Supreme Court Preview for Local Governments 2021-22

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The State and Local Legal Center (SLLC) files Supreme Court amicus curiae *briefs on behalf of the Big Seven national organizations representing state and local governments.*

*Indicates a case where the SLLC has or will likely file an *amicus* brief.

In *New York State Rifle and Pistol Association v. Corlett** the U.S. Supreme Court will decide whether states may prevent persons from obtaining a concealed-carry license for self-defense if they lack "proper cause." Per New York state law, in order to carry a concealed handgun for self-defense purposes a person must show "proper cause." New York case law requires an applicant to "demonstrate a special need for self-protection distinguishable from that of the general community" to satisfy the proper cause standard. The challengers in this case want to carry a concealed handgun but lack proper cause. A federal district court ruled against the challengers based on Second Circuit precedent. In a very brief opinion, noting that same Second Circuit case, the Second Circuit affirmed. In *Kachalsky v. County of Westchester* (2012), the Second Circuit held that "New York's handgun licensing scheme . . . requiring an applicant to demonstrate 'proper cause' to obtain a license to carry a concealed handgun in public" did not violate the Second Amendment. In *Kachalsky*, the Second Circuit applied intermediate scrutiny and upheld New York's law stating: "New York has substantial, indeed compelling, governmental interests in public safety and crime prevention" and "the proper cause requirement is substantially related to these interests." According to the challengers, *Kachalsky* was wrongly decided for the reasons the D.C. Circuit stated in *Wrenn v. District of Columbia* (2017). In that case the D.C. Circuit didn't apply intermediate scrutiny to the District of Columbia's similar "good reason" limit to obtain a concealed carry license. The D.C. Circuit held "the law-abiding citizen's right to bear common arms must enable the typical citizen to carry a gun." According to the Second Circuit, the "argument that *Kachalsky* was wrongly decided fails under this Court's precedents."

The City of Austin allows on-premises billboards to be digitized but not off-premises billboards. In *City of Austin, Texas v. Reagan National Advertising of Texas Inc.** two outdoor advertising companies claim that this distinction is "content-based" under the First Amendment. The City of Austin disagrees. In *Reed v. Town of Gilbert* (2015), the Supreme Court held that content-based restrictions on speech are subject to strict scrutiny, meaning they are "presumptively unconstitutional" under the First Amendment. In *Reed* the Court defined "content-based" broadly to include distinctions based on "function or purpose." Per Austin's Sign Code, "off-premises" signs advertise "a business, person, activity, goods, products or services not located on the site where the sign is installed." The City argued that the definition of off-premises is a time, place, or manner restriction based on the location of signs. The Fifth Circuit disagreed, stating: "*Reed* reasoned that a distinction can be facially content based if it defines regulated speech by its function or purpose. Here, the Sign Code defines 'off-premises' signs by their purpose: advertising or directing attention to a business, product, activity, institution, etc., not located at the same location as the sign."

In *Houston Community College System v. Wilson* the U.S. Supreme Court will decide whether the First Amendment restricts the authority of an elected body to issue a censure resolution in response to a member's speech. David Wilson was an elected trustee of the Houston Community College System (HCC). In response to the board's decision to fund a campus in Qatar, he arranged robocalls and was interviewed by a local radio station expressing his disagreement with the decision. He filed a lawsuit against HCC after it allowed a trustee to vote via videoconference, which he contended violated the bylaws. He sued the board again when it allegedly excluded him from an executive session. The board publicly censured him for acting in a manner "not consistent with the best interests of the College or the Board, and in violation of the Board Bylaws Code of Conduct." Wilson sued HCC and the trustees, asserting that the censure violated his First Amendment right to free speech. HCC argued that "it had a right to censure Wilson as part of its internal governance as a legislative body and that Wilson's First Amendment rights were not implicated." However, the Fifth Circuit noted it has repeatedly held that "a reprimand against an elected official for speech addressing a matter of public concern is an actionable First Amendment claim." In this case, Wilson was censured because of his speech.

In *Thompson v. Clark** the Supreme Court will decide whether the rule that a plaintiff must await favorable termination before suing for unreasonable seizure pursuant to legal process requires the plaintiff to show that the criminal proceeding against him has "formally ended in a manner not inconsistent with his innocence" or that the proceeding "ended in a manner that affirmatively indicates his innocence." Larry Thompson's sister-in-law, Camille, who was living with him, reported to 911 that Thompson was sexually abusing his week-old daughter. Thompson wouldn't let police into his apartment because they didn't have a warrant, blocked their path to entry, and allegedly shoved an officer. It was soon determined that Camille's report was false; she suffered from a mental illness which the officers "sensed" when they were in the apartment. Police arrested Thompson and he was charged with obstructing governmental administration and

resisting arrest. The prosecutor dropped charges against him "in the interests of justice." The Second Circuit held that Thompson couldn't bring a malicious prosecution claim because he failed to prove that the prosecution against him terminated favorably. In a 2018 case, *Lanning v. City of Glens Falls*, the Second Circuit held that malicious prosecution claims require "affirmative indications of innocence to establish favorable termination." In this case Thompson's innocence wasn't established because the only reason the prosecutor gave for dismissing charges against him was "the interests of justice."

In *Cummings v. Premier Rehab Keller** the Supreme Court will decide whether people who are discriminated against in violation of Title VI, Title IX, Section 504 of the Rehabilitation Act, Title II of the Americans with Disabilities Act, or the Affordable Care Act may sue for emotional distress damages. All these statues expressly incorporate the private right of action available to victims of discrimination under Title VI. Jane Cummings has been deaf since birth and is legally blind. She communicates mostly through American Sign Language (ASL). She contacted Premier, which offers physical therapy services, to treat her chronic back pain. She repeatedly requested that Premier provide an ASL interpreter, but it refused. She sued Premier under the Rehabilitation Act and the ACA for disability discrimination and sought emotional distress damages. The Fifth Circuit held that emotional distress damages aren't available under these statutes. The Rehabilitation Act and the ACA are Spending Clause legislation. According to the Fifth Circuit, the Supreme Court has "repeatedly" likened Spending Clause legislation to contract law—"in return for federal funds, the [recipients] agree to comply with federally imposed conditions." In *Barnes v. Gorman* (2002), the Supreme Court explained compensatory damages are available under Spending Clause legislation because federal-funding recipients are "on notice" that accepting such funds exposes them to liability for monetary damages under general contract law. In *Barnes*, the Supreme Court also held that punitive damages *aren't* available under Spending Clause legislation because they aren't generally available for breach of contract. So, federal funding recipients aren't "on notice" that they could be liable for punitive damages. According to the Fifth Circuit, emotional distress damages, like punitive damages are "traditionally unavailable in breach-of-contract actions." So, the court held, federal-funding recipients aren't on notice of them and can't be held liable for them.

In *CVS Pharmacy v. Doe** the U.S. Supreme Court will decide whether disability disparate impact claims may be brought under Section 504 of the Rehabilitation Act and therefore under Section 1557 of the Affordable Care Act (ACA). The Does are individuals living with HIV/AIDS who rely on employer-sponsored health plans for their medications. Per their prescription plan, to receive "in-network" prices they can only obtain specialized medication via mail or pick up at a CVS pharmacy. This means they must "forego essential counseling and consultation from specialty pharmacists." The Does sued CVS for disparate impact disability discrimination under the ACA. Section 1557 of the ACA prohibits federally funded health programs from discriminating based on race, color, national origin, sex, age, or disability. Section 1557 of the ACA incorporates the anti-discrimination provisions of various civil rights

statutes including, for disability, Section 504 of the Rehabilitation Act. So, to be able to sue for disparate impact disability discrimination under the ACA it must likewise be possible to sue for disparate impact disability discrimination under the Rehabilitation Act. The Ninth Circuit assumed that disparate-impact claims could be brought under *Alexander v. Choate* (1985), stating "the Supreme Court concluded that not all disparate-impact showings qualify as prima-facie cases under Section 504." The Ninth Circuit then applied the "test outlined in *Choate"* for assessing Section 504 claims and concluded the Does stated a claim for disability discrimination under the ACA. According to the Ninth Circuit, *Choate* required it to look to the ACA to determine "whether Does adequately alleged they were denied meaningful access to an ACA-provided benefit." The ACA requires that health plans cover prescription drugs as an "essential health benefit." The Ninth Circuit concluded: "Does have adequately alleged that they were denied meaningful access to their prescription drug benefit, including medically appropriate dispensing of their medications and access to necessary counseling."

In *Gallardo v. Marstiller** the U.S. Supreme Court will decide whether the federal Medicaid Act allows a state Medicaid program to recover reimbursement for Medicaid's payment of a beneficiary's past medical expenses by taking funds from the beneficiary's tort recovery that compensate for future medical expenses. Gianinna Gallardo has been in a persistent vegetative state since she was hit by a pickup truck getting off the school bus. Florida's Medicaid program has paid for almost $900,000 for her medical care. Her parents settled a case against multiple parties for $800,000. Per the settlement agreement, about $35,000 was for past medical expenses. The settlement also said some of its balance may represent compensation for future medical expenses. The Florida Agency for Health Care Administration (FAHCA) didn't participate in the settlement. The Medicaid statute requires states to enact third-party liability laws under which "the State is considered to have acquired the rights . . . to payment by any other party," "to the extent that payment *has been made* under the State plan for medical assistance." Per Florida law if a Medicaid recipient brings a tort action against a third party that results in a settlement, FAHCA is automatically entitled to half of the recovery (after 25 percent attorney's fees and costs), up to the total amount of medical assistance Medicaid has provided, from the settlement allocated for past and *future* medical expenses. FAHCA sought to recover not just the $35,000 specifically allocated by the parties for past medical expenses. It argued it was entitled to recover, to pay for past medical costs, the portion of the settlement representing compensation for Gallardo's future medical expenses. The Eleventh Circuit agreed. Gallardo argued that FAHCA could collect only the portion of the settlement allocated for past medical expenses because of the past tense of the language in the Medicaid statute: states have a right to payment from third parties "to the extent that payment *has been made*." According to the Eleventh Circuit, this language "simply provides *for what* the state can get reimbursed now that it has a general assignment on all medical expenses—it can recover medical expenses it has already paid." "[W]hile the language of the federal Medicaid statutes clearly prohibits FAHCA from seeking reimbursement *for* future expenses it has not yet paid (which it is not seeking to do

in this case), the language does not in any way prohibit the agency from seeking reimbursement *from* settlement monies for medical care allocated to future care."

The issue in *Becerra v. Empire Health Foundation* is whether the U.S. Department of Health and Human Services can, for calculating the disproportionate share hospital (DSH) payment, include in the Medicare fraction all of a hospital's patient days of individuals who qualify for Medicare Part A benefits, regardless of whether Medicare actually paid the hospital for those particular days. Medicare hospitals that "serve[s] a significantly disproportionate number of low-income patients," receive a DSH adjustment, which approximately reimburses them for the higher costs of providing care. The Medicare statute contains two fractions intended to capture a hospital's number of patient days attributable to two different groups of low-income patients—the Medicare fraction and the Medicaid fraction. The Medicare fraction looks at what proportion of the hospital's "patients who (for such days) were **entitled** to benefits under [Medicare] Part A" were also "**entitled**" to Supplemental Security income. In 2005 the HHS Secretary removed the word "covered" from the rule interpreting "entitled to [Medicare]" in the Medicare fraction. The practical effect was instead of counting only the hospital stay days *actually* paid for by Medicare Part A, all days Medicare theoretically *could have* paid for are counted. Someone who qualifies for and receives Medicare but whose hospital stay exceeds the 90 days allowed by Medicare theoretically could have their entire hospital stay covered by Medicare but in fact won't past 90 days. HHS argues that this rule is procedurally and substantively valid pursuant to the Administrative Procedure Act. The Ninth Circuit disagreed. The *Medicaid* fraction looks at what proportion of a hospital's non-Medicare patients, i.e., patients who are not "**entitled** to benefits under [Medicare] part A," were "**eligible** for [Medicaid]." Before HHS issued the rule at issue in this case, HHS contended that only patients who actually had their hospital stay paid for by Medicare or Medicaid would be considered "entitled to [Medicare]" or "eligible for [Medicaid]." In *Legacy Emanuel Hospital Health Center v. Shalala* (1996), the Ninth Circuit rejected HHS's interpretation of the word "eligible." In that case, "[w]e interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment.' In contrast, we interpreted the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria." In *Empire Health Foundation* the Ninth Circuit rejected HHS's interpretation of "entitled" as simply meeting the Medicare criteria, relying on *Legacy Emanuel*.

In *American Hospital Association v. Becerra* the U.S. Supreme Court will decide whether the Department of Health and Human Services (HHS) may set the reimbursement rates for drugs covered by Medicare based on acquisition cost and vary such rates by hospital type if HHS has not collected hospital acquisition cost data. When hospitals provide outpatient care for those insured by Medicare Part B, the federal government reimburses the hospitals for the cost of care. Until 2018 the federal government reimbursed all hospitals for prescription drugs at the same rate. Then the federal government reduced the reimbursement rate for 340B hospitals, who serve underserved populations, by 28.5%. 340B hospitals can obtain drugs much more cheaply than other hospitals. Subclause I of the Medicare statute allows HHS to calculate reimbursement rates

for covered drugs using acquisition **cost** "taking into account . . . **hospital acquisition cost survey data**." If acquisition cost survey data isn't available, Subclause II requires HHS to use the average **price** for the drug, "**adjusted** by [HHS] as necessary for purposes of this paragraph." Hospital acquisition cost data has never been available. So, until 2018, HHS used the average price metric to calculate one reimbursement rate. HHS points out that it has long understood average price to serve as a proxy for average acquisition cost. For 340B hospitals the average drug price exceeded the cost of the drugs. So, for 340B hospitals, per Subclause II, HHS "adjusted" payments "as necessary" based on cost. The American Hospital Association argued that reimbursing hospitals based on the cost of drugs is impermissible under Subclause II. "Because Congress required HHS to 'tak[e] into account' robust study data when setting [drug reimbursement] rates at average acquisition cost under subclause (I), the Hospitals argue, HHS cannot use its subclause (II) authority to adjust [the average sale price] in order to approximate acquisition cost." Applying *Chevron* deference, the D.C. Circuit concluded HHS's interpretation of Subclause II was reasonable. According to the D.C. Circuit: "For the Hospitals' argument to carry the day under *Chevron*, we would need to conclude that Congress unambiguously barred HHS from seeking to align reimbursements with acquisition costs under subclause (II), or that HHS's belief that it could do was unreasonable." "Given that the survey data contemplated by subclause (I) aims to assure the reliability of cost-acquisition data, we do not read the statute to foreclose an adjustment to [average sale price] under subclause (II) that is based on reliable cost measures of the kind undisputedly at issue here." The Supreme Courted added a second question regarding whether the American Hospital Association may even bring a lawsuit in this case. The relevant statute states "[t]here shall be no administrative or judicial review" of certain enumerated actions undertaken by HHS. HHS argues that changing the drug reimbursement rate is one of such unreviewable actions. The D.C. Circuit disagreed.