No. 25-361

In the Supreme Court of the United States

ASANTE, ET AL., PETITIONERS

v.

ROBERT F. KENNEDY, JR.,
SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

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

BRIEF FOR THE RESPONDENTS IN OPPOSITION

MICHAEL B. STUART
General Counsel
ELIZABETH C. KELLEY
Deputy General Counsel
LENA AMANTI YUEH
Acting Associate General Counsel
JOCELYN S. BEER
LINDSAY S. GOLDBERG
Attorneys
Department of Health and Human Services
Washington, D.C. 20201

D. JOHN SAUER
Solicitor General
Counsel of Record
BRETT A. SHUMATE
Assistant Attorney General
MICHAEL S. RAAB
MCKAYE L. NEUMEISTER
Attorneys
Department of Justice
Washington, D.C. 20530-0001
SupremeCtBriefs@usdoj.gov
(202) 514-2217

QUESTION PRESENTED

Whether 42 C.F.R. 431.52(b) requires that a state Medicaid plan provide supplemental payments to out-of-state hospitals, where the State awards the subsidy to in-state hospitals based on the historic aggregate amount of Medicaid services that each hospital provided and the State funds the subsidy with a tax imposed only on its in-state hospitals.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-29a) is reported at 133 F.4th 97. The opinion of the district court (Pet. App. 31a-54a) is reported at 656 F. Supp. 3d 185.

JURISDICTION

The judgment of the court of appeals was entered on April 4, 2025. A petition for rehearing was denied on July 17, 2025 (Pet. App. 57a, 59a). The petition for a writ of certiorari was filed on September 17, 2025. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

This case involves a challenge to final agency action by the Centers for Medicare & Medicaid Services (CMS) approving amendments to California's plan for its Medicaid program, known as Medi-Cal. The amendments

provide for supplemental payments to certain hospitals in California from July 2019 through December 2021 based on the historic aggregate amount of Medi-Cal services that each provided. Petitioners, a group of out-of-state hospitals located near California, contend that 42 C.F.R. 431.52(b) requires that California provide that supplemental payment to out-of-state hospitals because, they argue, the regulation requires that each State's Medicaid plan provide the same amount of payment for Medicaid services to out-of-state providers as in-state providers. Both the court of appeals—the only appellate court to have addressed the issue—and the district court rejected that contention. Pet. App. 10a-20a, 36a-39a.

1. a. Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq*. (Medicaid statute), establishes the Medicaid program as a cooperative federal-state program that "provides health insurance to [certain] low-income individuals." *Becerra* v. *Empire Health Found*., 597 U.S. 424, 430 (2022); see *United States ex rel. Schutte* v. *SuperValu Inc.*, 598 U.S. 739, 744 (2023). The program supplies "federal funds [to States] in exchange for the States' agreement to spend them in accordance with congressionally imposed conditions." *Armstrong* v. *Exceptional Child Ctr., Inc.*, 575 U.S. 320, 323 (2015). To receive federal funding, a State must adopt a Medicaid plan that satisfies federal requirements and submit it for approval by the Secretary of Health and Human Services (Secretary). 42 U.S.C. 1396a(a) and (b); see 42 C.F.R. 430.10.

The Secretary has delegated to CMS the responsibility for determining whether a state plan (or plan amendment) meets the requirements for approval. See 42 C.F.R. 430.12(c)(2), 430.15(b) and (c). If CMS approves the plan or amendment, the federal government

will pay the State a percentage of its relevant qualifying Medicaid expenses as federal matching funds. 42 U.S.C. 1396b(a)(1).

Three aspects of the Medicaid system and their application to Medi-Cal are presently relevant.

First, the Medicaid statute addresses the payments that a State must make for care and services covered by its Medicaid plan. 42 U.S.C. 1396a(30)(A). Each plan must provide for "payment for[] care and services" that "assure[s] that payments [both] are consistent with efficiency, economy, and quality of care" and "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." *Ibid.* Regulations codified at 42 C.F.R. Part 447 further govern "State plan requirements * * * concerning payments made by State Medicaid agencies for Medicaid services." 42 C.F.R. 447.1. Those regulations ensure that, *inter alia*, each State employs "[p]ayment rates" for "inpatient hospital services" that, at a minimum, "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide [those] services." 42 C.F.R. 447.253(b)(1). A provider may invoke appeal or exemption procedures to challenge the sufficiency of those payment rates. 42 C.F.R. 447.253(e).

Medi-Cal operates under an approved Medicaid plan that provides for "base payment rates" satisfying the relevant payment requirements. C.A. App. 536. The approved plan, *inter alia*, provides "base payment rate methodologies for out-of-state hospitals" that provide care and services to individuals insured by Medi-Cal which are "fairly consistent with the base payment rate

methodologies for in-state California hospitals." *Ibid.* The plan also extends certain aspects of its reimbursement methodology for in-state hospitals to "out-of-state border hospitals" located within 55 miles of California "to recognize the relatively higher likelihood of these border hospitals treating Medi-Cal beneficiaries due to their proximity to California." *Ibid.*

Second, the Medicaid statute acknowledges that, in addition to "base payment[s]," a State may, in certain circumstances, provide "supplemental payments" to certain providers that are "eligible to receive the supplemental payment[s]" under the State's plan. 42 U.S.C. 1396b(bb)(1)(B)(i)-(ii) and (2)(A) (Supp. II 2020); see C.A. App. 537. As relevant here, California provides supplemental payments to certain private "[g]eneral acute care hospital[s]," Cal. Health & Safety Code § 1250(a) (West 2016), that are "licensed" as such by the State, which the State funds through a tax called a quality assurance fee (QAF) imposed only on private general-acute-care hospitals in California. C.A. App. 540-541, 581-585; see Cal. Welf. & Inst. Code §§ 14169.52(a), 14169.55(b) (West 2018). "[R]ecogniz[ing] the essential role that hospitals play in serving the state's Medi-Cal beneficiaries," California enacted that tax-funded program with "the goal of increasing access to care and improving hospital reimbursement through supplemental Medi-Cal payments." Cal. Welf. & Inst. Code § 14169.50(a) and (b) (West 2018).

California distributes the relevant supplemental payments to qualifying private general-acute-care hospitals in rough proportion to the historical amount of Medi-Cal services that each hospital previously provided. See C.A. App. 540-545 (§§ B, C.3-.6, and D.2.a-.f); see also *id.* at 612-614. For the 2019-2020, 2020-2021,

and 2021-2022 fiscal-year subsidies at issue, each eligible hospital is awarded a general-acute-care supplemental payment equal to a dollar amount multiplied by the "total number of Medi-Cal general acute care days" of service that it provided "in the 2016 calendar year." *Id.* at 542-544 (§§ C.4 and D.2.a); see Cal. Welf. & Inst. Code §§ 14169.51(f) and (q), 14169.55(b)(1) (West 2018).

California funds its share of those supplemental payments with its QAF tax, which the State imposes on private "general acute care hospitals" licensed by California based on each hospital's total number of days of patient (not just Medi-Cal patient) care. See Cal. Welf. & Inst. Code §§ 14169.51(r), 14169.52(a), 14169.59(c)(2) (West 2018); C.A. App. 582. Public hospitals and small and rural hospitals, psychiatric and specialty hospitals, and new hospitals are exempt from that tax. C.A. App. 581; see Cal. Welf. & Inst. Code §§ 14169.51(*l*), 14169.52(a) (West 2018).

Out-of-state hospitals—which are licensed by other States—do not pay the QAF tax and are ineligible for California's QAF supplemental payments. C.A. App. 538, 581. If such hospitals were "subject[ed] to the quality assurance fee and [made] eligible to receive" California's subsidy, "they would pay more in fees than they would receive in supplemental payments." *Id.* at 538.

Third, a State's Medicaid plan must include—"to the extent required by regulations prescribed by the Secretary"—"provisions * * * with respect 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).

The relevant implementing regulation states that Section 1396a(a)(16) confers statutory authority to "prescribe State plan requirements for furnishing Medicaid

to State residents who are absent from the State." 42 C.F.R. 431.52(a). Exercising that authority, the regulation requires that each state plan "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" and certain conditions (*e.g.*, a medical emergency necessitating the services) are satisfied. 42 C.F.R. 431.52(b).

The Secretary has long interpreted Section 431.52 to require that, when medical services are provided to a State's Medicaid beneficiary in another State under specified circumstances, the State's Medicaid plan must "pay for [such] services"—*i.e.*, must "furnish[] Medicaid [coverage] to State residents" for out-of-state services —"to the same extent" that it would provide coverage for in-state services, 42 C.F.R. 431.52(a) and (b). See *Mary Hitchcock Mem'l Hosp.* v. *Cohen*, No. 15-cv-453, 2016 WL 1735818, at *13 (D.N.H. May 2, 2016). Under that interpretation, Section 431.52(b) simply addresses "what services will be paid for by Medicaid" when provided "in another state," "not what rates of payment will be made for those services." *Ibid.*; see *Asante* v. *California Dep't of Health Care Servs.*, 155 F. Supp. 3d 1008, 1012 n.1 (N.D. Cal. 2015) (discussing same interpretation in 1996 government amicus brief, available at 14-cv-3226 D. Ct. Doc. 51-2, at 44, 67-70 (Aug. 13, 2015)), rev'd on other grounds, 886 F.3d 795 (9th Cir. 2018).

b. In February 2020, CMS approved two amendments to California's Medicaid plan providing for QAF supplemental payments to private in-state hospitals from July 2019 through December 2021. C.A. App. 535-547, 606-615.

2. Petitioners—seven private hospitals in Oregon, Nevada, and Arizona and the corporate owner of three of those hospitals—filed this district court action under the Administrative Procedure Act (APA), 5 U.S.C. 701 *et seq.*, for judicial review of CMS's February 2020 approval of California's Medicaid plan amendments. Pet. App. 2a, 34a-35a; C.A. App. 17-18, 46-48; see *id.* at 12-50 (complaint). As relevant here, petitioners argued that the aforementioned Medicaid regulation—Section 431.52—requires California's QAF supplemental payments to be provided equally to out-of-state hospitals. C.A. App. 48.

The district court granted summary judgment to the government. Pet. App. 31a-55a. The court rejected petitioners' contention that Section 431.52 requires a state plan to pay the same supplemental payments to in-state and out-of-state providers. *Id.* at 36a-39a. The court instead determined that deference is warranted under *Kisor* v. *Wilkie*, 588 U.S. 558 (2019), to the agency's reasonable interpretation of the regulation as "requir[ing] only that Medicaid cover out-of-state medical services for beneficiaries to the same extent as it covers in-state services." Pet. App. 38a-39a (citation omitted).

3. a. The court of appeals affirmed. Pet. App. 1a-29a. The court rejected petitioner's contention that Section 431.52 imposes "a payment-parity requirement" requiring the "same amount of Medicaid [supplemental] payments" for in-state and out-of-state providers, *id.* at 11a, 16a. See *id.* at 10a-20a. The court, however, did not adopt the Secretary's construction of Section 431.52. The court instead determined that the regulation did not govern "supplemental payments" like California's QAF payments because it interpreted the regulation as addressing only "base payments given in the State's ca-

pacity as a Medicaid beneficiary's health-care insurer—i.e., insurance payments for a specific service rendered to a specific beneficiary." *Id.* at 12a.

The court of appeals reasoned that Section 431.52(a) identifies "the statutory basis for the regulation and sets out its scope" as imposing requirements for "'furnishing Medicaid to State residents who are absent from the State.'" Pet. App. 12a-13a (quoting 42 C.F.R. 431.52(a)). That language, the court stated, shows that the regulation "specifically applies when the State is 'furnishing Medicaid *to State residents*,'" that is, "when the State provides Medicaid insurance to a beneficiary" which pays "the costs of her medical care." *Id.* at 13a (citation omitted). "QAF supplemental payments," the court observed, do "not 'furnish[] Medicaid *to State residents*'" under the regulation because, "[u]nlike base payments," they "do not reimburse providers for the costs of providing specific services to specific beneficiaries" and thus "do not amount to insurance payments to Medi-Cal beneficiaries for the costs of medical services they receive." *Id.* at 5a, 14a (citation omitted).

The court of appeals determined that "the proper understanding of [S]ubsection (b)" of Section 431.52—which addresses "'pay[ments] for services furnished . . . to a beneficiary'"—is informed by "the overall scope of the regulation" that Subsection (a) identifies. Pet. App. 14a-15a (quoting 42 C.F.R. 431.52(b)) (brackets in original). Those payments, the court stated, when read "against the backdrop of [S]ubsection (a), are base payments for specific services given to a specific beneficiary, not supplemental subsidies extended to providers." *Id.* at 15a. The court emphasized that "[petitioners] themselves have stressed that 'QAF monies are NOT payments for services rendered.'" *Ibid.* (citation omitted).

The court of appeals observed that its interpretation is reflected in the "history of the regulation," which in 1970 required state plans to furnish "'[m]edical assistance'" to eligible individuals when they were out of state and, by 1978, required States to "'furnish medicaid'" to such individuals "'to the same extent that medicaid is furnished to residents in the State.'" Pet. App. 15a (quoting 45 C.F.R. 248.40(a)(1) (1971) and 42 C.F.R. 431.52(b) (1978)) (brackets in original). The court explained that the current "pay for services furnished * * * to a beneficiary" language, 42 C.F.R. 431.52(b)—which updated the earlier references to medical assistance and Medicaid—was adopted in a 1991 amendment that did not "purport[] to make any substantive changes to the regulation." Pet. App. 15a.

Finally, the court of appeals noted that petitioners "do not deny that they already receive supplemental Medicaid subsidies from their own States." Pet. App. 17a. The court found "no reason" to interpret Section 431.52(b) to require "windfall [payments] for out-of-state providers" from California's "subsidy pool, into which they do not pay." *Id.* at 16a-17a.

b. Judge Katsas dissented in relevant part. Pet. App. 21a-29a. He concluded that Section 431.52(b) applies to both base and supplemental payments and, thus, prohibits California's payment of QAF subsidies only to in-state hospitals. *Id.* at 23a-24a, 29a.

ARGUMENT

Certiorari is unwarranted. Petitioners contend (Pet. 17-24, 26-29) that the court of appeals erroneously interpreted Section 431.52(b) as inapplicable to "supplemental payments" to hospitals and argue (Pet. 25-26, 29-31) that that regulatory interpretation warrants review. The judgment of the court of appeals is correct,

its decision does not conflict with any decision of this Court or any other court of appeals, and its interpretation of the Medicaid regulation here does not present any question of exceptional importance that might warrant immediate review. Petitioners themselves acknowledge (Pet. 16, 30) that the court of appeals was "the first appellate court to address" the relevant interpretative question. And CMS has informed this Office that it intends to initiate rulemaking in the coming months to revise Section 431.52(b). The Court should therefore deny certiorari.

A. The Court Of Appeals Correctly Determined That Section 431.52(b) Does Not Regulate A State's Supplemental Payments To Medicaid Providers

As the court of appeals held, Section 431.52(b) does not govern "supplemental payments"—like California's QAF payments—that a State may make to providers in addition to the "base payments" paid for services furnished to a Medicaid beneficiary. Pet. App. 10a-20a.

1. a. It is common ground that Section 431.52 implements a provision of the Medicaid statute, 42 U.S.C. 1396a(a)(16), which provides that a State's Medicaid plan must include—"to the extent required by regulations prescribed by the Secretary"—"provisions (conforming to such regulations) with respect 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). Consistent with the statute's focus on provisions regarding the furnishing of medical assistance "to individuals" temporarily outside the State, *ibid.*, Section 431.52(a) explains that Section 431.52 exercises that statutory authority to prescribe requirements for "furnishing *Medicaid to State residents*" when they are outside the State, 42 C.F.R. 431.52(a)

(emphasis added). As the court of appeals correctly recognized, the regulation itself thus addresses the provision of "Medicaid insurance *to a beneficiary*"—*i.e.*, Medicaid coverage which pays "the costs of her medical care." Pet. App. 13a (emphasis added).

Section 431.52(a) does not, however, address supplemental subsidy payments like California's QAF subsidies. California's subsidies are based on the aggregate amount of Medi-Cal services that a hospital previously provided in a baseline period *before* the period in which the hospital provides services to a Medi-Cal beneficiary for which a payment could be due. See pp. 4-5, *supra*. As such, the court of appeals correctly recognized that those subsidies "do not reimburse providers for the costs of providing specific services to specific beneficiaries" and, thus, "do not amount to insurance payments to Medi-Cal beneficiaries for the costs of medical services they receive." Pet. App. 5a, 14a. Those subsidies do not implicate the regulation's requirements, which simply address the "*furnishing* [*of*] *Medicaid to State resident*s who are absent from the State." 42 C.F.R. 431.52(a) (emphasis added).

Petitioners themselves have conceded that California's "QAF monies are NOT payments for services rendered." Pet. App. 14a (citation omitted). And although petitioners now suggest that the court of appeals placed "undue weight" on this concession, Pet. 23 n.10, they have repeatedly confirmed their position about the nature of the QAF payments. See, *e.g.*, Pet. C.A. Br. 25 (arguing that a prior appellate decision "that pertains exclusively to Medi-Cal payment rates for services rendered" was inapposite because California's QAF payments "are completely independent from the payment rates hospitals receive for the Medi-Cal services they

render"); C.A. App. 508 (arguing that such "'supplemental payments'" are not "rates paid by a state for Medi-Cal services rendered" and "have nothing to do with the purchase of services") (citation omitted).

b. The court of appeals also correctly determined that Section 431.52's drafting history demonstrates that, "in all its iterations, the regulation has been concerned with furnishing Medicaid to a beneficiary when outside their home State." Pet. App. 15a-16a.

By 1978, Section 431.52(a) included the aforementioned text limiting the regulation to the "furnishing [of] medicaid to State residents who are absent from the State." 42 C.F.R. 431.52(a) (1978). Section 431.52(b)—which was then (as now) entitled "Payment for services"—likewise provided that, in relevant contexts, a State must "furnish *medicaid to a recipient*" who is a "resident of the State" while temporarily in another State "to the same extent that *medicaid is furnished to residents* in the State." 42 C.F.R. 431.52(b) (1978) (emphases added). That consistent textual focus on "furnish[ing] medicaid to a [state Medicaid] recipient" who is temporarily outside the State, *ibid.*, previously made clear that the regulation addressed only the furnishing of state Medicaid *coverage to individuals* for out-of-state services, not the amount of payment therefor.

Petitioner has argued that the regulation "now imposes an explicit 'payment' requirement, rather than just a 'coverage' requirement," because a "1991 amendment added a 'payment' requirement in the text of [Section 431.52(b)]." Pet. C.A. Br. 50. But the court of appeals correctly observed that the relevant regulatory amendments did not "purport[] to make any substantive changes to the regulation." Pet. App. 15a. CMS would not have significantly overhauled its regulation con-

cerning the extent of Medicaid *coverage* for out-of-state services into one imposing wholly new requirements for the *amount* of payment for those services, without any acknowledgement of that sea change.

Instead, Section 431.52 remains clear that the "[s]tatutory basis" for the regulation is a grant of authority to the Secretary to prescribe requirements for "furnishing Medicaid to State residents" who are absent from the State, 42 C.F.R. 431.52(a), *i.e.*, for furnishing Medicaid coverage "to" such beneficiaries. Subsection (b) exercises that authority to require each state plan to provide that "the State will pay for services furnished * * * to a beneficiary" in certain contexts in which the beneficiary is in another State "to the same extent" it would do so if the beneficiary were in the State. 42 C.F.R. 431.52(b). The Secretary for three decades thus reasonably interpreted that requirement to require that each State's Medicaid plan will *cover*—*i.e.*, "pay for"—certain "services" furnished "to a beneficiary" outside the State to the same extent as the "services" it would cover that are "furnished within its boundaries," *ibid.* See p. 6, *supra*.

c. Petitioners respond (Pet. 19-20) that text in Subsection (b) of Section 431.52 instructing a State to "pay for services" furnished in another State should not be interpreted as being limited by Subsection (a)'s description of the type of authority that the regulation exercises. To be sure, Section 431.52 now contains text that, if read in isolation, could point in different directions. But that ambiguity simply confirms the need to interpret the regulation in the context of all its provisions and the broader regulatory framework.

2. Petitioners focus (Pet. 17-19) most of their textual arguments on their contention that, given that the court of appeals interpreted Section 431.52(b) to govern "base

payments" for out-of-state services, it should have further determined that the regulation also covers "supplemental payments" like California's QAF subsidies, because "Medicaid base payments and supplemental payments both 'pay for services furnished.'" Pet. i, 17. Although the government's position has been that Section 431.52(b) does not govern even "base payment" rates for Medicaid services, it has not sought this Court's review to address that question, which is not squarely presented here. This case therefore does not present a suitable vehicle for the Court to consider whether Section 431.52(b) regulates "base payments." See also pp. 17-18 & n.2 , *infra*.

B. The Court Of Appeals' Interpretation Of Section 431.52(b) Implicates No Conflict Of Authority And Does Not Otherwise Warrant This Court's Review

Petitioners concede (Pet. 16, 30) that the court of appeals resolved an "issue of first impression" in holding that Section 431.52(b) does not govern the amount of "supplemental payments" that must be paid for out-of-state Medicaid services, Pet. 30. Petitioners thus acknowledge (*ibid.*) that no "circuit split" exists. Petitioners nevertheless portray (Pet. 16, 25-26, 29-31) the question whether that regulation applies to "supplemental payments" as "exceptionally important" because it "potentially affect[s] billions of dollars in Medicaid payments," Pet. 29 (capitalization altered). Certiorari is unwarranted for multiple reasons.

1. Petitioners vastly overstate the financial and other consequences of the court of appeals' determination that Section 431.52(b) does not govern the amount of "supplemental payments" for out-of-state services. Petitioners now assert (Pet. 3, 30) that their seven hospitals —some of which purportedly "treat more Medi-Cal pa-

tients" than "many California hospitals"—collectively lose about "$15 million annually" from QAF subsidies that they might obtain if they were inside California. But cf. Pet. C.A. Br. 23 (previously estimating $11.6 million). Petitioners also speculate (Pet. 30) that "billions of dollars [are] on the line" based on a projection that $110 billion is paid annually for every type of supplemental Medicaid payment. Petitioners, however, identify no sound basis for concluding that the court of appeals' interpretation of Section 431.52(b) will itself produce nationally significant differences in supplemental payments that warrant this Court's immediate review.[1]

Indeed, were the financial stakes as stark as petitioner suggests, other hospitals presumably would have brought suit in other courts before now. Hospitals have long been able to file APA actions challenging the approval of a State's Medicaid plan or amendments as inconsistent with Section 431.52(b), either in the districts in which the hospitals reside or in the District of Columbia (where the relevant federal-agency defendants are located). 28 U.S.C. 1391(e)(1)(A) and (C). Other hospitals in Oregon, Nevada, or Arizona that, like petitioners, desire supplemental payments from California's QAF subsidy may still bring suit in districts within the Ninth Circuit.

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[1] Although petitioners assert that over 32 States have laws that "discriminate against out-of-state hospitals in Medicaid reimbursement," Pet. 3 & n.1, they base that assertion on a source identifying differences in "base rate[s]" for out-of-state providers—not supplemental payments—under state "fee-for-service * * * Medicaid programs," Medicaid and CHIP Payment and Access Comm'n, *Medicaid Payment Policy for Out-of-State Hospital Services* 4 (Jan. 2020), https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid-Payment-Policy-for-Out-of-State-Hospital-Services.pdf.

Petitioners assert (Pet. 30) that the court of appeals' view that Section 431.52(b) is inapplicable to "supplemental" Medicaid payments will yield a "continuing race to the bottom" as States attempt to shift costs to out-of-state hospitals. But no such race appears underway. The government has for at least thirty years interpreted Section 431.52(b) to impose no restriction on the amount of payments—supplemental or otherwise—made to out-of-state providers. See p. 6, *supra*. Meanwhile, California and other States have had to submit their state Medicaid plans and amendments for determinations by CMS (or CMS's predecessor) that they satisfy all relevant federal requirements, including Section 431.52(b). If petitioners' purported "race to the bottom" is occurring, it has apparently been moving at an imperceptibly slow pace.

To the extent that petitioners complain that they receive insufficient payment for treating Medi-Cal patients, that complaint ultimately rests on the view that Medi-Cal's "base payments" to out-of-state hospitals are insufficient. But those "base payments" are fairly consistent with the base payments provided to hospitals in California, several categories of which are also ineligible to receive QAF subsidies (*e.g.*, new, specialty, or long-term-care hospitals). See pp. 3-4, *supra*; C.A. App. 540-541 (§ B.1.b, .c, and .2.b). And Medi-Cal's base payments must, at a minimum, be "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers." 42 C.F.R. 447.253(b)(1). Petitioners have not challenged the sufficiency of those payments in this case, nor have they apparently exercised their right to appeal California's base-payment rates under the Medi-Cal system. Cf. 42 C.F.R. 447.253(e). And petitioners' payment

complaints are further undermined by the fact that that they "do not deny that they already receive supplemental Medicaid subsidies from their own States." Pet. App. 16a.

Finally, petitioners suggest (Pet. 25-26) that the court of appeals' decision "calls into question the government's statutory authority" under 42 U.S.C. 1396b(a)(1) "to subsidize significant components of States' Medicaid plans" involving "supplemental payments" with "billions of dollars in Medicaid funding," Pet. 25 (capitalization altered). But as petitioners themselves recognize (Pet. 26), the court considered the relevant statute and found that its decision caused no such problem. Pet. App. 19a-20a. The court identified two alternate grounds for concluding that its interpretation of Section 431.52(b) would be consistent with the government's exercise of Section 1396b(a)(1) authority to provide federal funding for state supplemental payments. *Id.* at 19a. Yet petitioners criticize only the first of those theories, Pet. 25-26, which the court made clear it did not "definitively resolve" here, Pet. App. 19a. Petitioners do not even discuss the second independent basis under which the court's reading of Section 431.52(b) is consistent with federal funding authority for supplemental payments. See *id.* at 19a-20a.

2. Regardless, this Court's review would be unwarranted at this time given the prospect that Section 431.52(b) will soon be amended.

The D.C. Circuit's analysis in this case altered the regulatory status quo by interpreting Section 431.52(b) to govern the amount of "base payments" that must be provided to out-of-state Medicaid providers. Pet. App. 12a. The government's longstanding position has been that Section 431.52 regulates the extent of Medicaid

coverage to beneficiaries, not the amount of "base payments" or other payments to providers like the "supplemental payments" at issue here. See pp. 6, 12-13, *supra*. Since the panel's decision, CMS has informed States in connection with its ongoing review of state Medicaid plan amendments that "previously approved [base] payment methodologies that pay out of state providers differently * * * may be problematic in light of the D.C. Circuit['s] opinion" and, for that reason, "CMS is currently exploring options for how to proceed with this issue, which may include rulemaking." See, *e.g.*, Companion Letter from Todd McMillion, CMS Director, to Rebecca de Camara, Montana Medicaid Director 1 (Dec. 18, 2025), https://www.medicaid.gov/medicaid/spa/downloads/MT-25-0014.pdf. Consistent with that acknowledgement, CMS has provided the Department of Justice with initial drafts of a regulatory amendment to Section 431.52(b) and has informed this Office that it anticipates publishing a notice of proposed rulemaking as early as June 2026 that would include revisions to Section 431.52(b) as part of a larger package of regulatory changes.[2]

The potential that the text of Section 431.52(b) will soon be amended in response to the court of appeals' decision confirms that this Court's review based on the current text of that regulation is presently unwar-

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[2] Notwithstanding the regulatory complications presented by the court of appeals' analysis with respect to "base payments" for out-of-state providers, this case is not a suitable vehicle for this Court to consider the issue. Petitioners have not challenged the legal sufficiency of Medi-Cal's "base payments," and the question that they present asks only whether Section 431.52(b) applies to "supplemental payments." Pet. i. The most appropriate course to address the court's conclusion that Section 431.52(b) governs "base payments" is thus to amend the regulation itself.

ranted. Any decision that the Court might render in this case would have limited prospective effect if the regulatory text is materially revised. And if CMS ultimately elects not to amend the regulation, this Court should have future opportunities to consider whether to grant certiorari if the question presented is significant enough to produce further litigation over the meaning of Section 431.52(b).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

MICHAEL B. STUART
General Counsel
ELIZABETH C. KELLEY
Deputy General Counsel
LENA AMANTI YUEH
Acting Associate General Counsel
JOCELYN S. BEER
LINDSAY S. GOLDBERG
Attorneys
Department of Health and Human Services

D. JOHN SAUER
Solicitor General
BRETT A. SHUMATE
Assistant Attorney General
MICHAEL S. RAAB
MCKAYE L. NEUMEISTER
Attorneys

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