No. 10-283

OCT 27 2010

In The Supreme Court of the United States

DAVID MAXWELL-JOLLY, Director, California Department of Health Care Services,

Petitioner,

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.,

Respondents.

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

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether those 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 the federal law governing such rate-setting, 42 U.S.C. § 1396a(a)(30)(A).

CORPORATE DISCLOSURE STATEMENT

CHILDREN'S HOSPITAL AT MISSION, a California corporation, dba CHOC Children's at Mission, has no parent corporation, and no publicly-held company owns any stock in the above-named respondent.

FOUNTAIN VALLEY REGIONAL HOSPITAL AND MEDICAL CENTER, a California corporation, is 100% owned by OrNda Hospital Corporation, a California corporation that is 100% owned by Tenet HealthSystem HealthCorp, a Delaware corporation that is 100% owned by Tenet Healthcare Corporation (NYSE: THC), a publicly-held Nevada corporation. As of June 30, 2010, only one company reported to the Securities and Exchange Commission that it beneficially owned more than 10% of Tenet Healthcare Corporation's publicly traded common stock: Franklin Mutual Advisers, LLC (10.6%), which is not itself a publicly-held company, but is a subsidiary of a publicly-held company, Franklin Resources Inc. (NYSE: BEN).

HEART HOSPITAL OF BK, LLC, a North Carolina limited liability company, dba Bakersfield Heart Hospital, is owned by Heart Hospital of BK, LLC (the "Company"), a North Carolina limited liability company. As of September 30, 2008, HHBF, Inc., an indirectly owned subsidiary of MedCath Corporation ("MedCath"), held a 53.3% interest in the Company, and the physician members held the remaining 46.7% interest. MedCath is publicly traded on the NASDAQ under the symbol "MDTH."

CORPORATE DISCLOSURE STATEMENT – Continued

HOAG MEMORIAL HOSPITAL PRESBYTERIAN, a California corporation, dba Hoag Memorial Hospital Presbyterian in Newport Beach, has no parent corporation, and no publicly-held company owns any stock in the above-named respondent.

JOHN MUIR HEALTH, a California corporation, dba John Muir Medical Center – Concord Campus and as John Muir Medical Center – Walnut Creek Campus, has no parent corporation, and no publicly-held company owns any stock in the above-named respondent.

LANCASTER HOSPITAL CORPORATION, a California corporation, dba Lancaster Community Hospital, is owned by Universal Health Services of Palmdale, Inc., which is not a publicly traded company. The stock of Universal Health Services of Palmdale, Inc. is wholly owned by Universal Health Services, Inc., which is a publicly traded company. There are no publicly-held companies that own more than 10% of the stock of Universal Health Services, Inc.

ORANGE COAST MEMORIAL MEDICAL CENTER, a California corporation, ANAHEIM MEMORIAL MEDICAL CENTER, a California corporation, and SADDLEBACK MEMORIAL MEDICAL CENTER, a California corporation, have as a parent

CORPORATE DISCLOSURE STATEMENT –
Continued

corporation MEMORIAL HEALTH SERVICES, a California corporation. No publicly-held company owns any stock in the above-named respondents or parent corporation.

SAN ANTONIO COMMUNITY HOSPITAL, a California corporation, has no parent corporation, and no publicly-held company owns any stock in the above-named respondent.

SANTA ROSA MEMORIAL HOSPITAL, SRM ALLIANCE HOSPITAL SERVICES, a California corporation, dba Petaluma Valley Hospital, QUEEN OF THE VALLEY MEDICAL CENTER, a California corporation, and MISSION HOSPITAL REGIONAL MEDICAL CENTER, a California corporation, dba Mission Hospital, are all non-profit corporations. No publicly-held company owns any stock in the above-named respondents.

ST. HELENA HOSPITAL, a California corporation, CENTRAL VALLEY GENERAL HOSPITAL, a California corporation, and SAN JOAQUIN COMMUNITY HOSPITAL, a California corporation, have as a parent corporation ADVENTIST HEALTH SYSTEMS/WEST, a California corporation. No publicly-held company owns any stock in the above-named respondents or parent corporation.

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INTRODUCTION

There are no grounds for review here.[1] This case involves no conflict between the decisions of Federal courts of different circuits. Moreover, the Ninth Circuit's application of 42 U.S.C. § 1396a(a)(30)(A) is consistent with its plain terms and the interpretation of that statute by the federal CMS (Centers for Medicare & Medicaid Services).

Even if legitimate grounds for certiorari existed, this case would be a poor vehicle for review for at least three reasons. First, the decision that the petitioner seeks to have reviewed is based on a preliminary injunction, and not a final action. Review of such interlocutory decisions is strongly disfavored. Second, the rate change at issue here has not been approved, and may never be approved, by the federal CMS. Administrative disapproval of petitioner's rate change would make the decision of this Court moot. Third, this Court does not grant review in cases where a reversal would not change the position of the parties in some concrete fashion. In the instant action, a reversal would not change the ultimate outcome of the case because respondents can pursue

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[1] Respondents agree with petitioner that this case involves "substantially the same legal issues as the petitions for certiorari pending in *Maxwell-Jolly v. Independent Living Center of Southern California*, No. 09-958. . .and *Maxwell-Jolly v. California Pharmacists Association*, No. 09-1158[.]" Pet. 3. For the reasons set forth herein, and in the other cases, the petitions in all of these cases should be denied.

their claims in State court under a writ of mandate (Cal. Code of Civil Procedure § 1085).

STATEMENT

A. Statutory Framework

The State pays California hospitals for the inpatient services they provide to Medi-Cal beneficiaries in one of two ways. Under one approach, the California Medical Assistance Commission ("CMAC") negotiates contracts with selected hospitals. This system of reimbursement is known as the selective provider contracting program, and the hospitals that participate in it are called "contracting" hospitals. The State of California did not reduce the negotiated rates paid contract hospitals; hence, those types of facilities are not relevant to this lawsuit. Pet. App. 25.

Hospitals that do not have a contract are typically referred to as "noncontract" hospitals. For over twenty-five years (from 1982 through 2008), the State paid noncontract hospitals based on their "allowable costs," and then applied two different and highly sophisticated measures of "economy" and "efficiency" to those costs, the rate per discharge limit and the peer group limit. *See* App., *infra*, 1-85; 22 California Code of Regulations (C.C.R.) §§ 51545-51555. If a hospital's "allowable costs" fell below the rate per discharge limit and the peer group limit, then those costs were fully reimbursed as the costs of an "[e]conomically and [e]fficiently [o]perated" provider

of inpatient services. *See* App., *infra*, 5, 12-13; 22 C.C.R. §§ 51545(a)(30) and 51545(a)(70). This approach – which was based on sophisticated measures of "economy" and "efficiency" – had been approved by the federal CMS as complying with federal law.

In 2008, without federal approval, the State completely abandoned the sophisticated reimbursement methodology described above. On February 16, 2008, the California Legislature enacted Assembly Bill X3 5 (AB 5) in special session which, effective July 1, 2008, imposed an across-the-board ten percent reduction in the "allowable cost" reimbursement of *all* noncontract hospitals for the inpatient services they provide Medi-Cal recipients. Cal. Welf. & Inst. Code § 14166.245 (Pet. App. 25-41). Then, effective October 1, 2008, California enacted AB 1183 which further cut the amounts paid to noncontract hospitals to the lesser of the above-described 10% reduction or to the applicable CMAC average contract rate less 5 percent.[2] Cal. Welf. & Inst. Code § 14166.245 (Pet. App. 25-41).

Respondents showed that without an injunction of both AB 5 and AB 1183 they would have lost between 21% and 37% of their inpatient Medi-Cal reimbursement, which translated into an annual loss

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[2] In the instant case, respondents sought to enjoin only the rate cut under AB 5 because the rate reduction under AB 1183 had already been enjoined by the Ninth Circuit on April 6, 2009, in *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009). Pet. 11.

of between $40 and $55 million per year. Moreover, respondents submitted fifteen declarations which were virtually uncontested and unrefuted showing that they would have to curtail or eliminate significant programs, services, and capital expenditures as a result of the petitioner's draconian rate cuts.

Petitioner readily admits that both rate reductions were enacted predominantly for budgetary reasons. Furthermore, as of October 12, 2010, neither rate reduction had been approved by the federal CMS.

B. Factual Background

The respondents are nineteen hospitals located throughout California that provide services to Medi-Cal beneficiaries.

On November 14, 2008, respondents filed a Complaint in the Northern District of California challenging the validity of the AB 5 and the AB 1183 Medi-Cal rate reductions, and seeking a preliminary injunction enjoining the implementation of those rate cuts. Respondents subsequently amended their Complaint on December 4, 2009, primarily to add additional plaintiffs.

On January 14, 2009, respondents filed a motion for a preliminary injunction enjoining the application of the AB 5 and the AB 1183 rate cuts. The district court stayed the case in its entirety pending the

Ninth Circuit's decision in *Indep. Living Ctr. of Southern Cal., Inc. v. Shewry* and denied respondents' motion for a preliminary injunction without prejudice.

Plaintiffs appealed the denial of the preliminary injunction and requested that the Ninth Circuit grant an emergency injunction. On June 2, 2009, the Ninth Circuit vacated and remanded the appeal because the district court made no findings or conclusions in support of its order denying the preliminary injunction motion.

On June 4, 2009, the district court requested "supplemental brief[s]. . .explaining whether the Ninth Circuit's April 6, 2009 Order, *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009), requires the Court to enjoin the Medi-Cal reimbursement rate cuts at issue in the present case."

On June 12, 2009, respondents filed their Supplemental Memorandum to Enjoin AB 5, and on June 17, 2009, the petitioner filed a response. On June 26, 2009, without deciding respondents' motion to enjoin AB 5, the district court continued its stay of the case pending a hearing on the motion of plaintiffs *Santa Rosa Memorial Hospital, et al.*, for centralization of this case with others in the United States District Court for the Central District of California.

On September 9, 2009, after respondents' request for centralization was denied, the district court lifted the stay and invited the respondents to file an Amended Motion for Preliminary Injunction: "This case is no longer stayed. Based on recent Ninth

Circuit decisions, including *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. July 9, 2009), the Court will allow Plaintiffs – if they so desire – to file a new brief in support of an Amended Motion for Preliminary Injunction."

On November 18, 2009, after extensive briefing, the district court granted respondents' Amended Motion for Preliminary Injunction of the AB 5 rate cuts.

However, on the very next day, November 19, 2009, in response to a letter request from the petitioner, the district court stayed the case again. On November 23, 2009, respondents filed a Motion to Vacate Stay and to Restore Preliminary Injunction, which the district court granted on December 2, 2009.

After the court restored the preliminary injunction, the petitioner refused to reinstate the pre-AB 5 interim rates. As a result, on December 8, 2009, respondents moved for an Order to Show Cause as to why the petitioner should not be held in contempt for violating the preliminary injunction Order by continuing to implement and apply the ten percent reduction to the interim Medi-Cal payments to the respondents. On December 10, 2009, the district court issued a Clarifying Order confirming that "its preliminary injunction was always intended to enjoin the ten percent reductions in both interim and final payments."

A few hours after the district court issued its Clarifying Order, the petitioner sent a letter to the district court requesting that respondents post a bond and that the court again stay the preliminary injunction pending the submission of evidence and argument on the amount of the bond. Respondents objected to the petitioner's requests. On December 16, 2009, the district court issued an order denying petitioner's request for a bond. Petitioner appealed.

On May 27, 2010, the Ninth Circuit issued its decision. The Court noted that the instant appeal is controlled by *Cal. Pharm. Ass'n v. Maxwell-Jolly*, because both AB 1183 and AB 5 give "the Department of Health Care Services no discretion to alter the rate cuts at issue here." Pet. App. 2. It also noted that "[t]he Director's attempts to distinguish *Cal. Pharmacists Association* are unavailing." Pet. App. 2. Thus, it affirmed the district court holding "that Plaintiffs demonstrated a likelihood of success on the merits that the rate reductions violate 42 U.S.C. § 1396a(a)(30)(A)[.]" Pet. App. 2.

REASONS THE PETITION SHOULD BE DENIED

I. CERTIORARI SHOULD BE DENIED ON THE FIRST QUESTION BECAUSE THE DECISIONS BELOW ARE A CORRECT APPLICATION OF THIS COURT'S SETTLED SUPREMACY CLAUSE JURISPRUDENCE

Petitioner argues that "review is warranted because the Ninth Circuit's decision on this [preemption] issue conflicts with this Court's precedent establishing limits on private rights of action against the states." Pet. 16. By this statement, petitioner apparently is making two claims: (1) that respondents' Supremacy Clause claim should be dismissed because it does not meet the standards for maintaining a private right of action under 42 U.S.C. § 1983, and (2) that Congress did not intend to create a private right of action under 42 U.S.C. § 1396a(a)(30)(A). Neither claim has merit.

A. The Courts Do Not Require That Preemption Claims Meet The Same Standards As Claims Under Section 1983

This Court has *never* held that a claim for injunctive relief based on federal preemption must meet the standards for bringing an action under Section 1983. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), several large employers brought suit against the Acting Commissioner of the New York State Division of Human Rights claiming that the State's Human

Rights and Disability Benefits Laws were preempted by the federal Employee Retirement Income Security Act ("ERISA"). The Court held that the state legislation was preempted insofar as it prohibited practices that were unlawful under ERISA. The Court explained,

> [i]t is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights. 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; *see also Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 259 n.6 (1985) (describing *Shaw* as "reaffirming the general rule" that a plaintiff asserting preemption under the Supremacy Clause has stated a federal claim for injunctive relief); *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624 (1973) (enjoining a city ordinance preempted by the Federal Aviation Act); *Ray v. Atlantic Richfield Co.*, 435 U.S. 151 (1978) (enjoining the State of Washington's Tanker Law because it was preempted by the federal Ports and Waterways Safety Act); *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88 (1992) (holding that state licensing acts are preempted by the federal Occupational Safety and Health Act of 1979);

Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n, 461 U.S. 190 (1983); *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963).

Petitioner's argument fails to recognize that preemption and Section 1983 are completely different and separate avenues for enforcing federal law. The remedies available under Section 1983 are far more extensive than under preemption. Under Section 1983, a plaintiff can obtain 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. In contrast, a plaintiff with a preemption claim can seek only to enforce "the proper constitutional structural relationship between the state and federal governments." *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009).

Indeed, several members of this Court have stressed that preemption claims and Section 1983 serve different purposes and have different requirements. In *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103 (1989), for example, Justice Kennedy explained that even though he would have held that the plaintiff could not bring its action under Section 1983, nevertheless:

> we would not leave the [plaintiff] without a remedy. Despite what one might think from the increase of litigation under the statute in recent years, § 1983 does not provide the exclusive relief that the federal courts

> have to offer. . . . [P]laintiffs may vindicate [statutory] preemption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes.

Id. at 119 (Kennedy, J., dissenting) (citations omitted).

B. A Supremacy Clause Claim Does Not Depend On A Private Right Of Action

Petitioner also suggests that Congress did not intend to create a private right of action under 42 U.S.C. § 1396a(a)(30)(A). *See, e.g., Cort v. Ash*, 422 U.S. 66 (1975); *Alexander v. Sandoval*, 532 U.S. 275 (2001). That concept, however, is irrelevant because the remedy in the instant case is supplied by the Supremacy Clause, and does not depend upon an implied private right of action. As this Court has explained, "the existence of conflict cognizable under the Supremacy Clause does not depend on express congressional recognition that federal and state law may conflict." *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 388 (2000); *see also Verizon Maryland, Inc. v. Pub. Serv. Comm'n of Maryland*, 535 U.S. 635 (2002) (rejecting the assertion that a district court could not reach the merits of a preemption claim unless the plaintiff had demonstrated a statutory cause of action).

C. The Committee Reports Relating To The Boren Amendment Are Irrelevant

Petitioner cites a few sentences from Committee reports relating to the Boren Amendment, and jumps to the conclusion that "Congress, in repealing the Boren Amendment, evinced a clear intent. . .to preclude [all] private provider challenges[.]" Pet. 17. Petitioner is wrong.

The Boren Amendment (42 U.S.C. § 1396a(a)(13)(A)) and Section 1396a(a)(30)(A) are separate and distinct provisions of the Medicaid Act. At the time of the Boren Amendment's repeal, Section 1396a(a)(30)(A) had consistently been held to impose an independent, enforceable requirement in establishing reimbursement standards for provider services. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998); *Visiting Nurse Ass'n of North Shore, Inc. v. Bullen*, 93 F.3d 997, 1004 (1st Cir. 1996), *cert. denied*, 519 U.S. 1114 (1997); *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996); *Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993). The Boren Amendment's "repeal, like its enactment, modified § 13(A) alone; it effected no change to § 30(A)." *Alaska Dep't of Health & Soc. Servs. v. Centers for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-941 (9th Cir. 2005).

Petitioner's reliance on a 1997 committee report discussing the repeal of the Boren Amendment that described the repeal as precluding enforcement by providers of "any other" provision of Section 1396a,

H.R. Rep. No. 105-149, at 591 (1997), does not alter the fact that the text of Section 1396a(a)(30)(A) was not amended in 1997. Thus, the legislative history cited by petitioner is irrelevant. *See Doe v. Chao*, 540 U.S. 614, 626-627 (2004).

The legislative history cited by petitioner is also irrelevant for two additional reasons. Because respondents are not relying upon an implied private right of action to enforce Section 1396a(a)(30)(A), but instead are relying upon the Supremacy Clause, Congressional intent is not relevant. Also, when a State makes the decision to participate in the Medicaid program, it is bound to comply with federally imposed conditions, irrespective of whether or not the law contains a congressionally created implied private right of action. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

D. Over Half Of The Medicaid Expenditures In California Are Paid For With Federal Dollars

Although petitioner complains of the cost to comply with federal law (*see*, Pet. 20), the federal government matches or exceeds State dollars for Medi-Cal. The federal government paid half of California's Medi-Cal expenditures prior to October 2008, and will pay more than half of California's Medi-Cal expenditures for the period of October 2008 to December 2010 pursuant to the *American Recovery and Reinvestment Act of 2009* (hereinafter "*ARRA*"), Pub.

L. No. 111-5, 123 Stat. 115. Under the *ARRA*, the federal government is expected to spend over $11 billion on Medi-Cal for that period. Kaiser Commission on Medicaid and the Uninsured, *American Recovery and Reinvestment Act (AARA): Medicaid and Health Care Provisions* (Mar. 2009), at http://www.kff.org/medicaid/upload/7872.pdf. In return for this infusion of billions of federal dollars, it is only right that the State of California be required to comply with federal law.

E. There Is A Dearth Of Successful Supremacy Clause Cases Outside Of California

Petitioner baldly asserts that "DHCS is aware of over 40 Supremacy Clause lawsuits across the country that have been spurred by the Ninth Circuit's *Independent Living* decisions." Pet. 20. This statement should be rejected for several reasons. The Court has no way of knowing if the statement is correct because petitioner did not provide any details to support it; nor does petitioner demonstrate whether the rate at which Supremacy Clause cases are being filed has increased, decreased, or remained the same from prior years. Also, even though petitioner claims that the *Independent Living* decisions "spurred" the Supremacy Clause lawsuits, petitioner does not and cannot establish a causal connection between these two events. Indeed, since the *Independent Living Center* ("*ILC*") decisions are based on this Court's settled Supremacy Clause jurisprudence,

it is unlikely that the *ILC* cases were an instigating factor in any of the 40 cases cited by petitioner.

In connection with its petition for certiorari in *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, U.S. Supreme Court Case No. 09-0958, the petitioner here submitted detailed case information concerning the Supremacy Clause lawsuits that have been filed. *Id.* at Pet. App. 211a-223a. Based on that information, it is clear that only 14 Supremacy Clause cases were filed in federal courts outside of California, and that injunctions were issued in only two of those cases. *Id.* Thus, there is not an epidemic of Supremacy Clause cases outside of California, and the results of the few lawsuits that do exist demonstrate that States that properly follow the mandates of federal Medicaid law (as most do, except California) will not lose any Medicaid monies.

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

Petitioner claims that "[r]eview is also warranted to resolve a conflict among the courts of appeals on this [preemption] issue." Pet. 18. Petitioner is wrong here too.

Petitioner readily admits that "[t]he D.C., Fifth, Eighth, and Ninth Circuits have held that private parties may bring preemption claims under Spending Clause statutes even if Congress did not intend to make the statutes privately enforceable." Pet. 18. It

also concedes that "[t]he First Circuit. . .has indicated a willingness to allow private causes of action for preemption based on Spending Clause statutes even where the statute in question is not privately enforceable." Pet. 18 n.4. And, it acknowledges that "[s]everal other circuits [*e.g.*, Second, Third, Tenth]. . .have held that at least some preemption claims may be brought under non-Spending Clause statutes regardless of whether the federal statutes create privately enforceable rights." Pet. 18 n.4.

The only exception the Petitioner cites is the Eleventh Circuit, where it claims that the Court "has squarely held that 'the Supremacy Clause does not grant an implied cause of action,'" citing *Legal Envtl. Assistance Found., Inc. v. Pegues*, 904 F.2d 640 (11th Cir. 1990). Pet. 18, 19. However, petitioner misinterprets that decision and subsequent Eleventh Circuit case law. In *Pegues*, the alleged violation of federal law arose from the EPA Administrator's interpretation of federal law, which Alabama merely followed. The actual holding of *Pegues* was that "[b]oth [plaintiff] LEAF and the state agree that the proposed permits *comply* with the federal statute and regulations as they have been interpreted by the EPA. . . . LEAF's real dispute, therefore, is not with the state, but with the Administrator." *Id.* at 644 (emphasis added). 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. The court therefore rejected the plaintiff's attempt "to bootstrap a statutory claim that should be

asserted against the Administrator into a constitutional issue" of preemption. *Ibid.* Premised as it was on the conclusion that plaintiff was simply suing the wrong government, *Pegues* does not conflict with the decisions of the other circuits.

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), demonstrates that petitioner has misread *Pegues*. *BellSouth* involved a suit by a phone company against a state public service commission claiming that the commission's decision was contrary to the Federal Telecommunications Act of 1996. The *en banc* court 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 as well as any related issue of state law under its pendent state jurisdiction." *Id.* at 1278.

Moreover, this Court has repeatedly adjudicated claims by private parties asserting preemption by virtue of the Medicaid statute and other federal spending statutes. In *Arkansas Dept. of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), a Medicaid recipient sought a declaratory judgment that a state law was preempted by the Medicaid Act, and this Court unanimously agreed. In *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003), drug makers also brought an action asserting preemption of a state law under the Act. *See also*

Dalton v. Little Rock Family Planning Services, 516 U.S. 474, 476 (1996) (per curiam) (preemption under Medicaid); *Blum v. Bacon*, 457 U.S. 132, 138 (1982); *CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 663 (1993); *Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 269-270 (1985); *Pennsylvania Prot. & Advocacy, Inc. v. Houstoun*, 228 F.3d 423, 428 (3d Cir. 2000) (Alito, J.).

II. CERTIORARI SHOULD BE DENIED ON THE SECOND QUESTION BECAUSE THE DECISIONS BELOW ARE A CORRECT APPLICATION OF FEDERAL LAW

Petitioner contends that the Ninth Circuit's application of 42 U.S.C. § 1396a(a)(30)(A) is "atextual" and that it "conflicts with the holdings of every other circuit." Pet. 22, 24. Neither claim is correct.

A. The Court Of Appeals Correctly Applied 42 U.S.C. § 1396a(a)(30)(A)

42 U.S.C. § 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).

The decision below is fully consistent with the foregoing text. The plain language of the statute requires that States that participate in Medicaid "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." This language clearly requires that reimbursement rates be based upon an analysis of hospital costs sufficient to *assure* that payments are consistent with the efficiency, economy, and quality of care ("EEQ") factors.

The petitioner claims that 42 U.S.C. § 1396a(a)(30)(A) does not "require any type of study." Pet. 22. However, petitioner does not and cannot explain how it can otherwise "assure" that its "payments are consistent with efficiency, economy, and quality of care" without such a study. "Assure" is defined by Black's Law Dictionary as "to make certain and put beyond doubt." Black's Law Dictionary (6th ed. 1990). Without a study, petitioner cannot "make certain and put beyond doubt" that its payments are consistent with the EEQ factors.

Petitioner also claims that "a study would serve no useful purpose because rates are already based on providers' actual costs." Pet. 15. However, the fact that the rate reduction is based on actual costs doesn't obviate the need to study the effects of that rate reduction on the EEQ factors, nor does it mean that the rate, as reduced, would satisfy the EEQ requirements of Section 30(A).

Petitioner also objects to the requirement that the study be completed prior to the enactment of the rate reduction. This requirement exists because any consideration of the Section 30(A) factors is meaningful only if it actually impacts the rate setting process: "any analysis of reimbursement rates on the statutory factors of efficiency, economy, quality, and access to care, must have the potential to influence the rate-setting process." *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 596 F.3d 1098, 1109 (9th Cir. 2010). This is particularly true in cases like the instant one where the legislature is setting rates that cannot be changed by the state agency: "AB 1183 gives the Department no discretion to alter the rate cuts based on the Department's own analysis, and, therefore, the cuts were not 'based on' the Department's consideration of the relevant factors, but instead constituted a *post hoc* rationalization for a legislative decision that had already been made." *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 850 (9th Cir. 2009).

B. The Federal CMS Has Embraced The Ninth Circuit Analysis Of 42 U.S.C. § 1396a(a)(30)(A)

In *Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931 (9th Cir. 2005), the federal CMS rejected a state rate amendment on the ground that it was inconsistent with the statutory requirement of efficiency, economy, and quality of care. CMS disapproved the proposed amendment as inconsistent with Section 30(A) because the "proposed rates would substantially exceed the IHS [Indian Health Service] published rates" on which federal payments have historically been based. 424 F.3d at 937. It further explained that the IHS rates are "based on an analysis of statewide costs of the Alaska IHS facilities" and that, while it "might consider a request for a higher rate if supported by data showing costs that were not considered by IHS in setting the published rates, Alaska provided no such data to substantiate its proposed rates." *Id.* Hence, CMS concluded that, absent such data, the proposed rates "are not consistent with efficiency, economy, and quality of care" under Section 30(A). *Id.*

Thus, like the Ninth Circuit, CMS also requires that rates be based on a study of the EEQ factors.

C. The District Court Expressly Considered The Evidence Presented By The Petitioner And Correctly Rejected It

Prior to claiming that it relied on cost studies, the petitioner repeatedly argued that it was under no legal duty to consider cost studies when determining Medi-Cal rates under Section 30(A). In *Indep. Living Ctr. of Southern Cal., Inc. v. Shewry*, 2008 U.S. Dist. LEXIS 77525 (2008), petitioner claimed that "neither the Legislature, nor the Department has a duty to consider any particular factors or to conduct any particular studies."

Yet, in the district court here, the petitioner claimed that "there were three relevant studies before the Legislature prior to the enactment of AB 5" and that it conducted additional studies "[a]fter AB 5 was enacted, but prior to its July 1, 2008 implementation." Pet. 12. The District Court carefully reviewed each of these "studies" and correctly rejected them as not complying with the requirements of federal law.

One document the petitioner mentioned was the Legislative Analyst's Office ("LAO") Report analyzing the 2008-09 budget. According to the lower court, "the District Court for the Central District of California has already determined that 'all the Legislative Analyst's report shows is that such a report was prepared. Respondent has not shown that the Legislature ever reviewed or considered the concerns raised therein.'" Pet. App. 116. The lower court also stated that "[s]imilarly, here, Defendant has presented

no evidence that the Legislature or the Department ever reviewed or considered this report prior to setting the rate reductions that apply to Plaintiffs. Indeed, nowhere in the LAO Report is there any analysis of non-contract hospital costs." Pet. App. 116-117.

Another document referred to by the petitioner was the 2007 California Medical Assistance Commission ("CMAC") Annual Report. However, the district court found "that this report is irrelevant" because it "exclusively concerns contract hospitals, not the non-contract hospitals who are Plaintiffs in this case." Pet. App. 17.

The third document mentioned by the petitioner was the November 2005 analysis by the Department concerning a similar reimbursement rate reduction in 2004-2005. However, according to the lower court, the "Defendant presented no evidence that the Department or the Legislature actually reviewed it" and "[e]ven if they did, this document does not consider the impact of AB 5 on non-contract hospital costs." Pet. App. 17-18.

Relying upon the declarations of two Department employees, Liu and Wong, petitioner also contended that "the Department used the four-month period between the enactment and implementation of AB 5 to determine whether the reimbursement reductions satisfied the requirements of § 30(A)." Pet. App. 18.

According to the district court, "William Liu declares that the Department conducted an analysis

of the impact of [Cal. Welf. & Inst. Code] section 14166.245 prior to its implementation." Pet. App. 18. However,

> the document submitted to support this claim merely consists of annual estimates of recoupment collected by the PIRL program and percentages of total reimbursement for noncontract hospitals between 1999 and 2005. This document does not support the contention that the Director relied on responsible cost studies when adjusting the reimbursement rates at issue to determine whether these reimbursement rate reductions were consistent with efficiency, economy, quality of care, and access.

Pet. App. 18-19.

The district court also noted that Gary Wong had declared that "the Department analyzed whether the reduced reimbursement payments would be reasonable relative to hospitals' costs prior to implementation." Pet. App. 19. The court observed that Wong

> supports his claim by pointing to only two documents. The first is the November 2005 Analysis that the Court has already found inadequate to show that the Department complied with its statutory obligations. . .The second is a one-page, handwritten, summary comparison of how audited allowable costs compared to reported costs for unidentified noncontract hospitals between 2002 and 2005. . .This document is clearly inadequate to show the Department relied on

> responsible cost studies to determine that the ten percent reduction was consistent with efficiency, economy, quality of care, and access.

Pet. App. 19.

Based on the foregoing, the lower court concluded that "the Liu and Wong declarations and attached exhibits are not sufficient to show the Department complied with federal requirements." *Id.*

Thus, the district court carefully reviewed all of the information that the petitioner presented with respect to the EEQ factors, and correctly rejected it for the reasons set forth above.

D. The Decision Below Is Consistent With The Other Circuits

In *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 596 F.3d 1098, 1107 (9th Cir. 2010), the Ninth Circuit explicitly examined the approach used in other circuits and concluded that its "approach is consistent with that of our sister circuits, where in the context of legislative, as opposed to agency, rate-setting, they too have focused on ensuring that the legislative body had information before it so that it could properly consider efficiency, economy, quality of care, and access to services before enacting rates."

The decisions cited by petitioner are irrelevant for a variety of reasons.

The Eighth Circuit decision in *Minn. Homecare Ass'n, Inc. v. Gomez*, 108 F.3d 917 (8th Cir. 1997) is not factually similar to the instant case because it involved an *increase* by three percent in reimbursement rates, rather than the substantial rate cuts at issue here. Although the agency in *Gomez* did not provide any formal Section 30(A) analysis to the legislature, lobbyists "actively participated in the. . .legislative session." *Id.* at 918. As a result, "the legislature adequately considered § 30(A) when it raised reimbursement rates[.]" *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010). *See also Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) (holding that a state agency "must consider the relevant factors of equal access, efficiency, economy, and quality of care as designated in [Section 30(A)] when setting reimbursement rates.")

The Third Circuit decision in *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999), is also not factually similar because it involved the application of rates that even the federal CMS (formerly HCFA) had noted were too high: "Pennsylvania had good reason to revise these rates. For several years prior to 1994, the HCFA had been advising the Department that its reimbursement rates were high, given, among other reasons, changes in the drug marketplace." *Id.* at 847. The Third Circuit did not, however, find the mandates of Section 1396a(a)(30)(A) to be unessential. It noted that the agency's "process of decisionmaking" must be "reasonable and sound," and

that an agency "may not act arbitrarily and capriciously." *Id.* at 852-853.

The Fifth and Seventh Circuit cases cited by petitioner are not relevant because they address only the "equal access" prong of Section 1396a(a)(30)(A), and do not address the EEQ requirements. In *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000), the Fifth Circuit considered only "the question whether recipients' access will be impaired."[3] *Id.* at 934. Similarly, in *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996), the Seventh Circuit reviewed the requirements of 42 U.S.C. § 1396a(a)(30) only in connection with the question of "equal access" and not EEQ. *Id.* at 1028-1029.

Contrary to petitioner's claim, the First Circuit never has addressed the EEQ 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).

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[3] The Fifth Circuit decision in *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007) is also irrelevant because it considered only whether 42 U.S.C. § 1396a(a)(30)(A) conferred individual private rights that are enforceable under Section 1983, and never reached the application of the EEQ factors.

Thus, there is no conflict in the Courts of Appeals with respect to the meaning and application of the EEQ requirement, and thus no grounds for review.

III. THIS CASE IS A POOR VEHICLE FOR THE COURT'S REVIEW

There are a number of reasons why this case is a poor vehicle for the Court's review.

First, the opinion of which petitioner seeks review is an order sustaining a preliminary injunction, 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).

Second, this matter is not ripe for review because petitioner's rate changes have not been approved by the federal CMS. AB 5 was enacted on February 6, 2008, and instructed petitioner to "promptly seek any necessary federal approvals for the implementation of this section." *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, U.S. Supreme Court Case No. 09-0958, Pet. App. 160a. Also, federal law requires that "all plans receive approval by the federal government before they may be implemented, and that all amendments to plans must also be

federally approved." *Exeter Mem'l Hosp. Ass'n v. Belshe*, 145 F.3d 1106 (9th Cir. 1998). Despite these legal requirements, petitioner implemented the AB 5 rate cuts on July 1, 2008, without federal approval.

Furthermore, petitioner has intentionally stalled the federal review process. Petitioner submitted its state plan amendment to CMS on September 30, 2008, approximately three months after it implemented the AB 5 rate cuts. *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, U.S. Supreme Court Case No. 09-0958, Pet. App. 187a-210a. In December 2008, CMS responded with a nineteen-page request for additional information. *Id.* at Resp. App. 1a-20a. That letter concluded by explaining that the request for additional information "has the effect of stopping the 90-day clock with respect to CMS 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." *Id.* at Resp. App. 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 over 24 months since CMS sent that letter and respondents are informed by CMS that, as of October 12, 2010, petitioner had still not responded. Under the guidelines referenced in the CMS letter, when a State does not respond to a request for additional information within 90 days, CMS

"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), at http://www.cms.hhs.gov/smdl/downloads/smd010201.pdf (last visited October 9, 2010).

Due to petitioner's extraordinary delay in responding to CMS's request for additional information, it is unclear if and when approval or disapproval of the AB 5 rate reduction will occur. If CMS disapproves the rate reduction, which appears likely based on its guidelines, then the issues in this case will become moot. This uncertainty makes this case an extraordinarily poor vehicle to address petitioner's claims.

Third, 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). In this case, a reversal would not change the ultimate outcome of the case because respondents can seek the relief they want in State court by pursing a writ of mandate (Cal. Code of Civil Proc. § 1085). Indeed, the California courts have consistently compelled State officials to comply with provisions of the Medicaid Act, including the very statutory provision at issue in the instant case, 42 U.S.C. § 1396a(a)(30)(A). *See, e.g., Cal. Hospital Ass'n v. Maxwell-Jolly*, 2010 WL 3280274 (Cal. App. 1 Dist.) (2010); *Mission Hosp. Reg'l Med. Ctr. v. Shewry*, 168 Cal.App.4th 460 (2008),

rev. denied (Cal. 2009); *Cal. Ass'n for Health Servs. at Home v. Department of Health Servs.*, 148 Cal.App.4th 696 (2007); *Cal. Ass'n of Health Facilities v. Department of Health Servs.*, No. A107551, 2006 WL 3775842 (Cal. Ct. App. Dec. 26, 2006).

CONCLUSION

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

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Respectfully submitted,

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