No. 21-806

IN THE
Supreme Court of the United States

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, ET AL.,
Petitioners,

v.

IVANKA TALEVSKI, PERSONAL REPRESENTATIVE OF THE ESTATE OF GORGI TALEVSKI, DECEASED,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF CALIFORNIA MEDICAL ASSOCIATION AS *AMICUS CURIAE* SUPPORTING RESPONDENT

LONG X. DO
KYLE R. BRIERLY
ATHENE LAW LLP
5432 Geary Boulevard, #200
San Francisco, CA 94121
(415) 680-7419
long@athenelaw.com

STACEY M. LEYTON
Counsel of Record
BRONWEN B. O'HERIN
ALTSHULER BERZON LLP
177 Post Street, #300
San Francisco, CA 94108
(415) 421-7151
sleyton@altber.com

Counsel for Amicus Curiae
CALIFORNIA MEDICAL ASSOCIATION

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Constitution, Statutes, and Regulations

Other Authorities

INTERESTS OF *AMICUS CURIAE*[1]

The California Medical Association ("CMA") is a California non-profit, incorporated professional physician association. Founded in 1856 to develop, in the highest possible degree, the scientific truths embodied in the profession, CMA pursues its mission to promote the science and art of medicine, protection of public health, and the betterment of the medical profession on behalf of 50,000 members, most of whom practice medicine in all modes and specialties throughout California.

CMA and its members share the objective of promoting high quality, safe, and cost-effective health care for the people of their state, including through their state Medicaid program, known as Medi-Cal. CMA, on behalf of itself and its members, believes strongly that 42 U.S.C. § 1983 ("Section 1983") must remain an effective means to ensure that the promises of the Medicaid Act and other Spending Clause legislation are realized to benefit the public and patients.

INTRODUCTION

This Court should not revisit its consistent conclusion, over the past 50 years, that the enforceability of federal statutes through Section 1983 does not depend on whether the statutory provision at issue was

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[1] No counsel for a party authored this brief in whole or in part, and no person other than the *amicus curiae*, its members, or its counsel made a monetary contribution intended to fund the preparation or submission of this brief. Counsel of record for petitioners and respondent have filed letters granting blanket consent to the filing of *amicus* briefs in support of either or neither party.

enacted pursuant to Congress' Spending Clause authority. While Section 1983's text is clear on this point, Congress' 1994 ratification of the enforceability of Spending Clause statutes should settle any remaining questions.

The Medicaid Act is Spending Clause legislation that is essential to the health and wellbeing of the nation's population. The United States Department of Health and Human Services cannot meaningfully enforce Medicaid's mandates on its own. Thus, private enforcement through Section 1983 plays a critical role.

In *Blessing v. Freestone*, 520 U.S. 329 (1997), and *Gonzaga Univ. v. Doe*, 536 U.S. 273, 284 (2002), this Court provided guidance as to how courts should determine whether Congress intended particular statutory provisions to create rights enforceable via Section 1983. With that guidance, the lower courts are well positioned to ascertain whether Congress intended to create enforceable rights, including in cases brought by physicians and other Medicaid providers (on behalf of themselves or via third party standing). Such physicians and providers are particularly well suited to pursue private enforcement of those Medicaid provisions that confer important rights on vulnerable patients and their health care providers. This Court should preserve the critical role that private enforcement, including by Medicaid providers, plays in fulfilling the promise of one of the country's most important social programs, which for decades has delivered beneficial medical care to millions of needy Americans.

ARGUMENT

I. Well Settled Precedents Spanning Half a Century Have Made Rights Established in Spending Clause Legislation Enforceable Through Section 1983.

The Constitution's Spending Clause authorizes Congress to enact legislation providing for the general welfare. *See* U.S. Const. art. I, § 8, cl. 1. The Social Security Act, with Medicaid as Title IX, is one of a number of statutes passed by Congress pursuant to this authority. *See* 42 U.S.C. § 301 *et seq*. The civil rights statute 42 U.S.C. § 1983 provides that "[e]very person" acting under "color of" state law who "subjects, or causes to be subjected," another person "to the deprivation of any rights, privileges, or immunities secured by the Constitution *and laws,* shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress." 42 U.S.C. §1983 (emphasis added). Section 1983 thus provides a cause of action to enforce rights created by Congress through its laws, including those laws enacted pursuant to its Spending Clause authority.

For over half a century, this Court has heeded Section 1983's plain meaning, both implicitly recognizing and explicitly affirming that Section 1983 provides a cause of action for private enforcement of rights created by Spending Clause legislation. As early as 1968, in *King v. Smith*, the Court permitted welfare recipients' enforcement of the Social Security Act's reasonable promptness provision via a Section 1983 cause of action. 392 U.S. 309, 333-34 (1968). Six years later, in *Edelman v. Jordan*, 415 U.S. 651, 675 (1974), this Court explicitly recognized its earlier holding in

Rosado v. Wyman, 397 U.S. 397 (1970), "that suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States." *Edelman*, 415 U.S. at 675.

This Court then held explicitly, in a case involving a statute enacted pursuant to the Spending Clause, that Section 1983 "means what it says" and "undoubtedly embraces" claims against state actors alleging violation of rights grounded in federal laws such as the Social Security Act. *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980). Surveying a line of cases since *King v. Smith*, the Court held that such cases had resolved "any doubt" as to Section 1983's applicability to laws enacted pursuant to Spending Clause legislation. *Id.* at 4-6. The Court specifically observed that its "analysis in several … cases involving Social Security Act (SSA) claims" had "relied on the availability of a § 1983 cause of action." *Id.* at 5.

Since *Maine v. Thiboutot*, the Court has regularly reaffirmed that rights secured by Spending Clause legislation are properly enforced through Section 1983. *See, e.g.*, *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 521-22 (1990) (Medicaid providers can enforce a Medicaid Act right via Section 1983 and the federal government's power to "curtail federal funds to States whose plans are not in compliance with the Act" does not "foreclose reliance on § 1983 to vindicate federal rights"); *Wright v. City of Roanoke Redevelopment & Housing Authority*, 479 U.S. 418, 432 (1987) (rights conferred to tenants by a provision of the federal Housing Act are enforceable under Section 1983).

Even as it has refined the analysis for determining whether a law of Congress grants an enforceable right

to private litigants, the Court has consistently reiterated the fundamental principle that a Section 1983 cause of action is a proper vehicle for enforcing such rights. *See Gonzaga Univ.*, 536 U.S. at 284 (although the provision at issue did not create rights enforceable under Section 1983, noting that "§ 1983 generally supplies a remedy for the vindication of rights secured by federal statutes"); *Blessing*, 520 U.S. at 340 (outlining three-factor analysis for determining whether child support provision of Social Security Act gives rise to federal right enforceable via Section 1983); *Suter v. Artist M.*, 503 U.S. 347, 357-63 (1992) (analyzing whether a Social Security Act provision regarding foster-care programs "create[ed] a federally enforceable right … under § 1983" and holding that it did not).

Amicus agrees with Respondent that this Court's prior decisions correctly read the statutory text of Section 1983. What is more, for nearly thirty years, Congress's ratification of this Court's precedent allowing Section 1983 enforcement of Social Security Act rights has been eminently clear. In 1994, Congress amended the Social Security Act in response to an aspect of the 1992 *Suter* decision. In holding that a Social Security Act provision did not secure enforceable rights, *Suter* had considered it relevant that the provision was contained in a statute setting forth requirements for state plans seeking federal funding. *See* 503 U.S. at 363. Because many portions of the Social Security Act set forth state-plan requirements, *Suter*'s approach, if extended, could have had the effect of broadly curtailing Section 1983 enforcement actions.

Congress responded to that concern in 1994, making clear that it intended state-plan requirements imposed in Spending Clause enactments to be

enforceable via Section 1983, by enacting legislation specifying that a provision of the Social Security Act "is not deemed unenforceable because of its inclusion in a section … requiring a State plan or specifying the required contents of a State plan." 42 U.S.C. §§ 1320a-2, 1320a-10. A conference report accompanying the amendment explained, "The intent of this provision is to assure that individuals who have been injured by a State's failure to comply with the Federal mandates of the State plan titles of the Social Security Act are able to seek redress in federal courts to the extent they were able to prior to the decision in *Suter v. Artist M.*" H.R. Conf. Rep. No. 761, 103d Cong., 2d Sess. 926 (1994). Congress thus expressly affirmed the Court's holdings prior to *Suter* that rights secured through Spending Clause legislation such as the Social Security Act are enforceable in Section 1983 actions.[2]

Reversing this half-century of precedent, expressly ratified by Congress almost three decades ago, would disregard Congressional intent and settled expectations, without any legitimate justification. What is more, it would have far-reaching and devastating effects on the enforcement of important Social Security Act protections.

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[2] At the time of the Medicaid Act's original enactment, courts adhered to the "rights-remedies" principle—the notion that an explicit cause of action need not be drafted into a statute in order for a statutorily created right to have a remedy. *See* Donald H. Zeigler, *Rights, Rights of Action, and Remedies: An Integrated Approach*, 76 WASH. L. REV. 67, 71-84 (2001). It is thus unsurprising that Congress did not earlier memorialize the intent that the Act's provisions be enforceable through Section 1983.

II. The Medicaid Act Is Spending Clause Legislation of Monumental Importance to Millions of Americans.

Over its nearly 60-year lifespan, the Medicaid Act has arguably become the most impactful social welfare legislation in the country's history, under the Spending Clause or otherwise. Medicaid today covers nearly 82 million people in the United States—approximately one in four Americans.[3] Medicaid enrollment spiked by 28 percent during the COVID pandemic (an increase of almost 18 million), with Indiana and California seeing the largest increases.[4] Children make up 41 percent of the Medicaid population (33.7 million individuals).[5] And Medicaid covers more than 42 percent of all live births in the United States.[6]

Medicaid's footprint is particularly important in the *amicus'* state. Thirty-five percent (13.8 million) of

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[3] Centers for Medicare & Medicaid Services, *May 2022 Medicaid and CHIP Enrollment Trends Snapshot,* at 3 (2022), https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2022-medicaid-chip-enrollment -trend-snapshot.pdf (last visited Sept. 21, 2022).

[4] *Id.* at 3 and fig. 3.

[5] *Id.* at fig. 2.

[6] Centers for Medicare & Medicaid Services, *Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health*, at 13 (Dec. 2020), https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-beneficiary-profile.pdf (last visited Sept. 21, 2022).

California's 39.6 million residents are enrolled in Medicaid.[7]

It is no surprise that Medicaid spending accounts for over 20 percent of the average state's total budget, with federal funds covering 50 to 83 percent of those costs. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 581 (2012). Medicaid's large and continuously growing footprint makes it an "essential part of the U.S. health care landscape."[8]

Physician participation in Medicaid is also robust. Nationally, nearly 70 percent of physicians accept new Medicaid patients.[9] In community health centers, where low-income communities access primary care, virtually all physicians participate in Medicaid.[10] Fourteen states have participation rates of over 85 percent, and the rate of physician participation in

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[7] Kaiser Family Foundation, *Total Monthly Medicaid/CHIP Enrollment and Pre-ACA Enrollment* (May 2022), https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location% (Sept. 22, 2022).

[8] Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in A Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 6 (2006).

[9] E. Hing et al., *Acceptance of New Patients with Public and Private Insurance by Office-based Physicians: United States, 2013*, National Center for Health Statistics (March 2015), https://www.cdc.gov/nchs/products/databriefs/db195.htm (last visited Sept. 21, 2022).

[10] J. Paradise, *Three Findings About Access to Care and Health Outcomes in Medicaid*, Kaiser Fam. Found. (Mar. 23, 2017), https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/ (last visited Sept. 22, 2022).

Medicaid is equal to or greater than the rate of participation in private insurance in eight states.[11]

More recent scholarly treatment has focused on the effects of Medicaid expansion under the Affordable Care Act. Researchers have found that Medicaid expansion yielded positive changes among low-income adults in access to health care with health outcome improvements. That is, researchers concluded that Medicaid coverage improved the treatment of beneficiaries' chronic conditions, particularly through the increased use of prescription medications, including the treatment of substance use disorders.[12] Medicaid expansion also has been associated with improved self-reported health, with earlier care, and with improved surgical outcomes.[13] Extending Medicaid

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[11] *Id.*; J. Paradise, *Data Note: A Large Majority of Physicians Participate in Medicaid*, Kaiser Fam. Found. (May 10, 2017), https://www.kff.org/medicaid/issue-brief/data-note-a-large-majority-of-physicians-participate-in-medicaid/ (last visited Sept. 21, 2022).

[12] Ausmita Ghosh et al., *The Effect of Health Insurance on Prescription Drug Use Among Low-Income Adults: Evidence from Recent Medicaid Expansions*, 63 J. HEALTH ECON. 63, 64 (Jan. 2019); Johanna Catherine Maclean and Brendan Saloner, *The Effect of Public Insurance Expansions on Substance Use Disorder Treatment: Evidence from the Affordable Care Act*, 38 J. POL'Y ANAL. & MGMT. 366 (Spring 2019).

[13] Sommers et al., *Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*, HEALTH AFFAIRS, 36, no. 6: 1119, 1124 (June 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0293 (last visited Sept. 21, 2022) (Medicaid expansion "associated with significant improvements in access to primary care and medications, affordability of care, preventive visits, screening tests, and self-reported health"); J. Graves et al., *Medicaid Expansion Slowed Rates of Health Decline for Low-Income Adults in*

coverage to more Americans is associated with substantial improvements in mental health among low-income adults with chronic conditions.[14] Finally, new data suggests that Medicaid expansion reduced mortality rates among low-income adults.[15]

Due to improved health outcomes and health care coverage, states that expanded Medicaid under the Affordable Care Act saw improvements in the overall wellbeing of their residents. Researchers associated Medicaid expansion with a significant reduction in food insecurity.[16] Studies have also found Medicaid beneficiaries improved their dietary habits and reduced risky health behaviors, such as smoking.[17]

Researchers have repeatedly found that Medicaid programs are effective in promoting healthier lives.

Southern States, HEALTH AFFAIRS, 39, no. 1:67 (Jan. 2020), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00929?journalCode=hlthaff (last visited Sept. 21, 2022).

[14] T. Winkleman & V. Chang, *Medicaid Expansion, Mental Health, and Access to Care Among Childless Adults with and without Chronic Conditions*. J. GEN. INTERN. MED. 33, no. 3: 376, 380 (Mar. 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5834959/ pdf/11606_2017_Article_4217.pdf (last visited Sept. 22, 2022).

[15] S. Miller et al., *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data*, NAT'L BUREAU ECON. RES. at 2-3 (Jan. 2021), https://www.nber.org/system/files/working_papers/w26081/w26081.pdf (last visited Sept. 21, 2022).

[16] Gracie Himmelstein, *Effect of the Affordable Care Act's Medicaid Expansions on Food Security, 2010–2016*, 109 AM. J. PUB. HEALTH 1243 (Aug. 7, 2019).

[17] Xi He et al., *Medicaid Expansion and Non-alcoholic Beverage Choices by Low-income Households*, 29 HEALTH ECON. 1327 (Aug. 3, 2020); Chad Cotti et al., *Impacts of the ACA Medicaid expansion on health behaviors: Evidence from household panel data*, 28 HEALTH ECON. 219 (Nov. 15, 2018).

Studies have disclosed increases in health outcomes in uninsured populations versus those with any health insurance coverage, specifically in the areas of primary prevention and screening services, cancer care, chronic disease management (e.g., diabetes, hypertension, end-stage renal disease, HIV disease, and mental illness), hospital-based care, and overall mortality and general measures of health status.[18] Thus, not only is Medicaid a program relied upon by millions of Americans, but the benefits it brings to those Americans' lives result in a country that is healthier overall.

III. Private Enforcement Through Section 1983 Is Vital to Realizing Medicaid's Benefits.

With so much at stake for so many, it is crucial that Medicaid works as designed by Congress so that its intended benefits can be realized. Since the program's inception, and as expressly approved of by Congress, private enforcement has been a critical tool for ensuring that Medicaid works as designed and in fact delivers on the policy goals behind the Act's provisions, in the form of real health benefits for America's most vulnerable.

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[18] Institute of Medicine (US) Committee on the Consequences of Uninsurance, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE, National Academies Press (2002) at 47, https://nap.nationalacademies.org/catalog/10367/care-without-coverage-too-little-too-late (last visited Sept. 21, 2022).

A. Section 1983 Actions Are a Necessary Component of Medicaid's Enforcement Scheme.

The Medicaid program is a "'classic example of cooperative federalism"[19] whereby "the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals. [citation] Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services." *Wilder*, 496 U.S. at 502.

The U.S. Department of Health and Human Services ("HHS") has sole responsibility to review and approve state plans and amendments pursuant to 42 U.S.C. § 1316(a). Even aside from HHS's well-documented serious resource limitations,[20] the statutory process does not provide HHS with sufficient tools, nor does it provide beneficiaries or providers with adequate avenues to intervene, to prevent state violations of the Medicaid Act. That makes sense, because Congress contemplated that private enforcement would play a supplementary role.

HHS's oversight of state compliance with Medicaid Act requirements is limited. After a state Medicaid plan is approved, HHS cannot retract such approval or order amendments to the plan; rather, HHS may

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[19] Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 419 (2008).

[20] *See* 2014 WL 7366055, Brief of Former HHS Officials as Amici Curiae, *Armstrong v. Exceptional Child Center, Inc.*, Case No. 14-15 (filed Dec. 23, 2014), at *14-17.

only withhold federal financial participation to a state in whole or in part if HHS determines that the Medicaid state plan or its implementation by a Medicaid state agency violates Medicaid laws. *See* 42 U.S.C. § 1396c. A state may appeal such action by HHS pursuant to 42 C.F.R. part 430, subpart D, which "sets forth the rules for hearings to States that appeal a decision to disapprove State plan material (under § 430.18) or to withhold Federal funds (under § 430.35), because the State plan or State practice in the Medicaid program is not in compliance with Federal requirements." 42 C.F.R. § 430.360(a). Such appeals can take years to resolve.

Moreover, there is no means for any interested or affected private party to initiate a hearing or define the issues to challenge a state Medicaid plan or a state Medicaid agency's noncompliance with Medicaid laws. Interested private parties may apply to be recognized as a party to a pending administrative proceeding, but lack any power over the issues to be decided in the matter and cannot raise issues not formally initiated by HHS or the appealing state agency. *See* 42 C.F.R. §§ 430.60(a), 430.74. Associational standing and third party standing are not allowed. Only individuals or groups that have suffered injury and have interests within the zone of interests to be protected by the governing Medicaid provision may serve as parties. *Id.* § 430.76(b).

This structure creates two very serious enforcement problems on top of HHS's resource limitations. First, HHS's only means for enforcement—the withholding of funds from noncompliant states—"ultimately does not punish the state, but the very people the Medicaid Act is meant to benefit" by "depriving the poor of essential medical assistance." Br.

of Former HHS Officials, *supra* note 20, at *17-18; *see* also *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 52 (1981) (White, J., dissenting) (explaining that, as "a funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act," an agency's ability to withhold funds should not necessarily foreclose a private right of action).

Second, those who are most affected by and thus intimately familiar with a state's Medicaid noncompliance—that is, program beneficiaries and program providers—lack effective administrative mechanisms to bring instances of Medicaid noncompliance to HHS's attention, to initiate any administrative enforcement, or even to participate in administrative proceedings that are underway. Were enforcement actions by HHS the only means of enforcing Medicaid's provisions, a range of Medicaid violations would undoubtedly go unaddressed.

The availability of Section 1983 as a vehicle for private enforcement has served as a remedy to these two problems since Medicaid's inception. Important protections for Medicaid beneficiaries have been vindicated only through private enforcement in the federal courts via Section 1983. Thus, for example, private parties have enforced the Act's mandate that "medical assistance … be furnished with reasonable promptness," 42 U.S.C. §§ 1396a(a)(8), to prevent states from denying medically necessary services for budgetary reasons by placing eligible individuals onto waitlists. *See, e.g.*, *Sobky v. Smoley*, 855 F. Supp. 1123, 1148 (E.D. Cal. 1994); *see also Doe ex rel. Doe v. Chiles*, 136 F.3d 709, 717 (11th Cir. 1998) (reasoning

that delays of several years would be "far outside the realm of reasonableness").[21]

Over half a century since the Act's adoption, Section 1983 actions remain in most cases *the sole avenue* for entities other than HHS to enforce the Act's provisions and prevent violations that impinge upon individual rights. And they are the *only* means of enforcement that can provide a direct remedy to harmed beneficiaries, rather than effect a second harm to those beneficiaries through the withholding of Medicaid funds to noncompliant states.

B. The Circuits Are Well Experienced and Adept at Identifying Whether a Provision of Medicaid Secures an Enforceable Right.

In *Blessing v. Freestone* and *Gonzaga Univ. v. Doe*, this Court provided guidance as to how the lower courts should ascertain whether Congress intended a particular statutory provision to be enforceable via Section 1983. *Blessing* established a three-part test: "First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence. Third, the statute must unambiguously

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[21] Other circuit courts have similarly held this "reasonable promptness" provision to be privately enforceable through Section 1983. *See Waskul v. Washtenaw Cnty. Cmty. Mental Health*, 979 F.3d 426, 448 (6th Cir. 2020); *Romano v. Greenstein*, 721 F.3d 373, 377 (5th Cir. 2013); *Doe v. Kidd*, 501 F.3d 348, 357 (4th Cir. 2007); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 189 (3rd Cir. 2004); *Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002).

impose a binding obligation on the States.'" 520 U.S. at 340 (internal citations omitted).

The first prong of the test is particularly demanding, and *Gonzaga*'s guidance especially instructive: As the Court explained, when a provision's "text [is] phrased in terms of the persons benefited," that indicates that Congress intended to convey a private right to those persons. 536 U.S. at 284 (internal quotation omitted). Such phrasing is not easily shown: "anything short of an unambiguously conferred right" does not "support a cause of action brought under" Section 1983. *Id.* at 283. Only Congress's use of explicit "rights-creating[,] … individually focused terminology" that confers rights upon an "'identifiable class'" suffices to establish an actionable right. *Id.* at 283-84, 287 (internal quotations omitted).

Thus, for almost three decades, lower courts have had the benefit of this Court's guidance that the statutory text is the key to deciding whether Congress intended that a particular provision be enforceable. In most cases, the lower courts have generally been in agreement about particular provisions, including provisions aimed directly at promoting health and access to care. For example, there is consensus that 42 U.S.C. § 1396a(a)(10)(A), which requires states to provide medical assistance to all individuals who fall within the categorically eligible groups, has been held enforceable under Section 1983 by the circuits that have considered that question. *See Bontrager v. Ind. Family & Soc. Servs. Admin.*, 697 F.3d 604, 607 (7th Cir. 2012); *Watson v. Weeks,* 436 F.3d 1152, 1159-61 (9th Cir. 2006); *S.D. ex rel. Dickson v. Hood,* 391 F.3d 581, 604-06 (5th Cir. 2004); *Sabree,* 367 F.3d at 189-92. Similarly, both circuits that have decided the issue have held that 42 U.S.C. § 1396a(a)(43), which

requires states to provide access to early and periodic screening, diagnosis, and treatment ("EPSDT") services to individuals under age 21, agree that the provision can be privately enforced. *See John B. v. Goetz*, 626 F.3d 356, 363 (6th Cir. 2010); *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Hum. Servs.*, 293 F.3d 472, 479 (8th Cir. 2002); *see also, e.g.*, *Shakhnes v. Berlin*, 689 F.3d 244, 250-51 (2d Cir. 2012) (42 U.S.C. §1396a(a)(3) (requirement of "fair hearing" is enforceable via Section 1983); *Gean v. Hattaway*, 330 F.3d 759, 772-73 (6th Cir. 2003) (same); *supra* note 21 (circuits holding reasonable promptness provision, 42 U.S.C. § 1396a(a)(8), creates a right enforceable through Section 1983).

By contrast, the Act's requirement that services be allocated using "reasonable standards," 42 U.S.C. § 1396a(a)(17), has been held by the circuits that have considered the question not to be enforceable by Medicaid beneficiaries or providers. *See Davis v. Shah*, 821 F.3d 231, 244 (2d Cir. 2016); *Hobbs ex rel. Hobbs v. Zenderman*, 579 F.3d 1171, 1182 (10th Cir. 2009); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006); *Weeks*, 436 F.3d at 1162-63. And after *Gonzaga*, the circuit courts have unanimously rejected private actions to enforce the Act's directive that provider payments be set by methods that ensure they "are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" to make medical care equally available to Medicaid beneficiaries as in the private sector, 42 U.S.C. § 1396a(a)(30)(A). *See, e.g.*, *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007); *Mandy R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542-43 (6th Cir. 2006); *N.Y. Ass'n of Homes & Servs.*

for the Aging, Inc. v. DeBuono, 444 F.3d 147, 148 (2d Cir.2006) (*per curiam*); *Sanchez v. Johnson*, 416 F.3d 1051, 1059-61 (9th Cir. 2005); *Long Term Care Pharm. Alliance v. Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004).[22]

This Court's test for determining the availability of private enforcement via Section 1983 starts from the presumption that the statutory text offers the best indication of Congressional intent. Based on that instruction, the lower courts have sorted those statutory provisions that Congress meant to convey enforceable rights from those it did not. There is no reason for this Court to now override that test and hold that a provision's inclusion in an enactment pursuant to the Spending Clause authority somehow negates Congressional intent to convey an enforceable right.

C. Private Enforcement of Medicaid Provisions by Physicians and Their Medical Associations Through Section 1983 Is Vitally Important.

A physician's relationship with patients is founded upon the art and practice of medicine, which "is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering."[23] Such a relationship "is based on trust, which gives rise to physicians' ethical responsibility to place

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[22] The First Circuit reversed its earlier holding that this provision was enforceable after the benefit of this Court's guidance in *Gonzaga*. *See Long Term Care Pharm. Alliance*, 362 F.3d at 59.

[23] Amer. Med. Ass'n Code of Medical Ethics, Op. 1.1.1, https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships (last visited Sept. 21, 2022).

patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."[24] "Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients."[25] These ethical principles explain why physicians seek to enforce Medicaid provisions not only on their own behalf but also on behalf of their patients. In many cases, physicians and their medical associations are particularly well positioned to enforce the Act's protections through Section 1983.

In some cases, physicians or other providers may be the intended beneficiaries of a Medicaid provision that is phrased in rights-creating language and meets the other requirements set forth in *Blessing* and *Gonzaga*. For example, in *BT Bourbonnais Care, LLC v. Norwood*, 866 F.3d 815, 822-23 (7th Cir. 2017), the Seventh Circuit held that Medicaid providers (in that case, nursing home operators) were the intended beneficiaries of 42 U.S.C. § 1396a(a)(13)(A)'s requirement that states engage in a public process (with full notice-and-comment rights afforded to providers) when setting reimbursement rates. The court explained that Congressional amendments to the provision meant that providers no longer enjoyed a substantive right to certain rates, but noted the importance of the procedural rights conveyed by the amended provision because "providers may bring information to the

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[24] *Id.*

[25] Amer. Med. Ass'n Code of Medical Ethics, Op. 1.2.10, https://www.ama-assn.org/delivering-care/ethics/political-action-physicians (last visited Sept. 21, 2022).

Secretary's attention and urge him to consider a compliance action" and "information gleaned from the public process required by the statute can be used ... as the basis of a compliance challenge in state court, where providers could assert that the state is failing to comply with its rate-calculation policies." *Id.* at 822-23. Because Medicaid providers were the intended beneficiaries of the provision, the procedural requirements were specifically set forth and neither vague nor ambiguous, and the provision left no discretion for the state, the nursing home operators could enforce it via Section 1983. *Id.* at 821-22.

Other provisions of the Medicaid Act are similarly written with intent to grant rights to Medicaid providers and may be the subject of Section 1983 claims (though no circuit court has yet so held). *See*, *e.g.*, 42 U.S.C. §1396a(a)(37) (establishing standards for claims payment procedures and timelines); 42 U.S.C. §1396b(t) (establishing program requirements for the awarding of incentive payments to providers for adoption and meaningful use of certified EHR technology).

Even when a provision is written to benefit Medicaid beneficiaries rather than providers, physicians may sometimes be in a position to enforce it. In *Pediatric Specialty Care*, while recognizing that the EPSDT services provided in section 1396a(a)(43) are intended to benefit Medicaid recipients under the age of 21, the court nevertheless held that the patients' pediatricians could assert a Section 1983 claim for violation of this provision. 293 F.3d at 478. The Eighth Circuit relied on case law granting third party standing rights in other contexts and held that the physicians "have standing to assert the rights of their ... patients." *Id.* As this Court explained in *Singleton v. Wulff,* 428 U.S. 106, 115-117 (1976), third party

standing can be permitted where "the relationship between the litigant and the third party [is] such that the former is fully, or very nearly, as effective a proponent of the right as the latter." *See also Kowalski v. Tesmer,* 543 U.S. 125, 130 (2004) (third party standing may be permitted where "the party asserting the right has a 'close' relationship with the person who possesses the right" and "there is a 'hindrance' to the possessor's ability to protect his own interests").

Physicians who treat low-income patients insured through Medicaid generally possess resources and an interest in protecting these patients, and so can be ideal candidates for third party standing to enforce the rights of their vulnerable patients. Indeed, the confidential doctor-patient relationship that physicians have with Medicaid recipients, formed around the provision of medical care, often will satisfy the requirements for third party standing. Low-income Medicaid recipients frequently lack the resources and will to advocate for their rights under the Medicaid statute. Physicians therefore can meet the purpose of third party standing because they "can reasonably be expected properly to frame the issues and present them with the necessary adversarial zeal." *Sec'y of State of Md. v. Joseph H. Munson Co., Inc.,* 467 U.S. 947, 956 (1984); *see also Kowalski*, 543 U.S. at 130 ("In several cases, this Court has allowed standing to litigate the rights of third parties when enforcement of the challenged restriction *against the litigant* would result indirectly in the violation of third parties' rights") (internal quotations omitted).

Organized medicine—i.e., state associations like the *amicus* and other health care provider associations—has a critical enforcement role to play as well. Physicians may sometimes be unable to directly

litigate Section 1983 claims on behalf of themselves or their patients to vindicate Medicaid program rights. Lack of time and resources, fear of retribution, and inexperience in litigation are common barriers to physician lawsuits, but organized medicine can take up the task where such barriers arise.

It was a Virginia nonprofit association of state and private hospitals that brought the Section 1983 claim to require the state to comply with the Boren Amendment and pay hospital services rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated facilities." *Wilder,* 496 U.S. at 507. This Court held that the hospital association and all other plaintiffs could proceed with the Section 1983 claim because they had satisfied the intended beneficiary requirement of the *Blessing* standards. *Id.* at 510. In so holding, the Court presumed that the hospital association had associational standing to assert the rights of its provider members under Section 1983. *See Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 181 (2000) (organization has associational standing to enforce the rights of its members "when its members would otherwise have standing to sue in their own right, the interests at stake are germane to the organization's purpose, and neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit") (citing *Hunt v. Washington State Apple Adver. Comm'n*, 432 U.S. 333, 343 (1977)).

Other courts have recognized the associational standing of health care provider associations and advocacy organizations to assert the rights of their members or beneficiaries through Section 1983 actions enforcing Social Security Act provisions. For

instance, *Watson v. Weeks,* recognized that Medicaid-eligible Oregon residents and an advocacy organization could assert a Section 1983 claim to enforce the requirement that a state plan, pursuant to section 1396a(a)(10)(A), provide for home and community-based services as an alternative to Medicaid institutional nursing facility services. 436 F.3d at 1155. In *Westside Mothers v. Haveman,* 289 F.3d 852, 864 (6th Cir. 2002), a welfare rights organization sued state officials under Section 1983 for systemically depriving Medicaid recipients of EPSDT services under its Medicaid program.

Through associational standing, provider associations can stand in the shoes of their physician members and assert third party standing on behalf of patients. The Third Circuit so held in *Pennsylvania Psychiatric Soc. v. Green Spring Health Servs., Inc.*, 280 F.3d 278, 283 (3d Cir. 2002), where it recognized that a physician trade association could assert associational standing on behalf of its physician members, who themselves had third party standing to assert claims on behalf of their patients.

Physicians and their provider associations are uniquely positioned within the Medicaid system to enforce the Act's provisions. Their professional and ethical duty to their patients and their comparative levels of resources make them prime candidates to enforce provisions of Medicaid when their patients may be unable to do so. Provider associations further strengthen physicians' ability to litigate Section 1983 enforcement actions, as they pool resources and collectivize risk. While the private enforcement of Medicaid by beneficiaries and health care providers has been essential to ensuring that Medicaid's policy goals are realized, the Act's enforcement by physicians and

their provider associations further enhances such efforts. Were Section 1983 to become unavailable for enforcement of Medicaid Spending Clause provisions, however, such private enforcement efforts would disappear. This would not only compromise the vitality of Medicaid, it would deprive physicians and their medical associations of a valuable tool for protecting and caring for their most vulnerable patients' wellbeing.[26]

CONCLUSION

Amicus California Medical Association accordingly urges the Court to follow decades of precedent permitting private enforcement of Spending Clause legislation through Section 1983.

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[26] *Amicus* does not believe that preserving Section 1983 enforceability of Spending Clause legislation in this case would expand any existing exposure of physicians to state tort liability in federal courts on a Section 1983 claim, where state negligence standards and tort damages restrictions (e.g., so-called MICRA laws) might not apply. As a general matter, Section 1983 cannot be applied to private practice physicians who may be alleged to have committed professional negligence under state law because, in such circumstances, there is no state action or deprivation of a right guaranteed under the U.S. Constitution or federal law. Here, the petitioner is a county-owned and operated facility that is alleged to have violated the Federal Nursing Home Reform Act. To the extent the Court concludes that a Section 1983 claim can be applied to the petitioner in these circumstances, *amicus* does not believe such a holding could open the door for plaintiffs to convert state medical malpractice claims into federal Section 1983 claims.

Respectfully submitted,

LONG X. DO
KYLE R. BRIERLY
ATHENE LAW LLP
5432 Geary Boulevard, #200
San Francisco, CA 94121
(415) 680-7419
long@athenelaw.com

STACEY M. LEYTON
Counsel of Record
BRONWEN B. O'HERIN
ALTSHULER BERZON LLP
177 Post Street, #300
San Francisco, CA 94108
(415) 421-7151
sleyton@altber.com

Counsel for Amicus Curiae

September 23, 2022