contracted Johnson, Villegas-Grubb and Associates (JVGA) to conduct applicable studies. *Stip. Facts* at 4. JVGA's efforts were overseen by Sheila Pugatch, Principal Financial Specialist at IDHW, who manages the Office of Reimbursement Policy and has primary responsibility for setting Medicaid reimbursement rates in Idaho. *Id.* at 6.

JVGA surveyed Medicaid providers regarding the cost of providing services. *Id.* at 4. Based on its survey, JVGA submitted a report to the Idaho Legislature on November 30, 2006, recommending increases in reimbursement rates. JVGA continued to conduct studies, and in 2009, the IDHW submitted revised proposed rates that reflected further analysis. The current rates (implemented in July 2006), as well as those based on JVGA's surveys are set forth as follows:

	Current rate, effective July 1, 2006	JVGA rate proposed November 30, 2006	IDHW rate proposed in 2009
Daily Rate – High Support	$225.32	$228.48	$248.40
Daily Rate – Intense Support	$268.36	$342.72	$496.56

Despite, the proposed amendments based on JVGA's studies, the IDHW has not changed the reimbursement rates implemented in July 2006. According to Pugatch, the rate changes proposed in 2009 would have increased Idaho's Medicaid expenditures by $4 million. *Id.* at 6. Because Idaho's Legislature did not appropriate the necessary funds, the IDHW did not implement the proposed rate changes. *Id.* at 6. Thus, the current reimbursement rates are not based on the cost studies performed by JVGA between 2006 and 2009. *Id.* at 6.

There are currently 61 residential habilitation agencies, such as Plaintiffs, in Idaho. *Id.* at 7. There are 6,202 participants receiving supported living services. *Id.* Services covered by the DD Waiver are readily available to eligible participants; there are no waiting lists for any Medicaid services in Idaho. *Id.* The IDHW Critical Incident and Complaint Data Base, used to track Medicaid benefits and services complaints, including complaints related to access to services, shows no unresolved complaints for supported living services. *Id.* Neither plaintiff agency has turned away a prospective client based on an inability to afford providing them supported living services. *Id.*

LEGAL STANDARD

Plaintiffs challenge the IDHW's compliance with the Medicaid Act, and seek prospective and injunctive relief. Where a movant shows "there is no genuine dispute as to any material fact and the movant is

entitled to judgment as a matter of law," the court shall grant summary judgment in favor of the movant. Fed. R. Civ. P. 56(a). The parties in this case have stipulated to all relevant facts and filed cross motions for summary judgment, arguing that each is entitled to judgment as a matter of law. The Court now applies the relevant law to the stipulated facts before it.

ANALYSIS

The federal statutory provision at issue here is "§ 30A" of the Medicaid Act. Under that provision, participating states must set forth in their state plan, a process for the use of, and payment for, Medicaid Plan services. 42 U.S.C. 1396a(a)(30)(A). The plan should prevent unnecessary use of care and services, and ensure that payments "are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" to meet the need for care and services in the geographic area. *Id.*

The Ninth Circuit has interpreted § 30A as having both "substantive and procedural requirements." *Indep. Living Center v. Maxwell-Jolly,* 572 F.3d 644, 651 (9th Cir. 2009). Substantively, the agency administering its state's Medicaid program must set reimbursement rates "that bear a reasonable relationship to efficient and economical . . . costs of providing quality services." *Orthopaedic Hosp. v. Belshe,* 103 F.3d 1491, 1496 (9th Cir. 1997). To accomplish this, the agency must perform and "rely on

responsible cost studies . . . that provide reliable data as a basis for its rate setting." *Indep. Living Center,* 572 F.3d at 651. Where rates fail to "substantially reimburse providers their costs," there must be some justification other than "purely budgetary reasons." *Belshe,* 103 F.3d at 1499 n.3 (citing *Beno v. Shalala,* 30 F.3d 1057, 1069 (9th Cir. 1994)).

Ninth Circuit cases addressing alleged violations of § 30A have involved changes to reimbursement rates or methodologies, not maintenance of existing rates. *Cf Indep. Living Ctr. v. Shewry,* 543 F.3d 1047 (9th Cir. 2008); *Indep. Living Ctr. v. Shewry,* 543 F.3d 1050 (9th Cir. 2008); *Indep. Living Ctr. v. Maxwell-Jolly,* 572 F.3d 644; *Indep. Living Ctr. v. Maxwell-Jolly,* 590 F.3d 725 (9th Cir. 2009); *Cal. Pharmacists Ass'n v. Maxwell-Jolly,* 596 F.3d 1098 (9th Cir. 2010); *Dominguez ex rel. Brown v. Schwarzenegger,* 596 F.3d 1097 (9th Cir. 2010); *Indep. Living Ctr. v. Maxwell-Jolly,* 374 Fed.Appx. 690 (9th Cir. 2010). Indeed, this Court has addressed the validity of a reimbursement rate reduction, and rejected the rate change based on the IDHW's failure to rely on responsible cost studies. *Unity Service Coordination, Inc. v. Armstrong,* 2011 WL 864472 (D. Idaho, March 10, 2011).

Here, Plaintiffs do not challenge the propriety of a rate change action. Instead, they challenge the IDHW's inaction, or failure to amend existing reimbursement rates. The IDHW set rates in July 2006 based on "onsite observations of participants" and a survey of residential habilitation agencies. *Stip. Facts,* Dkt. 28 at 4. But subsequent studies, performed at

the IDHW's request, reveal that actual provider costs exceed the 2006 rates.

The IDHW highlights that there are no unresolved complaints regarding care for supported living clients. Also, Plaintiffs Inclusion and Exceptional Child Center have never turned away a client based on the cost of providing services. Given these stipulated facts, the record would appear to support that current rates are "consistent with efficiency, economy, and quality of care," as discussed by the Ninth Circuit in *Belshe,* 103 F.3d at 1496. However, the court in *Belshe* went on to say that "[provider] costs are an integral part of the consideration" that cannot be ignored. *Id.* at 1496-99.

Thus, to fulfill the substantive requirements of § 30A, a state agency must consider actual provider costs. To satisfy § 30A's procedural requirements, the IDHW cannot set rates based on responsible cost studies, then disregard undisputed evidence of increasing costs from studies completed in subsequent years.

The Court is reluctant to become entangled in the management of state government. Also, the Court is mindful that an order requiring the IDHW to amend its reimbursement rates will not cause requisite funding to appear; the ruling may in fact force the IDHW to reallocate funds from other programs. But the law is clear that budgetary concerns cannot form the sole basis for reimbursement rates. *Belshe,* 103 F.3d at 1499. The Court need not wait for

evidence of low quality care or insufficient access to services before intervention is warranted.

In supplemental briefing provided at the Court's request, the parties note that the Ninth Circuit stands alone in finding that § 30A includes procedural requirements to achieve economy, efficiency, access, and quality. *See Methodist Hospitals, Inc. v. Sullivan,* 91 F.3d 1026, 1030 (7th Cir. 1996); *Minnesota Homecare Assn. v. Gomez,* 108 F.3d 917, 918 (8th Cir. 1997); *Rite Aid of Penn., Inc. v. Houston,* 171 F.3d 842, 851 (3rd Cir. 1999); *Conn. Assn. of Health Care Facilities, Inc. v. Rell,* 395 Fed.Appx. 741, 742-43 (2d Cir. 2010). However, the United States Supreme Court denied a petition for writ of certiorari on this issue in the Ninth Circuit's decision in *Belshe. Belshe v. Orthopaedic Hosp.,* 522 U.S. 1044 (1998). Despite the positions taken by other circuits, the Ninth Circuit's clear holding in *Belshe* remains the controlling authority for the Court here.

Although the Supreme Court's recent grant of certiorari in *Indep. Liv. Ctr. v. Maxwell-Jolly,* 131 S.Ct 992 (2011), raises some question as to the long-term viability of the Ninth Circuit's holding in *Indep. Liv. Ctr. of So. Cal v. Shewry,* 543 F.3d 1050, 1065 (9th Cir. 2008), that development does not appear to have any direct significance here. In *Shewry,* the Ninth Circuit held that providers have standing under the Supremacy Clause to challenge a state law reducing reimbursement rates, as preempted by § 30A. On that issue, the Eleventh Circuit stands apart from a majority of sister circuits, including the Ninth Circuit,

which agree that provider standing exists. With this backdrop, the Court finds no reason to stay its decision here. Again, the Ninth Circuit's position is clear, and controls the outcome as discussed above.

The Court will therefore grant Plaintiffs' motion for summary judgment, and deny Defendants' motion for summary judgment.

ORDER

IT IS ORDERED THAT:

1. Plaintiffs' Motion for Summary Judgment (Dkt. 29) is **GRANTED**.

2. Defendants' Motion for Summary Judgment (Dkt. 30) is **DENIED**.

DATED: December 12, 2011

[SEAL] /s/ B. Lynn Winmill
B. Lynn Winmill
Chief Judge
United States District Court