No. 09-958

In The
Supreme Court of the United States

DAVID MAXWELL-JOLLY, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, PETITIONER,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., ET AL.

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

BRIEF OF RESPONDENTS SACRAMENTO FAMILY MEDICAL CLINICS, INC.; THEODORE MAZER, M.D.; RONALD B. MEAD, D.D.S.; AND ACACIA ADULT DAY SERVICES IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether individuals injured by a state law may maintain an action in federal court to enjoin a state official from enforcing that law on the ground that it is preempted by a federal law.

2. Whether a state law reducing Medicaid reimbursement rates is preempted by 42 U.S.C. § 1396a(a)(30)(A).

CORPORATE DISCLOSURE STATEMENT

Respondent Sacramento Family Medical Clinics, Inc. and respondent Acacia Adult Day Services have no parent corporations, and no publicly-held company owns any stock in those respondents.

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INTRODUCTION

The petition involves the validity of a state law that was only on the books for eight months, and that expired more than a year ago, in February 2009. That state law imposed a ten percent across-the-board reduction to Medicaid rates for providers of medical services and other health care providers, to the detriment of their patients. That state law has been submitted to the federal Department of Health and Human Services for approval, but that process has been stalled by petitioner's failure to respond to the federal government's requests for additional information.

The court of appeals correctly concluded, consistent with the settled practice of this Court and all the regional courts of appeals, that respondents could bring suit in federal court seeking an injunction to bar a state official from enforcing a preempted state law. Such suits give life to the Supremacy Clause.

The court of appeals also correctly concluded that the district court did not abuse its discretion in finding that respondents had established a likelihood of success on the merits of their claim that the federal Medicaid Act preempted the challenged state law. No court in the 45-year history of the Medicaid program has interpreted the Act to allow wholly budget-driven reductions to Medicaid rates without consideration of the effect of the reductions on efficiency, economy, and quality of care, or whether the reduced rates were

sufficient to enlist enough providers so that care and services are available to eligible individuals.

STATEMENT

A. Statutory Framework

1. Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (the "Medicaid Act"), is a cooperative federal-state program that provides federal financial assistance to participating States to enable them to provide medical treatment for the poor, elderly and disabled. A State's participation in Medicaid is voluntary. To receive federal funds, however, States are required to establish and administer their Medicaid programs through individual "State plans for medical assistance" approved by the federal Secretary of Health and Human Services (HHS). 42 U.S.C. § 1396. In response to the current economic crisis, the federal government currently pays California approximately $3.10 for every $2 the State spends through its plan. 75 Fed. Reg. 5,325, 5,326 (Feb. 2, 2010).

The State must comply with the approved plan until it either withdraws from the program or HHS approves an amendment to the state plan. *Exeter Memorial Hospital Ass'n v. Belshe*, 145 F.3d 1106 (9th Cir. 1998); 42 C.F.R. § 430.20(b)(2) (incorporating Section 447.256(a)(2), which incorporates Section 447.253(i), which provides that the state "Medicaid agency must pay for * * * services using rates determined in accordance with methods and standards specified in an approved State plan").

When a state plan amendment is submitted to HHS, HHS has 90 days to make a determination whether the amendment complies with the Medicaid Act. 42 U.S.C. § 1396n(f)(2). If HHS does not act within this time frame, the state plan amendment is considered approved. *Ibid.* If, however, HHS asks for more information from the State, HHS has a second 90-day time frame within which to approve or disapprove the amendment, beginning on the date the requested information is received from the State. *Ibid.*

The Medicaid Act provides specific requirements for state plans and reimbursement rates. Section 1396a(a)(30)(A), the provision at issue in this case, provides that a state plan

> must * * * provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary [1] to safeguard against unnecessary utilization of such care and services and [2] to assure that payments are consistent with efficiency, economy, and quality of care and [3] 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) (bracketed numbers added).

This case involves the requirements of Section 1396a(a)(30)(A) that mandate that a state plan establish payment rates for medical care and services available under the plan that are both consistent with quality medical care (the "quality of care" provision) and sufficient to enlist enough providers to ensure that medical care and services are as available to recipients as is generally available to the public in the same geographical area (the "equal access" or "enough providers" provision).

2. Prior to the legislation leading to this litigation, California's payments per enrollee were already the lowest in the nation, and not by just a small margin. California's Medi-Cal payments per enrollee in 2005 were less than 60% of the national average payments per enrollee and represented less than 35% of the annual payments per enrollee of large states, such as New York. C.A.E.R. 2062. There had been no increase in most Medi-Cal payment rates since 2001. Pet. App. 116a-117a. Furthermore, and undoubtedly related to historically low payment rates, participation by providers in California Medicaid has been a fraction of that in other state Medicaid programs. C.A.E.R. 1985.

On February 16, 2008, the California Legislature enacted Assembly Bill X3 5 ("AB 5") in a special session. Section 14 of AB 5 added Section 14105.19 to the Welfare and Institutions Code, which instructed the Director of the California Department of Health Care Services to cut reimbursement under the Medi-Cal fee-for-service program to physicians, dentists,

pharmacies, adult day health care centers, clinics, and other providers by ten percent. Cal. Welf. & Inst. Code § 14105.19(b)(1) (2008).[1] AB 5 provided that the ten percent rate cuts were to go into effect on July 1, 2008. *Ibid.*

In relevant part, the cuts provided by AB 5 expired eight months later, on February 28, 2009. The Legislature enacted Assembly Bill 1183 ("AB 1183"), on September 30, 2008. Section 44 of AB 1183 amended Section 14105.19 to make the rate reductions of AB 5, excluding non-contract hospitals, expire on February 28, 2009. Section 45 of AB 1183 added a new Section 14105.191 that, effective March 1, 2009, required a five percent rate cut for certain Medi-Cal fee-for-service payments and benefits, including pharmacies and adult day health care centers, and a one percent rate reduction for all other fee-for-service benefits. The cuts required by AB 1183 were not challenged in this action.

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[1] The State did so even though California's own independent Legislative Analyst's Office (LAO) recommended that the Legislature reject the rate cuts and explore alternative options to achieve savings. C.A.E.R. 3719-3721. That report also cautioned that the low reimbursement rates could negatively affect access and outcomes for Medi-Cal patients and could cause a shift to more expensive forms of care. C.A.E.R. 3718-3719. But, as the district court noted, petitioner did not show that the Legislature ever considered that report. Pet. App. 106a-107a n.10, 145a n.6.

B. Factual Background

1. Respondents are comprised of two sets of plaintiffs. The original plaintiffs are two Medi-Cal beneficiaries; three Medi-Cal pharmacies with more than 5,000 Medi-Cal beneficiaries; and an independent living center and Gray Panther groups with more than 5,000 clients or members who are Medi-Cal beneficiaries in the Medi-Cal fee-for-service program. Additional plaintiffs (the respondents filing this brief) were permitted to intervene during the pendency of the case. Those intervenors are a physician; a dentist; a medical clinic; and an adult day health care center also participating in the Medi-Cal program.

On April 22, 2008, the original respondents sued petitioner, the Director of the California Department of Health Care Services, in state court to prevent the implementation of AB 5. They alleged, inter alia, that the action of the State to implement the ten-percent payment reduction of AB 5 was void, contrary to and preempted under the Supremacy Clause by Section 1396a(a)(30)(A).[2] They sought a writ of mandate or an injunction to prohibit the Director of the Department of Health Care Services from implementing AB 5.

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[2] The original respondents also raised claims under the Americans with Disabilities Act, but later dismissed those claims without prejudice. Pet. App. 98a n.4.

Petitioner removed respondents' suit from state to federal court. The district court denied the original respondents' motion for injunctive relief, holding that they had not demonstrated a likelihood of success on the merits of their preemption claim because Section 1396a(a)(30)(A) did not create any judicially enforceable "rights."

2. The original respondents appealed. The court of appeals issued an order reversing the district court and remanding for consideration of the merits of their motion for preliminary injunction.

In a subsequent opinion explaining its order (Pet. App. 58a-93a), the court of appeals stated that "[t]he Supreme Court has repeatedly entertained claims for injunctive relief based on federal preemption, without requiring that the standards for bringing suit under [42 U.S.C.] § 1983 be met." Pet. App. 68a. The court analyzed in detail the numerous cases holding that claims for injunctive relief based on federal preemption may be brought absent any express right or cause of action. Pet. App. 68a-75a (citing, inter alia, *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624 (1973); *Ray v. Atlantic Richfield Co.*, 435 U.S. 151 (1978); and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983)).

The court also rejected petitioner's argument that a claim of preemption under a federal statute enacted pursuant to Congress's spending power, like the Medicaid Act, should be treated differently. Pet. App. 77a-83a. The court noted that this Court, and

the other circuits that have addressed the argument, have flatly rejected it. *Ibid.*

Petitioner's petition for rehearing and rehearing en banc were denied without recorded dissent. Petitioner then petitioned this Court for review, which this Court denied on June 22, 2009. *See* 129 S. Ct. 2828 (No. 08-1223).

3. a. Meanwhile, on remand, the district court issued a preliminary injunction on August 18, 2008, enjoining petitioner from implementing the AB 5 payment cuts with respect to doctors, dentists, prescription drugs, adult day health care centers, and clinics. Pet. App. 94a-124a.

The district court found that the original respondents demonstrated a likelihood of success on the merits because the Legislature enacted the rate reduction without any consideration of the relevant factors required by Section 1396a(a)(30)(A)—efficiency, economy, quality of care, and equality of access, as well as the effect of providers' costs on those relevant factors—and failed to show any justification other than purely budgetary concerns for rates that substantially deviate from the providers' costs. Pet. App. 100a-108a.

The court also found that the original respondents demonstrated irreparable harm resulting from implementation of AB 5. The court found that the cuts would cause "pharmacies to cease selling [generic prescription] drugs to Medi-Cal patients and depriv[e] 'thousands, if not millions' of Medi-Cal beneficiaries of much-needed pharmaceuticals." Pet.

App. 110a. It also found that pharmacies would "limit the scope of the services they provide to Medi-Cal beneficiaries, by, *inter alia*, discontinuing the provision of at least some prescription drugs * * * , turning away new Medi-Cal patients, or by laying-off pharmacy employees, and/or reducing pharmacy hours." Pet. App. 111a.

In addition, the court found that the rate reduction would cause doctors and other service providers (who had not received a rate increase since 2001) to "turn away" new Medi-Cal patients and either "stop treating [current] Medi-Cal patients, or, at a minimum, * * * reduce the services" provided to them. Pet. App. 116a-117a. This reduction in services "increased the burden on emergency rooms and community health clinics" and forced some adult day health care centers to close. Pet. App. 117a-118a.

Weighing the balance of the hardships and the public interest, the district court concluded that the "significant threat to the health of Medi-Cal recipients" that "reducing payments to health-care service providers will likely cause" outweighed any expected fiscal savings, which the district court noted were unlikely to materialize because "many Medi-Cal beneficiaries will turn to more costly forms of medical care, such as emergency room care." Pet. App. 121a-122a & n.14.

b. On petitioner's motion, the district court amended its preliminary injunction to be effective only to payments for services provided on or after

August 18, 2008, the date of its order, rather than on or after July 1, 2008, the effective date of the rate cuts. Pet. App. 125a-126a.

c. On November 17, 2008, the district court issued a similar preliminary injunction for providers of non-emergency medical transportation services and providers of home health services in the Medi-Cal fee-for-service program. Pet. App. 133a-153a.

The district court found respondents had shown a likelihood of success on the merits of their claim that petitioner had acted contrary to Section 1396a(a)(30)(A) by not considering relevant factors before enacting the rate reduction. Pet. App. 139a-147a.

The district court also found that the ten percent payment reduction of AB 5 "has forced or will force [non-emergency medical transportation services] and home health services providers to reduce the geographic area they are able to serve, to decline to take new Medi-Cal patients, and, in some cases, to cease furnishing services to existing Medi-Cal patients" and to "close their business" altogether. Pet. App. 148a-149a. This curtailment of services had "already prevented altogether some Medi-Cal beneficiaries from obtaining needed [medical] services" and forced others to enter nursing homes. Pet. App. 150a-151a.

4. With respect to the August 18 preliminary injunction, the court of appeals affirmed in part, reversed in part, and remanded in a published opinion. Pet. App. 1a-38a. One month later, the court affirmed

the November 17 preliminary injunction in an unpublished opinion. Pet. App. 54a-57a.

a. As to the August 18 preliminary injunction, the court of appeals affirmed the district court's determination that respondents had established a likelihood of success on the merits on three independent grounds. Pet. App. 10a-29a.

First, all of the courts of appeals to address the issue have held that Section 1396a(a)(30)(A) means, at a minimum, that state Medicaid rate reductions "may not be based solely on state budgetary concerns." Pet. App. 19a-20a (citing cases from the Third, Eighth, Ninth, and Tenth Circuits). The court of appeals found that "the record supports the district court's conclusion that 'the only reason for imposing the cuts was California's current fiscal emergency.'" Pet. App. 20a (quoting Pet. App. 107a). Thus, the court of appeals concluded, "quite apart from any procedural requirements * * * , the State's decision to reduce Medi-Cal reimbursement rates based solely on state budgetary concerns violated federal law." *Ibid.*

Second, the court of appeals held that the rate cut violated Section 1396a(a)(30)(A) under the interpretation adopted by the Third and Eighth Circuits, and urged by petitioner in this case, i.e., that the rate reductions be the result of a "reasonable and sound" decision-making process. Pet. App. 22a n.12. "Nothing in the record connects the decision to cut Medi-Cal reimbursement rates by 10 percent across-the-board to a fact-finding process initiated by state

officials." *Ibid.* Thus, even under the standard urged by petitioner, "the district court did not abuse its discretion in holding that [respondents were] likely to demonstrate that AB 5 frustrates the purpose of § [1396a(a)](30)(A)." *Ibid.*

Third, the court held that petitioner had not complied with the requirements of Section 1396a(a)(30)(A) as interpreted by its earlier decision in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998). Pet. App. 10a-12a.

Finally, the court of appeals noted that even if Section 1396a(a)(30)(A) only imposed a substantive obligation to set rates that achieve certain results, "the ten percent rate reduction might still conflict with the quality of care and access provisions of § [1396a(a)](30)(A), as the cuts have apparently forced at least some providers to stop treating Medi-Cal beneficiaries." Pet. App. 23a.

The court found no abuse of discretion in the district court's consideration of the other preliminary injunction factors. Pet. App. 25a-29a.

b. On respondents' cross-appeal, the court of appeals found that petitioner had waived its Eleventh Amendment immunity by removing the case from state to federal court. Pet. App. 33a-37a. The court observed that California law creates a cause of action for mandamus which permits "monetary awards against a state agency or official resulting from unlawfully withheld health and welfare payments." Pet. App. 34a-35a (citing California cases). Because

petitioner "enjoyed no sovereign immunity in state court against an order directing payment of retroactive benefits, it follows that [petitioner]—by removing the case to federal court—waived sovereign immunity in that forum as well." Pet. App. 36a. The court of appeals thus remanded with instructions that "the district court's injunction should extend to all services covered by that injunction and provided on or after July 1, 2008." Pet. App. 37a.

c. With regard to the November 17 preliminary injunction, the court of appeals affirmed in a separate unpublished opinion. Pet. App. 54a-57a. The court held that the cuts were unlawful for the reasons identified in its published opinion. Pet. App. 56a. It also held that there was no clear error in the district court's conclusion "that the rate reductions would force—or, in some cases, were already forcing—[non-emergency medical transportation] and home health-care agencies to reduce the geographic area served, decline to take new Medi-Cal patients, or stop treating Medi-Cal patients altogether." *Ibid.*

d. The court of appeals denied petitioner's petitions for rehearing en banc without recorded dissent. Pet. App. 154a-157a.

Nearly five months after the court's affirmance of the August 18 preliminary injunction, and a month after the denial of petitioner's petition for rehearing en banc, petitioner asked the court to vacate its published opinion and dismiss the appeals as moot.

In its motion, petitioner asked the court "to rescind its opinion in two appeals, Nos. 08-56422 [petitioner's appeal] & 08-56544 [respondent's cross-appeal], entered on July 9, 2009, and to dismiss the appeals as moot." 08-56422 C.A. Dkt. 105 at 1. Petitioner based its motion on the ground that, when the court of appeals "filed its opinion in the present appeal affirming the injunction of the reductions in [state law], those reductions were no longer in effect," and thus there "was nothing to enjoin." *Id.* at 2. Petitioner explained that the mootness issue only "became apparent as counsel was preparing the case for a potential petition for certiorari," thus explaining its delay in raising the issue. *Id.* at 1.

Respondents opposed the motion to dismiss as moot, noting that petitioner, in its June 2009 reply brief in this Court supporting its petition for certiorari in No. 08-1223, had taken precisely the opposite position regarding mootness; that petitioner could potentially seek to recover the "excess" payments made to respondents between the time the preliminary injunction went into effect and the time when AB 1183 went into effect; and that respondents' cross-appeal seeking retroactive relief was not moot in any event. 08-56422 C.A. Dkt. 108 at 5, 11, 12.

Contrary to petitioner's current representation (Pet. 12 & n.5), petitioner did *not* then concede that its own appeal was not moot. Instead, it urged the court to "dismiss the two appeals for lack of jurisdiction on the ground that the preliminary injunction at issue became moot by the enactment of AB 1183."

08-56422 C.A. Dkt. 109 at 15; *see also id.* at 2 ("The Director's Appeal (No. 08-56422) Was Moot When This Court Rendered Its Decision"); *ibid.* ("The Interlocutory Appeal of the Injunction Was Moot, Even Though a Live Controversy Remains Between the Parties in the District Court"); *id.* at 3 ("Accordingly, this Court lacked jurisdiction over the Director's appeal."). Petitioner nonetheless noted that "the potential for [the court of appeals] to enter an order reversing the trial court and authorizing interlocutory recoupment *could* supply a basis for [the court of appeals'] jurisdiction over the [petitioner's] appeal," *id.* at 7 (capitalization edited), but did not take a view on whether such a recoupment was permissible. Petitioner also asserted that the court of appeals lacked subject-matter jurisdiction over respondents' cross-appeal because it sought retroactive relief. *Id.* at 14.

The court of appeals rejected petitioner's motion but did not address petitioner's recoupment point. Pet. App. 42a-51a. Instead, the court of appeals held that it had jurisdiction over the appeals because respondents' request for retroactive relief—i.e., for full payment for the period from July 1, 2008 (the effective date of the rate cuts) to August 18, 2008 (the date of the preliminary injunction)—meant that "both parties retained an interest in the case despite the passage of AB 1183, which merely provided that the ten percent rate reductions would not continue past February 28, 2009." Pet. App. 47a.

In addition, the court felt "constrained to comment on the circumstances surrounding" petitioner's

new argument. *Id.* at 48a. The court was "particularly troubled" because petitioner claimed that it became aware of this new argument only while preparing a potential petition for certiorari relating to the court's opinion even though that "explanation [was] belied by the record of proceedings." *Id.* at 49a. In addition, petitioner had previously taken in this Court "the exact opposite position regarding mootness" of the appeals. *Id.* at 50a.

5. Petitioner did not move to stay the mandate, which issued on December 21, 2009. Subsequent events occurring in the district court are discussed in Part I.A, *infra*.

REASONS THE PETITION SHOULD BE DENIED

As with petitioner's earlier petition for certiorari, this case is not an appropriate vehicle to address the questions raised by petitioner. Indeed, in its application for an extension of time in which to file this petition, petitioner represented that there were other cases that "may present better vehicles for the Court's review." Pet. Application for Ext. of Time at 3-4, No. 09-A508 (Nov. 24, 2009).

Petitioner asserts that the decisions of the court below "spawned a new, national wave of Medicaid litigation," suggesting a drastic situation that warrants immediate intervention by this Court. Pet. 36. But California has been almost alone in demonstrating a flagrant disregard for the requirements embodied in the Medicaid Act. Consequently, the vast majority of

cases where injunctions have been granted impacting Medicaid reimbursement have been in California.

Petitioner, working with other state attorneys general, has identified only 13 cases filed in federal courts outside of California in the past 20 months. Pet. App. 219a-223a. According to petitioner's description, of those non-California cases, a total of two injunctions have been entered.[3] Thus, while lawsuits may be seeking relief under the Supremacy Clause (and it is unclear whether such suits are being filed at any greater rate than in previous years), the results of those suits demonstrate that States that properly follow the mandates of federal Medicaid law will not suffer budgetary "catastrophes" as a result of the preemption holding of the court below.

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[3] Accepting petitioner's descriptions, there also was one dismissal for failure to state a claim, one stipulated dismissal, one settlement, one stay pending settlement negotiations, and one denial of a preliminary injunction. Six cases are still at the briefing stage.

I. THE INTERLOCUTORY RULINGS AFFIRMING PRELIMINARY INJUNCTIONS ARE NOT APPROPRIATE VEHICLES TO ADDRESS PETITIONER'S CLAIMS

A. Events Occurring During And After The Court Of Appeals' Interlocutory Rulings Make These Cases Particularly Inappropriate To Address The Questions Raised By Petitioner

1. The opinions of which petitioner seeks review are, as petitioner admits (Pet. 37), "interlocutory decisions" sustaining preliminary injunctions, a posture that "of itself alone furnishe[s] sufficient ground" for denying review. *Hamilton-Brown Shoe Co. v. Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916). Review of such interlocutory decisions is strongly disfavored because "many orders made in the progress of a suit become quite unimportant by reason of the final result, or of intervening matters." *American Constr. Co. v. Jacksonville, T. & K. W. Ry. Co.*, 148 U.S. 372, 384 (1893).

If petitioner succeeds in the district court in defeating entry of a permanent injunction, for example, then petitioner will have prevailed without regard to anything ruled upon in these interlocutory opinions. That is precisely the view petitioner is currently taking in the district court. Petitioner contends that "additional triable issues of fact remain[] in this case" to be resolved at the permanent injunction stage. Dt. Ct. Dkt. 335 at 5. And petitioner told the court that it "plans to conduct discovery related to the more than 100 declarations filed by [respondents]

in support of their motions for preliminary injunction, as well as discovery relating to witnesses and facts that [petitioner] anticipates will be identified during discovery." *Ibid.* Thus, petitioner's representations to the district court demonstrate that it does not view the likelihood-of-success determination made at the preliminary injunction stage as insurmountable even under the court of appeals' rulings.

2. Even if these were not preliminary injunctions, there is a serious question at this point of the relief available to petitioner as a practical matter because it has (or will shortly) have paid out all the money in dispute with respondents covered by the preliminary injunctions directed at implementation of AB 5, which itself expired more than a year ago.

AB 5 required ten percent cuts in rates for only eight months, between July 2008 and February 2009. From the date of the preliminary injunctions, the ten percent cuts required by AB 5 were not in effect and thus full rates were paid to respondents from those points forward. Petitioner's motions in the district court for a stay of those preliminary injunctions were denied, and petitioner never sought a stay of those injunctions in the court of appeals or in this Court. Nor did petitioner seek a stay of the mandate of the court of appeals' subsequent opinion requiring an amendment of one of the preliminary injunctions to encompass the period of July 1, 2008 to August 18, 2008.

On remand, the district court thus amended that preliminary injunction to include those payments, Dt. Ct. Dkt. 328 at 1-2, and denied petitioner's motion to stay implementation of that order pending disposition of this petition for certiorari, Dt. Ct. Dkt. 338 at 3-6. Petitioner has since informed the district court that all of the retroactive payments should be completed no later than August 2010. Dt. Ct. Dkt. 358 at 2-4. So even if this Court granted certiorari, all of the rate reductions put at issue by the preliminary injunctions would have been paid in full before the Court were to issue an opinion on the merits.

Petitioner, at least at some points in the litigation, has suggested that it could recoup ten percent of the payments if it obtained reversal of the preliminary injunctions. But its views on this point have shifted over time, *see* pages 14-15, *supra*, and the legal basis of such recoupment has never been briefed by petitioner in any court. Further, even if petitioner has a legal basis for recoupment, respondents are aware of no situation in which petitioner has ever in the past sought recoupment when an injunction has been reversed in cases involving non-institutional providers. And, in fact, in the district court, petitioner described its view of how onerous and costly that task would be. Dt. Ct. Dkt. 361 at 5.

Petitioner has further suggested that it intends to obtain federal Medicaid funds to pay for the retroactive payments. *Id.* at 4. If petitioner then recouped the money from the providers, it might have to return

as much as two-thirds of the funds to the federal government.

So, for all these reasons, although there still is a live controversy, it is unclear how review of these opinions will have any practical effect on this dispute between the parties regarding the now-expired cuts of AB 5.

B. Review Of The First Question Presented Is Unwarranted Because The Court's Resolution Would Not Affect The Authority Of The District Court To Entertain Respondents' Preemption Claim

This case is not an appropriate vehicle to resolve the first question presented by petitioner—namely, whether individuals injured by a state law may maintain an action in federal court to enjoin a state official from enforcing that law on the ground that it is preempted by a federal law—because the Court's resolution of that question would not affect the authority of the district court to entertain respondents' claims. A well-established state cause of action also provides respondents a method for raising the same preemption claim. Pet. App. 34a-35a. This Court has denied review in comparable circumstances where the resolution of the question presented "could not change the result reached below, since petitioner would be liable under either federal or state law." Eugene Gressman *et al.*, *Supreme Court Practice* 248 (9th ed. 2007).

California law provides a private cause of action in which a party injured by a state official's failure to do what he or she is required to do may sue for a writ of mandamus to compel that state official to act. *See City of Dinuba v. County of Tulare*, 161 P.3d 1168, 1174 (Cal. 2007). This state cause of action has routinely been applied to require state officials to comply with federal law, including laws enacted under the Spending Clause. Thus, in *Green v. Obledo*, 624 P.2d 256 (1981), the California Supreme Court affirmed a writ of mandamus action brought by private individuals that invalidated a state regulation which violated federal requirements under the Aid to Families with Dependent Children program and required the state official to pay benefits to the individuals under the proper federal standard.

California courts have consistently relied on this state cause of action to compel state officials to comply with the Medicaid Act, including the very statutory provision—42 U.S.C. § 1396a(a)(30)(A)—that respondents have demonstrated petitioner violated in this case. *See, e.g., Mission Hosp. Reg'l Med. Ctr. v. Shewry*, 168 Cal.App.4th 460 (2008), rev. denied (Cal. 2009); *California Ass'n for Health Servs. at Home v. Department of Health Servs.*, 148 Cal.App.4th 696 (2007); *California Ass'n of Health Facilities v. Department of Health Servs.*, No. A107551, 2006 WL 3775842 (Cal. Ct. App. Dec. 26, 2006). Indeed, even while this case was pending, petitioner told the California Supreme Court that it did not dispute the existence of a "remedy per se" under California law for violations

of the federal Medicaid Act, and only challenged "the type of remedy" ordered by the state court in that case. Pet. Reply for Pet. for Rev. at 4 n.1, *Mission Hosp. Reg'l Med. Ctr. v. Shewry*, 2009 WL 608374, (Cal. Jan. 26, 2009) (No. S169353).

Although this state cause of action was not a basis for the interlocutory rulings of the court below, the court of appeals relied on the existence of the cause of action in holding that petitioner had waived its sovereign immunity in removing this case from state to federal court, a holding that petitioner does not challenge in this Court. Pet. App. 34a-35a; Pet. 11 n.4. This Court does not grant review in cases unless a reversal would change the position of the parties in some concrete fashion. *See The Monrosa v. Carbon Black Export, Inc.*, 359 U.S. 180, 183 (1959). That would not occur here because the preemption claims in this case can proceed in federal court regardless of what this Court decides about the cause of action. That is so because the preemption claims turn on substantial questions of federal law, *see Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308 (2005), and is particularly true in this case because petitioner removed the case to federal court at a time when the preemption claim was pendent to other federal claims, *see* note 2, *supra*.

C. Review Of The Second Question Presented Is Unwarranted Because The State Has Stalled The Federal Approval Process

There is also a lurking contingency that makes this case a poor vehicle. Petitioner's proposed state plan amendment reflecting AB 5's changes is still pending with HHS (Pet. 5), but petitioner has stalled that process.

AB 5 was enacted on February 16, 2008 and instructed petitioner to "promptly seek any necessary federal approvals for the implementation of this section." Pet. App. 160a. As a matter of state law, the cuts authorized by AB 5 went into effect on July 1, 2008. But it was not until September 30, 2008, that petitioner submitted its state plan amendment to HHS. Pet. App. 187a-210a. Petitioner explained to HHS that the state plan amendment it submitted for approval would "provide *authority* for the * * * payment reductions to specified providers and programs." Pet. App. 195a (emphasis added).

In December 2008, HHS responded with a nine-page request for additional information. App., *infra*, 1a-20a. With regard to compliance with Section 1396a(a)(30)(A), HHS explained that the state plan amendment that was submitted "is inadequate and does not provide sufficient information to understand the reimbursement methodology." App., *infra*, 8a. HHS asked petitioner to explain "[w]hat impact, if any, does this proposed [state plan amendment]

have on access to providers providing these non-institutional services in California?" App., *infra*, 9a.

That letter concluded by explaining that the request for additional information "has the effect of stopping the 90-day clock with respect to [HHS] taking further action on this State plan submittal" and stating that a "new 90-day clock will not begin until we receive your response to this request for additional information." App., *infra*, 20a. Finally, the letter stated that "[i]n accordance with our guidelines to all State Medicaid Directors dated January [2], 2001, we request that you provide a formal response to this request for additional information within ninety (90) days of receipt." *Ibid.*

It has now been 17 months since HHS sent that letter and respondents are informed by HHS that, as of March 30, 2010, petitioner has still not responded. Under the guidelines referenced in the HHS letter, when a State does not respond to a request for additional information within 90 days, HHS "will initiate disapproval action on the amendment." Letter from Timothy Westmoreland, Director, Health Care Finance Administration, U.S. Dep't of Health & Human Servs., to State Medicaid Directors, at 1 (Jan. 2, 2001), *available at* http://www.cms.hhs.gov/smdl/downloads/smd010201.pdf (last visited Apr. 15, 2010).

Due to petitioner's extraordinary delay in responding to HHS's request for additional information, it is unclear if and when that disapproval may occur. This uncertainty makes this an extraordinarily poor

vehicle to address petitioner's complaint (Pet. 15) that this litigation has usurped the role of HHS.

II. CERTIORARI SHOULD BE DENIED ON THE FIRST QUESTION FOR THE ADDITIONAL REASON THAT THERE IS NO DIVISION IN THE LOWER COURTS AND THE DECISIONS BELOW ARE A CORRECT APPLICATION OF THIS COURT'S SETTLED SUPREMACY CLAUSE JURISPRUDENCE

A. The Courts Of Appeals Have Uniformly Reached The Same Conclusion As The Court Below

Contrary to petitioner's claim (Pet. 21), there is no "confusion and conflict" in the decisions of the courts of appeals. In fact, every court of appeals is in accord with the holding of the court below that a federal court may resolve, on the merits, an action against a state official for injunctive relief alleging that a state law is preempted by a federal law.

In its petition, petitioner acknowledges that the D.C., First, Second, Third, Fifth, Eighth and Tenth Circuits are in accord with the court below. Pet. 21-22 & n.6. Three circuits they do not discuss—the Fourth, Sixth, and Seventh Circuits—also have held that preemption claims can be brought in federal court without regard to a cause of action in the pre-empting federal statute. *See Verizon Maryland, Inc. v. Global NAPS, Inc.*, 377 F.3d 355, 368-369 (4th Cir. 2004); *GTE North, Inc. v. Strand*, 209 F.3d 909, 916

(6th Cir.), cert. denied, 531 U.S. 957 (2000); *Illinois Ass'n of Mortgage Brokers v. Office of Banks & Real Estate*, 308 F.3d 762, 765 (7th Cir. 2002). Thus 11 of the 12 regional circuits are plainly in accord.

Petitioner is wrong in asserting (Pet. 22-23) that the Eleventh Circuit reached a contrary conclusion. *Legal Environmental Assistance Foundation, Inc. v. Pegues*, 904 F.2d 640 (11th Cir. 1990), cannot be read so broadly.[4] In any event, the Eleventh Circuit's subsequent en banc decision in *BellSouth Telecommunications, Inc. v. MCImetro Access Transmission Services, Inc.*, 317 F.3d 1270 (11th Cir. 2003), held that, apart from any express cause of action available under the statute, "[f]ederal courts must resolve the question of whether a public service commission's order violates federal law and any other federal question." *Id.* at 1278 (citing *Verizon Maryland Inc. v. Public Serv. Comm'n*, 535 U.S. 635 (2002)); *see also id.* at 1296 (Tjoflat, J., dissenting on other grounds) ("litigants may assert a private right of action for preemption under the Supremacy Clause").

Petitioner also points (Pet. 14, 23-24) to a divided panel decision in *Wilderness Society v. Kane County*, 581 F.3d 1198 (10th Cir. 2009), in which then-Judge

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[4] In *Pegues*, the alleged violation of federal law arose from the EPA Administrator's interpretation of federal law, which Alabama merely followed. *Id.* at 644. The court noted that Congress had created an express cause of action against the federal agency, but the plaintiffs had not relied on that cause of action. *Ibid.*

McConnell dissented in a case not involving Medicaid or any other Spending Clause legislation. But rehearing en banc was granted in that case on February 5, 2010, and one of the five questions the parties were asked to brief was whether plaintiffs have a right of action. Oral argument in that case is scheduled for May 4, 2010. Thus, to the extent petitioner is relying on the Tenth Circuit's opinion, review should be denied in this case and, depending on the en banc decision, the Court could revisit the issue, if appropriate.

B. This Court's Cases Permit Preemption Claims To Enjoin State Laws, Including In Cases Involving Federal Spending Clause Statutes

The court of appeals was correct. This Court has long permitted private parties to obtain injunctive relief against a state official to prevent injury from state laws that are preempted by federal law. *See* Richard H. Fallon, Jr., Daniel J. Meltzer & David L. Shapiro, *Hart & Wechsler's The Federal Courts & The Federal System* 903 (5th ed. 2003); 13D Charles A. Wright, Arthur R. Miller & Edward H. Cooper, *Federal Practice and Procedure* § 3566 (3d ed. 2008).

In *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), for example, employers sought a declaration that a New York law was preempted by a federal statute. The Court unanimously reached the merits of the employers' preemption claim even in the absence of a cause of action in the statute. It explained that a "plaintiff who seeks injunctive relief from state

regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve." 463 U.S. at 96 n.14. In *Verizon Maryland Inc. v. Public Service Commission*, 535 U.S. 635 (2002), the Court again unanimously sustained the jurisdiction of the federal courts to hear claims that state conduct (there, an order of the public service commission) was preempted by federal law.

The court below dutifully followed *Shaw* and *Verizon* in reaching the merits of respondents' pre-emption claim. Accepting petitioner's contrary view would call into question the propriety of many pre-emption cases brought against state officials in federal court by business interests, including several that have been heard by this Court on the merits in the past few Terms. *See, e.g.*, *Cuomo v. Clearing House Ass'n, L.L.C.*, 129 S. Ct. 2710 (2009); *Chamber of Commerce of the United States v. Brown*, 128 S. Ct. 2408 (2008); *Rowe v. New Hampshire Motor Transport Ass'n*, 552 U.S. 364 (2008); *Watters v. Wachovia Bank, N.A.*, 550 U.S. 1 (2007).

Petitioner suggests (Pet. 17-18, 22 n.6, 24-25) that preemption claims under Spending Clause statutes should be treated differently. But federal statutes based on the Spending Clause can preempt state laws. *See, e.g.*, *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 476 (1996) (per curiam) (Medicaid); *Lawrence County v. Lead-Deadwood Sch. Dist.*

40-1, 469 U.S. 256, 269-270 (1985) (Payment in Lieu of Taxes Act); *Blum v. Bacon*, 457 U.S. 132, 138 (1982) (Aid to Families with Dependent Children); *see also Pennsylvania Prot. & Advocacy, Inc. v. Houstoun*, 228 F.3d 423, 428 (3d Cir. 2000) (Alito, J.). Indeed, this Court has held that the Eleventh Amendment is not a bar to private parties seeking prospective injunctive relief against state officials to enforce Spending Clause statutes because such suits are necessary to vindicate the Supremacy Clause. *See Frew v. Hawkins,* 540 U.S. 431 (2004) (Medicaid); *Edelman v. Jordan*, 415 U.S. 651 (1974) (welfare).

Not surprisingly, this Court has repeatedly adjudicated claims by private parties brought in federal court against state officials asserting preemption by virtue of the Medicaid statute and other federal spending statutes. *See, e.g.*, *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006); *PhRMA v. Walsh*, 538 U.S. 644 (2003).

Preemption claims such as respondents' are consistent with the voluntary nature of States' participation in federal spending programs. States have a right to choose not to take federal monies. But once a State chooses to do so, it "must comply with [the federal statute's] mandates." *Winkelman v. Parma City Sch. Dist.*, 550 U.S. 516, 520 (2007).

C. There Is No Basis For Petitioner's Assertion That A Preemption Claim Must Satisfy The Standards Of An Implied Private Right Of Action Or 42 U.S.C. § 1983

Petitioner suggests that respondents' preemption claim should be dismissed because it does not meet the standards for a cause of action under an implied private right of action or under 42 U.S.C. § 1983. Pet. Br. 17-18. This Court has never used either standard for a preemption claim; indeed, respondent cites no case doing so.

1. This Court's decisions determining when Congress intended by implication to create a private right of action govern cases involving private defendants. *See, e.g.*, *Cort v. Ash*, 422 U.S. 66 (1975). Private defendants, however, are not governed by the Supremacy Clause and those cases thus have no relevance to suits alleging that a government official, if not enjoined, will violate the Supremacy Clause.[5]

2. Preemption claims and Section 1983 claims are distinct avenues of enforcing federal law. The

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[5] The same inquiry also has been applied to determine whether federal statutes that impose identical duties on public and private defendants can be privately enforceable. *See Alexander v. Sandoval*, 532 U.S. 275 (2001). But even in that case, there was no suggestion that plaintiffs who claim that a state law is preempted by a federal law which applies only to States would have to meet an implied private right-of-action analysis to enforce that preemption claim.

remedies available under Section 1983 are far more extensive than under preemption, including compensatory and punitive damages against state actors in their individual capacities, compensatory damages against municipalities, and attorneys' fees. *See City of Newport v. Fact Concerts, Inc.*, 453 U.S. 247 (1981); 42 U.S.C. § 1988. Preemption claims, in contrast, seek only to enforce the structural relationship between federal and state law by obtaining equitable relief against state and local officials in their official capacities.

In *Golden State Transit Corp. v. City of Los Angeles,* 493 U.S. 103 (1989), Justice Kennedy explained that even though he would have held that the plaintiff could not bring its action under Section 1983, nevertheless "plaintiffs may vindicate [statutory] preemption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes" and those statutes "do not limit jurisdiction to those who can show the deprivation of a right, privilege, or immunity secured by federal law within the meaning of § 1983." *Id.* at 119 (Kennedy, J., dissenting). In short, "§ 1983 does not provide the exclusive relief that the federal courts have to offer." *Ibid.*

3. Petitioner also suggests (Pet. Br. 18) that because of the oversight role of the federal government in the Medicaid program, a preemption claim should not be permitted. As this Court explained in *Verizon*, a preemption claim may proceed as long as the statute "does not *divest* the district courts of their

authority" under federal-question jurisdiction to review the state's "compliance with federal law." 535 U.S. at 642. There is nothing in the text or structure of the Medicaid Act that divests the courts of their authority to resolve a preemption claim. The federal government's ability to withhold federal funds does not preclude other federal remedies. *See Rosado v. Wyman,* 397 U.S. 397 (1970); *Blessing v. Freestone*, 520 U.S. 329, 346-348 (1997).

III. CERTIORARI SHOULD BE DENIED ON THE SECOND QUESTION FOR THE ADDITIONAL REASON THAT THERE IS NO RELEVANT DIVISION IN THE LOWER COURTS AND THE DECISIONS BELOW ARE A CORRECT APPLICATION OF THE MEDICAID ACT

Petitioner claims that the Ninth Circuit's interpretation of Section 1396a(a)(30)(A) is "unique." Pet. 30-31. But under any interpretation of Section 1396a(a)(30)(A) (including petitioner's different proposals in this Court and the court below), the court of appeals correctly held that the district court did not abuse its discretion in finding that respondents had established a likelihood of success on the merits of their claim that petitioner's ten percent rate cut was preempted.

A. The Court Of Appeals' Alternative Holdings Make These Inappropriate Cases In Which To Address The Proper Interpretation Of Section 1396a(a)(30)(A)

1. In one of its alternative holdings, the court of appeals relied on petitioner's own concession to sustain the district court injunctions.

In the court of appeals, petitioner acknowledged that "§ (a)(30)(A) requires the Department to perform a reasonably principled analysis when setting reimbursement rates" and urged that it had met that standard. 08-56422 Pet. C.A. Br. 27. The court of appeals held, however, that, even under that standard, "the district court did not abuse its discretion in holding that [respondents were] likely to demonstrate that AB 5" was preempted. Pet. App. 22a n.12.

Petitioner does not address that holding in its petition. It now asserts that no analysis, principled or otherwise, is required. But that argument was not fairly presented to the panel, and petitioner never informed the court (in its petitions for rehearing en banc or otherwise) that it was withdrawing its interpretation of what Section 1396a(a)(30)(A) requires. Review of the court of appeals' decisions would thus be inadvisable because petitioner did not press this argument below.

2. The court of appeals also held that "quite apart from any procedural requirements," the State's "decision to reduce Medi-Cal reimbursement rates based solely on state budgetary concerns violated

federal law." Pet. App. 20a. Petitioner acknowledges (Pet. 32) that the Third and Eighth Circuit have reached the same conclusion.

Petitioner suggests (Pet. 32) that the Fifth Circuit reached a contrary conclusion in *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908 (2000). But *Evergreen* focused exclusively on the "equal access" requirement of Section 1396a(a)(30)(A). *Id.* at 927 n.24. It was only with respect to the "equal access" provision that the court held that the reasons underlying the rate cut were not relevant. *Id.* at 927. It did not address whether inquiry into the reasons would be warranted with respect to whether payments were "consistent with efficiency, economy, and quality of care," which was the basis for the court of appeals' decisions below.

Absent a circuit conflict, review by this Court is unwarranted because the court of appeals' decisions independently rest on this holding.

B. The Outcome Would Be The Same Under Petitioner's Current Proposed Interpretation Of The Statute

The outcome in these cases would not change even under petitioner's current proposed interpretation, namely, that Section 1396a(a)(30)(A) "sets some substantive objecti[ves]," including that the rates cannot be so low "as to create an access or quality of care problem for beneficiaries." Pet. 33, 26; *see also* Pet. 31.

Although the court of appeals did not squarely reach this point, it stated that "the ten percent rate reduction might still conflict with the quality of care and access provisions of § [1396a(a)](30)(A), as the cuts have apparently forced at least some providers to stop treating Medi-Cal beneficiaries." Pet. App. 23a.

Moreover, the court of appeals sustained the district court's multiple findings that Medi-Cal recipients would experience irreparable harm because there would be fewer providers and less access to specialized medical services. *See* pages 8-9, 10, 13, *supra.* As HHS explained in a related context: "It is widely known that Medicaid payment rates, which are substantially lower than payment rates under Medicare or private insurance, may deter participation in Medicaid by physicians and dentists." *In re Texas Health & Human Servs. Comm'n*, No. A-07-93, 2008 WL 2625668, at *9 (HHS Departmental Appeals Bd. May 16, 2008). Given that the ten percent cut was on rates that had not been raised since 2001, and are near the bottom nationally, it should come as no surprise that California's cuts, done without any analysis, would result in substantive injury by creating access and quality of care problems.

C. The Court Of Appeals Correctly Interpreted Section 1396a(a)(30)(A) And The Decision Below Is Not Inconsistent With Other Courts Of Appeals

Petitioner incorrectly claims that the court of appeals' approach to the statute is unique to the extent

it allows Medicaid reimbursement rates to be enjoined based on a defective process that does not consider the providers' costs. Pet. 27-32.

1. Petitioner argues that a procedural reading of Section 1396a(a)(30)(A) is "atextual." Pet. 34. But the plain language of the statute requires the States that participate in Medicaid to "provide such methods and procedures" relating "to the payment for" medical care and services "to assure that payments are consistent with efficiency, economy, and quality of care." A State cannot do that without considering what services it can obtain at particular rates. The United States has embraced that analysis, explaining that in interpreting Section 1396a(a)(30)(A), "[a]n economically-operated system contemplates charges that bear some relationship to the cost of providing the service." U.S. Br. at 32, *Alaska Dep't of Health & Soc. Servs. v. Centers for Medicare & Medicaid Servs.*, 2004 WL 3155124 (9th Cir. Dec. 27, 2004) (No. 04-74204).

The statute's legislative history is fully consistent with the notion that States must at least consider the potential impact of Medicaid rate changes on provider participation before going forward with such changes. As explained by Congress, "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program." H.R. Rep. No. 101-247, at 389-390 (1989).

Nor is it contrary to *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), to interpret Section 1396a(a)(30)(A) consistent with its text and

history. Petitioner never cited *Pennhurst* in the court of appeals, and thus has waived this argument. In any event, *Bennett v. Kentucky Department of Education*, 470 U.S. 656 (1985), confirms that, as long as the recipient is on notice that the federal money it is receiving has conditions attached, *Pennhurst* does not require that "every improper" action be "specifically identified and proscribed in advance." *Id.* at 666; *see also Forest Grove Sch. Dist. v. T.A.*, 129 S. Ct. 2484, 2495 (2009) (*Pennhurst* is "satisfied" when prior judicial decisions give notice).

2. Petitioner claims that the decisions below are contrary to cases from the First, Third, Fifth, Seventh, and Eighth Circuits. Petitioner is wrong.

There is no difference between what the court held below and the Eighth Circuit's holding in *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519, 530 (1993), which sustained a preliminary injunction of a 20 percent reduction in Medicaid payment rates because the State had failed to "consider the relevant factors of equal access, efficiency, economy, and quality of care as designated in the statute when setting reimbursement rates." *Accord Minnesota Homecare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (affirming validity of *Reynolds*).

Contrary to petitioner's claim (Pet. 28), the Third Circuit has not held that Section 1396a(a)(30)(A) lacks a procedural component. In *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999), the court of appeals declined to find that Section

1396a(a)(30)(A) itself mandates that a State follow a particular process in setting Medicaid reimbursement rates, but did require the agency's "process of decision-making" to be "reasonable and sound." *Id.* at 853. The Third Circuit ultimately held that the State made Medicaid rate-setting decisions in a reasonable, sound manner that was at least in some way informed by consideration of the Section 1396a(a)(30)(A) factors. The same cannot be said of petitioner's actions, as the district court and court of appeals found.

The Fifth and Seventh Circuit cases cited by petitioner are not apt because they addressed only the "equal access" prong of Section 1396a(a)(30)(A), and did not address the efficiency, economy, and quality of care prong. *See Evergreen*, 235 F.3d at 927 n.24; *Methodist Hosps., Inc. v. Indiana Family & Soc. Servs.*, 91 F.3d 1026, 1029 (7th Cir. 1996). And in stark contrast to the rate cuts here, the methodology modifications challenged in *Methodist* were the result of a careful, deliberative process over a 12-month period during which a variety of issues and viewpoints were considered. 91 F.3d at 1030. Similarly, the rate reduction in *Evergreen* was the result of a public process that the court believed allowed for impacted parties to effectively comment before the cuts went into effect. 235 F.3d at 922. *Evergreen* ultimately rejected the plaintiffs' Section 1396a(a)(30)(A) claims only because it concluded there was an inadequate evidentiary showing that access would decline. *Id.* at 933-934. Based on the record in this case regarding beneficiary access to care, there is considerable reason to doubt that the Fifth or

Seventh Circuits would have found that the wholly arbitrary cuts at issue here complied with Section 1396a(a)(30)(A).

Finally, contrary to petitioner's claim, the First Circuit never has addressed the issue because it concluded that Section 1396a(a)(30)(A) could not be enforced through Section 1983. *See Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 59-60 (1st Cir. 2004).

Thus, petitioner's claimed conflict is illusory and provides no grounds for further review.

CONCLUSION

For the reasons set forth above, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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