No. 25-361

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

REPLY BRIEF FOR PETITIONERS

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INTRODUCTION

This case presents a clear legal error that affects billions of dollars in hospital reimbursements each year. Respondents' attempts to evade review of that important issue should be rejected.

Section 431.52(b) provides 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). Respondents do not seriously dispute that this plain language requires States to pay out-of-state and in-state hospitals equally for services furnished to Medicaid patients. Instead, respondents attempt to rewrite Section 431.52(b) based on regulatory "history" and "context"—nominally defending the D.C. Circuit's position while making clear that respondents think the D.C. Circuit's overall approach was wrong. But neither the D.C. Circuit's interpretation nor respondents' rejected alternative can overcome Section 431.52(b)'s straightforward mandate. California's supplemental payments are expressly made "for the provision of hospital … services," Cal. Welf. & Inst. Code §§ 14169.54(a), 14169.55(a), and thus are subject to Section 431.52(b)'s equal-payment mandate "for services furnished." And respondents cannot transform a provision explicitly addressing equal *payment* into one addressing only coverage. Section 431.52(b)'s meaning is clear, and it should be applied as written.

Respondents' other arguments do not dispel the urgent need for this Court's review. First, this Court has granted certiorari in numerous reimbursement cases despite the absence of a split in authority among federal courts of appeals. Given the importance of the issue,

involving billions of dollars in Medicaid funding, this Court need not wait before weighing in—especially when the majority and dissent below have already crystalized the issues and the D.C. Circuit's opinion will accelerate an ongoing race to the bottom among States. Second, respondents' argument regarding the sufficiency of California's Medicaid base payments to out-of-state hospitals is a red herring. Hospitals do not have a private right of action to challenge the sufficiency of base payments under federal law, which only serves to underscore the importance of Section 431.52(b)'s parity payment mandate as the key protection for hospitals. Finally, this Court should not rely on respondents' promise of rulemaking, which will not resolve the supplemental payment issue, as a reason to delay granting review. Moreover, the rulemaking process is long, contentious, and uncertain; it is far from guaranteed that any contemplated change to Section 431.52(b) will be adopted; and this Court has granted certiorari in previous cases despite the government representing that a rulemaking process was underway.

ARGUMENT

I. SECTION 431.52(b) PLAINLY MANDATES EQUAL PAYMENT ACROSS STATE LINES FOR SERVICES FURNISHED TO MEDICAID PATIENTS

The text of Section 431.52(b) could not be clearer: 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). Respondents do not even attempt to argue that this language supports their position and, in fact, concede that it "could point in different directions" than their favored interpretation. Opp. 13.

Section 431.52(b) both "says … what it means and means … what it says." *Hartford Underwriters Ins. Co.* v. *Union Planters Bank, N.A.*, 530 U.S. 1, 6 (2000). It is not limited solely to "base payments" or determining what services should be covered. Its mandate to "pay for services furnished … to the same extent," 42 C.F.R. § 431.52(b), requires parity in *payment* for those services.

Unable to draw any support from Section 431.52(b)'s operative text, respondents rely on a *different* provision and *different* language in superseded regulations to try to rewrite the text. But the regulatory context and history reinforce the plain meaning of Section 431.52(b).

First, Section 431.52(a), on which the D.C. Circuit heavily relied, undermines its erroneous interpretation of Section 431.52(b). Like the D.C. Circuit, respondents argue that Section 431.52(a) establishes the "[s]tatutory basis" for all of Section 431.52 as "furnishing Medicaid to State residents." Opp. 13 (quoting 42 C.F.R. § 431.52(a)). The D.C. Circuit then took the further leap of equating "furnishing Medicaid to State residents" with providing insurance coverage that makes base payments to providers, Pet. App. 13a-14a, while respondents argue that it is limited to providing Medicaid "coverage," and "does not govern even 'base payment' rates for Medicaid services," Opp. 14.

The most remarkable aspect of these "statutory basis" arguments is their failure to engage with the actual statute. Section 431.52(a) states that the Secretary's authority comes from "Section 1902(a)(16) of the Act," 42 C.F.R. § 431.52(a), which requires that state Medicaid plans "provide for inclusion, to the extent required by regulations prescribed by the Secretary, … 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) (emphasis added). In turn, the statute defines "medical assistance" to include "*payment* of part or all of the cost of … care and services." *Id.* § 1396d(a) (emphasis added).

In other words, "payment" is central—not incidental—to the statutory authority on which Section 431.52 is based. Indeed, Section 431.52 is titled "Payment for services furnished out of State." The argument that context somehow shows Section 431.52(b) is not an equal-payment mandate is thus completely wrong. The statutory backdrop and regulatory context strongly reinforce that Section 431.52(b) requires *payment* parity—just as it says.

Second, respondents argue that Section 431.52(b)'s plain text should not control because 1991 amendments that produced the current regulation did not "purport[] to make any substantive changes." Opp. 9 (quoting Pet. App. 15a). However, as petitioners have noted, the language in past iterations of Section 431.52(b) supports an equal-payment mandate. *See* Pet. 7-8. For example, a predecessor to the current regulation required "medical assistance" to "be furnished … to the same extent that such assistance is furnished under the plan *to meet the cost of medical care and services rendered*" for Medicaid patients receiving treatment, whether in-state or out-of-state. 45 C.F.R. § 248.40(a)(1) (1971); *see also* Pet. 7. This language prevents payment discrimination against out-of-state hospitals, both because it refers to the "cost" of "services rendered," and because, as noted, the Medicaid Act defines "medical assistance" to include "payment of part or all of the cost" of covered "care and services." 42 U.S.C. § 1396d(a); *see also* Pet. 19.

Third, respondents' position is not consistent with the goals and purposes of the Medicaid Act. "Nothing in Title XIX remotely suggests that a state may use federal funds to give its own hospitals preferential treatment and, at the same time, disadvantage out-of-state hospitals," and "[n]othing in section 1396(a) speaks in terms of a dichotomy in rate reimbursement built on state boundary lines[.]" *West Va. Univ. Hospitals, Inc.* v. *Casey*, 885 F.2d 11, 28-29 (3d Cir. 1989).

Fourth, respondents' half-hearted defense of the D.C. Circuit's position that only base payments are "for services furnished" does not withstand scrutiny. Respondents argue that petitioners conceded "QAF monies are NOT payments for services rendered." Opp. 10 (quoting Pet. App. 14a). However, the quoted statements were made in the context of discussing the market-participant exception to the Dormant Commerce Clause, where the point was that the payments were not for services furnished *directly to the State* as a market participant. Pet. C.A. Br. 25; C.A.J.A. 508. Respondents cannot change the meaning of the law based on statements taken out of context, and this Court "retains the independent power to identify and apply the proper construction of governing law." *Kamen* v. *Kemper Fin. Servs., Inc.*, 500 U.S. 90, 99 (1991).

California law clearly states that supplemental payments are "for the provision of hospital … services" and "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). Nor do respondents dispute that supplemental payments are calculated based on the number of Medi-Cal patient-days of treatment a hospital provides. *Id.* §§ 14169.54, 14169.55. Indeed, respondents concede

that supplemental payments are "based on the aggregate amount of Medi-Cal services that a hospital previously provided." Opp. 11. Respondents stress the time lag but never explain why a delayed payment for services is somehow no longer a payment "for services furnished" under Section 431.52(b). Hospitals are unfortunately accustomed to payment delays, and they do not change the inevitable conclusion that the supplemental payments at issue in this case fall squarely within Section 431.52(b)'s equal-payment mandate.

In short, the merits of this case are clear and one-sided. Neither the D.C. Circuit's interpretation nor respondents' alternative interpretation (which the D.C. Circuit rejected) comports with the clear meaning of Section 431.52(b).

II. THE QUESTION PRESENTED IS EXCEPTIONALLY IMPORTANT, AND REVIEW IS URGENTLY NEEDED

Unable to prevail on the merits, respondents attempt to downplay the question presented and offer other reasons to avoid the issue. The Court should reject those arguments and grant review to resolve the important issue in this case. Supplemental payments are central to the financing of hospital care, and hospitals and the public cannot afford to wait any longer while States blatantly discriminate against out-of-state hospitals.

A. Given The Importance Of This Case, This Court Should Not Wait For A Circuit Split

Respondents get nowhere quibbling with the stakes of this case. With over 71 million Americans on Medicaid and about 2% of Medicaid hospital stays occurring out-of-state, U.S. hospitals provide approximately 800,000 days of care to out-of-state Medicaid patients every

year, Pet. 29 & n.12, at an annual cost of approximately $2.4 billion.[1]

States have increasingly relied on supplemental payments as a core component of the overall compensation for hospitals serving Medicaid patients. Supplemental payments constituted 53% of all Medicaid payments to hospitals in fiscal year 2023. MACPAC, *MACStats: Medicaid and CHIP Data Book* 63-64 (Dec. 2024) (Ex. 24).[2] This figure was 60% in California and well over 70% in several other States. *Id.* Moreover, because base payments and the supplemental payments at issue here are both subject to the federal upper payment limit, base payments must generally fall when supplemental payments rise. *See* 42 U.S.C. § 1396b(bb)(1)(B)(iv).

Hospitals lose money on Medicaid patients even with supplemental payments, and they face an even more dire outlook without those payments. "[E]xcluding supplemental payments[,] Medicaid … paid less than 58 cents for every dollar hospitals spent caring for Medicaid patients in 2023." American Hosp. Ass'n, *Fact Sheet: Medicaid Hospital Payment Basics* (Feb. 2025).[3] "[E]ven including supplemental payments, Medicaid still pays less than the cost of providing care to Medicaid patients." *Id.*

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[1] Based on an average cost of $3,025 per inpatient day. McAllister, *State-by-State Breakdown – Average Cost of Hospital Stays in the U.S. 2025*, NCHStats (Nov. 21, 2025), https://nchstats.com/average-cost-of-hospital-stays-in-us/.

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

[3] *Available at* https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid-hospital-payment-basics.

Worse still, children will be disproportionately affected by CMS's failure to enforce Section 431.52(b)'s equal-payment mandate. Medicaid covers over 37 million children—nearly half of all children in the United States. American Acad. of Pediatrics, *AAP Analysis: 49% of Children Insured by Medicaid or CHIP* (Feb. 27, 2025).[4] CMS itself recognizes such children often must travel out-of-state for highly specialized care. CMS, *CMS Offers Roadmap for States to Help Connect Children with Complex Medical Conditions to Critical Medicaid Services* (Aug. 1, 2022).[5] "Nearly 90% of children's hospitals serve out-of-state patients, receiving payments from more than six states on average." Meyer, *Families with Sick Kids on Medicaid Seek Easier Access to Out-of-State Hospitals* (Apr. 5, 2021).[6]

Even though the magnitude of the problem demands swift action, respondents advocate delay because no circuit split has yet emerged. *See* Opp. 14, 19. But this Court has not hesitated to grant review in other important hospital-reimbursement cases even without circuit splits. Pet. 31 (citing *Advocate Christ Med. Ctr.* v. *Kennedy*, 145 S. Ct. 1262 (2025), and *American Hosp. Ass'n* v. *Becerra*, 596 U.S. 724 (2022)). Respondents fail to address those cases, or explain what waiting would

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[4] *Available at* https://publications.aap.org/aapnews/news/31491/AAP-analysis-49-of-children-insured-by-Medicaid-or.

[5] *Available at* https://www.cms.gov/newsroom/press-releases/cms-offers-roadmap-states-help-connect-children-complex-medical-conditions-critical-medicaid.

[6] *Available at* https://www.npr.org/sections/health-shots/2021/04/05/984435809/families-with-sick-kids-on-medicaid-seek-easier-access-to-out-of-state-hospitals.

accomplish when the D.C. Circuit's majority opinion and dissent have already crystallized the legal issues.

B. The Decision Below Risks Accelerating A Nationwide Race To The Bottom

The D.C. Circuit's decision threatens comity among the States, creating strong incentives to shift costs onto other States. *See* Pet. 30. Respondents insist there will be no race to the bottom because they have had the same flawed interpretation of Section 431.52(b) for the last 30 years—albeit an interpretation no judge on the D.C. Circuit adopted. But if past is prologue, it is hardly reassuring. Without enforcement of the payment-parity mandate, States have steadily increased the use of supplemental payments to favor in-state hospitals, and supplemental payments have now overtaken base payments as the majority of Medicaid payments to hospitals. MACPAC, *MACStats* 63-64 (Ex. 24).

Respondents also overlook that the race to the bottom was paused for the decade immediately preceding this litigation because of a settlement that resulted in QAF supplemental payments to petitioners. Pet. 13-14. Not only has that pause been lifted, but the D.C. Circuit's opinion will accelerate the problem, particularly given the D.C. Circuit's leadership on issues of administrative law.

It is no answer to argue that out-of-state hospitals receive supplemental Medicaid subsidies from their own States. Opp. 17. These supplemental payments are for the Medicaid patients those hospitals treat from their home States, and not for the Medicaid patients they treat from other States. This case is about the cost of Medicaid patients who are not treated in their home States.

C. Respondents' Argument Regarding The Sufficiency Of Base Payments Is A Red Herring

Attempting to divert attention from the true issue in this case, respondents reframe petitioners' arguments as a challenge to the sufficiency of base payments. *See* Opp. 16. It is true that permitting discrimination in supplemental payments has led to the reduction of already inadequate base payments. But it is misleading for respondents to suggest that the remedy lies in a suit challenging the adequacy of base payments. By statute, Medicaid plans are supposed "to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers." 42 U.S.C. § 1396a(a)(30)(A). However, this Court has held that there is no private right of action to enforce that statutory provision. *Armstrong* v. *Exceptional Child Ctr., Inc.*, 575 U.S. 320, 327-329 (2015). Like all other hospitals, then, petitioners have no federal cause of action to challenge the adequacy of California's base payments. Moreover, the Emergency Medical Treatment & Labor Act ensures that out-of-state hospitals cannot refuse to treat Medicaid beneficiaries from other States. 42 U.S.C. § 1395dd.

Section 431.52(b) thus stands as the only remaining guardrail protecting out-of-state hospitals from being subjected to extremely low reimbursement rates relative to in-state hospitals. Unless it is enforced as written, out-of-state hospitals would have no guarantee of being paid at even a modest fraction of the rate in-state hospitals receive for providing the same services.

Respondents' other diversion regarding base payments fares no better. They argue that Section 431.52(b) does not "govern even 'base payment' rates for Medicaid services"—a position rejected by the D.C. Circuit—but

then assert that "[t]his case … does not present a suitable vehicle for the Court to consider whether Section 431.52(b) regulates 'base payments'" because respondents have "not sought this Court's review to address that question." Opp. 13-14. That is a stunning argument. Respondents are implying that this Court should deny review precisely because the D.C. Circuit's opinion was *wrong*. That is completely backwards. Respondents' belief that the D.C. Circuit was wrong only underscores the need for this Court to definitively interpret Section 431.52(b).

D. The Court Should Not Delay Review Based On The Uncertain Prospect Of Rulemaking

For the first time in this litigation, respondents now state that CMS might amend Section 431.52 to eliminate the equal-payment mandate for base payments. Opp. 17-18. But that would do nothing to address the existing misallocation of supplemental payments, except compound it by extending it to base payments. This tactic also highlights the weaknesses in respondents' textual arguments, because if Section 431.52(b) stated what respondents believe it to say, there would be no need to consider changing the regulation.

Even if CMS were serious about pursuing rulemaking, uncertainties abound. Respondents admit CMS may "ultimately elect[] not to amend the regulation." Opp. 19. There could be significant debate within CMS, or HHS more generally, that calls into question any proposed amendment to Section 431.52(b). Concerns with any of the other rules within the "larger package of regulatory changes" could doom or delay the whole package. *See* Opp. 18. The agencies could run into issues during review by the Office of Information and Regulatory Affairs. Public comments from stakeholders could

necessitate further delays while the rule is overhauled in response. And any final rule could end up being set aside if there are any flaws in the administrative process, leading back to the current version of Section 431.52(b). That is far too much unpredictability to alter this Court's decisionmaking.

In previous cases, the Court has been undeterred by agencies' vague promises of rulemaking. For example, in *Knight* v. *Commissioner*, No. 06-1286, the government argued against this Court's review because "the process of preparing a notice of proposed rulemaking addressing the question at issue" was "underway." 2007 WL 1520971, at *6 (May 25, 2007). Despite the government's representation, this Court granted certiorari and resolved the question presented. *Knight* v. *Commissioner*, 552 U.S. 181, 187 (2008). The Court should take the same path here.

If the Court were to deny certiorari based on the vagaries of potential future rulemaking, it would be fundamentally unfair to the hospitals that will continue losing millions of dollars in the meantime. It would also set a bad precedent, making clear that this Court can be manipulated by vague statements—made for the first time after the Court calls for a response to a petition for certiorari—regarding potential future action that may never come to fruition.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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