

No. 01-1494

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

WESTSIDE MOTHERS, ET AL.,
Plaintiffs-Appellants,

v.

JAMES K. HAVEMAN, JR., ET AL.,
Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN

BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS, THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, THE AMERICAN HOSPITAL ASSOCIATION, THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, THE FEDERATION OF AMERICAN HOSPITALS, VHA INC., PREMIER, INC., KAISER FOUNDATION HEALTH PLAN, INC., THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY, THE AMERICAN ASSOCIATION FOR HOMECARE, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, THE MICHIGAN HEALTH & HOSPITAL ASSOCIATION, THE MICHIGAN PRIMARY CARE ASSOCIATION, THE KENTUCKY PRIMARY CARE ASSOCIATION, THE OHIO PRIMARY CARE ASSOCIATION, AND THE TENNESSEE HEALTH CARE CAMPAIGN IN SUPPORT OF APPELLANTS RECOMMENDING REVERSAL

Larry S. Gage
Barbara D. A. Eyman
Charles Luband
Aimee N. Wall
Powell, Goldstein, Frazer & Murphy
LLP
1001 Pennsylvania Avenue, N.W.
Washington, DC 20004
(202) 347-0066

Sara Rosenbaum (Of-Counsel)
Harold and Jane Hirsh Professor of
Health Law and Policy
School of Public Health and Health
Services
The George Washington University
2021 K Street, N.W., Suite 800
Washington, DC 20006
(202) 530-2343

Attorneys for *Amici Curiae*

TABLE OF CONTENTS

	<u>Page</u>
TABLE OF AUTHORITIES	iii
BRIEF <i>AMICI CURIAE</i>	1
INTERESTS OF <i>AMICI CURIAE</i>	1
SUMMARY OF THE ARGUMENT	2
ARGUMENT	6
A. The District Court’s opinion would fundamentally alter the Medicaid program as it exists today by undermining three of its most salient characteristics: 1) its entitlement nature; 2) its reliance on providers to deliver the benefits conferred; and 3) its use of intertwining rights and obligations to secure widespread participation.	6
B. Section 1983 enforcement of rights under Medicaid has always been a central element of the program’s design and one which states have long accepted as a condition of participation.	13
C. In withdrawing the availability of the private right of action under § 1983 for Medicaid, the District Court has left beneficiaries and providers with no effective remedies for a state deprivation of rights.	16
1. Federal enforcement.	17
2. State law enforcement rights.	18
D. In eliminating the entitlement that is at the core of Title XIX, the District Court’s decision would significantly impair the guaranteed access to health care services for low-income and vulnerable populations that has been the greatest achievement of the Medicaid program.	20
CONCLUSION	24

CERTIFICATION OF COMPLIANCE WITH FED. R. APP. P. 32(a)(7)(C)26
CERTIFICATE OF SERVICE27

TABLE OF AUTHORITIES

Cases

<i>Ala. Nursing Homes Ass’n v. Harris</i> , 617 F.2d 388 (5 th Cir. 1980)	14
<i>Babbitt v. State of Michigan</i> , 778 F. Supp. 941 (W.D. Mich. 1991).....	14
<i>Beal v. Doe</i> , 432 U.S. 438 (1977)	6
<i>Blessing v. Freestone</i> , 520 U.S. 329 (1997)	8
<i>Boatman v. Hammons</i> , 164 F.3d 286 (6 th Cir. 1998).....	14
<i>Children’s Hosp. & Health Ctr. v. Belshe</i> , 188 F.3d 1090 (9 th Cir. 1999), <i>cert. denied</i> , 530 U.S. 1204 (2000)	10
<i>Coalition of Mich. Nursing Homes, Inc. v. Dempsey</i> , 537 F. Supp. 451 (E.D. Mich. 1982)	14
<i>Colo. Health Care Ass’n v. Colo. Dep’t of Social Servs.</i> 842 F.2d 1158 (10 th Cir. 1988).....	14
<i>Concourse Rehabilitation & Nursing Ctr. v. Wing</i> , 150 F.3d 185 (2d Cir. 1998).....	14
<i>Doe v. Chiles</i> , 136 F.3d 709 (11 th Cir. 1998).....	14
<i>Lapeer County Med. Care Facility v. State of Michigan Dep’t of Soc. Servs.</i> , 765 F. Supp. 1291 (W.D. Mich. 1991).....	14
<i>Linton v. Commissioner of Health & Env’t</i> , 65 F.3d 508 (6 th Cir. 1995).....	14
<i>Marbury v. Madison</i> , 5 U.S. 137 (1803).....	20
<i>Md. Cmty. Health Sys. v. Glendening</i> , 115 F. Supp. 2d 599 (D. Md. 2000)	11
<i>Methodist Hosp., Inc. v. Sullivan</i> , 91 F.3d 1026 (7 th Cir. 1996).....	14
<i>Neb. Health Care Ass’n v. Dunning</i> , 778 F.2d 1291 (8 th Cir. 1985), <i>cert.</i> <i>denied</i> , 107 S.Ct. 947 (1987).....	14
<i>O’Reilly v. Wyman</i> , 305 F. Supp. 228 (S.D.N.Y. 1969).....	14

<i>Orthopaedic Hosp. v. Belshe</i> , 103 F.3d 1491 (9 th Cir. 1997), <i>cert. denied</i> , 522 U.S. 1044 (1998)	7, 10, 14
<i>Patsy v. Board of Regents</i> , 457 U.S. 496 (1982)	19
<i>Pennhurst State Sch. & Hosp. v. Halderman</i> , 451 U.S. 1 (1981).....	8, 15
<i>Pharm. Soc’y of Milwaukee County, Inc. v. Dep’t of Health & Soc. Servs.</i> , 79 F.R.D. 405 (E.D. Wis. 1978).....	14
<i>Riffenburg v. State of Michigan</i> , 1997 U.S. Dist. LEXIS 7073 (W.D. Mich. 1997).....	14
<i>Va. Hosp. Ass’n v. Baliles</i> , 868 F.2d 653 (4 th Cir. 1989).....	14
<i>Visiting Nurse Ass’n of N. Shore, Inc. v. Bullen</i> , 93 F.3d 997 (1 st Cir. 1996)	14
<i>Westside Mothers v. Haveman</i> , 133 F. Supp. 2d 549 (E.D. Mich. 2001).....	15
<i>Wilder v. Va. Hosp. Ass’n</i> , 496 U.S. 498 (1990)	7, 18, 19
<i>Wood v. Tompkins</i> , 33 F.3d 600 (6 th Cir. 1994).....	14
Statutes	
42 C.F.R. § 430.35	17
42 C.F.R. § 431.200	18
42 C.F.R. § 431.220	18
42 U.S.C. § 1396a(a)(25)(C).....	12
42 U.S.C. § 1396a(a)(27)	19
42 U.S.C. § 1396a(a)(3)	18
42 U.S.C. § 1396a(a)(30)(A)	10
42 U.S.C. § 1396a(a)(37).....	18
42 U.S.C. § 1396a(a)(40).....	12
42 U.S.C. § 1396a(a)(42).....	12

42 U.S.C. § 1396a(aa).....	11
42 U.S.C. § 1396a(w).....	12
42 U.S.C. § 1396b(m).....	10
42 U.S.C. § 1396c	17
42 U.S.C. § 1396d(a)(4)(B)	13
42 U.S.C. § 1396d(r).....	13
42 U.S.C. § 1396k(a)(1).....	11
42 U.S.C. § 1396n(f).....	18
42 U.S.C. § 1396r.....	12
42 U.S.C. § 1396r(c)(1)(A)(vi).....	18
42 U.S.C. § 1396r-4	10
42 U.S.C. § 1396r-5(d).....	12
42 U.S.C. § 1396u-2.....	10
42 U.S.C. § 1397aa(c).....	9
42 U.S.C. § 1397bb(b)(4)	9
42 U.S.C. § 1397dd.....	9
42 U.S.C. § 1936a(a).....	12
42 U.S.C. § 1983	passim
42 U.S.C. §§ 1396 <i>et seq.</i>	6
42 U.S.C. §§ 300x-21 <i>et seq.</i>	8
42 U.S.C. §§ 701 <i>et seq.</i>	8
Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711 (repealing the Boren Amendment)	15

Developmentally Disabled Assistance and Bill of Rights Act, Pub. L. No. 94-103, 89 Stat. 486, as amended, 42 U.S.C. §§ 6000 <i>et seq.</i> (1976 ed. and Supp. III).....	8, 9
Social Security Act of 1935, ch. 531 § 401, 49 Stat. 629, as amended (repealed 1996).....	10
Title IV-D of the Social Security Act, Pub. L. No. 93-647, §101(a), 88 Stat. 2351, as amended, 42 U.S.C. §§ 651 <i>et seq.</i>	8
Other Authorities	
Aaron Wildavsky, <i>The New Politics of the Budgetary Process</i> (1998).....	7
Am. Dental Ass'n, <i>1999 Survey of Dental Practice: Pediatric Dentists in Private Practice</i>	23
Cong. Research Service, <i>Medicaid Source Book: Background Data and Analysis</i> (1993) (GPO, Washington, D.C.)	21
Council of Teaching Hospitals, <i>COTH Survey of Hospital's Financial and General Operating Data, FY 1999</i>	23
E. Allen Farnsworth, <i>Contracts</i> , § 7.13 (1982)	16
<i>Fed. Judicial Review of State Welfare Practices</i> , 67 Colum. L. Rev. 84 (1967).....	14
<i>Governors Disagree on Bush Tax Cut Plan</i> , Fort Worth Star-Telegram, Feb. 26, 2001	21
H.R. 2491, 104 th Cong. (1995).....	15
H.R. 3507, 104 th Cong. § 2003 (1996).....	15
Inst. of Medicine, <i>America's Health Care Safety Net: Intact But Endangered</i> (National Academy Press, 2000).....	22, 24
Lewin Group, <i>TrendWatch Chartbook 2000: Trends Affecting Hospitals and Health Systems</i> , June 2000 (prepared for the Am. Hosp. Ass'n).....	24
Lynne Fagnani et al., <i>America's Safety Net Hospitals & Health Systems</i> , Nat'l Ass'n of Public Hospitals (Washington, D.C. 2000).....	23

March of Dimes, <i>Maternal, Infant, & Child Health in the United States, 2001: Data Book for Policy Makers</i> (2001).....	24
Nat’l Ass’n of Children’s Hospitals, <i>Annual Report of Financial Indicators of Children’s Hospitals</i> (Alexandria, Va. 1999)	23
Nat’l Ass’n of Cmty. Health Centers, Inc., <i>Access to Cmty. Health Care: A Nat’l & State Data Book</i> (1998).....	23
President William J. Clinton, <i>Message to the House of Representatives Returning Without Approval Budget Reconciliation Legislation</i> , 1995 Pub. Papers, 1853-55 (Dec. 6, 1995).....	15
<i>Restructuring Welfare and Medicaid: The Governor's Proposal: Hearing Before the Senate Comm. On Finance</i> , 104 th Cong. (1996) (statement of Gov. Tommy G. Thompson et al., on behalf of Nat’l Governors’ Ass’n).....	15
<i>Seeking Medicaid, In Court</i> , Wash. Post, Feb. 20, 1996	15
<i>States Adjust to Slowing Economy</i> , United Press Int’l, Feb. 28, 2001	21
U.S. Census Bureau, <i>Statistical Abstract of the United States: 2000</i>	6
U.S. Census Bureau, U.S. Dep’t of Commerce, Pub. No. P60-211, <i>Current Population Reports, Health Insurance Coverage: 1999</i>	22
U.S. Gen. Accounting Office, <i>A Glossary of Terms Used in the Fed. Budget Process</i> 57 (3d ed. 1981).....	7
U.S. Gen. Accounting Office, <i>Cmty. Health Centers: Adapting to Changing Health Care Env’t Key to Success</i> , GAO/HEHS-00-39 (March 2000)	23
Rules	
Fed. R. App. P. 25(c)	27
Fed. R. App. P. 29(b)	1
Fed. R. App. P. 29(d)	26
Fed. R. App. P. 32(a)(7).....	26
Fed. R. App. P. 32(a)(7)(B)(iii)	26

Constitutional Provisions

U.S. Const. art. I, § 8, cl. 13

BRIEF *AMICI CURIAE*

Pursuant to Federal Rule of Appellate Procedure 29(b), the National Association of Public Hospitals and Health Systems, the National Association of Community Health Centers, the American Hospital Association, the Catholic Health Association of the United States, the National Association of Children's Hospitals, the Association of American Medical Colleges, the Federation of American Hospitals, VHA Inc., Premier, Inc., Kaiser Foundation Health Plan, Inc., the American Academy of Pediatric Dentistry, the American Association for Homecare, March of Dimes Birth Defects Foundation, the Michigan Health & Hospital Association, the Michigan Primary Care Association, the Kentucky Primary Care Association, the Ohio Primary Care Association, and the Tennessee Health Care Campaign respectfully submit this brief *amici curiae* in support of Appellants and recommending reversal, under cover of the accompanying motion for leave to file.

INTERESTS OF *AMICI CURIAE*

Amici curiae are national organizations and state-based associations from the Sixth Circuit representing a broad spectrum of health care providers and foundations currently participating in or advocating on behalf of the Medicaid program. Collectively, *amici* represent virtually every hospital and health system in the country – public, private, non-profit, for-profit, children's hospitals, teaching

hospitals, etc. They also represent over 450 community health centers, pediatric dentists, home health care agencies and one of the largest health maintenance organizations serving Medicaid beneficiaries in the country.

Amici represent many of the health care providers who are the central sources of care for Medicaid populations in most communities. *Amici*'s interests are affected by the District Court's decision because, if upheld, the decision would directly affect the patients of members of *amici* organizations and would ultimately deprive the providers represented by *amici* of the opportunity to preserve the rights afforded to them by the Medicaid statute.

SUMMARY OF THE ARGUMENT

The District Court's opinion in this case failed to consider adequately either the real world complexities of the Medicaid program or the very serious real world consequences of its ruling. In 1965, Congress created the Medicaid program to provide certain low-income individuals with access to health care services by guaranteeing governmental payments to the providers of such services. By 1998, Medicaid guaranteed health care coverage for more than 40 million people.

Medicaid differs from most other statutes enacted pursuant to the Spending Clause of the Constitution¹ in at least three significant respects. First, Medicaid establishes a federal entitlement to medical assistance among eligible individuals.

¹ U.S. Const. art. I, § 8, cl. 1.

This entitlement has been direct and binding on participating states since 1965.

The entitlement nature of Medicaid, which distinguishes it from other general grant programs enacted pursuant to the Spending Clause, would be eliminated under the District Court's ruling.

Second, the benefits conferred through the program are not provided to eligible individuals directly through cash payments or in-kind assistance from the government. Rather, Medicaid benefits are provided indirectly through health care providers, managed care organizations (MCOs) and others who voluntarily participate in exchange for a legally enforceable promise that they will be paid. Without this voluntary participation of providers, there would be no Medicaid program. The District Court's decision ignores the importance of the crucial role played by providers (and others) and their legitimate expectation to be compensated for their services.

Third, in calling on providers and MCOs to deliver Medicaid benefits, Congress established an interlocking network of rights and responsibilities that is an indispensable element of the program. This network is not simply a bilateral "contract" between the federal and state governments; it is a multilateral arrangement involving beneficiaries, providers, states, the federal government and others. In overturning the ability of some of the participants to enforce their rights

through 42 U.S.C. § 1983, the District Court's decision would upset the delicate balance of rights and responsibilities established by Congress.

A private right of action through § 1983 has been one of the obligations of state participation in Medicaid since its inception. States' understanding of this obligation is well demonstrated through their longstanding acquiescence in federal court suits to enforce Medicaid rights and through their efforts to lobby Congress to eliminate such rights. To the extent that the District Court contends that states are not on notice that such enforceability is an obligation of participation in Medicaid it blatantly ignores this longstanding history.

In effectively eliminating the enforceability of rights on which beneficiaries and providers – and states themselves – have for years relied in making participation decisions, the District Court points to wholly inadequate remedies through federal agency action or state law as sufficient substitutes. Federal administrative enforcement mechanisms are far too blunt instruments to address discrete violations of the sort that are typically the subject of Medicaid litigation brought under § 1983. As a result, they have rarely, if ever, been used against states throughout the history of the program. State administrative remedies, on the other hand, generally apply only to disputes arising under the state Medicaid plan, not to disputes as to whether the plan complies with federal law. Because the states themselves are the final arbiters of the extent of enforceability of rights

under state law, that avenue does not guarantee adequate assurance of congressionally conferred rights.

In preventing beneficiaries, providers and other participants from enforcing their rights under Medicaid, the District Court would effectively eliminate the entitlement to medical assistance conferred by Congress. Beneficiaries would no longer be ensured that they would receive the benefits to which they are entitled. Providers, on whom Congress has relied to deliver covered health care services, would have no means of enforcing the rights on which their willingness to participate depends. Provider participation in Medicaid would most likely plummet, leaving millions of children and adults without care and overburdening those "safety net" providers that would likely remain.

The organizations that have signed this brief *amici curiae* represent a broad spectrum of health care providers that have chosen to participate in the Medicaid program based on the long-standing enforceability of the rights granted them by Congress. We believe that this Court cannot and should not decide the issues presented on appeal without considering the distinguishing characteristics of the Medicaid program and the potentially far-reaching consequences of its ruling.

ARGUMENT

- A. The District Court’s opinion would fundamentally alter the Medicaid program as it exists today by undermining three of its most salient characteristics: 1) its entitlement nature; 2) its reliance on providers to deliver the benefits conferred; and 3) its use of intertwining rights and obligations to secure widespread participation.**

In 1965, Congress enacted Medicaid through Title XIX of the Social Security Act ("Title XIX" or "the Medicaid Act")² as a cooperative federal-state program intended to ensure access to health care for individuals who lack the financial means to obtain needed health care on their own.³ Medicaid has become a pillar of the health care system, covering over 40 million people in 1998.⁴

An understanding of how the Medicaid program operates and its similarities to and differences with other programs enacted pursuant to the Spending Clause is crucial to this Court’s analysis of the enforceability of rights conferred thereunder.⁵ The District Court’s decision fails to examine the Medicaid program in any detail to determine whether it comports with the unstated assumptions about Spending

² 42 U.S.C. §§ 1396 *et seq.*

³ *See also Beal v. Doe*, 432 U.S. 438, 444 (1977) (recognizing purpose of Medicaid Act is to enable participating states to assist indigent individuals procure necessary medical services).

⁴ U.S. Census Bureau, *Statistical Abstract of the United States: 2000*, Table No. 172, at 116.

⁵ In contrast to the District Court’s uniform treatment of all Spending Clause programs, the three-part test firmly established through settled Supreme Court jurisprudence to determine whether a statute confers rights enforceable through § 1983 is nuanced enough to account for the kinds of differences among Spending

Clause programs that undergird its legal reasoning. In particular, three salient characteristics of the program are relevant to the analysis. First, Medicaid is an uncapped entitlement program. The rights conferred by Congress through an entitlement like Medicaid are fundamentally different from other state-administered benefits provided by federal legislation. Any individual in a participating state who meets the specified eligibility criteria is legally entitled to receive medical assistance benefits.⁶ The amount, duration and scope of such assistance is determined pursuant to federal laws and regulations and is not limited according to a fixed amount of federally appropriated funding.

The entitlement creates a legal obligation on the part of the federal and participating state governments to pay for and administer such medical assistance. As one oft-repeated definition of an entitlement explains, "[a]uthorizations for entitlements constitute a binding obligation on the part of the federal government, and eligible recipients have legal recourse if the obligation is not fulfilled."⁷

Clause programs discussed here. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 508-524 (1990).

⁶ Indeed, while the Medicaid entitlement is typically considered to be an entitlement for individual beneficiaries, it also creates an entitlement on the part of providers to be paid for all covered services provided to enrolled beneficiaries. *See* 42 U.S.C. § 1396a(a)(30)(A); *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998).

⁷ U.S. Gen. Accounting Office, *A Glossary of Terms Used in the Fed. Budget Process* 57 (3d ed. 1981); *See also* Aaron Wildavsky, *The New Politics of the Budgetary Process*, 442-43 (1998).

The contrast between an entitlement program and other federal grant programs enacted pursuant to the Spending Clause is directly relevant to the issues in this case. The vast majority of Spending Clause programs established by Congress are not entitlement programs but are simple grants to states to provide benefits to specified individuals or entities. For example, Title IV-D of the Social Security Act,⁸ the Spending Clause program at issue in *Blessing v. Freestone*,⁹ provides federal funding to states for the operation of a child support enforcement program. The Developmentally Disabled Assistance and Bill of Rights Act¹⁰ considered in *Pennhurst State School and Hospital v. Halderman*¹¹ offers funding to states to support programs to care for and treat the developmentally disabled. The funding is fixed and the intended beneficiaries of such programs do not have a right to open-ended assistance unrelated to the amount of available funding. The loosest form of such programs is a so-called "block grant," which provides states with lump-sum federal funds but contains only broad and unspecific guidance as to how to spend those funds.¹²

⁸ Pub. L. No. 93-647, §101(a), 88 Stat. 2351, as amended, 42 U.S.C. §§ 651 *et seq.*

⁹ 520 U.S. 329 (1997).

¹⁰ Pub. L. No. 94-103, 89 Stat. 486, as amended, 42 U.S.C. §§ 6000 *et seq.* (1976 ed. and Supp. III).

¹¹ 451 U.S. 1, 101 S. Ct. 1531, 67 L. Ed. 2d 694 (1981).

¹² Examples of block grant programs include the Maternal and Child Health Block Grant, 42 U.S.C. §§ 701 *et seq.*; and the Substance Abuse Prevention and Treatment Block Grant, 42 U.S.C. §§ 300x-21 *et seq.*

Title XXI of the Social Security Act, the State Children’s Health Insurance Program ("SCHIP") illustrates well the important differences between entitlement and non-entitlement grant programs. Like Medicaid, SCHIP is intended to provide health care coverage to low-income children. Unlike Medicaid, however, Congress has established fixed, state-by-state allotments of federal funds under SCHIP.¹³ Title XXI provides explicitly that it does not create an entitlement to services on the part of eligible individuals, although it does create an entitlement in the states to the allotted federal funds.¹⁴ As a result, eligible children are not guaranteed coverage once the federal funds run out. Over the years, states have lobbied Congress to transform Medicaid into a similar non-entitlement block grant program but have not been successful.¹⁵ Clearly SCHIP, Title IV-D, the Developmentally Disabled Assistance and Bill of Rights Act and similar grant programs are fundamentally different from entitlement programs such as Medicaid that establish detailed and open-ended, legally enforceable rights.

Second, states do not deliver Title XIX benefits directly to eligible individuals, but rather fulfill their obligations under the program through health care providers – physicians, dentists, hospitals, clinics, nursing homes, home health

¹³ 42 U.S.C. § 1397dd.

¹⁴ 42 U.S.C. § 1397bb(b)(4) (no individual entitlement); 42 U.S.C. § 1397aa(c) (entitled "State Entitlement").

¹⁵ See *infra* note 32.

agencies and others – and through managed care organizations (“MCOs”).¹⁶ Their voluntary participation is crucial to the program’s viability. Without an ample and robust statewide network of providers and MCOs willing to participate, states would be unable to operate a Medicaid program. This integral role played by providers distinguishes Medicaid from other grants-in-aid programs administered by states – even those that constitute an entitlement such as the old Aid to Families with Dependent Children (“AFDC”)¹⁷ program – in which states distribute financial or other assistance directly to eligible individuals or organizations. Without providers, there would be no Medicaid program.

Third, in enlisting providers to play this essential role in the delivery of Medicaid benefits, Congress established an elaborate network of inter-related rights¹⁸ and responsibilities for the several types of participants in Medicaid. In

¹⁶ Increasingly, states are opting to establish Medicaid managed care programs, which rely on MCOs, such as health maintenance organizations and preferred provider organizations to arrange and pay providers for health care services for beneficiaries in exchange for payments from the state. *See* 42 U.S.C. §§ 1396b(m), 1396u-2.

¹⁷ Social Security Act of 1935, ch. 531 § 401, 49 Stat. 629, as amended (repealed 1996).

¹⁸ Provider rights under Medicaid include, for example, the right to payment for rendering covered services to enrolled beneficiaries, 42 U.S.C. § 1396a(a)(30)(A); *see Orthopaedic Hosp. v. Belshe, supra*, the right of hospitals serving a disproportionate share of low-income Medicaid and uninsured patients to receive payment adjustments, 42 U.S.C. § 1396r-4; *see Children’s Hosp. & Health Ctr. v. Belshe*, 188 F.3d 1090 (9th Cir. 1999), *cert. denied*, 530 U.S. 1204 (2000), and the right of federally qualified health centers (“FQHCs”) to receive payment rates pursuant to a prospective payment system set forth in statute, 42 U.S.C. §

addition to the federal government and states, these necessary participants include beneficiaries, providers and MCOs (and perhaps other entities as well such as medical equipment suppliers and pharmaceutical companies). Each of these participants must affirmatively opt into the program; as with states, their participation is not mandated by federal statute. Yet, if they decide to participate, then like states they are legally bound to comply with the several obligations that such participation entails. Their decision to participate is typically based on a determination that the advantages of receiving the benefits conferred by statute (including intangible benefits derived from providing access to the poor) outweigh the costs of complying with the obligations imposed.

For example, to participate in Medicaid, beneficiaries must assign any rights they have to child support for medical expenses to the state.¹⁹ In addition, spouses of institutionalized beneficiaries must devote a portion of whatever monthly income they may receive to cover the cost of their care.²⁰ These obligations establish corresponding benefits for the state and federal governments by reducing their outlays.

Obligations assumed by providers include the agreement to accept Medicaid reimbursement as payment in full and not to bill beneficiaries any additional

1396a(aa); *see Md. Cmty. Health Sys. v. Glendening*, 115 F. Supp. 2d 599 (D. Md. 2000) (finding right of action, although no injury, under prior FQHC statute).

¹⁹ 42 U.S.C. § 1396k(a)(1).

charges,²¹ to comply with uniform reporting requirements,²² to submit to audits as required,²³ and to maintain certain policies and procedures with respect to advance directives.²⁴ Nursing homes in particular assume an extensive set of obligations in order to participate in the program.²⁵ Each of these provider obligations confers benefits to beneficiaries, states, the federal government or all three, both in ensuring program integrity and in securing certain beneficiary rights.

The situation is no different for states. They too must comply with a wide range of requirements imposed by federal law, including those pertaining to the contents of the state plan²⁶ and even the establishment of the Early and Periodic Screening, Diagnosis and Treatment benefits at issue in this case.²⁷ And just as beneficiary and provider obligations produce benefits for other participants, these obligations on the part of the state are the means of securing the benefits on which beneficiaries and providers rely.

Thus, these myriad rights and responsibilities are integrally related to each other, as one party's rights are another's responsibilities. No single obligation or set of obligations is expendable; all contribute to the overall balance of rights and

²⁰ 42 U.S.C. § 1396r-5(d).

²¹ 42 U.S.C. § 1396a(a)(25)(C).

²² 42 U.S.C. § 1396a(a)(40).

²³ *See, e.g.*, 42 U.S.C. § 1396a(a)(42).

²⁴ 42 U.S.C. § 1396a(w).

²⁵ *See* 42 U.S.C. § 1396r.

²⁶ *See* 42 U.S.C. § 1936a(a).

responsibilities designed by Congress. The District Court's opinion ignores Medicaid's multilateral nature. It upsets the balance established by Congress by rendering the rights of some of the participants unenforceable, thereby diminishing the obligations imposed on another (the states). In doing so, the opinion undermines the incentives for widespread participation.

The District Court's ruling, if upheld, would eliminate the enforceability of the promise to furnish coverage to eligible persons that elevates Medicaid from a general grant program to a legal entitlement, severely compromise the program's ability to rely on providers to deliver the benefits conferred and upset the delicately balanced network of rights and responsibilities on which the program is founded.

B. Section 1983 enforcement of rights under Medicaid has always been a central element of the program's design and one which states have long accepted as a condition of participation.

When Congress established all of these rights and responsibilities described above (and when states, beneficiaries and providers decided voluntarily to accept them), it established them as enforceable in federal court through § 1983. Federal court enforcement has been a central feature of Medicaid since its inception. Dating back to shortly after Medicaid's enactment, courts have entertained

²⁷ 42 U.S.C. § 1396d(a)(4)(B); *see also* 42 U.S.C. § 1396d(r).

beneficiary and provider suits against state officers to enforce Medicaid rights.²⁸

They routinely continue to do so to this day, both in the Sixth Circuit,²⁹ and in all other jurisdictions.³⁰ Indeed, Michigan itself has been subject to Medicaid enforcement actions several times.³¹

Similarly, states have repeatedly petitioned Congress for legislative relief from the private right of action that is so central an element of the Medicaid

²⁸ See, e.g., *Pharm. Soc’y of Milwaukee County, Inc. v. Dep’t of Health & Soc. Servs.*, 79 F.R.D. 405 (E.D. Wis. 1978); *O’Reilly v. Wyman*, 305 F. Supp. 228 (S.D.N.Y. 1969). See also Note, *Fed. Judicial Review of State Welfare Practices*, 67. Colum. L. Rev. 84, 109-115 (1967) (published shortly after enactment of Title XIX and demonstrating the relevance of contemporaneous § 1983 actions in the analogous welfare context).

²⁹ See, e.g., *Boatman v. Hammons*, 164 F.3d 286 (6th Cir. 1998); *Linton v. Commissioner of Health & Env’t*, 65 F.3d 508 (6th Cir. 1995); *Wood v. Tompkins*, 33 F.3d 600 (6th Cir. 1994).

³⁰ See, e.g., *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998); *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1022 (1998); *Concourse Rehabilitation & Nursing Ctr. v. Wing*, 150 F.3d 185 (2d Cir. 1998); *Boatman v. Hammons*, 164 F.3d 286 (6th Cir. 1998); *Visiting Nurse Ass’n of N. Shore, Inc. v. Bullen*, 93 F.3d 997 (1st Cir. 1996); *Methodist Hosp., Inc. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996); *Va. Hosp. Ass’n v. Baliles*, 868 F.2d 653 (4th Cir. 1989); *Colo. Health Care Ass’n v. Colo. Dep’t of Social Servs.* 842 F.2d 1158 (10th Cir. 1988); *Neb. Health Care Ass’n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), *cert. denied*, 107 S.Ct. 947 (1987); *Ala. Nursing Homes Ass’n v. Harris*, 617 F.2d 388 (5th Cir. 1980).

³¹ See, e.g., *Riffenburg v. State of Michigan*, 1997 U.S. Dist. LEXIS 7073 (W.D. Mich. 1997); *Lapeer County Med. Care Facility v. State of Michigan Dep’t of Soc. Servs.*, 765 F. Supp. 1291 (W.D. Mich. 1991); *Babbitt v. State of Michigan*, 778 F. Supp. 941 (W.D. Mich. 1991); *Coalition of Mich. Nursing Homes, Inc. v. Dempsey*, 537 F. Supp. 451 (E.D. Mich. 1982).

program.³² They have even achieved partial success in this effort.³³ Congress is the appropriate forum in which states should raise these issues. It is not for this Court to accomplish what states have conspicuously failed to achieve directly through Congress.

The District Court's opinion relies heavily on statements in *Pennhurst State School and Hospital v. Halderman*³⁴ that there can be no knowing acceptance of a condition on a Spending Clause program if a state is unaware of the conditions or unable to ascertain what is expected of it.³⁵ To the extent that this discussion in

³² For example, in 1995 and again in 1996, at the behest of the states, Congress considered bills to radically restructure Medicaid into a block grant rather than an entitlement program. A primary goal of the legislation was to eliminate all private rights of action under Medicaid. *See Restructuring Welfare and Medicaid: The Governor's Proposal: Hearing Before the Senate Comm. On Finance, 104th Cong.* (1996) (statement of Gov. Tommy G. Thompson et al., on behalf of Nat'l Governors' Ass'n) ("All of these features [of the Governors' proposal] would be designed to prevent states from having to defend against suits on eligibility and benefits in federal court."); *Seeking Medicaid, In Court*, Wash. Post, Feb. 20, 1996, at A10 ("the governors...don't want the federal courts as overseers...."). The legislation passed Congress but was vetoed in 1995. *See H.R. 2491, 104th Cong.* (1995); President William J. Clinton, *Message to the House of Representatives Returning Without Approval Budget Reconciliation Legislation, 1995 Pub. Papers, 1853-55* (Dec. 6, 1995). A revised version was proposed in 1996 but failed to pass Congress. *See H.R. 3507, 104th Cong. § 2003* (1996) (proposed § 1508 would have removed a right of action).

³³ In 1997, states convinced Congress to protect them from one avenue providers had used to challenge the adequacy of rates -- the so-called Boren Amendment. *See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711* (repealing the Boren Amendment).

³⁴ 451 U.S. 1 (1981).

³⁵ *Westside Mothers v. Haveman*, 133 F. Supp. 2d 549, 557 (E.D. Mich. 2001) (citing *Pennhurst v. Haldeman, supra*, at 17).

Pennhurst dealing with obligations in a statute is even relevant to the question of whether § 1983 provides a cause of action to enforce Medicaid rights, the District Court's underlying premise is unsupportable. Specifically, the District Court claims that states are not on notice that Medicaid rights may be enforced in federal courts because Title XIX does not contain explicit language creating a private right of action.³⁶ Yet, the long history of federal court enforcement combined with states' active efforts to convince Congress to change what they knew to be current law (i.e., § 1983 enforcement of Medicaid rights) demonstrate beyond any doubt that states were both aware of this avenue for relief and accepted it as binding law.

C. In withdrawing the availability of the private right of action under § 1983 for Medicaid, the District Court has left beneficiaries and providers with no effective remedies for a state deprivation of rights.

If the District Court's decision is upheld and § 1983 enforcement is eliminated, the only avenues available for enforcing the statutory requirements – enforcement by the Secretary of Health and Human Services ("the Secretary") and enforcement pursuant to state law – are entirely inadequate to preserve the Medicaid entitlement in its current form.

³⁶ Inexplicably, at this point in its analysis the District Court is content to discard the faulty contract analogy on which the rest of its decision is based, because clearly contract law would look to the parties' actions to determine their intent in making an agreement. *See* E. Allen Farnsworth, *Contracts*, § 7.13, at 514 (1982).

1. Federal enforcement.

If the Secretary decides that a state is not in compliance with federal Medicaid requirements or its state Medicaid plan, Title XIX grants him authority to disapprove the plan and/or any plan amendments or to withhold federal funds.³⁷ This blunt enforcement tool is inadequate to secure compliance with all of the statutory requirements and guarantee beneficiaries and providers their statutorily conferred rights.

For the Secretary to withhold federal funds either in part or in full is a step of enormous consequences for all involved. Practically, such action would be counterproductive and would likely result in the loss of medical assistance for beneficiaries. Politically, the pressure on the Secretary from both the state and Congress if he decided to withhold funds would be intense. Only in the rarest and most extreme circumstances would the Secretary take this extraordinary step. It simply is not a practical avenue for resolving disputes of a lesser magnitude.

The Secretary's authority to approve or disapprove state plans similarly does not adequately protect beneficiary and provider interests. The Secretary's interests in reviewing plan amendments are not co-equal with that of affected beneficiaries or providers. Only through the neutral review provided by the courts can those

³⁷ 42 U.S.C. § 1396c; 42 C.F.R. § 430.35. Some states operate part or all of their Medicaid programs under statutorily authorized waiver programs in which certain

rights be finally determined. Moreover, beneficiary and provider rights may be violated in instances unrelated to the contents of the state plan (for example, if state officers fail to comply with the state plan). For these reasons, the Supreme Court has explicitly held in the context of the Medicaid program that "the Secretary's limited oversight is insufficient to demonstrate an intent to foreclose relief altogether in the courts under § 1983."³⁸

2. State law enforcement rights.

While the Secretary's enforcement is too blunt a tool to adequately protect beneficiary and provider rights, residual avenues to enforce rights under state law are too narrow to serve as a substitute for § 1983 enforcement.

Federal Medicaid law requires only minimal state level review procedures. For example, federal law requires states to provide fair hearings to individuals "whose claim for medical assistance under the plan is denied or is not acted on with reasonable promptness."³⁹ States are also required to establish an administrative claims review process for providers.⁴⁰ And providers may have state law enforcement rights pursuant to the provider contracts that federal law

Medicaid requirements are waived. The Secretary is authorized to terminate these programs if he finds these states out of compliance. *See* 42 U.S.C. § 1396n(f).

³⁸ *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 522 (1990).

³⁹ 42 U.S.C. § 1396a(a)(3); *see* 42 C.F.R. §§ 431.200-431.250. Fair hearings must also be available for residents of skilled nursing facilities for specific rights granted to them. 42 U.S.C. § 1396r(c)(1)(A)(vi); 42 C.F.R. § 431.220.

⁴⁰ 42 U.S.C. § 1396a(a)(37).

requires states to establish.⁴¹ Aside from these provisions, states in general are not bound by federal law to grant state law review of decisions they make in the course of administering the Medicaid program.

These federally mandated state law review processes are clearly insufficient mechanisms to enforce the full panoply of federal rights established by Title XIX. The right to a hearing, for example, encompasses only disputes that involve benefits that are due under the state plan; it fails to reach situations where the legality of plan design is challenged under federal law. Similarly, administrative review procedures for providers may not reach issues of the legality of the state plan itself and federal law does not require any specific level of review. With respect to provider contracts, because states can largely dictate the terms of such agreements – including the extent of enforcement rights – they also control the scope of state law review.

Section 1983 jurisprudence has recognized the inadequacy of alternative state-level methodologies of enforcing federal rights.⁴² For this reason, the federal courts have generally not required exhaustion of state remedies before initiating a § 1983 suit.⁴³ Underlying these decisions is recognition of the significant benefit a

⁴¹ See 42 U.S.C. § 1396a(a)(27).

⁴² *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 522-23 (1990).

⁴³ *Patsy v. Board of Regents*, 457 U.S. 496, 516 (1982).

federal enforcement mechanism provides to ensure state compliance with federal law, rather than sole reliance on extremely limited state law mechanisms.

The District Court's decision in this case, if upheld, would essentially vitiate beneficiary and provider rights that have been so deliberately and, in some cases, specifically granted by Congress because, of course, if there is no effective enforcement there is no right.⁴⁴ The result would be devastating for the Medicaid program, the low-income families and individuals that are covered by it, and the health care safety net that it supports.

D. In eliminating the entitlement that is at the core of Title XIX, the District Court's decision would significantly impair the guaranteed access to health care services for low-income and vulnerable populations that has been the greatest achievement of the Medicaid program.

If affirmed, the District Court's decision would have extraordinary consequences for access to health care for Medicaid beneficiaries and other vulnerable populations. The loss of enforceability could be expected to produce three main consequences. First, more than 40 million of the nation's poorest and most disabled individuals would cease to have guaranteed coverage for health care services. Their access to care would be subject to the political and budgetary whims of the state unfettered by judicial oversight of its compliance with federal

⁴⁴ See *Marbury v. Madison*, 5 U.S. 137, 163 (1803) ("[I]t is a general and indisputable rule, that where there is a legal right, there is also a legal remedy by

law. Medicaid as such would be much closer to a block grant program where states' expenditure of federal funds is governed by only the loosest of federal guidelines. Given current budgetary pressures on state Medicaid programs,⁴⁵ the District Court's windfall grant to states of this extraordinary new flexibility would likely result in a narrowing of coverage in very short order.

Second, and as a direct result of the first consequence, thousands of physicians, health care professionals, and institutional providers could be expected to cease or significantly curtail program participation, since their right to payment derives from their patients' right to coverage. Low levels of provider participation in Medicaid have been an historic problem.⁴⁶ This decision, if upheld, would greatly exacerbate these difficulties by fundamentally altering providers' ability to participate. It is likely that a significant number of providers that comprise the membership of *amici* organizations would be unable to sustain current levels of care for Medicaid patients and would be forced to the conclusion that the costs and uncertainty of Medicaid participation are no longer outweighed by the benefits.

suit or action at law whenever that right is invaded." (quoting 3 William Blackstone, Commentaries *23)).

⁴⁵ *States Adjust to Slowing Economy*, United Press Int'l, Feb. 28, 2001 (Most states report that Medicaid is their most significant budgetary challenge.); Jay Root, *Governors Disagree on Bush Tax Cut Plan*, Fort Worth Star-Telegram, Feb. 26, 2001, at 15. ("Rising Medicaid costs were a top concern among the governors...")

⁴⁶ Cong. Research Service, *Medicaid Source Book: Background Data and Analysis* (1993) (GPO, Washington, D.C.), at 1063-1085.

Others would not officially terminate participation in Medicaid but would scale back the extent of it. The remaining core of participating providers would likely be dominated by those safety net providers that are most dependent on Medicaid revenues for their survival.

Which leads directly to the third consequence, the potential financial devastation of America's health care safety net – safety net hospitals, community health centers, children's hospitals and other providers that either have a legal obligation to furnish care without regard to ability to pay or who do so as a central element of their mission.⁴⁷ In providing essentially unreimbursed care for the uninsured, these providers have allowed us to continue to rely on a health care financing system that leaves nearly 43 million people without coverage.⁴⁸ Safety net providers tend on average to be far more dependent on Medicaid as their primary revenue source and to use those revenues not only to pay for care for the uninsured but also for investing in specialty services (e.g., trauma, burn, and neonatal intensive care) used by the entire community.⁴⁹

⁴⁷ Inst. of Medicine, *America's Health Care Safety Net: Intact But Endangered*, at 21-23 (National Academy Press, 2000) [hereinafter IOM Report].

⁴⁸ U.S. Census Bureau, U.S. Dep't of Commerce, Pub. No. P60-211, *Current Population Reports, Health Insurance Coverage: 1999*, Table A-1, at 14.

⁴⁹ IOM Report, *supra* note 47, at 54 ("Over the years, Medicaid has become an increasingly important revenue source for [core safety net] providers, accounting for about a third of revenues.").

Medicaid's role in supporting the health care safety net has been extensively documented. For example, forty-one percent of the net revenues received by members of the National Association of Public Hospitals and Health Systems are from Medicaid and thirty-three percent of their unreimbursed care is financed by supplemental Medicaid payments for hospitals serving a disproportionate share of Medicaid and other low-income patients.⁵⁰ Similarly, thirty-three percent of the patients of community health centers are covered by Medicaid, forty-one percent are uninsured while only fifteen percent have commercial insurance, as compared to the typical physician practice which is comprised primarily of privately insured patients (fifty-five percent) and only seven percent Medicaid patients.⁵¹

This integral role of Medicaid as the key source of support for the health care safety net has been recognized by the prestigious Institute of Medicine which, in a recent report, urged policymakers to take into account the potentially

⁵⁰ Lynne Fagnani et al., *America's Safety Net Hospitals & Health Systems*, Nat'l Ass'n of Public Hospitals, at 4-8 (Washington, D.C. 2000).

⁵¹ Nat'l Ass'n of Cmty. Health Centers, Inc., *Access to Cmty. Health Care: A Nat'l & State Data Book* (1998); U.S. Gen. Accounting Office, *Cmty. Health Centers: Adapting to Changing Health Care Env't Key to Success*, GAO/HEHS-00-39 (March 2000). For more information on the reliance of health care providers on Medicaid, see also Nat'l Ass'n of Children's Hospitals, *Annual Report of Financial Indicators of Children's Hospitals* (Alexandria, Va. 1999); Am. Dental Ass'n, *1999 Survey of Dental Practice: Pediatric Dentists in Private Practice*; Council of Teaching Hospitals, *COTH Survey of Hospital's Financial and General Operating Data, FY 1999*; Lewin Group, *TrendWatch Chartbook 2000: Trends Affecting Hospitals and Health Systems*, June 2000, at 43-45 (prepared for the Am. Hosp.

devastating impact of changes in Medicaid policy on the viability of the health care safety net.⁵² The changes in Medicaid policy that would be implemented in affirming this decision would be extremely damaging. Providers who are not completely dependent on Medicaid revenues for survival (i.e., non-safety net providers) would likely reduce if not eliminate their participation in Medicaid. Care for Medicaid patients would then be concentrated in safety net providers. Yet with no enforceable rights, Medicaid no longer would be the reliable source of revenue that it now is and its integral role in subsidizing care for the uninsured would be compromised. The result would be significantly reduced access to health care for all.

CONCLUSION

The *amici curiae* urge this Court to reject the District Court's fundamentally flawed analysis overturning decades of settled federal court jurisprudence and instead follow the law of the land as clearly and repeatedly articulated by the Supreme Court. To do otherwise would be tantamount to judicially legislating a fundamental change in the Medicaid program that states have failed to win through normal political processes, namely the elimination of the private right of action.

Ass'n); March of Dimes, *Maternal, Infant, & Child Health in the United States, 2001: Data Book for Policy Makers* (2001).

⁵² IOM Report, *supra* note 47, at 212.

The consequences for the American health care delivery system would be enormous and far reaching, with over 40 million people losing a guaranteed source of coverage and countless more facing a significant reduction in access to care because of the unsupportable stress placed on the health care safety net. *Amici* urge this Court to consider carefully all of the implications of this vital ruling.

For the foregoing reasons, *amici curiae* respectfully request this Court to reverse the judgment of the District Court

Respectfully submitted,

Larry S. Gage
Barbara D.A. Eyman
Charles Luband
Aimee N. Wall
Powell, Goldstein, Frazer & Murphy LLP
1001 Pennsylvania Avenue, N.W.
Washington, DC 20004

Sara Rosenbaum (Of-Counsel)
Harold and Jane Hirsh Professor of
Health Law and Policy
George Washington University School of
Public Health and Health Services
2021 K Street, N.W.
Washington, DC 20006

June 25, 2001

CERTIFICATION OF COMPLIANCE WITH FED. R. APP. P. 32(a)(7)(C)

I, Larry S. Gage, counsel for *amici curiae*, hereby certify that on this 25th day of June, 2001, that this brief, in accordance with the instructions contained in the Sixth Circuit's Notice to Counsel dated July 27, 1999, and Fed. R. App. P. 32(a)(7)(B)(iii), contains 6,036 words using Microsoft Word's word count feature, and thus, complies with the requirements of Fed. R. App. P. 29(d) and Fed. R. App. P. 32(a)(7) as it applies to briefs of *amici curiae*.

Larry S. Gage

CERTIFICATE OF SERVICE

I, Larry S. Gage, counsel for *amici curiae*, hereby certify that on this 25th day of June, 2001, I filed and served the foregoing brief *amici curiae* by causing an original, signed brief, and six correct copies, to be dispatched to the Clerk of this Court, and two correct copies of the brief to be dispatched to each of the following counsel (pursuant to Fed. R. App. P. 25(c)) via a third-party commercial carrier for delivery within 3 calendar days, postage prepaid:

Appellants:

Jennifer R. Clarke
Kelly L. Darr
Robin P. Sumner
Jacob I. Kobrick
Dechert, Price & Rhoads
1717 Arch Street
Suite 4000 Bell Atlantic Tower
Philadelphia, PA 19103-2793
(215) 994-2105

Appellees:

Erica Weiss Marsden
Office of the Attorney General
Social Services Division
235 S. Grand Avenue
Suite 206
Lansing, MI 48933
(517) 373-7702

Larry S. Gage