No. _____ 10-283 AUG 25 2010



# In The Supreme Court of the United States

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

*Petitioner,*

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.,

*Respondents.*

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

## PETITION FOR A WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

Under 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act, a state that accepts federal Medicaid funds must adopt a state plan containing "methods and procedures" to "safeguard against unnecessary utilization of . . . [Medicaid] services and . . . assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population." The Ninth Circuit, along with virtually all of the circuits to have considered the issue since this Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), has concluded that this provision does not confer any "rights" on Medicaid providers or recipients that are enforceable under 42 U.S.C. § 1983, and respondents do not contend otherwise. Nonetheless, in the present case, the Ninth Circuit held that § 1396a(a)(30)(A) preempted a state law that reduced certain Medicaid reimbursement payments to providers, because the California Legislature failed to conduct a specific type of study that the Ninth Circuit said was required.

The questions presented are:

1. Whether Medicaid providers may maintain a cause of action under the Supremacy Clause to enforce § 1396a(a)(30)(A) by asserting that the provision preempts a state law that reduces reimbursement rates.

**QUESTIONS PRESENTED** -- Continued

2. Whether a state law that reduces Medicaid reimbursements to providers may be held preempted by § 1396a(a)(30)(A) based on requirements that do not appear in the text of the statute.

## LIST OF PARTIES

1. Petitioner is David Maxwell-Jolly, Director of the California Department of Health Care Services.

2. Respondents are Santa Rosa Memorial Hospital; St. Helena Hospital; Queen of the Valley Medical Center; Central Valley General Hospital; San Joaquin Community Hospital; San Antonio Community Hospital; Children's Hospital at Mission; Saddleback Memorial Medical Center; Orange Coast Memorial Medical Center; Anaheim Memorial Medical Center; Hoag Memorial Hospital Presbyterian; Heart Hospital of BK, LLC; John Muir Health; SRM Alliance Hospital Services; Lancaster Hospital Corporation; Fountain Valley Regional Hospital and Medical Center; and Mission Hospital Regional Medical Center.

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## PETITION FOR A WRIT OF CERTIORARI

The Attorney General of the State of California, on behalf of David Maxwell-Jolly, Director of the California Department of Health Care Services (DHCS), respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

## OPINIONS BELOW

This petition seeks review of the opinion issued by the Ninth Circuit Court of Appeals on May 27, 2010. This opinion was not designated for publication. App., *infra*, 1. The three district court orders that led to the Ninth Circuit's opinion are unreported. App., *infra*, 5, 7, 9.

## STATEMENT OF JURISDICTION

The Ninth Circuit issued its opinion on May 27, 2010. App., *infra*, 1. Petitioner has not petitioned for rehearing or rehearing en banc. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

## CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution states:

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

U.S. Const. art. VI, cl. 2.

The Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), states in pertinent part:

> (a) Contents
>
> A State plan for medical assistance must –
>
> * * *
>
> (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. . . .

42 U.S.C. § 1396a(a)(30)(A).

California Welfare and Institutions Code section 14166.245 is set forth in the Appendix. App., *infra*, 25, 28, 35.

## INTRODUCTION

This petition raises substantially the same legal issues as the petitions for certiorari pending in *Maxwell-Jolly v. Independent Living Center of Southern California*, No. 09-958 (*Independent Living*), and *Maxwell-Jolly v. California Pharmacists Association*, No. 09-1158 (*California Pharmacists*). Those issues are (1) whether 42 U.S.C. § 1396a(a)(30)(A), a federal Medicaid statute that does not meet the criteria for private enforcement under 42 U.S.C. § 1983, may nonetheless be enforced against a state by private parties under a Supremacy Clause theory; and (2) whether a state statute that reduces Medicaid reimbursement rates to providers may be held preempted by § 1396a(a)(30)(A) based on requirements that do not appear anywhere in the statute.

This case is the latest in a line of Ninth Circuit decisions first creating, and then expanding, an atextual requirement that states must conduct a particular "study" before making reductions in Medicaid reimbursement rates. This requirement is not found in § 1396a(a)(30)(A)'s statutory text or its implementing regulations, and the Ninth Circuit's imposition of this requirement conflicts with every

other circuit to consider this issue – specifically, the First, Third, Fifth, Seventh, and Eighth Circuits.

The Ninth Circuit first created this "study" requirement in *Orthopaedic Hospital v. Belshe*, where it held that under § 1396a(a)(30)(A) a state "must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting." 103 F.3d 1491, 1496 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998). However, *Orthopaedic* was brought pursuant to 42 U.S.C. § 1983, and, following this Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), the Ninth Circuit effectively nullified *Orthopaedic* by holding that § 1396a(a)(30)(A) is not privately enforceable under § 1983. *See Sanchez v. Johnson*, 416 F.3d 1051, 1055-62 (9th Cir. 2005) (holding that the language and structure of § 1396a(a)(30)(A) do not evince any Congressional intent to create rights enforceable by Medicaid beneficiaries or providers).

In *Independent Living*, the Ninth Circuit revived *Orthopaedic*'s atextual "study" requirement in two steps. First, the Ninth Circuit held that the Supremacy Clause permits an end run around the requirement set forth in *Gonzaga* and other cases that, for there to be a private cause of action to enforce a federal statute, Congress must have unambiguously created a private substantive right and a private remedy. *Indep. Living Ctr. of S. Cal. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (*Indep. Living I*), *cert. denied*, 129 S. Ct. 2828 (2009). Second, the Ninth Circuit held that *Orthopaedic*'s judicially created

"study" requirement *preempts* any state laws that reduce Medicaid rates in the absence of such a study. *Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) (*Indep. Living II*), *petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958).

In *California Pharmacists Association v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010) (*California Pharmacists*), *petition for cert. filed*, 78 U.S.L.W. 3581 (U.S. March 24, 2010) (No. 09-1158), the Ninth Circuit expanded this already atextual "study" requirement in several ways. Specifically, *California Pharmacists* held, *inter alia*, that (1) a state must conduct the study *prior to enacting* the rate reduction (contradicting *Orthopaedic*, 103 F.3d at 1494, which had permitted a rate reduction to be implemented while the State completed the required study); (2) the state *legislature*, rather than the relevant state agency, must discharge the study requirement if the rate reduction is enacted by statute; (3) the study must expressly reference both § 1396a(a)(30)(A) and the specific statutory enactment at issue; (4) a study prepared specifically for a state legislature does not suffice unless the state *produces evidence that the legislature actually considered it*, and that evidence must consist of more than a reference to the study in a legislative committee agenda; and (5) the state must create a means of obtaining provider cost data if no such means currently exists; however, if no provider cost data exists, the state may use a proxy, but

the court has broad discretion to second-guess (and reject) the choice of proxy.

In *Dominguez v. Schwarzenegger*, 596 F.3d 1087 (9th Cir. 2010), *petition for cert. filed sub nom. Maxwell-Jolly v. California Pharmacists Association*, 78 U.S.L.W. 3581 (U.S. March 24, 2010) (No. 09-1158), the Ninth Circuit further expanded its "study" requirement. *Dominguez* held, *inter alia*, that (1) the state must conduct the study *even where it is not setting rates*, if the court determines that the state's actions could potentially have an impact on the rate-setting process; (2) the state must figure out a way to "study" costs *even if the providers in question do not incur any costs and provide only hourly labor*; and (3) the *only* permissible "metho[d] and procedur[e]" to assure that payments are consistent with efficiency, economy, quality of care, and access under § 1396a(a)(30)(A) is to conduct the specified "study," and the state *may not* use any alternative "methods and procedures" – such as setting rates through collective bargaining with the provider unions – to meet the Ninth Circuit's ever-shifting § 1396a(a)(30)(A) requirements.

In the present case, the Ninth Circuit has taken these atextual requirements one step further, holding that (1) the state must conduct a "study" even where a study would be pointless and inferior to the actual information from which the reimbursement rates are derived – namely, each hospital's individual reported costs; (2) the legislature must conduct a pre-enactment "study" even where it enacts a statute that

requires DHCS to study each hospital's reported costs through an audit prior to determining each hospital's "audited allowable costs," and sets the reimbursement rate at a reasonable percentage (90%) of those costs; (3) a Legislative Analyst's Office report provided to the legislature prior to enactment is not a sufficient "study," even where this report recommended not only that the specific rate reduction at issue be approved, but that the size of the reduction be *increased*; (4) a California Medical Assistance Commission report to the legislature is not a sufficient "study," even where it shows that a reduction in noncontract hospital reimbursement rates was appropriate to reduce the disparity in payments between contract and noncontract hospitals; (5) the legislature must conduct a pre-enactment study even where DHCS's pre-implementation studies established that the reduced rates would bear a reasonable relationship to hospitals' costs and would comply with the efficiency, economy, quality of care, and access requirements; and (6) the state was required to conduct a pre-enactment study even where post-implementation evidence conclusively demonstrates that the rate reduction (which was in place for more than 16 months before being preliminarily enjoined) has not, and will not, have any negative impact on quality of care or access to care.

As petitioner Maxwell-Jolly demonstrated in the *Independent Living* and *California Pharmacists* petitions, the Ninth Circuit's decision to allow private enforcement of § 1396a(a)(30)(A), coupled with its

willingness to impose ever-expanding atextual requirements, has created a new class of lawsuits that is wreaking havoc with California's ability to manage its $40 billion Medicaid budget and its ability to plan its way out of its budget crisis through sensible Medicaid reform. Untethered from any statutory or regulatory language, the rules announced by the Ninth Circuit keep changing, and they become more onerous with each iteration. Congress put an administrative agency, rather than the courts, in charge of Medicaid for a reason: to work with the states on an ongoing basis, with regular communication and guidance, to ensure that they understand and comply with Medicaid requirements. Court-imposed injunctions, issued in private suits based on judicially created, atextual requirements, that subject the States to massive liability, undermine Congressional intent and the cooperative federalism that is supposed to animate the program. These issues are important, recurring, national in scope, and the subject of conflicting and erroneous decisions among the circuits (as demonstrated in the *Independent Living* and *California Pharmacists* petitions), and therefore merit review.

## STATEMENT OF THE CASE

1. On February 16, 2008, the California Legislature enacted AB 5, which, *inter alia*, reduced by

10% the reimbursement rates for inpatient services provided by "noncontract hospitals"[1] under Medi-Cal, California's version of the federal-state Medicaid program. *See* App., *infra*, 25. Specifically, California Welfare and Institutions Code § 14166.245 states that "[w]hen calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to . . . [n]inety percent of the hospital's audited allowable cost[s]." *See* App., *infra*, 26, 31, 38; Cal. Welf. & Inst. Code § 14166.245(c)(3).[2]

The Legislature delayed the implementation of § 14166.245 for over four months after its enactment, to July 1, 2008, for the specific purpose of allowing DHCS to analyze the potential impact of this 10% reduction. The Bill Analysis from the Assembly Committee on Budget states:

> The primary purpose of the delay of the reduction until the start of the new fiscal year [July 1, 2008] is to allow time for further

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[1] Most California hospitals are "contract hospitals," meaning that they negotiate contractual Medi-Cal reimbursement rates with the State. Hospitals that do not agree to contractual Medi-Cal reimbursement rates are known as "noncontract hospitals."

[2] Section 14166.245 was amended by AB 1183 in September 2008 to add additional rate reductions. App., *infra*, 28-34. However, AB 1183's additional rate reductions were previously enjoined in a separate case, and accordingly only the 10% reduction under AB 5 is at issue here. App., *infra*, 11.

> review of provider rates during the regular budget process *to identify any particularly critical consequences of the reduction and to evaluate the possibility of using a more refined approach* to mitigate those consequences while still achieving savings.

*See* Cal. Bill Analysis, AB 5 Assem. (February 14, 2008) (emphasis added) (available online at www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0001-0050/abx3_5_cfa_20080214_132238_asm_comm.html).

The California Legislature directed DHCS to "promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan." App., *infra*, 27; Cal. Welf. & Inst. Code § 14166.245(f). On September 30, 2008, DHCS submitted a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services (CMS), which remains pending. That SPA encompassed all of the AB 5 reductions, including the 10% reduction in rates for inpatient services in noncontract hospitals. In response to a request from CMS, DHCS subsequently split the September 30, 2008 SPA into four separate SPAs that it submitted on October 29, 2008.

2. On November 14, 2008, respondents filed a complaint for injunctive and declaratory relief in the Northern District of California seeking to invalidate AB 5's 10% rate reduction for inpatient services provided by noncontract hospitals, as well as additional rate reductions enacted under AB 1183. Respondents sought relief under the Supremacy Clause

of the United States Constitution, and the district court had jurisdiction pursuant to 28 U.S.C. § 1331. Respondents filed an amended complaint seeking this same relief on December 4, 2008. On January 14, 2009, *almost 11 months after AB 5 was enacted and more than six months after it was implemented*, respondents filed a motion for preliminary injunction to enjoin the rate reductions under AB 5 and AB 1183. On February 23, 2009, the district court denied the motion and stayed the case pending the Ninth Circuit's decision in *Independent Living II*, which was subsequently issued on July 9, 2009.[3] On September 9, 2009, the district court lifted the stay, and on October 12, 2009, respondents filed an amended motion for preliminary injunction, in which they sought to enjoin only the rate cuts under AB 5, noting that the additional rate reductions under AB 1183 had already been enjoined by the Ninth Circuit on April 6, 2009 in *California Pharmacists Association v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009).

In opposing the preliminary injunction, DHCS submitted a broad array of evidence concerning the legislative process that led to the enactment of AB 5,

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[3] The procedural history of the stay is somewhat complex and includes an interlocutory appeal to the Ninth Circuit, a remand, a brief lifting of the stay in June 2009, and then a further stay pending a hearing before the United States Judicial Panel on Multidistrict Litigation on a motion to transfer this case to the Central District of California (which was denied).

as well as extensive evidence concerning the impact of the 10% rate reduction.

Specifically, there were three relevant studies before the Legislature prior to the enactment of AB 5. First, a Legislative Analyst's Office (LAO) Report analyzing the 2008-2009 budget specifically analyzed the rate cuts for inpatient services in noncontract hospitals and recommended not only that they be approved, but that these cuts *be even deeper*. Second, the California Medical Assistance Commission (CMAC) Annual Report to the Legislature for 2007 showed that noncontract hospitals provided just 11.2% of Medi-Cal inpatient services but received 20.1% of Medi-Cal payments for those services, costing the Medi-Cal program almost twice as much as contract hospitals relative to the services provided. The CMAC Report also found that contract hospitals saved the State over $551 million in fiscal year 2006-2007 compared to what the State would have paid if these hospitals had been noncontract hospitals. Third, in November 2005, DHCS had conducted an analysis of similar 10% rate cuts in fiscal year 2004-2005 and found that they complied with federal law and would not impact quality of care or access to care, both considerations under § 1396a(a)(30)(A).

After AB 5 was enacted, but prior to its July 1, 2008 implementation, DHCS conducted additional studies of AB 5's potential impact for the specific purpose of assessing AB 5's compliance with § 1396a(a)(30)(A) as interpreted by the Ninth Circuit. In those studies, DHCS found that a noncontract

hospital's "audited allowable costs" are usually approximately 97-98% of its reported costs, and thus that the 10% reduction would still compensate approximately 87-88% of hospitals' reported costs. In addition, DHCS's studies noted that all noncontract hospitals would be compensated at a minimum of 90% of their audited allowable costs, and that this was within the "range of reasonableness" that federal courts found acceptable under the reasonable-cost-based rate standard of the Boren Amendment. DHCS's studies further noted that many noncontract hospitals receive supplemental reimbursements on top of their basic rate, which pushes total reimbursement above 100% of audited allowable costs for several hospitals, even after the 10% reduction.

Finally, after AB 5 was implemented, DHCS updated its analysis of the 10% rate cut's compliance with § 1396a(a)(30)(A) twice more (in January 2009 and again in February 2009), confirming that these cuts are consistent with efficiency, economy, quality of care, and access. Specifically, DHCS found that AB 5's cuts would reduce the 17 respondent hospitals' aggregate revenues by just 0.6%, and reduce their aggregate net profits – which totaled $355 million in 2007 – by less than 4%. In addition, DHCS noted that approximately 89-90% of Medi-Cal hospital inpatient days are provided by contract hospitals, with noncontract hospitals providing the remaining 10-11%. And DHCS further noted that small and rural noncontract hospitals were exempted from these payment reductions for dates of service on or after

November 1, 2008, eliminating any concerns that the reductions might have a greater impact on such hospitals due to their unique circumstances. Based on these findings and the findings in the other studies, DHCS determined that AB 5's reimbursement reductions for inpatient services by noncontract hospitals would not affect quality of care or access to care. Indeed, despite the fact that these cuts were in effect for more than 16 months before they were enjoined, there is no evidence that they have caused any problems with quality of care or access.

On November 18, 2009, the district court entered an order preliminarily enjoining DHCS from implementing AB 5's rate cuts for inpatient services in the 17 respondent hospitals. App., *infra*, 9-24. The district court held that such cuts are preempted by § 1396a(a)(30)(A) because the State did not conduct the "study" required by *Independent Living II*. App., *infra*, 13-20. Although there are numerous studies in the record showing that these cuts comply with § 1396a(a)(30)(A) and would not impact access or quality of care, the district court held that AB 5 was preempted because there was insufficient evidence that the Legislature or DHCS had specifically "considered" these studies in enacting AB 5. App., *infra*, 16-18. On November 19, 2009, the district court stayed the entire case, including the preliminary injunction it had issued the previous day. App., *infra*, 7-8. However, on December 2, 2009, the court reversed itself and issued an order vacating the stay in

part and restoring the preliminary injunction. App., *infra*, 5-6.

3. DHCS appealed the orders granting and restoring the preliminary injunction, and on May 27, 2010, the Ninth Circuit affirmed the preliminary injunction in an unpublished decision. App., *infra*, 1-4. DHCS argued that the *Orthopaedic – Independent Living – California Pharmacists* line of cases is distinguishable because none of the rates at issue in those cases were based on providers' costs, while here the reimbursement rates for inpatient services in noncontract hospitals are *specifically based on each individual hospital's audited allowable costs*, thereby rendering any "study" unnecessary. However, the Ninth Circuit rejected DHCS's arguments, holding that prior line of cases controlling and extending its atextual § 1396a(a)(30)(A) requirement to robotically mandate a "study" in *all circumstances*, even where such a study would serve no purpose because rates are already based on providers' actual costs. App., *infra*, 1-4.

## REASONS FOR GRANTING THE PETITION

1. The Court should grant the petition to consider whether a private party may bring a preemption challenge under a Spending Clause statute, 42 U.S.C. § 1396a(a)(30)(A), that is not otherwise enforceable by private parties under 42 U.S.C. § 1983 or an implied right of action theory. This issue is already

pending before this Court in the petitions for certiorari filed in *Independent Living*, No. 09-958, and *California Pharmacists*, No. 09-1158.

As demonstrated in the *Independent Living* and *California Pharmacists* petitions, review is warranted because the Ninth Circuit's decision on this issue conflicts with this Court's precedent establishing limits on private rights of action against the states. To bring a private suit to enforce a federal statute, a plaintiff must show clear and unambiguous evidence of Congressional intent to create both a private right of action and a private remedy under that statute, and further that the provision to be enforced is not so "vague and amorphous" as to strain judicial competence. *See, e.g.*, *Cort v. Ash*, 422 U.S. 66, 78 (1975); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981); *Gonzaga*, 536 U.S. at 280-86. "[W]here the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit, whether under § 1983 or under an implied right of action." *Gonzaga*, 536 U.S. at 286. "Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). Absent clear evidence of Congressional intent "to create not just a private right but also a private remedy . . . a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." *Id.* at 286-87.

The Ninth Circuit's theory exempts all Supremacy Clause actions from these requirements, holding that any plaintiff who alleges a conflict between state and federal law *automatically* has a private right of action, regardless of whether or not Congress intended to create one. Indeed, the Ninth Circuit's theory permits a private right of action *even where Congress clearly and unambiguously intended not to permit one*. That is precisely the case with § 1396a(a)(30)(A), where Congress, in repealing the Boren Amendment, evinced a clear intent not only to reverse parts of *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 502 (1990), which had held that the Boren Amendment's rate-setting requirements were privately enforceable under § 1983, but also to preclude private provider challenges to Medicaid rates under other provisions. "It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of [§ 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive." H.R. Rep. No. 105-149, at 591 (1997); *see also Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 540 n.15 (3d Cir. 2002) (en banc) (Alito, J.) ("One of Congress's main objectives – perhaps its dominant objective – in repealing the Boren Amendment was to take away the right to sue under § 1983."). This Court has recognized that "[i]n legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but

rather action by the Federal Government to terminate funds to the State." *Pennhurst*, 451 U.S. at 28.

Review also is warranted to resolve a conflict among the courts of appeals on this issue. The 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. *See Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 819 n.3 (D.C. Cir. 2004); *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 330-35 (5th Cir. 2005); *Lankford v. Sherman*, 451 F.3d 496, 509-13 (8th Cir. 2006); *Independent Living I*, 543 F.3d at 1055-65 (9th Cir. 2008).[4]

Meanwhile, the Eleventh Circuit has squarely held that "the Supremacy Clause does not grant an

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[4] The First Circuit, while not addressing the precise question presented here, 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. *See Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 73 (1st Cir. 2001). Several other circuits, meanwhile, while not having addressed this issue in the context of a Spending Clause statute, nonetheless 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. *See, e.g., W. Air Lines, Inc. v. Port Auth. of N.Y. & N.J.*, 817 F.2d 222, 225-26 (2d Cir. 1987); *St. Thomas-St. John Hotel & Tourism Ass'n v. Virgin Islands*, 218 F.3d 232, 241 (3d Cir. 2000); *Wilderness Soc'y v. Kane County*, 581 F.3d 1198 (10th Cir. 2009), *rehearing en banc granted*, 595 F.3d 1119 (10th Cir. 2010).

implied cause of action," and that private rights of action to enforce statutory rights must be created by Congress in accordance with the criteria set forth in *Cort*. *See Legal Envtl. Assistance Found., Inc. v. Pegues*, 904 F.2d 640, 641, 643-44 (11th Cir. 1990); *see also Bellsouth Telecomm. v. Town of Palm Beach*, 252 F.3d 1169, 1189-92 (11th Cir. 2001) (applying *Cort* factors in assessing whether a private preemption claim could proceed). The Tenth Circuit's decision in *Wilderness Society* also deserves mention for its lengthy dissent by Judge McConnell rejecting "the astounding idea that any time a state action arguably conflicts with a federal law, a cause of action exists" under the Supremacy Clause. 581 F.3d at 1233. Judge McConnell cited this Court's well established rule that, "[u]nless Congress has expressly or impliedly granted private persons a cause of action to enforce federal law . . . there is no basis for such a suit." *Id.* (citing *Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran*, 456 U.S. 353 (1982)). He further cautioned that, "[i]f 'preemption' were a sufficient basis for a cause of action, then every federal statute would implicitly authorize a private cause of action against a state or local governmental defendant. That is not the law." *Id.*

The Ninth Circuit's theory (also embraced by the D.C., Fifth, and Eighth Circuits) has opened up a flood of new litigation challenging state actions under the Supremacy Clause based on federal statutes that are not privately enforceable under § 1983 or an implied right of action. In addition to the dozens

(literally) of § 1396a(a)(30)(A) lawsuits filed in the wake of *Independent Living I* and *II*, plaintiffs in California and many other states also have been bringing preemption challenges under numerous other federal statutes and regulations, including 42 U.S.C. § 1396a(a)(17) and 42 C.F.R. § 440.230(b), *see V.L. v. Wagner*, 669 F. Supp. 2d 1106 (N.D. Cal. 2009); a purely hortatory "purposes" provision of the American Recovery and Reinvestment Act of 2009, H.R. 1, 111th Cong., Pub. L. No. 111-5 (1st Sess. 2009), § 5000(a), *see Gray Panthers of San Francisco v. Schwarzenegger*, No. C 09-2307 PJH, 2009 WL 2880555 (N.D. Cal. Sept. 1, 2009); and the Child Welfare Act, 42 U.S.C. §§ 672(a) & 675(4)(A). *See Morales v. Wagner*, Nos. CPF 05-505687, 05-505783, & 05-505888 (Cal. Super. Ct. (San Francisco)). All told, DHCS is aware of over 40 Supremacy Clause lawsuits across the country that have been spurred by the Ninth Circuit's *Independent Living* decisions. The Supremacy Clause injunctions in California alone have already cost the State almost $1 billion in lost Medicaid savings, and those losses are likely to continue to grow as additional new cases are filed.

Moreover, the Ninth Circuit's Supremacy Clause theory will inevitably lead to even more conflict and confusion among the circuits, not just with respect to § 1396a(a)(30)(A), but also with regard to virtually any Spending Clause statute that Congress did not intend to make privately enforceable. Rather than permitting the Department of Health and Human Services (HHS) to exercise its regulatory duties

as Congress intended, which would ensure uniform interpretation and application of the Medicaid Act's requirements by a single agency with the appropriate expertise, the Ninth Circuit's rule instead thrusts the courts into this regulatory role. This will certainly lead to more inconsistent interpretations across various jurisdictions, as courts will be forced to grapple with precisely those "vague and amorphous" statutory provisions that Congress never intended to be privately enforced.

Petitioner believes that both *Independent Living* and *California Pharmacists* are excellent vehicles for deciding the first question presented for the reasons set forth in those petitions. This case presents an excellent vehicle as well, as petitioner expressly preserved this first question presented in both the district court and the Ninth Circuit, and this case presents a fully developed record for the Court's review.

2. The Court also should grant the petition to consider whether state statutes that reduce Medicaid reimbursement payments to certain providers may be preempted based on requirements that do not appear in the text of the preempting federal statute, § 1396a(a)(30)(A). This issue, too, is already pending before this Court in both the *Independent Living*, No. 09-958, and *California Pharmacists*, No. 09-1158, petitions for certiorari.

The present case is the latest in a series of cases in which the Ninth Circuit has imposed an ever-changing, judicially created rule, under the guise of

interpreting § 1396a(a)(30)(A), that state laws reducing Medicaid reimbursement rates are preempted unless the state (1) studied the impact of the reductions on the § 1396a(a)(30)(A) factors of efficiency, economy, quality of care, and access; and (2) considered responsible studies of providers' costs, to ensure that the reduced rates would bear a reasonable relationship to those costs. *Independent Living II*, 572 F.3d at 651-52. However, neither § 1396a(a)(30)(A) nor any of its implementing regulations requires any type of study, nor do they require that rates bear any relationship to providers' costs.

In *California Pharmacists* and *Dominguez*, the Ninth Circuit dramatically expanded these already atextual requirements, requiring that:

(1) The study must be completed *prior to enactment* of the rate reduction, and not merely prior to implementation. *Cal. Pharmacists*, 596 F.3d at 1105-07.

(2) If the rate reductions are imposed by statute, the study obligation must be discharged *by the legislature itself*, and not another state agency. *Cal. Pharmacists*, 596 F.3d at 1105-07.

(3) The study must expressly reference both § 1396a(a)(30)(A) and the specific statutory enactment at issue. *Cal. Pharmacists*, 596 F.3d at 1107-09; *Dominguez*, 596 F.3d at 1097.

(4) The state must produce evidence to show that the legislature *actually "consider[ed]"* the studies

that were before it. The Ninth Circuit does not specify how much, or what type, of evidence is required, but held that a reference to the study in a legislative agenda is not sufficient.[5] *Cal. Pharmacists*, 596 F.3d at 1107-09; *Dominguez*, 596 F.3d at 1097.

(5) The state must figure out a way to "study" costs *even if the providers in question do not incur any costs and provide only hourly labor*. If the state does not have a means of obtaining provider cost data, it must either create a means to obtain such data or, if such data is unavailable, rely on a proxy. If the state relies on a proxy, the court has broad discretion to second-guess (and reject) the state's choice of proxy. *Cal. Pharmacists*, 596 F.3d at 1112; *Dominguez*, 596 F.3d at 1096-97.

(6) The state must conduct the study *even where it is not setting rates*, if the court determines that the state's actions could potentially have an impact on the rate-setting process. *Dominguez*, 596 F.3d at 1093-96.

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[5] For example, how many members of the legislature must "actually consider" the study for it to count? May legislators rely on the advice of colleagues and/or staff members, or must each individual legislator personally read the study? Are legislators required to submit declarations, or include official findings in the text of the statute, to show that they considered the study? If not, how else might they show that they "actually considered" a study that was before them? These questions seem absurd, but under the Ninth Circuit's rule *a state legislature cannot make Medicaid rate reductions without answering them.*

(7) The *only* permissible "metho[d] and procedur[e]" to assure that payments are consistent with efficiency, economy, quality of care, and access under § 1396a(a)(30)(A) is to conduct the specified "study." The state *may not* use any alternative "methods and procedures" – such as setting rates through collective bargaining with the provider unions – to meet the Ninth Circuit's ever-shifting § 1396a(a)(30)(A) requirements. *Dominguez*, 596 F.3d at 1093-96.

In the present case, the Ninth Circuit expanded its judicially created "study" requirement to an even more absurd degree, requiring the state to "study" the § 1396a(a)(30)(A) factors and providers' costs even where the statute expressly provides that rates are based on each individual hospital's costs, and even where those costs are required to be studied by DHCS, via an audit, prior to the final "cost report settlement." App., *infra*, 26, 31, 38.

Review is warranted because the Ninth Circuit's atextual interpretation of § 1396a(a)(30)(A) conflicts with the holdings of every other circuit to address this issue – specifically, the First, Third, Fifth, Seventh, and Eighth Circuits. *See Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 56 (1st Cir. 2004); *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 933 n.33 (5th Cir. 2000), *overruled in part on other grounds*, *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007), *cert. denied*, 129 S. Ct. 34 (2008); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030

(7th Cir. 1996); *Minn. HomeCare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam).[6]

Moreover, the Ninth Circuit's repeated willingness to stretch and change this judicially created, atextual rule as a basis for federal preemption of state laws conflicts with this Court's longstanding preemption precedents. The Ninth Circuit's holding that preemption can be based upon a judicially created rule, entirely divorced from anything that Congress intended, conflicts with this Court's holding that "the purpose of Congress is the ultimate touchstone in every pre-emption case." *Wyeth v. Levine*, ___ U.S. ___, 129 S. Ct. 1187, 1194 (2009). In addition, the Ninth Circuit's holding that preemption can arise from a statute as vague and amorphous as § 1396a(a)(30)(A) directly undermines this Court's precedents establishing a strong presumption against federal preemption of state laws regulating health and safety "unless that was the clear and manifest purpose of Congress." *Id.* at 1195; *see also Hillsborough County v. Automated Med. Labs.*, 471 U.S. 707, 715 (1985) (recognizing "the presumption that state or local regulation of matters related to health and safety is not invalidated under the Supremacy

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[6] While the Eighth Circuit has required states to "consider" the impact of rate changes before implementing them, *see Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993), it has made clear that no study or other "formal analysis" is required, particularly where the reduction is implemented by statute and thus subject to the legislative process. *See Minn. HomeCare*, 108 F.3d at 918.

Clause"); *Pennhurst*, 451 U.S. at 28 ("In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.").

The impact of the Ninth Circuit's ever-shifting requirements has been devastating, crippling California's ability to manage its $40 billion Medicaid program by rendering every decision subject to a potential court-imposed injunction based on constantly changing rules that are untethered to any statutory or regulatory text. These injunctions have cost the State of California almost $1 billion to date, with greater losses certain to follow if this Court does not intervene. Further, the Ninth Circuit has usurped a significant portion of the regulatory oversight that Congress expressly delegated to HHS under the Medicaid program, subjecting states to inconsistent and unpredictable requirements. Review is warranted to effectuate Congressional intent and restore the proper roles of the courts and regulatory agencies in the oversight of the Medicaid program.

Petitioner believes that the *Independent Living* and *California Pharmacists* petitions are both excellent vehicles for reaching the second question presented for the reasons set forth in those petitions. In particular, *California Pharmacists* presents this issue in the context of two published opinions setting forth in great detail the Ninth Circuit's extensive judicially created requirements that lack any textual support in

§ 1396a(a)(30)(A). However, in the instant case the Ninth Circuit has expanded those requirements to an even further extreme. If the Court would prefer to reach the full panoply of requirements that the Ninth Circuit has now imposed, it should grant the present petition (and hold the *Independent Living* and *California Pharmacists* petitions pending the disposition of this case).

## CONCLUSION

For each of the foregoing reasons, the petition for a writ of certiorari should be granted.

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Respectfully submitted,

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