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 THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS AND THIRTY-ONE PRIMARY CARE ASSOCIATIONS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICI CURIAE*

The National Association of Community Health Centers (NACHC), a nonprofit and tax-exempt organization, is the national membership organization for federally-funded community health centers, also known as Federally-qualified health centers, or FQHCs.[1] Founded in 1971, NACHC promotes health centers' mission and purpose through extensive education, training, and advocacy.

The thirty-one individual *Amici Curiae* Primary Care Associations ("PCAs") are State or regional nonprofit organizations that provide training and technical assistance to health centers and facilitate collaboration between health centers and State authorities to best meet constituent needs. The full list of *Amici* PCAs is printed in an appendix to this brief.

Health centers are predominantly community-based, patient-directed nonprofit organizations that receive, or are eligible to receive, federal grant funding under Section 330 of the Public Health Service Act and that play a vital role in our nation's health care safety-net by providing primary and other health care and related services to medically underserved populations in all fifty states, the District of Columbia, Puerto Rico, and other

1. Pursuant to Supreme Court Rule 37.6, *Amici* certify that no party or counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *Amicus Curiae* NACHC or its counsel made a monetary contribution to preparation or submission of the brief. The parties respectively filed blanket written consent to the filing of *Amicus Curiae* briefs in support of either or neither party.

U.S. territories, regardless of any individual patient's insurance status or ability to pay. 42 U.S.C. § 254b(a)(1). In addition to providing comprehensive care to approximately one in eleven Americans, FQHCs serve on the front lines in preventing, treating, and containing serious, nationwide public health threats such as the HIV epidemic, the opioid addiction crisis, and the ongoing COVID-19 pandemic. Over the past 50 years, Congress has made substantial appropriations for health center grants and has enacted complementary Medicaid payment provisions to ensure health centers' continued viability.

Amici wish to apprise the Court of the broad-based and far-reaching legal, social, and economic implications this matter poses for health centers and the more than twenty-eight million individual patients—in more than 11,700 rural and urban communities—for whom they provide care. No health center is a party to this action, but all health centers could be significantly impacted by the Court's decision in this case.

INTRODUCTION

Amici, appearing on behalf of the nation's federally-funded community health centers, urge the Court to preserve its well-established § 1983 jurisprudence. As detailed below, Congress created two federal health care programs that serve as principal sources of public funding for health centers: Section 330 of the Public Health Service ("PHS") Act and the Medicaid Program. Congress has legislated consistently for years, striking a careful balance between these programs by defining their respective scopes, requiring health centers to contract with State Medicaid agencies while assigning to

States clear payment obligations for services rendered to beneficiaries, enacting detailed health centers' payment rights, and passing provisions to prevent cross-subsidies between the programs, particularly impeding use of Section 330 grants to make up insufficient Medicaid payments by States.

While State Medicaid agencies have repeatedly shirked their obligation to cover health centers' costs in treating Medicaid beneficiaries, threatening that balance, Congress, legislating against the backdrop of the Court's § 1983 jurisprudence, has reinforced health centers' rights, aware that a § 1983 action is the well-established mechanism to enforce such rights. Congress did not create a separate mechanism to challenge State noncompliance with health centers' Medicaid payment rights. It did not have to: doing so would have been redundant.

Contrary to petitioners' framing of the first question presented, no historical evidence compels the Court to jettison its decades-long interpretation of the plain text of § 1983. Congress's decades of careful crafting of interrelated provisions in the PHS and Medicaid Acts amply demonstrate why this Court should not upend its § 1983 jurisprudence. To eviscerate § 1983 rights would require ignoring clear statutory language and concluding, against plain text and the weight of federal health care program legislation, that Congress never intended these express rights to apply to health centers. The Court should reaffirm its Section 1983 jurisprudence.

SUMMARY OF THE ARGUMENT

The U.S. Department of Health and Human Services ("HHS") administers the Community Health Center

Program and the Medicaid Program. Both programs form part of a carefully reticulated "dual funding mechanism" that provides health centers financial resources to serve the healthcare needs of the Nation's most vulnerable. *See Cmty. Health Care Ass'n of N.Y. v. Shah*, 770 F.3d 129, 136 (2d Cir. 2014); *Three Lower Cnties. Cmty. Health Servs., Inc. v. Maryland*, 498 F.3d 294, 303 (4th Cir. 2007). To mitigate the risk that PHS Act § 330 grant funds offset losses resulting from the failure of State Medicaid agencies to cover the costs of services to Medicaid beneficiaries, Congress requires health centers "to make every reasonable effort to collect reimbursement for health services to beneficiaries . . . . on the basis of the full amount of fees and payments for such services without application of any discount." 42 U.S.C. § 254b(k)(3)(F)–(G).

The historical interplay between congressional action and this Court's jurisprudence makes clear Congress's intent that health centers enforce their Medicaid payment rights via 42 U.S.C. § 1983. Congress's initial enactment and each subsequent congressional endorsement of FQHCs' Medicaid payment rights occurred against the clear, decades-long backdrop of this Court's § 1983 jurisprudence, which, beginning in the late 1960s, recognized that rights conferred on beneficiaries of Social Security Act programs are among the "rights, privileges, or immunities secured by the Constitution and laws" enforceable through a § 1983 action. *See*, *e.g.*, *King v. Smith*, 392 U.S. 309 (1968). Indeed, enforcement of rights conferred via Spending Clause legislation has, for federal courts, been an unremarkable, routine matter for half a century.

Health centers' suits under § 1983 have been crucial to enforce Medicaid payment rights against unlawful

State action, and thereby protect the careful balance Congress struck between the Health Center and Medicaid programs. A ruling shutting the courts' doors to health centers' enforcement actions would eliminate Congress's intended check on unlawful State Medicaid agency practices, with millions of dollars in required payments at stake, impacting scores of individual patients who depend on health centers for their primary and preventive care needs.

While the instant case directly implicates beneficiary rights, the first question presented casts a considerably—and unnecessarily—broad net that captures providers who, like health centers, have express statutory rights against unlawful State Medicaid payment practices. Removing the intended vehicle for enforcing these rights—42 U.S.C. § 1983—would contravene clear congressional intent, nullify Congress's solution to a well-documented problem of chronic State Medicaid agency underpayment, and disrupt a well-established legal framework on which health centers have long relied to vindicate their statutory payment rights and ensure they can continue to meet the healthcare needs of the Nation's most vulnerable.

ARGUMENT

I. The Health Center Program and Health Centers' Medicaid Payment Rights: A Carefully Reticulated Statutory Scheme to Provide Health Care to Millions of Medically Underserved Individuals

The U.S. Department of Health and Human Services ("HHS") administers two programs of critical importance to both public health and the case at hand: the Community

Health Center Program and the Medicaid Program. The former—authorized under Section 330 of the Public Health Service ("PHS") Act, 42 U.S.C. § 254b, and administered through HHS's Health Resources and Services Administration (HRSA)—provides discretionary grant funding to community-based health centers to provide primary and preventive care and related services to medically underserved populations without regard to income level or insurance status. 42 U.S.C. §§ 254b(a)(1) & (k)(3)(G)(iii). The latter program, authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, and administered through HHS's Centers for Medicare and Medicaid Services ("CMS"), is a jointly-funded, jointly-administered State and Federal program enacted to make health care available to individuals unable to afford necessary medical services. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Since their inception, both programs have been continually funded through periodic Spending Clause legislation; they form part of a carefully reticulated "dual funding mechanism" that provides health centers financial resources to serve the health care needs of the nation's most vulnerable. *Cmty. Health Care Ass'n of N.Y.*, 770 F.3d at 136.[2] To ensure the programs are not duplicative and that each respective funding source covers only its intended costs, Congress has explicitly prohibited cross-subsidies and provided health centers with special payment rights—enforced via § 1983—to hold State Medicaid agencies accountable for their full share when Medicaid beneficiaries receive health center services.

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2. Section 330 grants represent approximately fourteen percent of health center revenue, while Medicaid payments represent forty percent. *See generally* U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Bureau of Primary Health Care, *Health Center Program UDS Data: Table 9D: Patient Related Revenue* (2020).

A. Health Centers: Accessible Health Care and Services for the Medically Underserved

For half a century, federally-funded community health centers have been the main source of community-based, cost-effective, and accessible health care for underserved low-income and poor persons and families. Congress first authorized the Health Center Program in Section 501 of the Special Health Revenue Sharing Act of 1975, Pub. L. 94-63, 89 Stat. 342–46. Health center patients are disproportionately poor: ninety-one percent are under 200 percent of the Federal Poverty Line ("FPL"); sixty-eight percent of patients are at or below 100 percent FPL; forty-eight percent of patients are Medicaid beneficiaries; and twenty-three percent are uninsured. *See* NACHC, *Community Health Center Chartbook 2022* (Jan. 2022), Fig. 1-6. Accordingly, most health center patients (seventy-nine percent) are either publicly insured—i.e., they are Medicare or Medicaid beneficiaries (or dually eligible)—or lack insurance altogether. *Id.* at Fig. 1-5.

Health centers provide services to one in every eleven people in the United States at an estimated annual costs savings of $1,263 (24 percent less) per patient when compared to non-health center users. *See* NACHC, *supra,* Fig. 4-8. The Health Center Program has grown with ample bipartisan support. By design, health centers "occupy a unique place in the health services ecology." *Cmty. Health Care Ass'n of N.Y.*, 770 F.3d at 157. Congress created the Health Center Program to provide a "vital function in delivering healthcare to underserved populations." *Three Lower Cnties.,* 498 F.3d at 303. To receive § 330 grant funding, a health center must satisfy HRSA that it is: located in a medically underserved area

or is serving a special, medically underserved population such as the homeless, migrant or seasonal farmworkers, or public housing residents; community–based with a patient majority Board of Directors "who, as a group, represent the individuals being served by the center;" providing healthcare services to Medicaid recipients; and serving all residents of its community. *See* 42 U.S.C. § 254b(a)(1), (k)(3)(A), (E), (G)(i), (H)(i).

As a condition of their § 330 grant funding, health centers must provide patients a comprehensive array of "required" and "additional" health care and enabling services in, *inter alia*, family medicine, internal medicine, pediatrics, obstetrics and gynecology, diagnostic laboratory and radiology, perinatal care, well-child care and immunizations against vaccine-preventable diseases, preventive health screenings and services, and emergency care. *See* 42 U.S.C. §§ 254b(b)(1)–(2) (defining "required" and "additional" services). Section 330 grant recipients are Federally-qualified health centers ("FQHCs") for purposes of both the Medicare and Medicaid Programs, as well as other federal public health programs. 42 U.S.C. §§ 1395x(aa)(4) (Medicare), 1396d(l)(2)(B) (Medicaid). FQHC status entitles health centers to specific payment rights in those programs—discussed *infra*—that strike a balance between FQHC's § 330 grant funds and payments for FQHC services to program beneficiaries.

B. Congress Prohibits Health Centers from Using PHS Act § 330 Grant Funds to Subsidize the Costs of Services to Medicaid Beneficiaries

States make payments directly to health centers for services they furnish to Medicaid beneficiaries. *See*

42 C.F.R. § 430.0. To mitigate the risk that § 330 grant funds offset Medicaid underpayment, Congress requires health centers "to make every reasonable effort to collect reimbursement for health services to [Medicaid] beneficiaries" "on the basis of the full amount of fees and payments for such services without application of any discount." 42 U.S.C. §§ 254b(k)(3)(F)–(G). The Health Center Program's early years made it apparent that, despite health centers' best efforts, State Medicaid agencies often failed to pay the full cost of services. By the late 1980s, Congress heard testimony that "on average, Medicaid payment levels to Federally–funded health centers cover less than 70 percent of the costs incurred by the centers in serving Medicaid patients." H.R. Rep. No. 101-247, at 392–93, *reprinted in* 1989 U.S.C.C.A.N. 2118–19. The resulting payments from Health Center Program funding to cover the Medicaid reimbursement gap motivated Congress to enact Section 6404 of the Omnibus Budget Reconciliation Act of 1989 ("OBRA"), Pub. L. 101-239, 103 Stat. 2106 (1989). The legislation guaranteed health centers are paid 100 percent of their reasonable costs of providing services to Medicaid beneficiaries "[t]o ensure that Federal '[PHS]' Act grant funds are not used to subsidize health center or program services to Medicaid beneficiaries," because "[t]o the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever." H.R. Rep. No. 101-247, at 392–93; *see also Three Lower Cnties.*, 498 F.3d at 297 (Congress passed the "100 percent reimbursement" requirement to ensure health centers do not subsidize Medicaid); *Cmty. Health Care Ass'n of N.Y.*, 770 F.3d at 155 (Congress intended no § 330 subsidy of

Medicaid). As the Second Circuit explained, the § 330 and Medicaid "dual funding mechanism allows the FQHC to allocate most of its direct grant dollars towards treating those who lack even Medicare or Medicaid coverage," *Cmty. Health Center v. Wilson-Coker*, 311 F.3rd 132, 134 n.2 (2d Cir. 2002), while ensuring grant funds do not subsidize Medicaid.

C. FQHC Services are a Mandatory Medicaid Benefit and State Medicaid Programs Must Reimburse Health Centers 100 Percent of the Reasonable Costs of Services

FQHC services are a mandatory Medicaid benefit for which States must fully reimburse health centers in accordance with statutory requirements. 42 U.S.C. § 1396a(10)(A), 1396a(bb), 1396d(a)(2)(C). As a condition of participation in Medicaid, states must comply with all "detailed federally mandated standards." *Three Lower Cnties.*, 498 F.3d at 297; *accord Cmty. Health Care Ass'n of N.Y.*, 770 F.3d at 135. Although States' participation is voluntary, "[b]y 1982 every State had chosen to participate in Medicaid." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 542 (2012). Each State Medicaid program must submit to CMS a State plan, *i.e.*, "a comprehensive written statement . . . describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with" applicable statutes, regulations, and official HHS issuances. *See* 42 U.S.C. § 1396a(a); 42 C.F.R. § 430.10. A State's Medicaid program becomes eligible for Federal financial participation —*i.e.*, the federal/state sharing of the State's expenditures—on CMS approval of the State plan. *See* 42 U.S.C. § 1396-1 ("The sums made available under this section shall be used

for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance"); 42 C.F.R. § 430.10 (delegating to CMS the authority to approve State plans).

Each participating State must, at a minimum, cover in its State plan certain specified services—commonly called mandatory benefits. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. §§ 430.0, 430.35; *see also Cal. Ass'n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1014–15 (9th Cir. 2013); *accord Ariz. All. for Cmty. Health Ctrs. v. Ariz. Health Care Cost Containment Sy.*, ___ F.4th ___ , 2022 WL 4005328, at *5 (9th Cir. 2022). Each State plan "must [also] describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program." 42 C.F.R. § 447.201(b).

With the enactment of 1989 OBRA, § 6404, "Federally-qualified health center services" became a mandatory Medicaid benefit for which States must provide a specified payment. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(2)(C).[3] Thus "[a] state Medicaid plan must provide payment for [covered] services rendered by FQHCs and RHCs [rural health clinics]." *Am. Indian Health & Servs. Corp. v. Kent*, 24 Cal. App. 5th 772, 778, 234 Cal. R. Ct. 3d 583, 587–88 (Cal. Ct. App. 2018) (citing 42 U.S.C. § 1396a(bb)); *see also Three Lower Cnties.*, 498 F.3d 294; *Pee Dee Health Care, P.A. v. Sanford*, 509 F.3d 203, 207 (4th Cir. 2007). On a per-visit basis, State Medicaid programs must reimburse

3. Congress created a Medicare FQHC benefit, effective October 1, 1991, to further the same anti-subsidy approach 1989 OBRA implemented for Medicaid. *See* Omnibus Reconciliation Act ("ORA") of 1990, Pub. L. 101-508, § 4161 (1990).

each FQHC operating within its borders for 100 percent of its reasonable and related costs in furnishing "[FQHC] services" and "any other ambulatory services offered by a [FQHC] and which are otherwise included in the [State Medicaid] plan." 42 U.S.C. §§ 1396a(bb)(1), 1396d(a)(2)(C), 1396d(*l*)(2); *see also Cmty. Health Care Ass'n of N.Y.*, 770 F.3d at 136 (providing relevant historical context and legislative history). The form of this 100 percent reimbursement requirement has shifted over time. Its initial formulation, in place for over a decade, required participating States to reimburse FQHCs retrospectively for "100 percent . . . of [each FQHC's] costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in [FQHC Medicare] regulations . . . ." 42 U.S.C. § 1396a(a)(13)(C) (enacted in 1989 OBRA, repealed and replaced in 2000); *Three Lower Cnties.*, 498 F.3d at 297.

In 1997, three years before Congress mandated the current FQHC Medicaid payment system, it enacted still extant provisions that reinforced States' obligation to pay "100 percent" of each health center's reasonable and related costs of providing "FQHC services," reduced only by payments received from an MCO. The Balanced Budget Act ("BBA") of 1997, Pub. L. 105-33, § 4712, 111 Stat. 251 (1997), mandated that State Medicaid programs pay each FQHC the difference, if any, between (1) its reasonable costs of providing FQHC services and (2) payments made to it by a State-contracted MCO. *See* 42 U.S.C. § 1396a(bb)(5) (States shall make supplemental payments no less frequently than every four months).

The current health center Medicaid payment methodology, enacted in 2000 and codified at 42 U.S.C.

§ 1396a(bb), retained the 1997 BBA managed care provisions and the 100-percent-of-reasonable-costs reimbursement approach, utilized since the original enactment of FQHC legislation in 1989 OBRA. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act ("BIPA") of 2000, Pub. L. 106-554, § 702, 114 Stat. 2763 (2000), established the current methodology, which requires States to pay, effective January 1, 2001, a fixed, per-visit rate unique to each health center, based on 100 percent of the FQHC's reasonable costs in fiscal years 1999 and 2000, adjusted annually by an inflation factor and as necessary to reflect any changes in the scope of services during the fiscal year. 42 U.S.C. § 1396a(bb)(2), (3). For any entity first qualifying as an FQHC after 2000, the per-visit rate is determined based on the rates established for FQHCs in the same or adjacent area with a similar case load, or (if no similar FQHCs exist) according to a similar methodology or other tests of reasonableness as specified by the HHS Secretary. 42 U.S.C. § 1396a(bb)(4). This "prospective payment system" ("PPS") relieved FQHCs from annually submitting cost data, while maintaining required patient visit data reporting and mandating full Medicaid reimbursement. *See Three Lower Cnties.*, 498 F.3d at 298.[4]

Health centers' Medicaid payment rights have remained virtually unaltered since 2000.[5] However,

4. The Medicaid statute permits State Medicaid agencies to use an alternative payment methodology ("APM") to the prospective payment system, but only if the FQHC agrees and the APM results in payments not less than the amount the FQHC would receive under PPS. 42 U.S.C. § 1396a(bb)(6).

5. Congress reinforced FQHC payment rights in § 10501 of the Patient Protection and Affordable Care Act ("ACA"), Pub. L. 111-

substantial underpayments have resulted from myriad unlawful State Medicaid agency practices including, *inter alia*: failure to fully reimburse at the PPS rate; refusal to pay for services rendered to out-of-network beneficiaries; refusal based on unlawful criteria to make supplemental payments; significant delay in full payment; and elimination from coverage of certain services included in the FQHC Services mandatory benefit. *See*, *e.g.*, *N.J. Primary Care Ass'n, Inc. v. N.J. Dep't of Hum. Servs.*, 722 F.3d 527, 540 (3d Cir. 2013); *Cmty. Health Care Ass'n*, 770 F.3d at 153–55; *Three Lower Cnties.*, 498 F.3d at 302–03; *Cal. Ass'n of Rural Health Clinics*, 738 F.3d at 1015.

II. The Historic Interplay Between Congressional Action and this Court's Jurisprudence Makes Clear Congress's Intent that Health Centers' Medicaid Payment Rights be Enforceable via § 1983

The historic interplay between congressional action and this Court's jurisprudence makes clear Congress's intent that health centers enforce their Medicaid payment rights via § 1983. While "[t]his Court generally assumes that, when Congress enacts statutes, it is aware of this Court's relevant precedents," no assumption need be made with regard to the Court's § 1983 jurisprudence. *Ysleta del Sur Pueblo v. Texas*, 142 S. Ct. 1929, 1940 (2022) (internal citation omitted); *see also Merck & Co. v. Reynolds,* 559 U.S. 633, 648 (2010) ("We normally assume that, when Congress enacts statutes, it is aware of relevant judicial precedent."). Congress has reaffirmed health centers' Medicaid payment rights, repeatedly strengthened and

148 (2010), establishing a prospective payment system for Medicare services furnished at FQHCs, effective October 1, 2014.

expanded the Health Center Program since its first authorization in 1975, and legislated to clarify that, notwithstanding this Court's decision in *Suter v. Artist M.*, 503 U.S. 347 (1992), rights created in Social Security Act programs are enforceable "to the extent they were . . . prior to [that] decision." H.R. Conf. Rep. 103-761, 103rd Cong., at 926 (1994) (discussed *infra*).

The initial enactment and each subsequent congressional endorsement of FQHCs' Medicaid payment rights occurred against the clear, decades-long backdrop of this Court's § 1983 jurisprudence, which, beginning in the late 1960s, recognized that rights conferred on Social Security Act program beneficiaries are among the "rights, privileges, or immunities secured by the Constitution and laws" enforceable through a § 1983 action. *See*, *e.g.*, *King*, 392 U.S. at 311 (endorsing plaintiffs' reliance on § 1983 to enforce beneficiaries' rights in Aid to Families with Dependent Children ("AFDC")); *Rosado v. Wyman*, 397 U.S. 397 (1970) (clarifying program participants need not pursue federal administrative remedies before filing § 1983 action to secure state officials' compliance with AFDC provisions); *Goldberg v. Kelly*, 397 U.S. 254 (1970) (concluding AFDC recipients could challenge benefit denial, reduction, or termination through § 1983 action); *Townsend v. Swank*, 404 U.S. 282 (1971) (concluding state eligibility standards contrary to federal AFDC requirements were proper subject of § 1983 action).

In short, for approximately fifty years, Congress has enacted enforceable rights in Spending Clause legislation recognizing 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 v. Jordan, 415 U.S. 651, 675 (1974) (citing *Rosado*). Were that not assurance enough, in *Maine v. Thiboutot*, 448 U.S. 1 (1980)—decided over forty years ago—this Court held that "any doubt" about the application of § 1983 had been resolved by more than half a dozen decisions "involving Social Security Act (SSA) claims" that had "relied on the availability of a § 1983 cause of action." *Id.* at 4–5.

In 1989, when Congress added FQHC services to the mandatory Medicaid benefits list and incorporated, through OBRA, the requirement that States pay FQHCs 100 percent of their reasonable costs of providing Medicaid services, a § 1983 action was the well-established mechanism to enforce such rights; there was no need to create a redundant enforcement mechanism to challenge State noncompliance with health centers' Medicaid payment rights. *See*, *e.g.*, *King*, 392 U.S. 309; *Rosado*, 397 U.S. 397; *Goldberg*, 397 U.S. 254; *Townsend*, 404 U.S. 282; *Edelman*, 415 U.S. 651. Moreover, a year after OBRA's enactment, in *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498 (1990), the Court held that providers could challenge, through a § 1983 action, State payment methodologies contrary to a then in-effect statutory provision that required reasonable and adequate Medicaid reimbursement rates. Of note, the *Wilder* court rejected the State's argument that the HHS Secretary's general authority to "curtail federal funds to States whose plans are not in compliance with the Act" was sufficient "to foreclose reliance on § 1983 to vindicate federal rights." *Id.* at 521–22; *see also Armstrong v. Exceptional Child Center, Inc.*, 575 U.S. 320, 328 (2015) (concluding a "provision for the Secretary's enforcement by withholding funds might not, *by itself*, preclude the availability of equitable relief") (emphasis in original).

Any doubt as to congressional awareness of this Court's decisions is dispelled by an examination of Congress's 1994 reaction to the 1992 decision in *Suter v. Artist M.*, 503 U.S. 347 (1992). Via the colloquially dubbed "*Suter* fix," Congress not only affirmed decades of this Court's precedents, but also explicitly clarified that "individuals who have been injured" by a State's failure to comply with Social Security Act program requirements may seek redress in the federal courts "to the extent they were able to prior to" the *Suter* decision. H.R. Conf. Rep. 103-761, at 926. In *Suter*, the Court had determined that a § 1983 action was not available to enforce a provision that required a foster-care program's State plan to "provide[] that, in each case, reasonable efforts will be made" before "the placement of a child in foster care, to prevent or eliminate the need for removal of the child from his home," and "to make it possible for the child to return to his home." *Suter*, 503 U.S. at 351 (quoting 42 U.S.C. § 671(a)(15) (1988)). The Court explained that "[t]he term 'reasonable efforts'" placed "only a rather generalized duty on the State," and did not "confer an enforceable right upon the Act's beneficiaries." *Id.* at 363.

Reacting to that decision in relatively short order, Congress clarified—in the 1994 Improving America's Schools Act and Social Security Act Amendments, respectively—that mere inclusion of a provision among a Social Security Act program's State plan requirements does not render that provision unenforceable under § 1983. *See* Improving America's Schools Act of 1994, Pub. L. 103-382, § 555(a), 108 Stat. 3518, 4057–4058 (*codified at* 42 U.S.C. § 1320a-2); Social Security Act Amendments of 1994, Pub. L. 103-432, § 211(a), 108 Stat. 4398, 4460 (*codified at* 42 U.S.C. § 1320a-10). While Congress left

undisturbed the Court's holding regarding the State plan requirement at issue in *Suter*, it added these identical provisions to protect persons' ability to enforce rights-creating language in Spending Clause legislation.

Congress' post-*Suter* enactment of key health center program Medicaid payment provisions in its 1997 BBA, § 4712 (managed care) and 2000 BIPA, § 702 (current prospective payment methodology)—followed this Court's unbroken line of § 1983 precedents, including the decision in *Blessing v. Freestone*, 520 U.S. 329 (1997). There, the Court noted that although § 1983 "safeguards certain rights conferred by federal statutes, a § 1983 plaintiff "must assert the violation of a federal right, not merely a violation of federal law" and provided a three-part test to determine whether a particular statutory provision gives rise to an enforceable federal right. *Id.* at 340–41.

Passed in 2000, three years after *Blessing* and with presumptive Congressional awareness of that decision, BIPA § 702 serves as the model of post-*Blessing* rights-creating draftsmanship, setting forth in mandatory language a clear, well-formulated, binding obligation on States to pay health centers according to a detailed methodology set out in the statute. *See* 42 U.S.C. § 1396a(bb) ("Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the [Medicaid] State plan shall provide for payment for services . . . furnished by a Federally-qualified heath center . . . in accordance with the provisions of this subsection."). Two years after BIPA's enactment, in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), the Court elaborated that the inquiry is "whether . . . Congress intended to confer individual rights upon a

class of beneficiaries" with "rights-creating language." *Id.* at 285, 290 (citations and quotations omitted). Throughout the years, this Court's § 1983 cases informed Congress's health center program legislation, including health centers' right to payment based on 100 percent of reasonable costs in OBRA (1989), the right to supplemental payments and other Medicaid managed care provisions in BBA (1997), and prospective payment system rights in BIPA (2000). Indeed, Congress reaffirmed in 2005 that § 330 grant funds should not subsidize Medicaid underpayments. *See* H.R. Con. Res. 231, 109th Cong. (2005) ("Whereas without the assurance of sufficient Medicaid funding under the PPS, FQHCs would likely be forced to cross-subsidize Medicaid underpayments with Federal [PHS Act § 330] grant dollars intended to care for the uninsured."); *see also* S. Con. Res. 65, 109th Cong. (2005). These incremental legislative actions, plus Congress's *Suter* fix, confirm that Spending Clause legislation gives rise to enforceable rights in § 1983 actions.

Congress has neither disturbed, nor ever needed to alter, health centers' reliance on § 1983 as the mechanism to enforce their Medicaid payment rights. Instead, Congress has continued to provide significant grant funding to health centers, secure in the knowledge that States could not compel use of grant funds to subsidize Medicaid and that health centers hold legally enforceable rights to full Medicaid reimbursement. In an uninterrupted chain of appropriations spanning fiscal years 2011 through 2022, Congress has authorized $57.6 billion in health center grant funding.[6] Congress has

6. *See* NACHC, *Federal Grant Funding*, *Federal Health Center Appropriation History FY10-FY22*; *see also* Consolidated

additionally appropriated extensive direct pandemic support to health centers, including over $9.6 billion in COVID-19 supplemental funding.[7] These funds, as discussed *supra*, are meant to "fill the gap" between operations' costs and revenues, which exists in large part due to health centers' provision of services to uninsured individuals and low-income patients who qualify for mandatory sliding fee assistance, as well as costs incurred in providing crucial—but largely unreimbursed—enabling services like language interpretation and translation, transportation, care management, and other beneficiary supports. U.S. Gov't Accountability Off., G.A.O. 19-

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Appropriations Act, 2021, Pub. L. 116-260 (2020), § 301 (health center program funding extension through fiscal year 2023); Coronavirus Aid Relief and Economic Security Act (CARES Act), Pub. L. 116-136, § 3831 (2020); Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. 114-10, § 221 (2015); Third Continuing Appropriations for Fiscal Year 2018, Pub. L. 115-96, § 3101 (2017); Bipartisan Budget Act of 2018, Pub. L. 115-123 (2018), §§ 50901(a), 50901(c), 50901(d); Further Continuing Appropriations Act, 2020 and Further Health Extenders Act of 2019, Pub. L. 116-69 (2019), §§ 1101(a), 1101(c); Further Consolidated Appropriations Act, 2020, Pub. L. 116-94 (2019), §§ 401(a), 401(c).

7. *See* Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. 116-123, 134 Stat. 149 (2020) ($100 million for grants to prevent, prepare for, and respond to coronavirus); CARES Act, § 3211(a) ($1.32 billion for grants for prevention, diagnosis, and treatment of COVID-19); Paycheck Protection Program and Healthcare Enhancement Act, Pub. L. 116-139, H.R. 266, Div. B, Tit. I, 134 Stat. 626 (2020) ($600 million for grants for certain coronavirus-related costs); American Rescue Plan Act of 2021, Pub. L. 117-2, § 2601 (2021) ($7.6 billion for grants to cover costs of services, supplies and equipment related to coronavirus and to modify, enhance and expand health care services and infrastructure).

496, *Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund* at 13 (2019).[8] These grants, however, are not meant to backfill a State's obligation to cover the costs of services to Medicaid beneficiaries.

III. Health Centers' Experience Enforcing Medicaid Payment Rights Demonstrates the Ease with which Courts Apply this Court's § 1983 Jurisprudence to Adjudicate Statutory Rights in Spending Clause Legislation

Health centers' decades of experience protecting their Medicaid payment rights in federal courts via § 1983 actions underscore that enforcement of Social Security Act program rights through such actions has, for federal courts, been an unremarkable, routine matter for half a century. The standards this Court set out in *Blessing* and *Gonzaga*, built on preceding cases, are eminently workable, placing no strain on judicial competence.

Lower courts have had little trouble applying this Court's § 1983 precedents to health centers' Medicaid payment rights consistently and predictably. Five Circuit Courts of Appeal have determined that health centers may enforce Medicaid payment provisions through § 1983 actions. *See Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56 (1st Cir. 2005) (§ 1983 action to enforce payment provisions in 42 U.S.C. § 1396a(bb)); *Three Lower*

8. Demand for care far outpaces funding. Health centers incurred a cost of care gap exceeding $2 billion in services to uninsured individuals in 2020 alone. NACHC Chartbook, Fig. 6-3. A seventeen percent gap in Medicaid collections exacerbates this underfunding. *Id.* at Fig. 6-1.

Cnties., 498 F.3d 294 (4th Cir. 2007) (same); *Concilio de Salud Integral de Loiza, Inc. v. Perez-Perdomo*, 551 F.3d 10 (1st Cir. 2008) (§ 1983 action to challenge State supplemental payment methodology under § 1396a(bb)(5)); *N.J. Primary Care Ass'n*, 722 F.3d 527 (3d Circuit holding same); *Cal. Ass'n of Rural Health Clinics,* 738 F.3d 1007 (§ 1983 action in 9th Circuit to challenge State's refusal to cover services within FQHC services mandatory benefit); *accord Ariz. All. for Cmty. Health Ctrs.*, __ F.4th __ , 2022 WL 4005328, at *5; *Legacy Cmty. Health Servs., Inc. v. Smith*, 881 F.3d 358, 371 n.13, 372, 373 (5th Cir. 2018), *cert. denied*, 139 S. Ct. 211 (2018) (concluding § 1983 was proper vehicle to enforce FQHC payment rights as "§ 1396a(bb) issues a command to benefit FQHCs by requiring that they are fully reimbursed"). A sixth Circuit Court of Appeals permitted such a suit without discussing the issue. *See Cmty. Health Care Ass'n of N.Y.,* 770 F.3d 129 (2d Cir. 2014). No Court of Appeal has held to the contrary.

An illustrative example of express Congressional intent communicated in keeping with well-established § 1983 precedents, Congress utilized specific "rights-creating language" in the Medicaid Act to "confer individual rights" on health centers in "clear and unambiguous terms." *Gonzaga*, 536 U.S. at 290. Of course, not all provisions in Spending Clause legislation give rise to rights enforceable through § 1983 actions. *See, e.g.*, *Blessing*, 520 U.S. at 341 (Congress may foreclose remedy); *Gonzaga*, 536 U.S. at 283 ("reject[ing] the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983"); *see also Pa. Pharms. Ass'n v. Houstoun*, 283 F.3d 531, 536 (3d Cir. 2002) (en banc) ("It is important to keep in mind that the question whether a statute is intended

to benefit particular plaintiffs is quite different from the question whether the statute in fact benefits those plaintiffs."). But health centers' experience enforcing their Medicaid payment rights provides ample evidence that this Court's analytical test is workable. *See*, *e.g.*, *N.J. Primary Care Ass'n*, 722 F.3d at 539 (applying *Blessing/Gonzaga* and concluding health center may bring § 1983 action to vindicate right to full payment under Medicaid statute but not to enforce requirement of federal approval of State plan amendments).

The right to payment for services rendered to Medicaid beneficiaries, as this Court requires, "is not unduly vague nor amorphous such that the judiciary cannot enforce it." *Pee Dee Health Care, P.A.*, 509 F.3d at 212. On the contrary, courts have applied the statute's specific methodologies as intended, delivering the crucial health center relief Congress envisioned. *See*, *e.g.*, *Rio Grande*, 397 F.3d at 75; *Three Lower Cnties.*, 498 F.3d at 301, 304; *N.J. Primary Care Ass'n*, 722 F.3d at 540 ("The provision sets forth a relatively simple equation. . . . "); *Cal. Ass'n*, 738 F.3d at 1013; *Legacy*, 881 F.3d at 372 ("Specific requirements that states reimburse FQHCs for certain services, at certain amounts, are far from overly vague or amorphous."). Finally, the statute imposes a mandatory obligation, requiring in § 1396a(bb) that the State plan "shall provide for payment for services." *See*, *e.g.*, *Rio Grande*, 397 F.3d at 74; *Concilio*, 551 F.3d at 17; *N.J. Primary Care Ass'n*, 722 F.3d at 542; *Three Lower Cnties.*, 498 F.3d at 299; *Cmty. Health Care Ass'n*, 770 F.3d at 137; *Cal. Ass'n*, 738 F.3d at 1013; *Legacy*, 881 F.3d at 372. These decisions enforcing health center payment rights showcase the Court's fundamental principle that "[w]hen the statutory language is plain, the sole function of

the courts—at least where the disposition required by the text is not absurd—is to enforce it according to its terms." *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (internal quotation marks omitted).[9]

IV. Health Centers Have a Concrete Reliance Interest in Maintaining the Stability and Continuity of the Court's § 1983 Jurisprudence

Health centers' § 1983 suits have been crucial to enforce Medicaid payment rights against unlawful state action. As the Second Circuit recognized, "[f]rom the creation of dual funding sources for FQHCs, in the form of direct [PHS Act § 330] federal grants and indirect federal Medicaid dollars filtered through the States, FQHCs faced regulatory problems that, at least in part, compromised their mission to treat a constituency of 'those who lack… even Medicaid coverage.'" *Cmty. Health Care Ass'n of N.Y.*, 770 F.3d at 136 (internal citation omitted). As Medicaid reimbursements account for approximately forty percent of a typical health center's annual revenue, *see supra* n.2, full and timely payment is critical.

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9. This Court's recent term provided further confirmation that courts are aptly suited to resolve controversies over proper enforcement of payment provisions in Social Security Act programs. In *American Hosp. Ass'n v. Becerra*, 596 U.S. __, 142 S. Ct. 1896 (2022), the Court adjudicated a controversy over proper application of a 340B program outpatient drug safety net hospital payment provision. The Court's unanimous opinion described the reimbursement rate provision at issue in terms equally applicable to health centers' Medicaid payment provisions, explaining that "[t]he statute…reflects a careful congressional focus not only on the goal of proper reimbursement rates, but also on the appropriate means to that end." *Id.* at 1903.

State Medicaid agencies have repeatedly failed to fully reimburse health centers as required by federal law, jeopardizing their financial and operational viability. *See*, *e.g.*, *Rio Grande*, 397 F.3d at 76 (Puerto Rico's failure to make required payments "a key cause" of FQHC's "financial difficulties"); *Concilio*, 551 F.3d at 15 ("the only wraparound [§ 1396a(bb)(5)] payments defendant has ever made to [FQHC] plaintiffs were made as a result of injunctive orders [entered in § 1983 suits FQHCs filed to enforce their Medicaid payment rights]"); *N.J. Primary Care Ass'n*, 722 F.3d at 534 (New Jersey's insufficient Medicaid payments "resulted in severe budget shortfalls, including as much as $400,000 for one FQHC"); *Three Lower Cnties.*, 498 F.3d at 299 (Maryland's Medicaid payment methodology "invariably fails to close the gap between the [MCO's] payments [to FQHCs] and the per-visit amount to which FQHCs are entitled under the Medicaid Act. . . . For the most recent quarter on which it presented data . . . the shortfall was on the order of $500,000"); *Cmty. Health Care Ass'n*, 770 F.3d at 156–57 (rejecting New York's claim that it owed FQHCs no payments and its contention that FQHCs must absorb the costs of providing out-of-network Medicaid services); *Cal. Ass'n of Rural Health Clinics*, 738 F.3d at 1010–11 (California's cost-cutting legislation impermissibly eliminated certain mandatory FQHC services from Medicaid coverage); *accord Ariz. All. for Cmty. Health Ctrs.*, ___ F.4th ___ , 2022 WL 4005328, at *5 (Arizona's categorical exclusion of certain services within the FQHC services mandatory benefit violated the Medicaid Act).

Currently, all but seven States (Alabama, Arkansas, Delaware, Kansas, New Hampshire, South Dakota and Wyoming) issue health centers' Medicaid payments in two steps, an interim payment followed by an additional

("reconciled") payment for the balance owed based on a center's annual PPS rate. Peter Shin *et al.*, *What are Talevski's Implications for Community Health Centers and their Patients? Estimating the Impact of Losing Federally Enforceable Medicaid FQHC Payment Rights, Data Note,* GW Health Policy & Management Matters (Sept. 14, 2022) at 3–4. States often take years to "reconcile" those interim payments, or fail to make them altogether, thwarting Congress's command against cross–program subsidies and straining health center finances.

Based on 2021 data alone, health center revenue withheld until interim payments are reconciled accounts for $1.7 billion in California, as much as sixty percent of health center revenue in Indiana, and fifty-four percent in New Jersey. *Id.* at 4. And this money trickles slowly to health centers: nationwide, in 2021, health centers received a combined $643 million in late reconciled payments to cover Medicaid services rendered in previous years. *Id.* at 3. Left uncorrected, States' failures to timely reconcile interim payments against centers' PPS rates would lead to a 500,000 to 3.2 million reduction in patients seen, staffing reductions of 4,500 to 29,000 full time equivalents, and a reduction in patient visits of between two million and thirteen million. *Id.* at 4. "Furthermore, these estimates do not take into account the potential impact of the Court's decision on Medicaid beneficiaries themselves. If beneficiaries were to lose their enforceable right to coverage, PPS payments…would have no bearing on health centers because their patients would have lost Medicaid entirely and therefore, visits previously insured through Medicaid would become uninsured visits [which would need to be covered with § 330 grant funds or other resources]." *Id.* at 4–5.

A recent survey of State and regional Primary Care Associations conducted by *Amicus* NACHC shows the operational impact for health centers of unlawful State practices that cause PPS payment issues. Eleven of sixteen responding PCAs—representing 289 health centers in sixteen states (twenty-one percent of the Nation's centers), seven million patients (twenty-three percent of the Nation's 2021 total), and a combined $4.1 billion in Medicaid revenue, of which thirty-three percent was derived from reconciled payments—indicated that their member health centers had experienced problems receiving full and timely Medicaid payments. *Id.* at 5. This in turn created operational challenges including cancelled or delayed development of new sites, delayed staff hiring, staff retention problems, service termination, and reduced operations. *Id.* Five PCAs indicated they were still negotiating long-overdue health centers' interim payment settlements. *Id.* Health centers directly reported similar issues. Out of the 148 responding health centers from forty-one states and Puerto Rico, more than half (eighty-one out of 148) reported at least one operational impact when Medicaid payments fell below their anticipated PPS rate, including: staff retention issues (twenty-three percent), inability to make new hires (twenty-five percent), and cancelled, delayed, or scaled-back plans to add or expand sites or services (eleven, eighteen, and fifteen percent, respectively). *Id.* at 6.

A ruling shutting the courts' doors to health centers' actions to correct, as Congress envisioned, unlawful States' Medicaid practices would directly impact scores of individual patients who depend on health centers for their primary and preventive care needs. Health centers serve one in three people living in poverty in the United

States, one in every eight children, one in seven people of a racial or ethnic minority, one in every five uninsured persons, and one in every five Medicaid beneficiaries. NACHC Chartbook, *supra,* Fig. 1-1. Health centers provide services to more than 376,000 veterans and may be the only primary care providers to vulnerable populations in certain communities. U.S. Gov't Accountability Off., G.A.O. 19-496, *Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund* at 1 (2019); NACHC Chartbook, Fig. 1-2. And the program is growing. HHS's data for the 2020 reporting period places the total number of health centers at 1,375, a twenty-two percent increase in the decade since 2010, with 28,590,897 patients served that year. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *National Health Center Program Uniform Data System (UDS) Awardee Data* (2022).

Today, as the nation responds to multiple public health emergencies, tens of thousands of health center staff continue serving their communities in all fifty states, the District of Columbia, Puerto Rico, and other territories. The continued viability of health centers as providers of necessary primary care and related services to almost thirty million people nationwide, as well as the viability of thousands of other providers in Spending Clause programs, turns in no small degree on recognition that Congress has enacted unassailable provider (and individual beneficiary) rights in Spending Clause legislation. For health centers, Congress provided both express payment rights and an established cause of action to enforce them.

To avoid negating congressional intent *vis-à-vis* the health center program, *Amici* urge the Court to reaffirm

its sound, long-standing § 1983 jurisprudence, resolving this matter on the narrowest basis for its disposition and deciding only the questions necessary to its resolution. *See*, *e.g.*, *Off. of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 423 (1990); *Washington State Grange v. Washington State Republican Party*, 552 U.S. 442, 450 (2008) (Court's "established practice" is to not "formulate a rule . . . broader than is required by the precise facts to which it is to be applied") (quoting *Ashwander v. TVA*, 297 U.S. 288, 347 (1936) (Brandeis, J., concurring)). To hold otherwise "would eviscerate…significant aspects of the statutory text," *American Hosp. Ass'n*, 142 S. Ct. at 1905, obliterating the carefully designed, express payment framework and enforceable program rights Congress enacted against the backdrop of the Court's § 1983 decisions, which read the statute as written, to provide a vehicle to challenge States' violations of "rights, privileges, or immunities secured by the Constitution and laws." 42 U.S.C. § 1983.

CONCLUSION

For the foregoing reasons, *Amici* respectfully urge the Court to reaffirm its Section 1983 jurisprudence.

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APPENDIX

APPENDIX — LISTING OF INDIVIDUAL *AMICI CURIAE* PRIMARY CARE ASSOCIATIONS

1. Alameda Health Consortium
2. Arizona Alliance for Community Health Centers
3. Association for Utah Community Health
4. Bi-State Primary Care Association
5. California Primary Care Association
6. Colorado Community Health Network
7. Community Care Network of Kansas
8. Community Health Center Alliance for Patient Access
9. Community Health Center Association of Connecticut
10. Community Health Center Association of Mississippi
11. DC Primary Care Association
12. Florida Association of Community Health Centers
13. Health Center Association of Nebraska
14. Illinois Primary Health Care Association
15. Indiana Primary Health Care Association

16. Iowa Primary Care Association

17. Maine Primary Care Association

18. Maryland Community Health System

19. Michigan Primary Care Association

20. Mid-Atlantic Association of Community Health Centers

21. Minnesota Association of Community Health Centers

22. Montana Primary Care Association

23. National Health Care for the Homeless Council

24. New Jersey Primary Care Association

25. North Carolina Community Health Center Association

26. Northwest Regional Primary Care Association

27. Ohio Association of Community Health Centers

28. Pennsylvania Association of Community Health Centers

29. Tennessee Primary Care Association

30. Texas Association of Community Health Centers

31. Washington Association for Community Health