No. 25-

IN THE

Supreme Court of the United States

ASANTE, *et al.*,

Petitioners,

v.

ROBERT F. KENNEDY, JR., IN HIS OFFICIAL CAPACITY, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

DEAN L. JOHNSON
DEAN L. JOHNSON, INC.
181 Utsalady Rd.
Camano Island, WA 98282

THOMAS J. WEISS
WEISS & ZAMAN
16946 Ventura Blvd.
Encino, CA 91316

SETH P. WAXMAN
Counsel of Record
THOMAS G. SAUNDERS
OLU O. OISAGHIE
WILMER CUTLER PICKERING HALE AND DORR LLP
2100 Pennsylvania Ave., NW
Washington, DC 20037
(202) 663-6000
seth.waxman@wilmerhale.com

GARY M. FOX
WILMER CUTLER PICKERING HALE AND DORR LLP
7 World Trade Center
250 Greenwich St.
New York, NY 10007

QUESTION PRESENTED

Under 42 C.F.R. § 431.52(b), a State's Medicaid plan must "pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State." Petitioners are "border hospitals" in neighboring states who are located within 55 miles of California and treat a substantial number of California Medicaid (Medi-Cal) patients. Despite Section 431.52(b)'s clear equal-payment mandate, Medi-Cal pays out-of-state hospitals less than in-state hospitals for furnishing the same care to California residents. Specifically, California denies out-of-state hospitals that treat Medi-Cal patients any portion of the more than $4 billion in additional federal supplemental funds that California distributes only to in-state hospitals.

The question presented is:

Whether a State's Medicaid program violates 42 C.F.R. § 431.52(b)'s equal-payment requirement by denying supplemental payments to out-of-state hospitals, thereby paying in-state hospitals more than out-of-state hospitals that furnish the same services to the State's Medicaid patients.

PARTIES TO THE PROCEEDING

Petitioners are Asante, Asante Rogue Regional Medical Center (formerly known as Asante Rogue Valley Medical Center), Asante Three Rivers Medical Center, Asante Ashland Community Hospital, Renown Regional Medical Center, Renown South Meadows Medical Center, Sky Lakes Medical Center, and Yuma Regional Medical Center.

Respondents are Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services; the U.S. Department of Health and Human Services (HHS); Dr. Mehmet Oz, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services; and the Centers for Medicare and Medicaid Services (CMS).

CORPORATE DISCLOSURE STATEMENT

Petitioners certify that they are non-profit corporations with no parent corporations, and no publicly held company owns 10% or more stock in any one of them.

DIRECTLY RELATED PROCEEDINGS

This petition arises from the following proceedings:

- *Asante* v. *Kennedy*, No. 23-5055 (D.C. Cir. Apr. 4, 2025).
- *Asante* v. *Azar*, No. 20-cv-601 (D.D.C. Feb. 14, 2023).

Counsel for petitioners is not aware of any other proceedings that are directly related to this case within the meaning of Rule 14.1(b)(iii).

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

PARTIES TO THE PROCEEDING ii

CORPORATE DISCLOSURE STATEMENT ii

DIRECTLY RELATED PROCEEDINGS ii

TABLE OF AUTHORITIES v

INTRODUCTION 1

OPINIONS BELOW 4

JURISDICTION 4

STATUTORY PROVISIONS INVOLVED 4

STATEMENT 5

A. Statutory And Regulatory Background 5

1. Federal law mandates that each State pay for services furnished in another State "to the same extent" as it pays for services furnished within its boundaries 5

2. Base payments and supplemental payments 8

3. Supplemental payments under California's QAF program 10

B. Factual Background 12

C. Procedural History 13

REASONS FOR GRANTING THE PETITION 16

TABLE OF CONTENTS—Continued

Page

I. THE D.C. CIRCUIT'S RULING CONTRADICTS THE PLAIN TEXT OF FEDERAL LAW 17

A. The Plain Text Of The Equal-Payment Regulation Applies Equally To Medicaid Base Payments And Supplemental Payments 17

B. The D.C. Circuit Failed To Justify Its Atextual Reading Of The Equal-Payment Provision 19

C. The D.C. Circuit's Atextual Reading Threatens The Government's Statutory Authority For Billions Of Dollars In Medicaid Funding 25

D. The D.C. Circuit Relied On State-Level Policy Considerations To Deprive Out-Of-State Hospitals Of Their Supplemental Payments 26

II. THE QUESTION PRESENTED IS EXCEPTIONALLY IMPORTANT, POTENTIALLY AFFECTING BILLIONS OF DOLLARS IN MEDICAID PAYMENTS 29

CONCLUSION 31

TABLE OF AUTHORITIES

CASES

Page(s)

Advocate Christ Medical Center v. *Kennedy*, 145 S. Ct. 1262 (2025) 31

American Hospital Association v. *Becerra*, 596 U.S. 724 (2022) 31

Cherokee Nation of Oklahoma v. *Babbitt*, 117 F.3d 1489 (D.C. Cir. 1997) 29

Children's Hospital & Medical Center v. *Bonta*, 97 Cal. App. 4th 740 (2002) 3, 12-13

Cove Associates Joint Venture v. *Sebelius*, 848 F. Supp. 2d 13 (D.D.C. 2012) 29

Kamen v. *Kemper Financial Services, Inc.*, 500 U.S. 90 (1991) 24

STATUTES

42 U.S.C.
§ 1395dd 17
§ 1396 ..... 4, 29
§ 1396a 5, 15-16, 18, 20-21, 25-26
§ 1396a (1965) 6
§ 1396a (1980) 7
§ 1396b 9, 12, 16, 23, 25-26, 28
§ 1396d 19, 21

Medicaid Act, Pub. L. No. 89-97, 79 Stat. 286 (1965) 6

Medicare and Medicaid Amendments, Pub. L. No. 96-499, 94 Stat. 2609 (1980) 7

TABLE OF AUTHORITIES—Continued

Page

Cal. Welf. & Inst. Code
§ 14169.31 11
§ 14169.50 ..... 11, 18
§ 14169.51 11
§ 14169.54 ..... 2, 11, 15, 18
§ 14169.55 ..... 11, 15, 18
§ 14169.83 28

REGULATIONS

42 C.F.R.
§ 430.12 5
§ 431.52 (1979) 7
§ 431.52 (1991) 8
§ 431.52 ..... 1-2, 4-7, 14-23, 25, 27-28, 30
§ 433.54 28
§ 433.66 28
§ 433.68 28
§ 433.72 28
§ 436.403 5
§ 447.1 ..... 16, 24
§ 447.272 9
§ 447.321 9

45 C.F.R. § 248.40 (1971) 7

ADMINISTRATIVE AND LEGISLATIVE MATERIALS

56 Fed. Reg. 8832 (Mar. 1, 1991) 8

77 Fed. Reg. 29,002 (May 16, 2012) 8

Cal. Assembly Bill 1383 (2009) 10

TABLE OF AUTHORITIES—Continued

Page

OTHER AUTHORITIES

American Hospital Association, *The Cost of Caring: Challenges Facing America's Hospitals in 2025* (Apr. 2025), https://www.aha.org/system/files/media/file/2025/04/The-Cost-of-Caring-April-2025.pdf 9

CMS, *General DSH Audit and Reporting Protocol*, https://www.medicaid.gov/medicaid/downloads/general_dsh_audit_reporting_protocol.pdf (visited Sept. 17, 2025) 24

CMS, *Medicaid Eligibility Policy*, https://www.medicaid.gov/medicaid/eligibility-policy (visited Sept. 17, 2025) 5, 29

KFF, *Key Facts About Hospitals* (Feb. 19, 2025), https://www.kff.org/key-facts-about-hospitals/?entry=national-hospital-spending-medicare-and-medicaid-spending 29

MACPAC, *MACStats: Medicaid and CHIP Data Book*, https://www.macpac.gov/wp-content/uploads/2024/12/MACSTATS_Dec2024_WEB-508.pdf 10, 30

MACPAC, *Medicaid Base and Supplemental Payments to Hospitals* (Apr. 2024), https://www.macpac.gov/wp-content/uploads/2024/05/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf 8-9, 28

TABLE OF AUTHORITIES—Continued

Page

MACPAC, *Medicaid Managed Care Capitation Rate Setting* (Mar. 2022), https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf 22

MACPAC, *Medicare Payment Policy*, (Mar. 2025), https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf 9

MACPAC, *Medicaid Payment Policy for Out-of-State Hospital Services* (Jan. 2020), https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid-Payment-Policy-for-Out-of-State-Hospital-Services.pdf 3, 29

MACPAC, *Oversight of Upper Payment Limit Supplemental Payments to Hospitals* (Mar. 2019), https://www.macpac.gov/wp-content/uploads/2019/03/Oversight-of-Upper-Payment-Limit-Supplemental-Payments-to-Hospitals.pdf 10

Mosbergen, Dominique, *U.S. Delays Hospital Payments as Medicaid Scrutiny Intensifies*, Wall St. J. (May 2, 2025), https://www.wsj.com/health/healthcare/medicaid-hospital-payments-delay-15a1ab26 30

INTRODUCTION

California's Medicaid plan violates the clear federal command to "pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries." 42 C.F.R. § 431.52(b). California pays in-state hospitals that treat Medi-Cal patients both a "base payment" and a "supplemental payment," but pays out-of-state hospitals that also treat Medi-Cal patients only a base payment, denying out-of-state hospitals the supplemental payment received by in-state hospitals for providing the same services. California thus fails to pay for services furnished to Medi-Cal patients in another State "to the same extent" as services furnished in California.

Over a strong dissent by Judge Katsas, the D.C. Circuit approved this unequal treatment through a strained interpretation that defies the plain language of Section 431.52(b). This gutting of the equal-payment regulation will have profound consequences nationwide. States have increasingly relied on supplemental payments as a core component of the overall compensation paid to hospitals for furnishing services to Medicaid patients. Supplemental payments constituted 53% of all Medicaid payments to hospitals nationwide in fiscal year 2023. This figure was 60% in California and well over 70% in several other States. Exempting such supplemental payments from Section 431.52(b)'s equal-payment mandate would permit blatant discrimination against out-of-state hospitals when they furnish services to patients who need care outside their home States.

Section 431.52(b)'s text is clear and straightforward. The D.C. Circuit's reasons for circumventing its plain command were the opposite. The D.C. Circuit majority relied almost entirely on the language of a *different*

subsection of 42 C.F.R. § 431.52 than the one at issue in this case. The subsection it relied upon states that federal law "authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State." 42 C.F.R. § 431.52(a). The panel majority concluded that this general statement in subsection (a) limits the scope of subsection (b) and that supplemental payments "do not constitute 'furnishing Medicaid'" because, in the panel's view, they are not "insurance payments." App. 14a. The panel asserted that "even if the payment … relates in some way to the provision of services, that does not mean that those supplemental subsidies amount to insurance payments to Medicaid beneficiaries." App. 16a (citation omitted). The panel cited no authority for this novel interpretation of 42 C.F.R. § 431.52, nor is there any such authority.

In dissent, Judge Katsas emphasized that California's Medicaid plan "violates the clear command" of 42 C.F.R. § 431.52(b). App. 29a. He stated that the supplemental payments at issue here are "extra payments to in-state hospitals for services furnished through Medicaid," App. 24a, which "are keyed to the number of Medi-Cal patient days of each hospital" and thus are based explicitly on the quantity of services furnished to Medi-Cal patients by each hospital, App. 25a. Moreover, California law states that the supplemental payments are made "for the provision of … hospital services." *Id.* (quoting Cal. Welf. & Inst. Code § 14169.54(a)). Denying the supplemental payments to out-of-state hospitals thus violates the command that a State must "pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries." 42 C.F.R. § 431.52(b). Moreover, as Judge Katsas pointed out, the panel majority's contrary reading would

undermine the legal basis for providing federal funding to make supplemental payments even to in-state hospitals.

This Court's review is urgently needed to restore federal law as written rather than as reimagined by the panel majority. The impact of the D.C. Circuit's decision on petitioners is profound. Petitioners are all "border hospitals" within 55 miles of the California border. "Border hospitals" provide over 70% of the inpatient services that Medi-Cal beneficiaries receive outside California. Indeed, the largest hospitals among petitioners treat more Medi-Cal patients each year than many California hospitals. Because out-of-state hospitals often treat Medi-Cal patients on an emergency basis, the acuity of these Medi-Cal patients is over twice the acuity of the average Medi-Cal patient treated by in-state California hospitals. *Children's Hosp. & Med. Ctr.* v. *Bonta*, 97 Cal. App. 4th 740, 760 (2002).

The impact of the case extends far beyond petitioners. It affects how all States across the country may structure supplemental payments under their Medicaid plans, implicating billions of dollars in healthcare spending. As noted, States have steadily increased their reliance on supplemental payments to hospitals to the point that such payments now constitute the majority of state payments to hospitals under Medicaid. As States' reliance on supplemental payments has become entrenched, discriminatory policies like California's have unfortunately become commonplace. Indeed, over 32 States now have laws in effect that discriminate against out-of-state hospitals in Medicaid reimbursement.[1] This

[1] *See* Medicaid and CHIP Payment and Access Commission (MACPAC), *Medicaid Payment Policy for Out-of-State Hospital Services* (Jan. 2020), https://www.macpac.gov/wp-content/uploads/

promotes a race to the bottom as States like California unfairly shift the costs of caring for the State's Medicaid beneficiaries to out-of-state hospitals.

This petition for a writ of certiorari should be granted, and the Court should restore the equal-payment requirement in 42 C.F.R. § 431.52(b).

OPINIONS BELOW

The D.C. Circuit majority opinion (App. 1a-20a) and dissent (App. 21a-29a) are reported at 133 F.4th 97. The D.C. Circuit's order denying panel rehearing (App. 57a) and order deny rehearing en banc (App. 59a) are unreported, but the latter is available at 2025 WL 1997427. The district court's opinion (App. 31a-54a) is reported at 656 F. Supp. 3d 185. The district court's order (App. 55a) is unreported.

JURISDICTION

The D.C. Circuit entered judgment on April 4, 2025. App. 1a. Petitioners timely filed a rehearing petition, which the D.C. Circuit denied on July 17, 2025. App. 57a; App. 59a. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant statutory and regulatory provisions are reproduced in the Appendix. App. 61a-68a.

2020/01/Medicaid-Payment-Policy-for-Out-of-State-Hospital-Services.pdf. MACPAC is a non-partisan agency within the legislative branch that was statutorily created to advise Congress. *See* 42 U.S.C. § 1396.

STATEMENT

A. Statutory And Regulatory Background

The Medicaid program pays for healthcare services provided to low-income individuals and families, children, pregnant women, seniors, and people with disabilities. CMS, *Medicaid Eligibility Policy*.[2] Nationwide, Medicaid provides healthcare coverage to over 71 million Americans. *Id.* To participate in Medicaid, States must comply with both the Medicaid Act and the regulations promulgated by the Department of Health and Human Services (HHS). 42 U.S.C. § 1396. When a State creates or modifies its Medicaid plan, the Centers for Medicare and Medicaid Services (CMS), a component of HHS, must approve the plan to ensure its compliance with federal law. 42 C.F.R. § 430.12(c); *see* 42 U.S.C. § 1396(a)-(b).

1. Federal law mandates that each State pay for services furnished in another State "to the same extent" as it pays for services furnished within its boundaries

The Medicaid Act requires that every State's Medicaid plan comply with federal regulations "prescribed by the Secretary" of HHS regarding "the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom." 42 U.S.C. § 1396a(a)(16); *see also* 42 C.F.R. § 436.403(a) (requiring an agency administering a State's Medicaid plan to "provide Medicaid to eligible residents of the State, including residents who are absent from the State").

---

[2] *Available at* https://www.medicaid.gov/medicaid/eligibility-policy (visited Sept. 17, 2025).

Regulations prescribed by the HHS Secretary establish the following equal-payment requirement.

> A State plan must pay for services furnished in another State *to the same extent* that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State, and any of the following conditions is met:
>
> (1) Medical services are needed because of a medical emergency;
>
> (2) Medical services are needed and the beneficiary's health would be endangered if he were required to travel to his State of residence;
>
> (3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;
>
> (4) It is general practice for beneficiaries in a particular locality to use medical resources in another State.

42 C.F.R. § 431.52(b) (emphasis added).

Federal law has long required equal payment in Medicaid reimbursement rates between in-state and out-of-state hospitals. When it was enacted in 1965, the Medicaid Act mandated equal payment by requiring all States to reimburse providers—both in-state and out-of-state—based on the "reasonable cost of … services." Medicaid Act, Pub. L. No. 89-97, 79 Stat. 286, 296 (1965). This requirement was reflected in 42 U.S.C. § 1396a(a)(13) (1965), which provided that state plans

must provide "for payment of the reasonable cost … of inpatient hospital services provided under the plan." The implementing regulation at that time, which was a precursor to the regulation at issue in this case, recited in pertinent part:

> Medical assistance will be furnished to eligible individuals who are residents of the State but are absent therefrom *to the same extent* that such assistance is furnished under the plan *to meet the cost of medical care and services* rendered to eligible individuals in such State[.]

45 C.F.R. § 248.40(a)(1) (1971) (emphases added).

In 1980, Congress replaced the statutory requirement to make payments based on actual cost with the requirement to reimburse facilities at rates "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." Medicare and Medicaid Amendments, Pub. L. No. 96-499, 94 Stat. 2609, 2650-2651 (codified as amended at 42 U.S.C. § 1396a(a)(13)(E) (1980)). Shortly before this legislative change, HHS reworked the wording of its regulation pertaining to the equal treatment of in-state and out-of-state hospitals:

> (b) *Payment for services.* A State plan must provide that the State will furnish medicaid to a recipient who is a resident of the State while that recipient is in another State, to the same extent that medicaid is furnished to residents in the State …

42 C.F.R. § 431.52 (1979). The regulation at issue here assumed nearly its present form in 1991 when it was amended to state:

> (b) *Payment for services*. A State plan must pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State …

56 Fed. Reg. 8832, 8847 (Mar. 1, 1991) (codified at 42 C.F.R. § 431.52 (1991)). The word "recipient" was changed to beneficiary" in 2012. 77 Fed. Reg. 29,002, 29,028 (May 16, 2012).

Federal law has thus required equal payment between in-state and out-of-state hospitals for decades.

2. Base payments and supplemental payments

States make two main types of Medicaid payments to hospitals. First, States make base payments to hospitals, typically on a per-claim basis. *See* MACPAC, *Medicaid Base and Supplemental Payments to Hospitals* 3-4 (Apr. 2024) ("MACPAC, *Medicaid Payments*").[3] Second, most States make use of supplemental payments to increase the compensation hospitals receive for furnishing services. *Id.* at 4. In this case, California makes supplemental payments to in-state hospitals based on the number of days of care provided to Medi-Cal beneficiaries, but denies these supplemental payments to out-of-state hospitals that also furnish services to Medi-Cal patients.

A state plan must ensure that "the total Medicaid payments made to an inpatient hospital provider,

---

[3] *Available at* https://www.macpac.gov/wp-content/uploads/2024/05/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf.

including the supplemental payment, will not exceed upper payment limits." 42 U.S.C. § 1396b(bb)(1)(B)(iv). The "[u]pper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles." 42 C.F.R. § 447.272(b)(1) (inpatient services); *id.* § 447.321(b)(1) (same for outpatient hospital services).

The upper payment limit imposes an effective cap on state Medicaid payments to hospitals so that the *combination* of base payments *and* supplemental payments can be no higher than the rate Medicare would pay for the same services. Thus, supplemental payments that count toward the upper payment limit "cover the difference between … base payments" and, at most, "the amount that Medicare would have paid for the same service." MACPAC, *Medicaid Payments* 6. The Medicare rate is itself 17% below the cost of providing care,[4] so even in-state hospitals that receive supplemental payments from California lose money when treating Medi-Cal patients, and the losses are much greater at out-of-state hospitals that also furnish services to Medi-Cal patients but are denied supplemental payments.

States have increasingly used supplemental payments to make up larger shares of their payments to

---

[4] *See* MACPAC, *Medicare Payment Policy* 79-81 (Mar. 2025), https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf; American Hosp. Ass'n, *The Cost of Caring: Challenges Facing America's Hospitals in 2025*, at 1 (Apr. 2025) ("Medicare reimbursement continues to lag behind inflation — covering just 83 cents for every dollar spent by hospitals in 2023, resulting in over $100 billion in underpayments"), https://www.aha.org/system/files/media/file/2025/04/The-Cost-of-Caring-April-2025.pdf.

hospitals. *See* MACPAC, *Oversight of Upper Payment Limit Supplemental Payments to Hospitals* 38 (Mar. 2019) (noting a nearly four-fold increase in supplemental payments subject to the upper payment limit from fiscal year 2000 to 2011).[5] In fiscal year 2023, supplemental payments constituted 53% of all Medicaid payments to hospitals nationwide, including over 60% of Medicaid payments to hospitals in California and well over 70% of such payments in several other States. *See* MACPAC, *MACStats: Medicaid and CHIP Data Book* 63-64 (Dec. 2024) (Ex. 24).[6]

Rising supplemental payments mean that base payments to hospitals must generally decline due to the constraint on total reimbursement to hospitals imposed by the upper payment limit.

3. Supplemental payments under California's QAF program

In October 2009, California enacted Assembly Bill 1383, creating a supplemental payment program that California refers to as its quality assurance fee (QAF) program. C.A.J.A. 278. The program is implemented pursuant to a state plan amendment developed by the California Department of Health Care Services (DHCS), which is approved by CMS. C.A.J.A. 655. Under this program, California collects a quality assurance fee from certain California hospitals while exempting other hospitals, such as public, rural, long-term care, and some

---

[5] *Available at* https://www.macpac.gov/wp-content/uploads/2019/03/Oversight-of-Upper-Payment-Limit-Supplemental-Payments-to-Hospitals.pdf.

[6] *Available at* https://www.macpac.gov/wp-content/uploads/2024/12/MACSTATS_Dec2024_WEB-508.pdf.

specialty hospitals. Cal. Welf. & Inst. Code §§ 14169.31(h), 14169.51(*l*). At least 42% of California hospitals do not pay any quality assurance fees. C.A.J.A. 433 n.11.

These quality assurance fees are deposited into a segregated fund and then matched with an even greater amount of federal Medicaid money. C.A.J.A. 655. Each year, the fees are then returned to all California hospitals that treat Medi-Cal patients (including hospitals that did not pay a quality assurance fee to California), along with over $4 billion in additional federal money. *Id.*; *see also* Cal. Welf. & Inst. Code § 14169.50(a).

The fundamental purpose of California's QAF program has been to direct as many *federal* dollars as possible to hospitals that provide services to Medi-Cal beneficiaries without imposing any net financial burden on the State. The California State Legislature explicitly acknowledged this purpose in California Welfare & Institutions Code § 14169.50(a), which recites the Legislature's intention to "obtain all available federal funds to make supplemental Medi-Cal payments to hospitals."

Under California law, supplemental payments to hospitals are expressly made "for the provision of hospital … services," and the "supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services," such as base payments. Cal. Welf. & Inst. Code §§ 14169.54(a), 14169.55(a). These supplemental payments are calculated based on the number of Medi-Cal patient-days of treatment that a hospital provides, adjusted based on the acuity of the care. *Id.* §§ 14169.54, 14169.55. However, California does not make these supplemental payments to out-of-state hospitals that also furnish services to Medi-Cal patients.

California does not condition an in-state hospital's receipt of supplemental payments on that hospital's payment of quality assurance fees—*i.e.*, in-state hospitals receive supplemental payments even if they do not pay any fees under the QAF program. C.A.J.A. 655. In fact, federal law prohibits California from implementing its QAF program through a quid pro quo arrangement. *See* 42 U.S.C. § 1396b(w)(4)(B); C.A.J.A. 627.

B. Factual Background

Petitioners are out-of-state hospitals owned by nonprofit entities. C.A.J.A. 283. Petitioners are based in States neighboring California and all qualify as "border hospitals," as defined by California's DHCS, because they are located within 55 miles of the California border. C.A.J.A. 126. "Border hospitals," including petitioners, "provide over 70 percent of inpatient care that Medi-Cal patients receive out of state." C.A.J.A. 110. This includes essential and expensive trauma services because, on many occasions, the border hospitals "'are the closest major trauma centers available to Medi-Cal participants residing in California.'" C.A.J.A. 254 (quoting *Children's Hosp.*, 97 Cal. App. 4th at 760) (citation modified).

Petitioners Renown Regional Medical Center and Asante Rogue Regional Medical Center are "the two largest out-of-state providers of hospital services to California Medi-Cal patients." C.A.J.A. 287. Renown Regional Medical Center is located in Reno, Nevada, and "is the only trauma center between Sacramento, California and Salt Lake City, Utah." C.A.J.A. 283. Similarly, Asante Rogue Regional Medical Center is located in Medford, Oregon, and "is the only trauma center between Portland, Oregon, and Redding, California." *Id.* For the one-year period from July 1, 2017, to June 30,

2018, petitioners provided the following patient-days of care to Medi-Cal beneficiaries:

- Renown (two hospitals) – 6,614
- Asante (three hospitals) – 2,045
- Yuma Regional Medical Center – 586
- Sky Lakes Medical Center – 461

C.A.J.A. 287. In fact, Renown Regional Medical Center treats more Medi-Cal patients than 183 private hospitals in California, and Asante Rogue Regional Medical Center treats more Medi-Cal patients than 101 private hospitals in California. C.A.J.A. 209.

"[D]ue to the trauma care and other forms of intensive care" that petitioners provide, "they attract 'Medi-Cal patients who are much sicker, and therefore require a greater expenditure of resources and costs, than the typical in-state Medi-Cal patient.'" C.A.J.A. 254 (quoting *Children's Hosp.*, 97 Cal. App. 4th at 760). Indeed, the acuity (*i.e.*, the severity of a patient's medical condition) of the average Medi-Cal patient at petitioners Renown Regional Medical Center and Asante Rogue Regional Medical Center is "more than twice as high" as the acuity of the average Medi-Cal patient at in-state hospitals. C.A.J.A. 16 (quoting *Children's Hosp.*, 97 Cal. App. 4th at 760 n.12). Despite this higher acuity and higher cost, California excludes these hospitals from receiving supplemental payments for the services they furnish to Medi-Cal patients.

C. Procedural History

When California initially implemented its QAF program, petitioners and others swiftly filed suit challenging their exclusion from reimbursement. C.A.J.A. 19. As a result of that litigation, petitioners succeeded in

securing a settlement under which they received supplemental payments. C.A.J.A. 20. Under a series of subsequent settlement agreements, which were renewed every two years under each new state plan amendment, the payments continued for almost a decade. *Id.*

In 2019, California changed course and excluded petitioners and other border hospitals from receiving supplemental payments. C.A.J.A. 561-562, 581-587, 629-630. In 2020, CMS approved California's new state plan. C.A.J.A. 535-538, 589-590, 606-609. Petitioners promptly challenged CMS's approval of California's plan because it excluded out-of-state hospitals from receiving supplemental payments. C.A.J.A. 13. Petitioners alleged violations of federal Medicaid regulations, as well as violations of the dormant Commerce Clause and the Equal Protection Clause. C.A.J.A. 13-14. In 2023, the district court granted summary judgment in respondents' favor. App. 31a-54a (opinion); App. 55a (order).

A divided panel of the D.C. Circuit affirmed. App. 1a-20a. In relevant part, the majority determined that the operative equal-payment provision, subsection (b) in 42 C.F.R. § 431.52, is limited to "base payments given in the State's capacity as a Medicaid beneficiary's healthcare insurer—*i.e.*, insurance payments for a specific service rendered to a specific beneficiary." App. 12a.

Rather than focusing on the plain text of subsection (b), the majority concocted a limitation on out-of-state hospital reimbursement from the general language in neighboring subsection (a), which is a different subsection of Section 431.52 that merely identifies the HHS Secretary's statutory basis for "prescrib[ing] State plan requirements for furnishing Medicaid to State residents who are absent from the State." 42 C.F.R. § 431.52(a) (citing Section 1902(a)(16) of the Social Security Act,

codified at 42 U.S.C. § 1396a(a)(16)); App. 12a-14a. The majority reasoned that supplemental payments "do not fit comfortably within that language" covering the "furnishing [of] Medicaid to State residents who are absent from the State." App. 14a (quoting 42 C.F.R. § 431.52(a)).

Turning to the regulatory history, the majority also quoted the different iterations of the equal-payment requirement and insisted—without further analysis or authority—that the requirement in Section 431.52(b) "has consistently addressed base payments made in the State's capacity as an insurer … rather than supplemental payments." *See* App. 15a-16a.[7]

Judge Katsas dissented, strongly disagreeing with the majority's interpretation of the governing regulation. App. 21a-29a. In his view, the supplemental payments "violate the out-of-state payment regulation because they flow only to in-state hospitals," giving in-state hospitals "*additional* compensation for treating Medi-Cal beneficiaries." App. 23a. California's Medi-Cal plan, Judge Katsas noted, itself recognizes that supplemental payments are "extra payments to in-state hospitals for services furnished through Medicaid," including "'hospital inpatient services.'" App. 24a (quoting C.A.J.A. 543). He also explained that the California State Legislature declared the supplemental payments to be "'for the provision of … hospital services' to Medi-Cal beneficiaries." App. 25a (quoting Cal. Welf. & Inst. Code §§ 14169.54(a), 14169.55(a)). Judge Katsas

---

[7] The majority also held that California's scheme for paying supplemental payments does not violate the dormant Commerce Clause (App. 6a-8a) or the Equal Protection Clause (App. 8a-10a). Those issues are not directly before this Court.

concluded that by denying supplemental payments to out-of-state hospitals, California's "payment scheme violates the clear command" of 42 C.F.R. § 431.52(b). App. 29a.

Judge Katsas warned that the majority's view cannot be correct because it could "foreclose federal funding for any portion of the QAF payments." App. 26a. Specifically, if supplemental payments are not for furnishing care, and thus do not qualify as "medical assistance" under 42 U.S.C. § 1396a(a)(16), then they would likely fall outside the scope of the statute authorizing federal spending for "medical assistance" in 42 U.S.C. § 1396b(a)(1). App. 26a-27a. He further reasoned that supplemental payments count toward the upper payment limit, meaning that supplemental payments must be viewed as "payments 'for Medicaid services.'" App. 27a (quoting 42 C.F.R. § 447.1).

In May 2025, petitioners filed a petition for panel rehearing or rehearing en banc. The D.C. Circuit denied rehearing in July 2025. App. 57a (panel order); App. 59a (en banc order).

REASONS FOR GRANTING THE PETITION

The D.C. Circuit's decision flouts the plain language of the operative regulation. In so doing, it gives a green light to blatant discrimination between in-state and out-of-state hospitals. If allowed to stand, the decision below could affect billions of dollars in Medicaid supplemental payments made by States across the country using federal funds. Although the split D.C. Circuit panel is the first appellate court to address the question presented, this issue warrants immediate review because it is a question of exceptional national importance with implications for comity among the States, and the D.C.

Circuit's defiance of the regulatory text is clear. This Court should grant the petition and reverse.

I. THE D.C. CIRCUIT'S RULING CONTRADICTS THE PLAIN TEXT OF FEDERAL LAW

The D.C. Circuit's decision permits States to pay less to out-of-state hospitals than they pay to in-state hospitals for furnishing the same services to Medi-Cal beneficiaries. This discrimination violates the plain text of 42 C.F.R. § 431.52(b) and deprives border hospitals, including petitioners, of supplemental payments for the critical services they are obliged to provide to Medi-Cal patients. *See* 42 U.S.C. § 1395dd (Emergency Medical Treatment and Active Labor Act mandating that hospitals provide emergency care to individuals regardless of their ability to pay); App. 1a-20a (majority opinion).

A. The Plain Text Of The Equal-Payment Regulation Applies Equally To Medicaid Base Payments And Supplemental Payments

The straightforward language in 42 C.F.R. § 431.52(b) requires that a State must pay for Medicaid services provided to beneficiaries who are outside the State "to the same extent" it pays for those services within its boundaries when certain conditions (not at issue here) are satisfied. Medicaid base payments and supplemental payments both "pay for services furnished"—that is, both types of payments reimburse hospitals for the costs of the medical care they provide to Medicaid patients. Thus, the equal-payment provision in subsection (b) applies equally to both base payments and supplemental payments.

Section 431.52(b) imposes a clear mandate regarding payments made for Medicaid services furnished outside a State:

> A State plan *must* provide that the State *will pay* for services furnished in another State *to the same extent* that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State.

42 C.F.R. § 431.52(b) (emphases added). This provision says what it means and means what it says: A State must pay an out-of-state hospital just as much as an in-state hospital for furnishing services to the State's Medicaid beneficiaries.

The title of Section 431.52(b) states that it broadly addresses "[p]ayment for services," not just base payments linked to particular medical procedures. 42 C.F.R. § 431.52(b). The operative text likewise contains no provision limiting the relevant payments "for services furnished" to base payments. Indeed, even the D.C. Circuit majority did not purport to find any language in Section 431.52(b) itself that supported its narrow interpretation of this subsection.

As a matter of plain meaning, California's supplemental payments are "for services furnished" because they are monies paid to hospitals as compensation for treating Medi-Cal patients. California law specifies that supplemental payments are provided as "supplemental Medi-Cal payments to hospitals," made specifically "*for the provision of hospital … services*," and calculated based on each hospital's Medi-Cal patient-days. Cal. Welf. & Inst. Code §§ 14169.50(a), 14169.54(a), 14169.55(a) (emphasis added). Because supplemental payments are for "services furnished," they are subject to the equal-payment mandate in 42 C.F.R. § 431.52(b).

The Medicaid Act confirms this plain-text reading of subsection (b). Under 42 U.S.C. § 1396a(a)(16), a State's

"plan for medical assistance must … provide for inclusion … of provisions … with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom," as the HHS Secretary shall specify in regulations. The phrase "[m]edical assistance" is defined as the "payment of part or all of the cost" of covered "care and services" provided to Medicaid beneficiaries "or the care and services themselves." *Id.* § 1396d(a). Thus, so long as a State's supplemental payments contribute to the "payment of part or all of the cost of" covered care or services, those supplemental payments qualify as "medical assistance" and must be provided "to the same extent" to both in-state and out-of-state hospitals 42 C.F.R. § 431.52(b).

B. The D.C. Circuit Failed To Justify Its Atextual Reading Of The Equal-Payment Provision

The D.C. Circuit majority did not cite anything in the text of Section 431.52(b) that supported its narrow interpretation. Instead, the D.C. Circuit majority departed from the plain text of Section 431.52(b)'s equal-payment mandate based entirely on a different subsection reciting the regulation's "[s]tatutory basis." 42 C.F.R. § 431.52(a). This was error for multiple reasons.

First, nothing in Section 431.52(a) purports to limit Section 431.52(b)'s operative command that a State must "pay for services furnished in another State to the same extent that it would pay for services furnished within its borders." Section 431.52(a) merely states:

> (a) *Statutory basis*. Section 1902(a)(16) of the [Social Security] Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.

To say that subsection (a) is a slender reed for reinterpreting subsection (b) is an understatement. Section 431.52(a) does not state—or even imply—that it restricts Section 431.52(b). Provisions must be read in context, but a high-level introductory statement in a different subsection provides no basis for rewriting an operative command. Moreover, the regulatory section in which subsections (a) and (b) appear, 42 C.F.R. § 431.52, is titled "Payments for services furnished out of State." The similarity in the titles for Section 431.52 and subsection (b) confirms that subsection (b) is the operative provision, and thus any analysis of the mandate in Section 431.52 should focus on subsection (b).

Second, the D.C. Circuit majority compounded its error by interpreting "furnishing Medicaid to State residents" in Section 431.52(a) to refer exclusively to "the State provid[ing] Medicaid insurance to a beneficiary," which the majority then equated with making base payments. App. 13a. The term "furnishing Medicaid to State residents" is not a restrictive term, but an expansive one. It refers generally to the *entirety* of what a State does to facilitate medical care for its residents through the Medicaid program. It says nothing about "insurance" payments, let alone "base" payments. And it does not in any way limit the other provisions in the regulation to base payments in the manner described by the D.C. Circuit majority.

If there were any doubt on that point, the D.C. Circuit majority should have heeded its own admonition to consider context. Section 431.52(a) is a description of what "Section 1902(a)(16) of the Act"—*i.e.*, 42 U.S.C.

§ 1396a(a)(16)—"authorizes."[8] Section 431.52(a)'s use of the term "furnishing Medicaid" in describing what the statute "authorizes" is thus best understood as shorthand for what the statute in fact authorizes—a simpler way to refer to the lengthier provisions in the statute. Yet the D.C. Circuit majority's entire interpretation of Section 431.52(b) depended on the implausible proposition that "furnishing Medicaid" in Section 431.52(a)'s description of what the statute authorizes imposes a new restriction *not contained in the statute* that contradicts the plain meaning of subsection (b). Shorn of that error, the D.C. Circuit majority's entire opinion unravels.

Third, the D.C. Circuit majority's heavy emphasis on the phrase "furnishing Medicaid," and purported distinction of furnishing "medical assistance," contradicted its own explanation of HHS's stated intentions regarding the scope and impact of changes to the regulations. The D.C. Circuit majority tried to distinguish these two terms when defending its narrow interpretation. App. 17a-19a. But elsewhere in its opinion, it said exactly the opposite when describing the regulation's history. Specifically, it stated that "[n]either of the amendments purported to make any substantive change to the regulation" when the language shifted from stating that "'[m]edical assistance will be furnished to eligible individuals who are residents of the State but are absent therefrom'" to stating that the "'State will furnish

---

[8] As noted, the statute being described refers broadly to "the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom," 42 U.S.C. § 1396a(a)(16), and "medical assistance" is defined as "payment of part or all of the cost" of covered "care and services" provided to Medicaid beneficiaries "or the care and services themselves." *Id.* § 1396d(a).

Medicaid … while the recipient is in another State.'" App. 15a.

The D.C. Circuit majority was right that no substantive difference was intended, but wrong to ignore its own point later when it staked its entire opinion on a purported difference between "furnishing medical assistance" and "furnishing Medicaid."

Fourth, even if Section 431.52(a)'s description of the statute somehow limited Section 431.52(b)'s operative command and the term "furnishing Medicaid" in Section 431.52(a) somehow had a restrictive meaning, the D.C. Circuit majority still erred by creating an "insurance" requirement for triggering Section 431.52(b)'s equal-payment mandate and equating that standard with base payments. As noted earlier, the terms "insurance" and "base" payment appear nowhere in Section 431.52(b), and thus the majority's interpretation was unmoored from the text.

Compounding the problem, the D.C. Circuit relied on a misguided conception of how Medicaid payments and traditional health-insurance payments operate. States furnish Medicaid using a variety of mechanisms. Today, "[c]omprehensive managed care," which relies on "fixed period payments, also referred to as capitation payments," is "the primary Medicaid delivery system in nearly three-quarters of the states." MACPAC, *Medicaid Managed Care Capitation Rate Setting* 1 (Mar. 2022).[9] It was thus incorrect, as a descriptive matter, for the court of appeals to conclude that "furnishing Medicaid" refers exclusively to fee-for-service *base* payments when the predominant way States furnish Medicaid

[9] *Available at* https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf.

relies on other per-patient payment systems to providers. The decision below relied on a one-size-fits-all understanding of what it means to provide insurance that was incorrect.

In any event, the equal-payment provision does not recognize as legally relevant, and does not limit its application based on, the specific forms of payment a State uses to "pay for services furnished" to their Medicaid beneficiaries. 42 C.F.R. § 431.52(b). Instead, the regulation's equal-payment mandate applies generally to *all* payments for "services furnished" to Medicaid beneficiaries, without regard to how States may categorize those payments under their Medicaid plans. *See id.*[10]

Fifth, the D.C. Circuit majority's misreading of subsection (b) is inconsistent with other Medicaid statutory and regulatory provisions that consider base payments and supplemental payments together rather than separately. For example, both base payments and supplemental payments count against the federal upper payment limit, 42 U.S.C. § 1396b(bb)(1)(B)(iv), and qualify for matching federal funds, *id.* § 1396b(a)(2)-(7). *See* App. 27a (Katsas, J., dissenting). As Judge Katsas stated, "only payments 'for Medicaid services' count"

---

[10] The D.C. Circuit majority placed undue weight on the statement in petitioners' Commerce Clause argument that "QAF monies are NOT payments for services rendered." App. 14a. That statement was made in the context of addressing the market-participant exception to the dormant Commerce Clause, and the point was simply that services rendered to *patients* are not services rendered to the *State* as a market participant. *See* C.A.J.A. 508; *see also* C.A.J.A. 507 ("The Market Participation Exception is Irrelevant"). Petitioners were *not* discussing whether QAF supplemental payments qualify as payments for "services furnished" within the meaning of 42 C.F.R. § 431.52(b).

against such upper payment limits, "[s]o under the regulations, payments 'for Medicaid services' must include base and supplemental payments.'" *Id.* (quoting 42 C.F.R. § 447.1).

The majority chose to ignore the upper payment limit because "its proper interpretation [was] not before" the court. App. 20a. But there is no reason not to "consider all pertinent regulations in seeking to best construe the one directly at issue." App. 28a n.3 (Katsas, J., dissenting); *see also Kamen* v. *Kemper Fin. Servs., Inc.*, 500 U.S. 90, 99 (1991) ("When an issue or claim is properly before the court, the court is not limited to the particular legal theories advanced by the parties, but rather retains the independent power to identify and apply the proper construction of governing law.").

Sixth, in addition to the upper payment limit, the D.C. Circuit majority's interpretation is undermined by the reporting requirements for the Disproportionate Share Hospital (DSH) program, which is another type of federal supplemental payment program. The DSH program requires that States report to the federal government the supplemental payments made to out-of-state hospitals, and the reports filed by the States show that many States make supplemental DSH payments to out-of-state hospitals.[11]

---

[11] CMS, *General DSH Audit and Reporting Protocol* 3, https://www.medicaid.gov/medicaid/downloads/general_dsh_audit_reporting_protocol.pdf (requiring reporting of "supplemental" and "DSH" Medicaid payments hospitals receive "from other States"—*i.e.*, States other than "the State in which the hospital is located"); *see also*, *e.g.*, C.A.J.A. 390 (reporting Medicaid Disproportionate Share Hospital supplemental payments to out-of-state hospitals).

C. The D.C. Circuit's Atextual Reading Threatens The Government's Statutory Authority For Billions Of Dollars In Medicaid Funding

The D.C. Circuit's defiance of the plain text of Section 431.52(b), and the direct impact on out-of-state hospitals across the country that would be barred from receiving supplemental payments, are sufficient on their own to warrant review. But the damage done by the opinion does not end there.

The D.C. Circuit's faulty reading calls into question the government's statutory authority to subsidize significant components of States' Medicaid plans. *See* App. 26a-27a (Katsas, J., dissenting). If supplemental payments do not qualify as "pay[ing] for services furnished in another State" within the meaning of 42 C.F.R. § 431.52(b), or even as "furnishing Medicaid" within the D.C. Circuit majority's restrictive reading of 42 C.F.R. § 431.52(a), it is difficult to see how supplemental payments would qualify as part of "the total amount expended … as medical assistance under the State plan" within the meaning of 42 U.S.C. § 1396b(a)(1). This is significant because the federal government's authority to provide federal funds for supplemental payments depends on those payments being considered amounts expended for "medical assistance." 42 U.S.C. § 1396b(a)(1). Indeed, there is statutory symmetry: Federal funding authority depends on the funds being "expended … as medical assistance," *id.*, and Section 431.52(b)'s equal-payment mandate was promulgated under authority to issue regulations "with respect to the furnishing of medical assistance," *id.* § 1396a(a)(16). Thus, as Judge Katsas explained, the D.C. Circuit majority's attempt to carve supplemental payments out of Section 431.52(b)'s equal-payment mandate threatens the statutory basis

for providing federal funds to make those payments—jeopardizing supplemental payments even for California's in-state hospitals. *See* App. 27a (Katsas, J., dissenting).

The D.C. Circuit majority attempted to dodge this problem by suggesting, without deciding, that there might be a difference between total "amount[s] expended … as medical assistance" under 42 U.S.C. § 1396b(a)(1) and "furnishing of medical assistance to individuals" under 42 U.S.C. § 1396a(a)(16). App. 18a-19a. However, that is not a sustainable distinction because both statutory provisions speak to Medicaid beneficiaries receiving the same thing—*i.e.*, "medical assistance." The far more sensible reading is that supplemental payments both qualify as eligible for federal funding and are subject to the equal-payment requirement, eliminating the cloud of uncertainty created by the D.C. Circuit majority regarding the federal government's authority to fund the supplemental payments. The proper reading also avoids difficult questions about whether the D.C. Circuit's restrictive interpretation of the equal-payment mandate poses constitutional problems under the dormant Commerce Clause.

D. The D.C. Circuit Relied On State-Level Policy Considerations To Deprive Out-Of-State Hospitals Of Their Supplemental Payments

The D.C. Circuit majority further erred by relying on the policy design behind California's QAF program to justify excluding out-of-state hospitals from receiving supplemental payments. App. 16a-17a. How California chooses to fund its QAF program as a matter of state-level policy is irrelevant to California's obligation to follow federal requirements in making supplemental

payments under its Medicaid plan. *See* App. 28a (Katsas, J., dissenting).

California has chosen to finance its contribution to supplemental payments through quality assurance fees collected from some (but not all) California hospitals. California's legislative choice to collect fees from a subset of in-state hospitals does not alter the unequivocal mandate that California "pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries." 42 C.F.R. § 431.52(b).

The D.C. Circuit majority reasoned that requiring California to provide out-of-state hospitals with supplemental payments would amount to a "windfall" for border hospitals (App. 16a-17a), but that view misunderstands California's QAF funding mechanism. Out-of-state hospitals would not receive a "windfall" in the form of supplemental payments because California "does not offer" supplemental payments "in return for" quality assurance fees. App. 28a (Katsas, J., dissenting). At least 42% of California hospitals do not pay any quality assurance fees. C.A.J.A. 433 n.11. Also, in a single year, from July 1, 2020, through June 30, 2021, there were 40 non-designated public hospitals and 26 designated public hospitals in California that received $44.8 million and $105.9 million, respectively, in money connected to the QAF program despite paying no quality assurance fees. C.A.J.A. 284-285. In fact, California cannot condition payments to hospitals on their contribution to the QAF program, as federal regulations forbid States from linking Medicaid fees and supplemental payments in such a manner. App. 28a (Katsas, J., dissenting).

Far from preventing a windfall, California's refusal to make supplemental payments to border hospitals

exacerbates the inevitable financial *shortfall* those hospitals face when they are required to treat Medi-Cal beneficiaries. *See* MACPAC, *Medicaid Payments* 4. California thus shifts the costs of providing care for California residents onto hospitals in other States.

The D.C. Circuit suggested that out-of-state hospitals could "opt into" California's QAF program, meaning that they could pay quality assurance fees for their entire patient population in exchange for supplemental payments based on the number of Medi-Cal patient-days of care they provide. App. 4a (citing Cal. Welf. & Inst. Code § 14169.83). But HHS has determined that an opt-in system likely violates federal law. *See* 42 U.S.C. § 1396b(w)(4)(B); C.A.J.A. 309 (email from HHS informing California's DHCS that "a hospital tax where certain providers would be able to voluntarily opt in … in exchange for a Medicaid supplemental payment" is "a non-bona fide provider donation, as prohibited by" 42 C.F.R. §§ 433.66, 433.54); C.A.J.A. 337 (DHCS expressing concern that "the premise of a voluntarily paid tax may be an impermissible hold harmless arrangement" under 42 C.F.R. §§ 433.68(f), 433.72(b)). The alleged option of paying quality assurance fees is thus illusory.

In any event, the policy choices underlying California's decision on how to fund its portion of the QAF program in order to unlock larger amounts of federal funding do not vitiate the plain text of the federal equal-payment provision in 42 C.F.R. § 431.52(b). However California wishes to finance its program of supplemental payments, HHS and CMS do not have discretion to override the clear requirement in the regulation to "pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State." *Id.* "An agency is required to

follow its own regulations." *Cherokee Nation of Okla.* v. *Babbitt*, 117 F.3d 1489, 1499 (D.C. Cir. 1997). This Court's review is necessary to correct this grave misreading of black-and-white federal law.

II. THE QUESTION PRESENTED IS EXCEPTIONALLY IMPORTANT, POTENTIALLY AFFECTING BILLIONS OF DOLLARS IN MEDICAID PAYMENTS

The federal Medicaid program is the largest single source of healthcare coverage in the United States. As of April 2025, Medicaid covered over 71 million Americans, including low-income individuals and families, children, pregnant women, seniors, and people with disabilities. CMS, *Medicaid Eligibility Policy*. Approximately 2% of Medicaid hospital stays occur outside the patient's State of residence. MACPAC, *Medicaid Payment Policy for Out-of-State Hospital Services*, *supra* n.1 (Table A-1). Thus, U.S. hospitals provide nearly 800,000 days of care each year to out-of-state Medicaid patients.[12]

Supplemental payments reduce the inevitable financial shortfalls hospitals face when treating Medicaid patients. Because supplemental payments consist primarily of federal funds, *see* C.A.J.A. 67 (citing *Cove Assocs. Joint Venture* v. *Sebelius*, 848 F. Supp. 2d 13, 16-17 (D.D.C. 2012); 42 U.S.C. § 1396), they have grown steadily and now comprise *over half* of all Medicaid payments

[12] In 2023, there were 561 hospital inpatient days per 1,000 people. KFF, *Key Facts About Hospitals* (Feb. 19, 2025), https://www.kff.org/key-facts-about-hospitals/?entry=national-hospital-spending-medicare-and-medicaid-spending. Based on 71,100,316 Medicaid beneficiaries, the statistics translate into 39,831,000 Medicaid patient days. *Id.* Because approximately 2% of Medicaid hospital stays occur outside the patient's State of residence, there are roughly 800,000 patient-days of care per year provided by out-of-state hospitals.

to U.S. hospitals, *see* MACPAC, *MACStats* 63-64 (Ex. 24).

In this case, petitioners alone are losing approximately $15 million annually in payments under California's QAF program. C.A.J.A. 96. Nationwide, the stakes are far higher. The federal government sends approximately $110 billion to the States per year in supplemental payments to hospitals for their care of the needy. *See* Mosbergen, *U.S. Delays Hospital Payments as Medicaid Scrutiny Intensifies*, Wall St. J. (May 2, 2025).[13] Even if some States do not discriminate against out-of-state hospitals, there are billions of dollars on the line.

The decision also impacts comity among the States. If the decision below is permitted to stand, there will be a continuing race to the bottom as States try to shift as many costs as they can onto out-of-state hospitals that are required to treat patients in emergency situations. Medical emergencies do not respect state lines, and residents who live near state borders or who are traveling often have no choice but to seek care in another State. A proper interpretation of Section 432.52(b) would reduce friction and make clear that States are responsible for the cost of caring for their own Medicaid residents wherever they receive care, eliminating the incentive to dump those costs onto hospitals in other States.

Given the exceptional national importance of the question presented, immediate review is urgently needed. Although the D.C. Circuit resolved the question as an issue of first impression, the Court should not let the problem fester while waiting for a circuit split to

[13] *Available at* https://www.wsj.com/health/healthcare/medicaid-hospital-payments-delay-15a1ab26.

develop. The debate between the D.C. Circuit majority and the strong dissent has fully crystalized the issues for this Court. And the stakes are too high to wait. *See, e.g.*, *Advocate Christ Med. Ctr.* v. *Kennedy*, 145 S. Ct. 1262 (2025) (resolving Medicare hospital-reimbursement case with no circuit split); *American Hosp. Ass'n* v. *Becerra*, 596 U.S. 724 (2022) (reversing D.C. Circuit in Medicare hospital-reimbursement case with no circuit split).

Unless this Court intervenes, a substantial sum of federal Medicaid funding will be misallocated as out-of-state hospitals remain woefully undercompensated for the critical care they provide to other States' Medicaid beneficiaries. This Court's review is urgently needed.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

DEAN L. JOHNSON
DEAN L. JOHNSON, INC.
181 Utsalady Rd.
Camano Island, WA 98282

THOMAS J. WEISS
WEISS & ZAMAN
16946 Ventura Blvd.
Encino, CA 91316

SETH P. WAXMAN
Counsel of Record
THOMAS G. SAUNDERS
OLU O. OISAGHIE
WILMER CUTLER PICKERING
HALE AND DORR LLP
2100 Pennsylvania Ave., NW
Washington, DC 20037
(202) 663-6000
seth.waxman@wilmerhale.com

GARY M. FOX
WILMER CUTLER PICKERING
HALE AND DORR LLP
7 World Trade Center
250 Greenwich St.
New York, NY 10007

SEPTEMBER 2025