

Medicaid Access After Health Reform: The Shifting Legal Basis for Equal Access

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I. INTRODUCTION

Carol is fifty-three and has cancer that has metastasized to her brain and liver.¹ She is enrolled in Medicaid.² Her long-term primary care physician recently informed her that she is no longer treating Medicaid patients.³ Randy is forty-six and has been unemployed for fifteen months.⁴ He is enrolled in Medicaid and in desperate need of a root canal.⁵ His local dentist recently informed him that Medicaid no longer covers the procedure.⁶ Shannon has an eight-year-old son who needs his tonsils and adenoids removed.⁷ He is enrolled in Medicaid.⁸ Unfortunately, the nearest specialist that accepts Medicaid patients is more than two hours away.⁹

Due to the current financial crisis, states are cutting Medicaid to balance financially-strained state budgets.¹⁰ Some states are taking a hard look at opting out of Medicaid altogether.¹¹ On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (The Affordable Care Act),¹² which adds approximately seventeen million new beneficiaries to already strained Medicaid rolls.¹³ Despite this mandate, Congress has failed to enact fundamental reimbursement reforms needed to assure access to quality care.¹⁴

¹ Steven Sack, *As Medicaid Payments Shrink, Patients Are Abandoned*, N.Y. TIMES, Mar. 15, 2010, <http://www.nytimes.com/2010/03/16/health/policy/16medicaid.html>.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ Sack, *supra* note 1.

⁸ *Id.*

⁹ *Id.*

¹⁰ Marilyn Werber Serafini and Julie Appleby, *States May Face Showdown With Feds Over Cutting Medicaid Rolls*, KAISER HEALTH NEWS, Feb. 3, 2011, <http://www.kaiserhealthnews.org/Stories/2011/January/28/medicaid-maintenance-of-effort.aspx>.

¹¹ Althea Fung, *Texas Considers Opting Out of Medicaid*, NATIONAL JOURNAL, Nov. 15, 2010, <http://www.nationaljournal.com/texas-considers-opting-out-of-medicaid-20101115>.; David McGrath Schwartz, *Wary of Health Care Reform, Gibbons Weighs Rejecting Federal Medicaid Funds*, LAS VEGAS SUN, Jan. 15, 2010, <http://www.lasvegassun.com/news/2010/jan/15/wary-health-care-reform-gibbons-weighs-rejecting-f/>.

¹² Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

¹³ Karyn Schwartz & Anthony Damico, EXPANDING MEDICAID: COVERAGE FOR LOW-INCOME ADULTS UNDER HEALTH REFORM 1, 1 (The Henry J. Kaiser Family Foundation 2010).

¹⁴ David Hogberg, *ObamaCare Rules For Paying Doctors Might Spur Exodus*, INVESTOR'S BUSINESS DAILY, Mar. 30, 2010, <http://www.investors.com/NewsAndAnalysis/Article.aspx?id=528916>; Pay Wechsler & Chad Terhune, *Dr. Orr Begins Home Pilot as Health Law Brings Medicaid Surge*,

For example, Medicaid reimbursement rates are still well below those of Medicare and private insurance.¹⁵ The Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 make strides towards increasing access by tying Medicaid rates to Medicare reimbursement; however, the rate match applies only to care furnished by primary care physicians in 2013 and 2014.¹⁶ Moreover, the scope of Medicaid providers classified as primary care physicians is narrow¹⁷ and does not include care providers in the most needed specialty practices. Thus, even after the passage of the Affordable Care Act, patients continue to face a two-tiered payment system resulting in disparities in access to care. This Comment explores Medicaid's Equal Access provision,¹⁸ also known as § 30A, which Congress enacted to assure access to care among Medicaid beneficiaries.¹⁹ This broad and worthy goal has run into multiple road blocks in the hands of the judiciary, and Congress has been quite slow to respond.²⁰

Traditionally, providers and beneficiaries could enforce the Equal Access provision under 42 U.S.C. § 1983 as a civil rights claim by asserting that Medicaid reimbursement was so low that it discouraged provider participation and detrimentally impacted access to care.²¹ In the

BUSINESSWEEK, Mar. 31, 2010, <http://www.businessweek.com/news/2010-03-31/dr-orr-begins-home-pilot-as-health-law-brings-medicaid-surge.html>; John V. Jacobi, *Medicaid Cuts: Where's the Outrage?*, HEALTH REFORM WATCH (March 16, 2010), <http://www.healthreformwatch.com/2010/03/16/medicaid-cuts-where%e2%80%99s-the-outrage/> ("If Medicare services or provider rates were cut, or threatened to be cut to balance the budget, the firestorm would be epic. Republicans would accuse Democrats suggesting such cuts of stealing from the elderly. Democrats would accuse Republicans suggesting such cuts of trying to abolish Medicare. AARP would express outrage, and if it didn't do so loudly enough tea partiers would urge seniors to burn their AARP cards in an incongruous support of a government health care program. So where's the outrage when states faced with budget cuts look first to cut Medicare's sister program, Medicaid?").

¹⁵ See Stephen Zuckerman, Aimee F. Williams & Karen E. Stockley, *Trends in Medicaid Physician Fees, 2003-2008*, 28 HEALTH AFFAIRS 510, 517 (Apr. 2009).

¹⁶ Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029.

¹⁷ *Id.* (matching Medicaid payments for family medicine, general internal medicine, and pediatric medicine at 100% or more of Medicare payments for primary care).

¹⁸ 42 U.S.C. § 1396a(30)(A) (2006); see Part III *infra*.

¹⁹ 42 U.S.C. § 1396a(30)(A).

²⁰ Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 677 (2006); Edward Alan Miller, *Federal Administrative and Judicial Oversight of Medicaid: Policy Legacies and Tandem Institutions under the Boren Amendment*, PUBLIUS: THE JOURNAL OF FEDERALISM (2007); Jacobi, *supra* note 14.

²¹ *Pre-Gonzaga*, a circuit split existed regarding whether providers or beneficiaries could enforce the equal access provision using 42 U.S.C. § 1983. Compare *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531 (3d Cir. 2002), and *Walgreen Co. v. Hood*, 275 F.3d 475 (5th Cir. 2001) (noting that providers are not intended beneficiaries and do

1990s, a circuit split developed regarding the provision's interpretation.²² After the landmark decision by the Supreme Court in *Gonzaga University v. Doe*,²³ providers and beneficiaries seeking to enforce the Equal Access provision pursuant to § 1983 have achieved success in only one circuit, leaving five sister circuits that refuse to recognize a cause of action.²⁴ Now, rather than filing suit under § 1983, providers and patients are seeking to enforce § 30A under the Supremacy Clause of the United States Constitution.²⁵ Having achieved success under this novel cause of action,²⁶ courts are being asked to re-examine a revived pre-*Gonzaga* circuit split with respect to the statute's interpretation. The Supreme Court recently granted certiorari to hear a case addressing whether providers and patients have a cause of action under the Supremacy Clause to enforce the Equal Access provision.²⁷ The Court, however, declined to hear argument regarding the interpretation of the statute.²⁸ The Court will hear oral argument with respect to the ability to enforce the Medicaid statute via the Supremacy Clause during its 2011 term.²⁹

not have a cause of action under § 1983 to enforce § 30(A)), *with* *Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 1004 (1st Cir. 1996), *Methodist Hosp., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996), *and* *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 526 (8th Cir. 1993) (noting that providers have a cause of action under § 1983 to enforce 30(A)). *See also* *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997) (hearing and deciding in favor of a provider (hospital) based on a § 1983 cause of action seeking to enforce 30(A), but never addressing the hospital's right to sue as a provider).

²² *Compare* *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998), *Minn. Homecare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997), *and* *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 51, 530 (8th Cir. 1993) (noting that § 30(A) is a procedural standard that requires a study), *with* *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 933 (5th Cir. 2000), *Rite Aid, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999), *and* *Methodist Hosps, Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (noting that § 30(A) is not procedural and does not require a study but a substantive result).

²³ 536 U.S. 273 (2002).

²⁴ *Compare* *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007), *Mandy R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006), *Westside Mothers v. Olszewski*, 454 F.3d 532 (6th Cir. 2006), *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), *and* *Long Term Care Pharm. Alliance v. Ferguson*, 362 F.3d 50 (1st Cir. 2004), *with* *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005 (8th Cir. 2006), *vacated on other grounds*, *Selig v. Pediatric Specialty Care, Inc.*, 551 U.S. 1142 (2007).

²⁵ *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009); *Memorandum of Law in Support of Plaintiff's Motion for a Preliminary Injunction, Conn. Assoc. of Health Care Facilities, Inc. v. Rell*, No: 3:10-CV-136 (D. Conn. Feb. 16, 2010).

²⁶ *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008).

²⁷ *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., Inc.*, 130 S. Ct. 3349 (2010).

²⁸ *Id.*

²⁹ *Maxwell-Jolly v. Santa Rosa Mem. Hosp.*, No. 10-283, 2011 U.S. LEXIS 735, 735 (Jan. 18, 2011).

This Comment, in Part II, provides a brief overview of the United States health care system, including the Medicaid program and in Part III, offers an analysis of the Equal Access provision. Part IV examines the willingness of several circuits to enforce the provision under § 1983, as well as their eventual retreat. Part V provides a brief overview of the ability to enforce federal law, including the Equal Access provision, under the Supremacy Clause. Finally, Part VI calls for Congress to extend a private right of action to providers and beneficiaries allowing private enforcement of Medicaid's requirements and urges Congress to provide states the option of accepting universal, federal rates, thus discharging any liability under a private cause of action. Part VI also urges Congress to expand and implement the accountable care organization concept at the state-wide level in order to assure access to quality care.

II. AN OVERVIEW OF THE UNITED STATES HEALTH CARE SYSTEM

A. Health Care Spending: Costs and Coverage

Health care spending in the United States is projected to reach 19.3% of gross domestic product in 2019.³⁰ Recently, health spending was evenly split between the private and public sectors; but public spending will likely comprise more than half of overall health expenditures in 2012.³¹ Private sector spending consists of private insurance,³² out-of-pocket payments,³³ philanthropy, and charity care.³⁴ Public sector health spending consists of Medicare and Medicaid,³⁵

³⁰ CENTERS FOR MEDICARE & MEDICAID SERVICES, OFFICE OF THE ACTUARY, NATIONAL HEALTH STATISTICS GROUP, NATIONAL HEALTH EXPENDITURE PROJECTIONS 2009-2019 (2010); THE HENRY J. KAISER FAMILY FOUNDATION, TRENDS IN HEALTH CARE COSTS AND SPENDING (March 2009) (noting health spending includes public and private expenditures and amounts to approximately \$2.5 trillion, or \$8,160 per U.S. resident).

³¹ Christopher J. Truffer, Sean Keehan, Sheila Smith, Jonathan Cylus, Andrea Sisko, John A. Poisal, Joseph Lizkonits & M. Kent Clemens, *Health Spending Projections Through 2019: The Recession's Impact Continues*, 29 HEALTH AFFAIRS 1, 1 (Feb. 2010) (noting the recession, rising unemployment, the aging baby boom population, and changing demographics are all predicted to influence health spending over the upcoming decade);

³² THE HENRY J. KAISER FAMILY FOUNDATION, TRENDS IN HEALTH CARE COSTS AND SPENDING (March 2009) (noting that private insurance payments constitute 64% of private sector spending).

³³ *Id.* (noting that out-of-pocket payments constitute 22% of private sector spending).

³⁴ *Id.* (noting that other expenditures constitute 13% of private sector spending).

³⁵ JENNIFER JENSON, GOVERNMENT SPENDING ON HEALTH CARE BENEFITS AND PROGRAMS: A DATA BRIEF 1, 5 (Congressional Research Service June 16, 2008) (noting just under \$1 trillion in public funds were allocated to health spending in 2006. Of this amount, approximately 73% was spent on Medicare and Medicaid).

veterans and employee benefits,³⁶ research grants, and local public health programs.³⁷ Due to spiraling costs, these programs are embroiled in the controversy surrounding health care reform.³⁸ As noted by President Obama, “[a]lmost all of the long-term deficit and debt that we face relates to the exploding costs of Medicare and Medicaid And if we don’t get control over that we can’t get control over our federal budget.”³⁹

The two largest components of public health spending are Medicare, which provides medical assistance to those over sixty-five,⁴⁰ and Medicaid, which provides assistance for the categorically needy.⁴¹ Effective 2014, all individuals with an income of less than 133% of the poverty level will be eligible for Medicaid.⁴² Currently, those not eligible for medical assistance from a publicly-funded program can obtain insurance through employers, in the private market, or remain uninsured.⁴³ Effective 2014, all individuals will be required to obtain health insurance.⁴⁴

³⁶ *Id.* (noting that approximately 6% of overall public health spending was for federal employees, military personnel, and retirees in 2007).

³⁷ *Id.* (noting that approximately 21% of overall public health spending was for other expenditures such as SCHIP, the NIH, the FDA, Research, and State and Federal Public health activity in 2007).

³⁸ Transcript of Bipartisan Healthcare Summit (Feb. 26, 2010), <http://www.kaiserhealthnews.org/Stories/2010/February/25/health-care-reform-transcript.aspx> [hereinafter Healthcare Summit].

³⁹ *Id.*

⁴⁰ 42 U.S.C. § 1395c (2006). Individuals 65 or over are eligible as well as those with end stage renal disease, provided that the individual also meets certain additional requirements such as citizenship or residency and employment tax provisions. *Id.*

⁴¹ *Id.* § 1396a(10)(A). Medicaid eligibility must be granted based on financial criteria to those belonging to a categorical group such as children, parents with dependent children, pregnant women, and people with severe disabilities. *Id.*

⁴² The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

⁴³ CENTER ON BUDGET AND POLICY PRIORITIES, THE NUMBER OF UNINSURED AMERICANS IS AT AN ALL-TIME HIGH 1, 2 (2006). The uninsured population was approximately 46.6 million or 15.9% of the population in 2006. *Id.* The employer-sponsored and individually-purchased market covered approximately 150 million or 68% of the population in 1996. *Id.*

⁴⁴ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010). Compare *Thomas More Law Ctr v. Obama*, 720 F. Supp. 2d 882 (2010) (finding minimum coverage constitutional) and *Liberty Univ., Inc. v. Geithner*, 2010 U.S. Dist. LEXIS 125922 (Nov. 30, 2010) (finding minimum coverage provision constitutional), with *Florida v. U.S. Dep’t of Health and Human Serv.*, 2011 U.S. Dist. LEXIS 22464 (Mar. 3, 2011) (finding minimum coverage provision unconstitutional) and *Virginia v. Sebelius*, 728 F. Supp. 2d 768 (2010) (finding minimum coverage provision unconstitutional).

Approximately 25% of Americans are enrolled in Medicare or Medicaid.⁴⁵ Enrollment is evenly split between the two programs, with some populations covered by both.⁴⁶ Due to the recent economic recession, the aging baby boom population, and the Affordable Care Act, enrollment in public programs is predicted to increase substantially.⁴⁷

B. Federal and State Control

Under the current statutory framework, the federal and state governments are required to provide medical assistance to eligible providers and beneficiaries.⁴⁸ Medicare is a federal program administered by the federal government, while Medicaid is a federal and state partnership administered by the states.⁴⁹ The Medicaid Act is a conditional spending statute that sets forth a federal framework in which each state voluntarily agrees to implement a public health program according to federal standards.⁵⁰ In return for their participation, states receive federal financial support.⁵¹ As Medicaid populations increase and state budgets dwindle, every state that participates in the program is obligated to maintain a federally-mandated level of care.⁵²

Unlike the federal government, state governments are generally bound by state constitutions that require a balanced budget.⁵³ According to the National Association of State Medicaid Directors, state budgets shortfalls in 2011 will total \$140 billion.⁵⁴ Due to limited resources and burgeoning obligations, states are looking to cut expenditures, and many are looking to cut Medicaid.⁵⁵ Medicaid cuts will likely impact the access to and the quality of the care available to the neediest populations.⁵⁶

⁴⁵ CENTER ON BUDGET AND POLICY PRIORITIES, THE NUMBER OF UNINSURED AMERICANS IS AT AN ALL-TIME HIGH 1, 2 (2006).

⁴⁶ *Id.*

⁴⁷ TRUFFER ET AL., *supra* note 31, at 1.

⁴⁸ 42 U.S.C. § 1395c (2006); 42 U.S.C. § 1396a (2006).

⁴⁹ 42 U.S.C. § 1396a.

⁵⁰ *Id.*

⁵¹ *Id.* For an in depth discussion, see Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS L.J. 7 (2001).

⁵² *Id.* § 1396a(30)(A).

⁵³ RONALD SNELL, STATE BALANCED BUDGET REQUIREMENTS: PROVISIONS AND PRACTICE (National Conference of State Legislatures 2004).

⁵⁴ Kevin Sack & Robert Pear, *States Consider Medicaid Cuts as Use Grows*, N.Y. TIMES, Feb. 18, 2010, <http://www.nytimes.com/2010/02/19/us/politics/19medicaid.html>.

⁵⁵ *Id.*

⁵⁶ Zuckerman, et al., *supra* note 15, at 517; see Sack & Pear, *supra* note 54.

C. Medicaid

Congress enacted Medicaid under Title XIX of the Social Security Act in 1965.⁵⁷ It is now the largest means-tested entitlement program in the country.⁵⁸ As of mid-2010, all fifty states had voluntarily agreed to participate in the program.⁵⁹ Of the approximately sixty million Medicaid enrollees, half are children, accounting for \$49 billion in Medicaid expenditures.⁶⁰ In contrast, 10% of enrollees are elderly and account for \$77 billion in Medicaid spending.⁶¹ Long-term care makes up almost one-third of total Medicaid expenditures, accounting for close to half of all long-term care expenditures in the United States.⁶² Individuals with disabilities account for approximately 42% of total Medicaid spending.⁶³

In order to receive federal funds under Medicaid, a state must submit a “state plan” for providing “medical assistance” to eligible beneficiaries.⁶⁴ The definition of “medical assistance” is unclear, and thus, a circuit split has developed regarding its interpretation.⁶⁵ Participating states are required to establish or designate a “single state agency” to supervise the administration of the state plan that must comply with statutory requirements established by the federal

⁵⁷ See Grants to States for Medical Assistance Programs Act (the Medicaid Act), Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified at 42 U.S.C. §§ 1396 et seq.).

⁵⁸ Rosenbaum & Rousseau, *supra* note 51, at 7.

⁵⁹ See THE HENRY J. KAISER FAMILY FOUNDATION, MEDICAID: A PRIMER: KEY INFORMATION ON THE NATION’S HEALTH PROGRAM FOR LOW-INCOME PEOPLE 4 (2009) [hereinafter KAISER FOUNDATION].

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² JUDITH FEDER, HARRIET L. KOMISAR, ROBERT B. FRIEDLAND, LONG-TERM CARE FINANCING: POLICY OPTIONS FOR THE FUTURE 33 (Georgetown University Long-Term Care Financing Project 2007).

⁶³ *Id.* (stating that individuals with disabilities account for 14% of enrollees and account for \$115.5 billion)

⁶⁴ 42 U.S.C. § 1396a (2006); Jane Perkins, *Symposium: Barriers to Access to Health Care: Medicaid: Past Successes and Future Challenges*, 12 Health Matrix 7, 9–10 (Winter 2002).

⁶⁵ Compare *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (noting that medical assistance is solely financial), with *Bryson v. Shumway*, 308 F.3d 79 (1st Cir. 2002), and *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998) (noting that medical assistance means more than financial assistance including actual services). See Alison C. Sorkin, *Financial Assistance For Medicaid’s Continued Existence: The Need For The United States Supreme Court To Adopt The Tenth Circuit’s Definition of Medical Assistance*, 85 DENV. U.L. REV. 725, 745–51 (2008) (arguing that medical assistance should mean financial assistance); Kenneth R. Wiggins, *Medicaid and the enforceable Right to Receive Medical Assistance: The Need For A Definition of “Medical Assistance”*, 47 WM AND MARY L. REV. 1487, 1512 (2006) (arguing that a blanket definition as financial and actual services is not practical).

government.⁶⁶ For example, states must provide certain types of care⁶⁷ and abide by the statutory eligibility criteria.⁶⁸ Overall, the Medicaid Act and its regulations provide states a degree of flexibility in determining eligibility, benefits, and reimbursement rates.⁶⁹

When states participate in the program, the federal government matches a percentage of the state's Medicaid expenditures.⁷⁰ This is called the Federal Medical Assistance Percentage (FMAP).⁷¹ There is no upper limit on the amount the federal government spends on Medicaid because its matching FMAP portion is wholly dependent on state expenditures.⁷² FMAP ranges from a required minimum of 50% to approximately 75%.⁷³ Effective 2014, FMAP will substantially increase to cover newly enrolled Medicaid beneficiaries under the Affordable Care Act.⁷⁴ This increase should help states accommodate the increased obligation under the health reform legislation.

To receive medical assistance, eligible patients register with the appropriate state agency⁷⁵ and the state then reimburses providers for care.⁷⁶ Alternatively, states may purchase a managed care plan which reimburses providers at a negotiated rate.⁷⁷ Congress does not require private providers to participate in Medicaid, but has instead enacted a

⁶⁶ 42 U.S.C. § 1396a.

⁶⁷ For example, inpatient hospital care, outpatient hospital care, nursing facility care, physician services, labs and x-rays, family planning early periodic screening diagnostic, and treatment services for those under 21. *Id.* § 1392a(10)(A).

⁶⁸ Enrollment is based on categorical and financial eligibility and state residency/citizenship. *Id.* § 1396a. Effective 2014, all individuals earning less than 133% of the poverty line will be eligible for Medicaid. *Id.*

⁶⁹ *Id.* See Rosenbaum & Rousseau, *supra* note 51, at 20–25.

⁷⁰ 42 U.S.C. § 1396 et seq.

⁷¹ *Id.* See KAISER FOUNDATION, *supra* note 59, at 19; CHRISTIE PROVOST PETERS, FMAP: THE FEDERAL SHARE OF MEDICAID COSTS 1 (The National Health Policy Forum, George Washington University Jan. 15, 2009).

⁷² 42 U.S.C. § 1396 et seq.

⁷³ 74 Fed.Reg. 62315-17 (Nov. 27, 2009). For example, Maryland and Massachusetts receive a 50% federal match for state funds spent on medical assistance, while Mississippi and West Virginia receive an approximate 75% federal match for state funds spent on medical assistance. *Id.*

⁷⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010). FMAP for state spending to cover newly eligible Medicaid beneficiaries under the Affordable Care Act is 100% in 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and each year thereafter. THE HENRY J. KAISER FAMILY FOUNDATION, PATIENT PROTECTION AND AFFORDABLE CARE ACT: SUMMARY OF COVERAGE PROVISIONS, (2010).

⁷⁵ 42 U.S.C. § 1396a.

⁷⁶ *Id.* See KAISER FOUNDATION, *supra* note 59, at 13.

⁷⁷ KAISER FOUNDATION, *supra* note 59, at 13 (noting that the most common delivery system for Medicaid assistance is managed care, with nearly 2/3 enrolled in a form of managed care such as a health maintenance organization or primary care case management arrangement).

flexible statutory framework that allows states to set reimbursement rates in order to entice enough providers to assure patients' access to care.⁷⁸ Provider participation is financially motivated,⁷⁹ and often influenced by administrative difficulties and numerous other factors.⁸⁰ On average, physician reimbursement rates for Medicaid are approximately 60% of the average private and public rates.⁸¹ Consequently, provider participation in Medicaid is low, as is access to care.⁸²

In contrast, many hospitals and facilities are required to provide care in particular circumstances under the Hill Burton Act,⁸³ the Emergency Medical Treatment and Labor Act,⁸⁴ and state charity care

⁷⁸ 42 U.S.C. § 1396a(30)(A).

⁷⁹ See Zuckerman et al., *supra* note 15, at 517; Sack, *supra* note 1; Jacob Goldstein, *Should Medicaid Pay More for Primary Care?*, WALL ST. J., Jan. 6, 2010, <http://blogs.wsj.com/health/2010/01/06/should-medicare-pay-more-for-primary-care/>; James A. White, *Hey, Docs: Walgreens Also Says Medicaid Doesn't Pay Enough*, WALL ST. J., Jan. 14, 2010, <http://blogs.wsj.com/health/2010/01/14/hey-docs-walgreens-also-says-medicare-doesnt-pay-enough/>; Jonathon Cohn, *On the House: How The Health Care Bill Could Make Doctors Richer and Help the Poor*, THE NEW REPUBLIC, Jan. 5, 2010, <http://www.tnr.com/article/health-care/the-house>.

⁸⁰ See Jessica Greene, Jan Blustein and Beth C. Weitzman, *Race, Segregation, and Physicians' Participation in Medicaid*, 84 THE MILBANK QUARTERLY 239, 239 (2006) (race). See Peter Margolis, *Factors Associated with Pediatricians' Participation in Medicaid in North Carolina*, 267 JAMA 1942, 1942 (1992) (cultural barriers and misinformed physicians). See Senator John Barrasso, Health Care Summit (Feb. 25, 2010) (potential Medicare malpractice liability). The Senator first noted that "many, many doctors . . . take care of everyone, regardless of ability to pay." *Id.* Then, in response to current reform proposals to expand coverage through Medicaid, the Senator stated, "to put 15 million more people on Medicaid, a program where many doctors in the country do not see them . . . how are you going to help those folks? And, Mr. President, when I talk to doctors, they say, I have a way: Put all the doctors who take care of Medicaid patients under the Federal Torts Claim Act. That will help them, because they're not getting paid enough to see the patients. But if . . . they accept those patients and then their liability insurance is covered under the Federal Tort Claims Act, I think you'd have a lot more participation in that program." *Id.*

⁸¹ See Zuckerman et al., *supra* note 15, at 510.

⁸² Sean Jessee, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 EMORY L.J. 791, 796 (2009) (citing various studies regarding provider participation in Medicaid including Janet D. Perloff et al., *Which Physicians Limit Their Medicaid Participation, and Why*, 30 Health Servs. Res. 7, 7-8, 22 (1995); Christine M. Shaffer, *The Impact of Medicaid Reforms & False Claims Enforcement: Limiting Access by Discouraging Provider Participation in Medicaid Programs*, 58 S.C. L. REV. 995, 1002 (2007).

⁸³ The Hospital Survey and Construction Act (the Hill-Burton Act), P.L. 79-725 (1946), required hospitals to provide uncompensated care for 20 years after receiving federal funds to modernize hospitals. The Hill-Burton Program of 1975, Title XVI of the Public Health Service Act, provided financial subsidies to health facilities and required the participating facilities to provide care uncompensated care to eligible individuals.

⁸⁴ EMTALA, 42 U.S.C. § 1395dd (2006), requires that hospitals that accept Medicare and have an emergency department provide a medical screening to determine whether an emergency medical condition exists, and if so to provide stabilizing treatment.

statutes.⁸⁵ Yet, even when required to provide care, hospitals are not immune against inadequate rates and continue to lose approximately \$0.14 on every dollar spent on Medicaid care.⁸⁶ For example, private insurance has historically paid hospitals twice the amount paid by Medicaid and Medicare rates are generally two-thirds higher than Medicaid reimbursement.⁸⁷ This discrepancy has resulted in hospital closures in medically underserved areas, limited health care access for the poor, and a rise in inadequate care due to inadequate personnel and equipment.⁸⁸

Under the new reform legislation, the number of individuals eligible to enroll in Medicaid will undoubtedly increase.⁸⁹ Due to a variety of political and financial pressures, states are contemplating cuts to already low Medicaid reimbursement rates.⁹⁰ In turn, providers will likely file suit to preserve access for Medicaid patients.⁹¹ Given the economic crisis and Medicaid's expansion, the courts will continue to be at the center of the controversy, namely, the enforceability and interpretation of Medicaid's guarantees.⁹²

⁸⁵ Many states also mandate that certain types of hospitals provide care regardless of an individual's ability to pay. See N.J.S.A. 26:28-18 et al. (creating a program to reimburse charity care payments). Finally, while its pervasiveness may be debated, bankruptcy certainly plays a role as an alternative health care safety net. See David Dranve & Michael L. Millenson, *Medical Bankruptcy: Myth Versus Fact*, 25 HEALTH AFFAIRS 74, 74 (Feb. 2006); Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL'Y & ETHICS 239, 240 (2010).

⁸⁶ WILL FOX & JOHN PICKERING, HOSPITAL & PHYSICIAN COST SHIFT: PAYMENT LEVEL COMPARISON OF MEDICARE, MEDICAID, AND COMMERCIAL PAYERS 5 (Milliman Dec. 2008).

⁸⁷ *Id.*

⁸⁸ Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J. L. AND MED. 191, 198 (1995).

⁸⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

⁹⁰ Sack & Pear, *supra* note 54.

⁹¹ Susan Haigh, *Nursing Homes Sue State of Connecticut*, SEATTLE TIMES, Jan. 29, 2010, http://seattletimes.nwsource.com/html/localnews/2010921081_apctnursinghomeslawsuit1stldwritethru.html. The Connecticut Association of Health Care Facilities filed a lawsuit against Gov. M. Jodi Rell in federal court due to the states inadequate nursing home Medicaid spending. *Id.*

⁹² On average the federal government provides over half of Medicaid funds. CHRISTINE SCOTT, FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) FOR MEDICAID, 1 (Congressional Research Service, 2005). Yet, many financially strapped states argue that when Congress increases the number of individuals eligible for Medicaid and expands benefits, it does so by simply creating a new set of unfunded mandates. See Kevin Sack & Robert Pear, *Governors Fear Medicaid Costs in Health Plan*, N.Y. TIMES, Jul. 19, 2009, <http://www.nytimes.com/2009/07/20/health/policy/20health.html>. In response to recent reform proposals to expand Medicaid in order to provide greater access to care, Gov. Phil Bredesen of Tennessee stated fears regarding "the mother of all unfunded mandates." *Id.* Similarly, Gov. Chris Gregoire of Washington stated, "[a]s a

As one health scholar has suggested, “Medicaid is a program loved by few, denigrated by many, and misunderstood by most.”⁹³ Notwithstanding, many scholars are quick to point out that “Medicaid has served as a legislative vehicle for an astonishing range of medical and public health initiatives.”⁹⁴ United States Senator Lamar Alexander of Tennessee said that Medicaid’s expansion “dumps 15 to 18 million low-income Americans into a Medicaid program that none of us would want to be a part of because 50% of doctors won’t see new patients. So it’s like giving someone a ticket to a bus line where the busses only run half the time.”⁹⁵

Importantly, Medicaid’s Equal Access provision⁹⁶ requires that states “assure that payments 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.”⁹⁷ The statute’s goal is to prevent the exact concerns expressed by opponents of Medicaid’s expansion. Thus, if Senator Alexander is right—and there is substantial evidence that Medicaid participants face significant obstacles to accessing care⁹⁸—then states are violating federal law when they adopt low rates that negatively impact access. Alternatively, the federal law may be so lax in its enforcement and mandates that it has become substantively ineffective. Although the Affordable Care Act recognizes disparities in access and seeks to expand coverage by increasing Medicaid enrollment, it fails to address fundamental problems that arise, at least in part, due to limited federal oversight and low state reimbursement rates creating a two-tiered,

governor, my concern is that is we try to cost-shift to the states we’re not going to be in a position to pick up the tab.” *Id.*

⁹³ Alan Weil, *There’s Something About Medicaid*, 22 HEALTH AFFAIRS 13, 15 (Jan./Feb. 2003).

⁹⁴ Rosenbaum & Rousseau, *supra* note 51, at 9 (noting the reduction of infant mortality among low income populations, the improvement of community based long-term care for the elderly and disabled, the provision of insurance for low income individuals, aid to safety-net hospitals, and coverage with of women with breast and cervical cancer).

⁹⁵ Senator Lamar Alexander, Healthcare Summit, *supra* note 38.

⁹⁶ 42 U.S.C. § 1396a(30(A)) (2006). *See* Part III, *infra*.

⁹⁷ 42 U.S.C. § 1396(a)(30)(A). For a general discussion see Watson, *supra* note 88.

⁹⁸ THE HENRY J. KAISER FAMILY FOUNDATION, MEDICAID BENEFICIARIES AND ACCESS TO CARE, (October 2009); Donald B. Marron, Acting Director of the Congressional Budget Office, CBO Testimony regarding Medicaid Spending Growth and Options for Controlling Costs before the United States Senate Special Committee on Aging 17 (Jul. 13, 2006), <http://www.cbo.gov/ftpdocs/73xx/doc7387/07-13-Medicaid.pdf>.

fragmented system of care.⁹⁹ In order to ensure access to quality care for the newly covered Medicaid beneficiaries, it is crucial to reform Medicaid's reimbursement and enforcement mechanisms, specifically the Equal Access provision.

III. THE EQUAL ACCESS PROVISION: 42 U.S.C. § 1396A (30)(A)

From 1965 to 1972, the federal government rarely reviewed Medicaid reimbursement rates set by the states.¹⁰⁰ After 1972, Congress required states to pay rates set by the Department of Health and Human Services (HHS) based on the Medicare program.¹⁰¹ In order to encourage greater flexibility in state decision-making, Congress amended this requirement, enacting the Boren Amendment in 1980.¹⁰² The Boren Amendment required states to adopt rates that were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."¹⁰³ In 1997, Congress repealed the Boren Amendment which "in essence . . . allowed states to divorce Medicaid rates from the cost of care, possibly further restricting the rates paid to hospitals for services to Medicaid patients."¹⁰⁴

In 1989, Congress enacted the Equal Access provision ("§ 30(A)").¹⁰⁵ Like the Boren Amendment, § 30(A) regulates state Medicaid rates.¹⁰⁶ Unlike the Boren Amendment, § 30(A) focuses primarily on access rather than costs.¹⁰⁷ Initially, language similar to that

⁹⁹ Dennis G. Smith, *Medicaid Expansion Ignore States' Fiscal Crises*, The Heritage Foundation, Jan. 5, 2010, <http://www.heritage.org/Research/Reports/2010/01/Medicaid-Expansion-Ignores-States-Fiscal-Crises>. See Healthcare Summit, *supra* note 38. U.S. Representative Peter Roskram stated, "I think one of the problems, to get to this coverage issue, is that the premise of this bill is that coverage is expanded through Medicaid, welfare." *Id.*

¹⁰⁰ Edward A. Alan, *Federal Administrative and Judicial Oversight of Medicaid: Policy Legacies and Tandem Institutions under the Boren Amendment*, 38 *PUBLIUS: THE JOURNAL OF FEDERALISM* 315, 321 (2007).

¹⁰¹ For an in depth discussion, see Rosemary H. Ratcliff, *The Mistakes of Medicaid: Provider Payment During the Past Decade and Lessons For Health Care Reform in the 21st Century*, 35 *B.C. L. REV.* 141, 144 (1993).

¹⁰² Pub. L. No. 95-499 § 962(a), 94 Stat. 2650 (1980) (Boren Amendment); Pub. L. No. 97-35 § 2173, 95 Stat. 808 (1981); (Pub. L. No. 97-35 § 2174(a), 95 Stat. 809 (1981)).

¹⁰³ Pub. L. No. 95-499 § 962(a), 94 Stat. 2650 (1980) (Boren Amendment).

¹⁰⁴ BARBARA A. ORMOND AND HEIDI KAPUSTKA, *IMPACT OF BOREN AMENDMENT REPEAL ON HOSPITAL SERVICES FOR MEDICAID ELIGIBLES* 6 (2003).

¹⁰⁵ 42 U.S.C. 1396a(30)(A); Watson, *supra* note 88, at 198–99.

¹⁰⁶ 42 U.S.C. 1396a(30)(A); Watson, *supra* note 88, at 198–99.

¹⁰⁷ *Compare* 42 U.S.C. 1396a(30)(A) (noting that rates must be sufficient to enlist providers so that services are available under Medicaid to the extent available to the general population), *with* Pub. L. No. 95-499 § 962(a), 94 Stat. 2650 (1980) (noting rates must be "reasonable and adequate to meet the costs" of providers).

of § 30(A) was found only in regulations and required that “payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.”¹⁰⁸ Congress then acknowledged the lack of enforcement by inserting the language of the regulation into the Medicaid Act.¹⁰⁹ Thus, § 30(A) requires that a state plan must:

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure^[110] that payments^[111] are consistent^[112] 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.¹¹³

In order to measure a state’s compliance with the statute, the Secretary of HHS has urged the courts to apply a multifactor test.¹¹⁴ The availability of health services to the Medicaid population in a particular geographic area is compared to that of individuals with private or public insurance in the same area.¹¹⁵ The provision sets a floor for reimbursement rates by

¹⁰⁸ 42 C.F.R. § 447.204 (2010).

¹⁰⁹ *Ark. Med. Soc’y v. Reynolds*, 6 F.3d 519, 526 (8th Cir. 1993) (citing H.R. Rep. No. 101-247, 101st Cong., 1st Sess. 389-90 (1989), *reprinted in* 1989 U.S.C.A.N. 2060, 2115-16).

¹¹⁰ *Rite Aid, Inc. v. Houstoun*, 171 F.3d 842, 852 n.10 (3rd Cir. 1999) (quoting “‘Assure’ is defined by Black’s Law Dictionary as ‘to make certain and put beyond doubt. To . . . ensure positively.’ BLACK’S LAW DICTIONARY 123 (6th ed. 1990). Webster’s Third New International Dictionary defines “assure” similarly as ‘to make certain the coming or attainment of: ensure,’ in its sixth definition for the term.” WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 133 (1986)).

¹¹¹ *Evergreen Presbyterian Ministries, Inc. v. Hood* 235 F.3d 908, 932 n.31 (5th Cir. 2000) (“We note that the statute in section 30(A) speaks in terms of payments, rather than rates. While a reimbursement rate is a form of payment, there are other types of payment to providers, such as those to DSHs and, possibly, co-payments made by recipients. These additional payments must also be taken into account in assessing whether the payments in the aggregate will be adequate.”).

¹¹² *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997) (“‘Consistent’ means in agreement with, compatible, or conforming to the same principles or course of action. [...] For payments to be consistent with efficiency, economy and quality of care, they must approximate the cost of quality care provided efficiently and economically.”) (citations omitted).

¹¹³ 42 U.S.C. § 1396(a)(30)(A) (2006). For a general discussion see Watson, *supra* note 88.

¹¹⁴ *Clark v. Kizer*, 758 F. Supp. 572, 576 (E.D. Cal. 1990).

¹¹⁵ *Id.* (citing H.R. Rep. No. 247, 101st Cong., 1st Sess. 390, *reprinted in* 1989 U.S. Code Cong. & Ad. News at 1906, 2116; Department of Health, Education and Welfare, Handbook of Public Assistance Administration, Supplement D: Medical Assistance

requiring that rates are at least sufficient to ensure that providers are able to offer quality care¹¹⁶ and access¹¹⁷ to the Medicaid population equal to that of other individuals in the same market.¹¹⁸ The provision also imposes a ceiling on provider payments, requiring that payments are no more than what is efficient and economical.¹¹⁹ Fundamentally, § 30(A) provides states with a degree of flexibility in setting provider payments, but attempts to balance important stakeholder interests by protecting participating providers, eligible patients, and the federal budget.¹²⁰

Currently, the circuit courts are split regarding whether § 30(A) imposes a procedural or a substantive requirement.¹²¹ The Eighth¹²² and Ninth Circuits¹²³ have held that § 30(A) requires states to conduct a study

Programs (1966-67) Part 7-5340). It is not clear, according to the circuit courts, whether Congress intended that the entity charged with ensuring compliance by making the comparative analysis is the Department of Health and Human Services, the state, or the court. *See* Part IV, *infra*.

¹¹⁶ Bruce E. Landon, Eric C. Schneider, Sharon-Lise T. Normand, Sarah Hudson Scholle, Gregory Pawlson, & Arnold M. Epstein, *Quality of Care in Medicaid Managed Care and Commercial Health Plans*, 298 JAMA, 1674, 1674 (2007) (concluding that Medicaid managed care enrollees receive lower quality care than private pay enrollees).

¹¹⁷ Teresa A. Coughlin, Sharon K. Long & Yu -Chu Shen, *Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States*, 24 HEALTH AFFAIRS 1073, 1073 (2005) (noting that national analysis show that access to care among Medicaid beneficiaries generally matches that of the privately insured, except for dental and prescription drugs, but also noting that state-level analysis shows more variation and presence of a gap in access).

¹¹⁸ 42 U.S.C. § 1396(a)(30)(A); *see* Moncrieff, *supra* note 20, at 677.

¹¹⁹ 42 U.S.C. § 1396(a)(30)(A); *see* Moncrieff, *supra* note 20, at 677.

¹²⁰ 42 U.S.C. § 1396(a)(30)(A). Providers are ensured a sufficient rate of reimbursement, patients are ensured quality and access, and the federal government is ensured rates are not too high as to cover inefficient care. *Id.*

¹²¹ *Compare* Ark. Med. Soc’y, Inc. v. Reynolds, 6 F.3d 519, 530 (8th Cir. 1993), *Minn. Homecare Ass’n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997), *and* *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1500 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998) (noting that § 30(A) is a procedural standard that requires a study) *with* *Rite Aid, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999), *Methodist Hosps, Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996), *and* *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 933 (5th Cir. 2000) (noting that § 30(A) is not procedural and does not require a study but only a substantive result).

¹²² *Ark. Med. Soc’y v. Reynolds*, 6 F.3d 519, 522 (8th Cir. 1993). The Eighth Circuit held that Arkansas violated §30(A) “[b]ecause [the agency] failed to consider the rate reduction’s impact on equality of access, efficiency, economy, and quality of care,” and because its decision was driven by budgetary pressures. *Id.*

¹²³ *Orthopaedic Hosp. v. Belshe*, 103 F. 3d 1491, 1492 (9th Cir. 1997). The Ninth Circuit held that in order to comply with § 30(A) , the state must consider the cost of quality care. *Id.* Thus, the state must “rely on responsible cost studies, its own or others’, which provide reliable data as a basis for its rate setting.” *Id.* Moreover, the rates adopted must “bear a reasonable relationship to efficient and economical hospitals’ costs of providing quality services, unless the state Department shows some justification for rates that substantially deviate from such costs.” *Id.* A budget shortfall is not sufficient to justify deviation from costs. *Id.* Because the state did not consider or study costs nor

or investigation regarding the impact of rate cuts in order to satisfy federal law.¹²⁴ The Eighth¹²⁵ and Ninth Circuits¹²⁶ looked to the purpose of §30(A)—to assure equal access to care—and suggested that this purpose could not possibly be assured if Medicaid reimbursement rates were driven by budgetary pressures and adopted without actually considering the impact of such a decision on the access to and quality of care. Conversely, the Third¹²⁷ and Seventh Circuits¹²⁸ have held that the provision does not require procedural compliance, but instead requires that states achieve a substantive result. The courts explained that the statute does not contain language that requires a particular procedure, consideration, or study with respect to access to care, but instead requires states to achieve a result, meaning state Medicaid rates must actually achieve equal access to care among Medicaid patients when compared to private pay patients in the same geographic area.¹²⁹

The United States filed an amicus brief in early 2011 arguing that it was not necessary for the Supreme Court to grant certiorari regarding the interpretation of § 30(A) because HHS has agreed to issue an

offer a justifiable excuse, the court held that the reimbursement rate-setting procedure violated § 30(A). *Id.*

¹²⁴ Ark. Med. Soc’y v. Reynolds, 6 F. 3d at 522; Orthopaedic Hosp. v. Belshe, 103 F.3d at 1492.

¹²⁵ Ark. Med. Soc’y v. Reynolds, 6 F. 3d at 530–31.

¹²⁶ Orthopaedic Hosp. v. Belshe, 103 F. 3d at 1500.

¹²⁷ Rite Aid, Inc. v. Houstoun, 171 F.3d 842, 850 (3rd Cir. 1999). The court reasoned that the language of the statute is outcome-oriented and leaves states with the flexibility to set rates, as long as their decisions result in “substantive compliance with its specified factors of efficiency, economy, quality of care, and access.” *Id.* The Third Circuit, however, parted ways with the Seventh Circuit by holding that state rate setting decisions must not be arbitrary or capricious as to violate principles of administrative law, rejecting the view that a state could set rates like those in the private market and then respond to the rate’s effect on quality and access. *Id.* Therefore, while § 30(A) did not require states to consider costs or to rely on a study, under state agency principles, the decision must not be arbitrary or capricious. *Id.* By failing to consider an important aspect of the issue or acting contrary to evidence, a state acts arbitrarily, but this does not suggest that a state must consider or study all factors. *Id.* Therefore, the Third Circuit interpreted § 30(A) as mandating only substantive compliance like the Seventh Circuit, whereas the principles of administrative law govern the procedural aspects of the decision. *Id.*

¹²⁸ Methodist Hosps. v. Sullivan, 91 F.3d at 1027. The court held that that § 30(A) contains no procedural requirement, because when compared to the Boren Amendment, which expressly required “findings,” the Equal Access provision is absent of similar language. *Id.* Moreover, the court suggested that it is almost impossible for a state to conduct a study to determine what effect a rate change will have, because a study will likely be flawed by dishonest answers and lack of cooperation. *Id.* Therefore, the court stated, the statutory language requires a state “to produce a result, not to employ any particular methodology for getting there.” *Id.*

¹²⁹ *Houstoun*, 171 F.3d at 851–52; *Methodist Hosps.*, 91 F.3d at 1030.

authoritative interpretation in the coming year interpreting the statute.¹³⁰ The rule may include, “a determination whether [§](30)(A) protects interests of providers at all following repeal of the Boren Amendment; what procedural or substantive requirements the statute imposes on States with respect to beneficiaries; and how the various provisions of [§](30)(A) and other Medicaid requirements interact.”¹³¹ The Supreme Court denied certiorari as to the interpretation of § 30(A), likely in response to the position of the United States regarding the commitment by HHS to issue a new interpretive rule.¹³² Notably, HHS issued a proposed rule on May 6, 2011, to “create a standardized, transparent process for States to follow as part of their broader efforts” to satisfy § 30(A).¹³³

IV. ENFORCING THE EQUAL ACCESS PROVISION WITH 42 U.S.C. § 1983

Enacted as part of the Civil Rights Act of 1871, 42 U.S.C. § 1983 provides a mechanism to pursue civil remedies against state or local actors who violate federal rights.¹³⁴ In *Blessing v. Freestone*,¹³⁵ the Supreme Court adopted a three-part test to evaluate whether a statute creates enforceable rights.¹³⁶ Under this test, when a court hears a § 1983 suit in which the plaintiff alleges that a government actor violated federal rights created by a statute, the court must (1) examine whether Congress intended that the statute benefit the plaintiff, (2) determine whether the right is not so “vague and amorphous” as to strain judicial competence, and (3) assess whether the statute imposes an unambiguous obligation on the state.¹³⁷ The Court further stated that a right asserted under a statute is only enforceable pursuant to § 1983 if it is “couched in mandatory rather than precatory terms.”¹³⁸

¹³⁰ Brief of United States as Amici Curiae Supporting Respondents, *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., Inc.*, 2010 U.S. LEXIS 4190 (2010).

¹³¹ *Id.*

¹³² *Maxwell-Jolly v. Santa Rosa Mem. Hosp.*, No. 10-283, 2011 U.S. LEXIS 735, 735 (Jan. 18, 2011).

¹³³ 76 Fed. Reg. 26342 (May 6, 2011).

¹³⁴ 42 U.S.C. § 1983 (2006) (“Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress”); *see also* Jane Perkins, *Using § 1983 to Enforce Federal Laws*, 38 CLEARINGHOUSE REV. J. POVERTY L. & POL’Y, 720, 720 (Mar./Apr. 2005).

¹³⁵ 520 U.S. 329 (1997).

¹³⁶ *Id.* at 340–41.

¹³⁷ *Id.*

¹³⁸ *Id.* at 341.

In 1990, the Supreme Court held in *Wilder v. Virginia Hospital Association*¹³⁹ that a plaintiff could pursue a private cause of action under § 1983 to enforce a state's compliance with Medicaid's Boren Amendment.¹⁴⁰ The Court applied the *Blessing* test and said that "there can be little doubt that health care providers are the intended beneficiaries."¹⁴¹ The Court further stated that "[t]he Boren Amendment is cast in mandatory rather than precatory terms: the state plan 'must' provide for payment . . . of hospitals according to rates the State finds are reasonable and adequate."¹⁴² Finally, the Court observed that "[a]lthough some knowledge of the hospital industry might be required to evaluate a State's findings with respect to the reasonableness of its rates, such an inquiry is well within the competence of the judiciary."¹⁴³

The Court found that the Boren Amendment, with similar demands as § 30(A), created rights enforceable by private citizens under § 1983.¹⁴⁴ The Court also observed that "[t]he right is not merely a procedural one that rates be accompanied by findings and assurances (however perfunctory) of reasonableness and adequacy; rather the Act provides a substantive right to reasonable and adequate rates as well."¹⁴⁵ After the *Wilder* decision, which allowed private suits against states setting inadequate Medicaid rates, Congress eventually repealed the Boren Amendment; however, *Wilder* served as a seminal case for many Medicaid enforcement actions throughout the 1990s and persists as a seminal case for enforcing the Medicaid Act.¹⁴⁶

¹³⁹ 496 U.S. 498 (1990).

¹⁴⁰ *Id.* at 524.

¹⁴¹ *Id.* at 510. Supporting the proposition that Congress intended that providers could file suit in federal court the Court noted that "in response to several States freezing their Medicaid payments to health care providers, Congress amended the Act in 1975 to require States to waive any Eleventh Amendment immunity from suit for violations of the Act. Congress believed the waiver necessary because the existing means of enforcement—*noncompliance procedures instituted by the Secretary or suits for injunctive relief by health care providers—were insufficient to deal with the problem of outright noncompliance because they included no compensation for past underpayments.*" *Id.* at 516–17. (citations omitted) (emphasis added).

¹⁴² *Id.* at 512 (citations omitted).

¹⁴³ *Id.* at 520.

¹⁴⁴ *Id.* at 524.

¹⁴⁵ *Wilder*, 496 U.S. at 510.

¹⁴⁶ Interestingly, Chief Justice John Roberts, acting as Deputy Solicitor General at the time, filed a brief in *Wilder* arguing that Medicaid's Boren Amendment does not confer rights enforceable under § 1983. See John Roberts' Problematic Record on Disability Rights, The Bazelon Center for Mental Health Law, <http://www.bazelon.org/issues/disabilityrights/judicialnominees/roberts.htm> (last visited Mar. 20, 2010).

A. The Blessing Test

Under the *Blessing* test, applied by the Supreme Court in *Wilder*, the circuit courts have consistently held that beneficiaries could pursue a cause of action pursuant to § 1983 when seeking to enforce § 30(A).¹⁴⁷ The circuit courts split when asked to determine whether providers could also file suit.¹⁴⁸ For example, in *Arkansas Medical Society v. Reynolds*,¹⁴⁹ the Eighth Circuit held that both providers and beneficiaries could pursue a cause of action under § 1983 to enforce § 30(A).¹⁵⁰ The court reasoned that § 30(A) was intended to benefit providers because it pertains to the level of reimbursement rates, and Congress also intended to benefit beneficiaries by covering beneficiary access in the statute.¹⁵¹ Thus, the first prong of the *Blessing* test was satisfied as to both providers and beneficiaries.¹⁵² The court stated that the mandatory obligation requirement of prong two was also satisfied because the language of the Medicaid Act expressly provided that a state “must” comply, which was “wholly uncharacteristic of a mere suggestion or nudge.”¹⁵³ Finally, the court reasoned that § 30(A) was not too vague and amorphous as to strain judicial application because its legislative history was clear, many federal courts had already held that the provision was sufficiently specific, and when compared to the Boren Amendment which passed the *Blessing* test in *Wilder*, the language of § 30(A) was much less ambiguous.¹⁵⁴

Conversely, in *Evergreen Presbyterian Ministries, Inc. v. Hood*,¹⁵⁵ the Fifth Circuit held that providers could not file suit under § 1983.¹⁵⁶

¹⁴⁷ Long Term Care Pharm. Alliance v. Ferguson 362 F.3d 50 (2004); Ark. Med. Soc’y, Inc. v. Reynolds, 6 F.3d 519 (8th Cir. 1993); Visiting Nurse Ass’n v. Bullen, 93 F.3d 997 (1st Cir. 1996); Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908 (5th Cir. 2000).

¹⁴⁸ Compare Walgreen Co. v. Hood, 275 F.3d 475 (5th Cir. 2001), and Pa. Pharmacists Ass’n v. Houstoun, 283 F.3d 531 (3d Cir. 2002) (noting that providers are not intended beneficiaries and do not have a cause of action under 1983 to enforce 30(A)), with Visiting Nurse Ass’n of N. Shore, Inc. v. Bullen, 93 F.3d 997 (1st Cir. 1996), Methodist Hosp., Inc. v. Sullivan, 91 F.3d 1026 (7th Cir. 1996), and Ark. Med. Soc’y, Inc. v. Reynolds, 6 F.3d 519 (8th Cir. 1993) (noting that providers have a cause of action under 1983 to enforce 30(A)). See also Orthopaedic Hosp. v. Belshe, 103 F.3d 1491 (9th Cir. 1997) (hearing and deciding in favor of a provider (hospital) based on 1983 cause of action seeking to enforce 30(A), but never addressing the hospital’s right to sue as a provider).

¹⁴⁹ 6 F.3d 519 (8th Cir. 1993).

¹⁵⁰ *Id.* at 526.

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Id.* (citations omitted).

¹⁵⁴ *Id.* at 527.

¹⁵⁵ 235 F.3d 908 (5th Cir. 2000).

¹⁵⁶ *Id.* at 928–29.

The Fifth Circuit applied the *Blessing* framework and concluded that the thrust of the statute was directed at patient access, and Congress only indirectly intended to benefit providers by ensuring that rates were set in a manner consistent with this goal.¹⁵⁷ Therefore, because the Fifth Circuit held that providers, as opposed to beneficiaries, did not pass prong one of the *Blessing* test, the court held that they could not pursue claims under § 1983.¹⁵⁸ The Fifth Circuit recognized, however, that “if the reimbursement rate reductions should result in the widespread demise of providers or discharge of Medicaid patients for fiscal reasons, the access of Medicaid recipients to care and services . . . may violate section 30(A)’s command of equal access.”¹⁵⁹ Yet, the court explained, under the *Blessing* test, “the fact that evidence of financial distress is relevant in a suit brought by Medicaid recipients does not amount to an individual entitlement on the part of any provider under the statute.”¹⁶⁰ In 2002, the Supreme Court clarified the *Blessing* test, making judicial determinations regarding whether a statute creates an enforceable right under § 1983 more consistent. The new framework, however, has essentially eliminated the ability of both providers and beneficiaries to successfully pursue a cause of action enforcing § 30(A) under § 1983.

B. The Impact of Gonzaga

In *Gonzaga v. Doe*,¹⁶¹ the Supreme Court once again examined whether a cause of action was available under § 1983 to enforce rights created by federal law.¹⁶² The Washington Supreme Court held that the Family Educational Rights and Privacy Act (FERPA) “gives rise to a federal right enforceable under § 1983.”¹⁶³ The Supreme Court granted certiorari to resolve a split among state courts and the federal circuits and to clarify ambiguities in the *Blessing* test.¹⁶⁴

The Court first reviewed its prior decisions on the issue, explaining that the typical remedy for a state’s failure to comply with a Spending Clause statute is the termination of federal funds.¹⁶⁵ Next, the Court stated that only twice has it held that Spending Clause legislation gives

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* at 929.

¹⁶⁰ *Id.*

¹⁶¹ 536 U.S. 273 (2002).

¹⁶² *Id.* at 276.

¹⁶³ *Id.* at 278.

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* at 280.

rise to enforceable rights.¹⁶⁶ Finally, the Court discussed ambiguities in its prior decisions¹⁶⁷ and adopted a new test for determining whether a federal statute creates rights enforceable under § 1983.¹⁶⁸

According to the *Gonzaga* court, Congress must “speak with a clear voice and manifest an unambiguous intent to confer individual rights.”¹⁶⁹ In order to determine Congressional intent, the statute must be analyzed for “right-or duty-creating language” that benefits the challenging party.¹⁷⁰ Next, rather than focusing on the aggregate population, a statutory provision must focus on the individual.¹⁷¹ Finally, a centralized enforcement mechanism – or “comprehensive remedial scheme” – in the statute at issue supports the finding that there is no individual right to pursue action under § 1983.¹⁷² Applying this framework, the Court held that FERPA does not create a statutory right enforceable under § 1983.¹⁷³ Since *Gonzaga*, several courts have similarly limited the availability of a private cause of action to enforce federal law either by concluding that a statute does not contain rights-creating language or focuses on an aggregate population rather than particular beneficiaries.¹⁷⁴

Post-*Gonzaga*, the circuits are split on whether a cause of action under § 1983 is viable when enforcing § 30(A).¹⁷⁵ For example, the

¹⁶⁶ *Gonzaga*, 536 U.S. at 280 (citing *Wright v. Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418 (1987); *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498 (1990)).

¹⁶⁷ *Id.* at 282–83 (“[C]onfusion has led some courts to interpret *Blessing* as allowing plaintiffs to enforce a statute under § 1983 so long as the plaintiff falls within the general zone of interest that the statute is intended to protect We now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983.”).

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* at 280.

¹⁷⁰ *Id.* at 284 n.3 (citing *Cannon v. Univ. of Chicago*, 441 U.S. 677, 690 n.13 (1979)).

¹⁷¹ Jane Perkins, *Issue Brief: Update on Federal Court Access – Medicaid § 1983 and Preemption Cases*, (Jan. 2007), www.nls.org/conf2007/1983%20preemption%20fact%20sheet.pdf.

¹⁷² *Gonzaga*, 536 U.S. at 287 n.5.

¹⁷³ *Id.* at 290. As an interesting aside, Chief Justice Roberts, prior to his appointment to the Supreme Court, successfully argued *Gonzaga* before the Court. See John Roberts’ Problematic Record on Disability Rights, The Bazelon Center for Mental Health Law, <http://www.bazelon.org/issues/disabilityrights/judicialnominees/roberts.htm> (last visited Mar. 20, 2010).

¹⁷⁴ Jon Donnenberg, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 YALE L.J. 1498, 1520–21 (2008); Jane Perkins, *Using § 1983 to Enforce Federal Laws*, 38 CLEARINGHOUSE REV. J. POVERTY L. & POL’Y. 720, 720 (Mar./Apr. 2005).

¹⁷⁵ *Compare* *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007), *Mandy R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006), *Westside Mothers v. Olszewski*, 454 F.3d 532 (6th Cir. 2006), *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), and *Long Term Care Pharm. Alliance v. Ferguson*, 362 F.3d 50 (1st Cir. 2004) with *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 443 F.3d 1005 (8th Cir. 2006), *vacated on other grounds*, *Selig v. Pediatric Specialty Care, Inc.*, 551 U.S. 1142 (2007).

Eighth Circuit refused to overturn its pre-*Gonzaga* holding which allowed providers to file suit under § 1983 alleging that a state Medicaid agency violated § 30(A).¹⁷⁶ The Eighth Circuit observed that *Gonzaga* did not overrule *Wilder*.¹⁷⁷ Moreover, the court stated that the “proposition that the Medicaid Act may create enforceable rights, even for health care providers, is far from novel.”¹⁷⁸ Finally, and perhaps even more importantly, the court interpreted § 30(A) under the *Gonzaga* framework and held that even after *Gonzaga*, the plaintiffs still prevailed because, among other things, Congress clearly intended for providers and beneficiaries to benefit.¹⁷⁹

Conversely, the Fifth Circuit readily overturned its pre-*Gonzaga* decision. In *Equal Access for El Paso v. Hawkins*,¹⁸⁰ the court noted the effect of *Gonzaga* and held that under the new framework, § 30(A) is not enforceable because the statute “speaks only to the state and the Secretary” and focuses on the aggregate rather than the individual.¹⁸¹ Moreover, the court stated that the statute has a “systematic focus that deals with institutional policy and procedures, rather than an individualized focus concerned with whether the needs of any particular person or class of recipients have been satisfied.”¹⁸²

Since *Gonzaga*, the First, Second, Third, Fifth, Sixth, Ninth, and Tenth Circuits have ruled that there is no private right of action under § 1983 when enforcing § 30(A).¹⁸³ The door is not closed, however, as

¹⁷⁶ *Pediatric Specialty Care, Inc.*, 443 F.3d at 1015. Pre-*Gonzaga*, the Eighth Circuit held that both providers and beneficiaries could file suit under § 1983. *Ark. Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993). In *Pediatric Specialty Care Inc.*, the state requested that the Eighth Circuit overturn this decision to accommodate the Supreme Court’s restrictive *Gonzaga* analysis and the court refused. 443 F. 3d 1005, 1015 (8th Cir. 2006). First, the Eighth Circuit observed that *Gonzaga* was issued on June 20, 2002, and while its decision was filed ten days before *Gonzaga*, its mandate did not issue until July 2002. *Id.* “Thus, *Gonzaga* [was] not an intervening decision of a superior tribunal, as is required before we may overturn matters previously settled as the law of the case.” *Id.* Therefore, the court could not, as a matter of precedent and procedure, overturn its decision regarding the ability to enforce § 30(A). *Id.*

¹⁷⁷ *Id.*; see also *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498 (1990).

¹⁷⁸ *Pediatric Specialty Care, Inc.*, 443 F.3d at 1015.

¹⁷⁹ *Id.*

¹⁸⁰ 509 F. 3d 697 (5th Cir. 2007).

¹⁸¹ *Id.* at 703.

¹⁸² *Id.* at 704. The Fifth Circuit reversed the lower court’s decision which relied on the pre-*Gonzaga* precedent. *Id.* The Fifth Circuit then remanded the claim with direction to dismiss with prejudice. *Id.* The plaintiffs in *Equal Access for El Paso, Inc.* also asserted a Supremacy Clause claim in the same case before the Fifth Circuit, yet the Fifth Circuit did not address the claim and remanded with direction to dismiss with prejudice. *Id.* Also, the district found in favor of the plaintiffs on the § 1983 claim, but strangely predicts reversal on appeal due to the *Gonzaga* decision. *Id.*

¹⁸³ *Compare Long Term Care Pharm. Alliance v. Ferguson*, 362 F.3d 50, 56–59 (1st Cir. 2004), *N.Y. Ass’n of Homes & Servs. for the Aging, Inc. v. DeBuono*, 444 F.3d 147,

the Eighth Circuit adamantly refused to let *Gonzaga* stand in the way of provider and beneficiary rights under the Medicaid Act.¹⁸⁴ Notwithstanding, as the ability to enforce rights under the Medicaid Act narrows, providers and beneficiaries have since pursued new legal theories when seeking to ensure state compliance.

V. EQUAL ACCESS AND THE SUPREMACY CLAUSE

Medicaid providers and beneficiaries are now successfully pursuing suits to enforce § 30(A) under the Supremacy Clause, reaffirming the binding obligations of Medicaid on all states that choose to participate in the program.¹⁸⁵ The Medicaid Act is the supreme law of the land and Medicaid's Equal Access provision requires that states provide equal access to quality care by setting reimbursement rates at an adequate level to entice providers to participate.¹⁸⁶ If a state refuses to comply by acting contrary to the statute, its actions conflict with federal law.¹⁸⁷ Where state and federal laws conflict, the federal law prevails.¹⁸⁸ Thus, if a state reimburses providers at rates that are insufficient to assure quality and access, the state is in violation of federal law and the unlawful state action must be enjoined.¹⁸⁹

A. The Supremacy Clause

The Supremacy Clause states that the "Constitution, and the Laws of the United States . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the contrary notwithstanding."¹⁹⁰ Unlike claims under § 1983 that involve securing a right to individuals,

148 (2d Cir. 2006), *Pa. Pharmacists*, 283 F.3d at 541–42, *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 702–03 (5th Cir. 2007), *Westside Mothers v. Olszewski*, 454 F.3d 532, 541–43 (6th Cir. 2006), *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005), and *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1146–48 (10th Cir. 2006), with *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005 (8th Cir. 2006), *vacated on other grounds*, *Selig v. Pediatric Specialty Care, Inc.*, 551 U.S. 1142 (2007).

¹⁸⁴ *Pediatric Specialty Care, Inc.*, 443 F.3d at 1015. *But, see* *Minn. Pharm. Ass'n v. Pawlenty*, 690 F. Supp. 2d 809, 816 (D. Minn. 2010) (refusing to allow a § 1983 suit to enforce § 30(A) despite the holding in *Pediatric Specialty Care, Inc. v. Arkansas Department of Human Services*).

¹⁸⁵ *Supra*, note 184.

¹⁸⁶ 42 U.S.C. § 1396a(30)(A) (2006).

¹⁸⁷ U.S. CONST. art. VI, cl. 2; *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008).

¹⁸⁸ Federal law and regulations have the same pre-emptive effect. *See* *Fed. Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 152 (1982).

¹⁸⁹ *Indep. Living Ctr. of S. Cal., Inc.*, 543 F.3d at 1065.

¹⁹⁰ U.S. CONST. art. VI, cl. 2.

preemption involves protecting the nation's federal structure.¹⁹¹ Courts apply a different standard when analyzing preemption claims.¹⁹² Jurisdiction under preemption theory does not invoke the *Gonzaga* analysis; thus, providers and beneficiaries can successfully pursue a cause of action under this theory as an alternative to § 1983.¹⁹³

The Supreme Court, in *PHRMA v. Walsh*,¹⁹⁴ implicitly affirmed the theory that state law can be preempted by the Medicaid Act.¹⁹⁵ In *PHRMA*, the plaintiff alleged that a state regulation that required pre-authorization for prescription drugs was preempted by the Medicaid statute.¹⁹⁶ Without expressly addressing preemption jurisdiction, the plurality reached the merits of the case, thus implicitly affirming the court's jurisdiction.¹⁹⁷

The Supreme Court has not directly addressed whether § 30(A) preempts state law. Circuit courts, however, have enforced § 30(A) under the Supremacy Clause, applying a conflict by implication analysis.¹⁹⁸ Under this theory, the challenging party bears the burden of overcoming the presumption of a state statute's validity, which can be done here by showing an actual conflict with § 30(A).¹⁹⁹ According to extensive Supreme Court precedent and decisions by the circuits, a cause of action exists to enjoin a state from implementing legislation in violation of federal law.²⁰⁰ The remedy for this cause of action, however, is limited.²⁰¹ Unlike a cause of action under § 1983, which can result in the payment of civil penalties and attorneys fees, plaintiffs filing suit

¹⁹¹ *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 117 (1989); *Verizon Maryland Inc. v. Public Serv. Comm'n*, 535 U.S. 635 (2002).

¹⁹² *Golden State Transit Corp.*, 493 U.S. at 117.

¹⁹³ For an in depth discussion, please see Rochelle Bobroff, *§ 1983 and Preemption: An Alternative Means of Court Access For Safety Net Statutes*, 10 LOY. J. PUB. INT. L. 27 (2008); SARAH SOMERS, *THE SUPREMACY CLAUSE, PREEMPTION AND ENFORCEMENT OF MEDICAID* (National Health Law Program May 21, 2007).

¹⁹⁴ 538 U.S. 644 (2003) (plurality). *See also* *Arkansas Dep't of Health & Human Servs.*, 547 U.S. 268 (2006) (holding Medicaid Act preempts state law).

¹⁹⁵ *Planned Parenthood v. Sanchez*, 403 F.3d at 331–32 (citing *Walsh*, 538 U.S. at 661–68).

¹⁹⁶ *Walsh*, 538 U.S. at 675.

¹⁹⁷ *Id.* at 661–69.

¹⁹⁸ According to preemption doctrine, state laws that “interfere with, or are contrary to the laws of Congress, made in pursuance of the Constitution” are preempted. *Gibbons v. Ogden* 22 U.S. 1, 9 (1824). In order to determine whether preemption exists, the court must first examine Congressional intent. *Id.* A state's actions can be preempted by express statutory language, by implication from a congressional scheme, or by implication from conflict. *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1065 (9th Cir. 2008).

²⁰¹ Bobroff, *supra* note 194; Somers, *supra* note 194.

under the Supremacy Clause are generally afforded only prospective injunctive relief.²⁰²

B. The Rise of Medicaid Preemption

The Eighth Circuit, in *Lankford v. Sherman*,²⁰³ concluded that a preemption claim to enforce Medicaid's requirements was viable even in the absence of a cognizable § 1983 claim.²⁰⁴ The court examined a plaintiff's attempt to enforce Medicaid's comparability and reasonable-standards requirements under both § 1983 (post-*Gonzaga*) and the Supremacy Clause.²⁰⁵ Applying the *Blessing* test and the constricting standards of *Gonzaga*, the court concluded that the plaintiff had no § 1983 cause of action.²⁰⁶

The court then addressed the viability of a preemption claim and expressly noted that preemption claims afford plaintiffs an alternative theory of relief because they are analyzed under a different legal framework than § 1983 claims.²⁰⁷ Moreover, the Supremacy Clause requires that when states choose to accept the benefits of Spending Clause legislation they must comply with federal requirements.²⁰⁸ Therefore, even if no cause of action exists under § 1983, the Eighth Circuit concluded it was free to examine state compliance with federal law under the Supremacy Clause.²⁰⁹ The Fifth Circuit followed, holding that providers "have an implied cause of action to seek injunctive relief from a state statute purportedly preempted by federal Spending Clause legislation."²¹⁰ So far, all circuit courts that have addressed the issue have held that the Medicaid Act is the supreme law of the land and presumptively affords a cause of action under the Supremacy Clause.²¹¹

²⁰² *Winter v. Natural Res. Def. Council*, 129 S. Ct. 365, 374 (2008) (noting well-established framework for injunctive relief which requires a showing of a likelihood of success on the merits, irreparable harm, that the balance of equities are in the moving parties favor, and that the relief is in the public interest).

²⁰³ 451 F.3d 496 (8th Cir. 2006).

²⁰⁴ *Id.* at 500.

²⁰⁵ *Id.* at 500. See 42 U.S.C. §§ 1396a(a)(10)(B), (a)(17) (2006).

²⁰⁶ *Lankford*, 451 F.3d at 509.

²⁰⁷ *Id.* (citing *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 108 (1989)).

²⁰⁸ *Id.* at 510.

²⁰⁹ *Id.*

²¹⁰ *Planned Parenthood v. Sanchez*, 403 F.3d 324, 325 (5th Cir. 2005).

²¹¹ *Compare* *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1060–61 (9th Cir. 2008), *Sanchez*, 403 F.3d at 331–32, *Lankford v. Sherman*, 451 F.3d at 496, *with* *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007). In *Equal Access*, the plaintiffs asserted Supremacy Clause and § 1983 claims and the court held that no § 1983 cause of action existed, yet completely ignored and never addressed the Supremacy Clause claim and remanded the case for dismissal with prejudice. 509 F.3d at 704.

The Second and Ninth Circuits have both addressed whether § 30(A) in particular can be enforced pursuant to preemption theory. In *Independent Living Center of Southern California, Inc. v. Shewry*,²¹² a group of providers and beneficiaries challenged California's plan to cut provider reimbursement by 10%.²¹³ The district court dismissed the claim, holding that § 30(A) does not confer rights under the *Gonzaga* framework, and therefore, the claim also failed under the Supremacy Clause.²¹⁴ The Ninth Circuit reversed, noting that "[t]he Supreme Court has repeatedly entertained claims for injunctive relief based on federal preemption, without requiring that the standards for bringing suit under § 1983 be met."²¹⁵ Moreover, the court stated "even as the Supreme Court has tightened the requirements for seeking damages under § 1983, it has consistently reaffirmed the availability of injunctive relief to prevent state officials from implementing state legislation allegedly preempted by federal law."²¹⁶ The court concluded that its decision "simply reaffirm[ed] over a century's worth of precedent."²¹⁷ The Ninth Circuit was the first court to hold that a cause of action under the Supremacy Clause is available when seeking to enforce § 30(A).

It must be emphasized that the statutory remedies available under § 1983 are no longer available.²¹⁸ For example, a cause of action based on § 1983 includes legal damages and attorney's fees for successful plaintiffs, while a preemption cause of action generally affords neither.²¹⁹ Moreover, courts interpreted the Medicaid Act, including § 30(A) pre-*Gonzaga*, analyzing it under the § 1983 framework. Now that the cause of actions differs, courts have been urged to reinterpret § 30(A). The Ninth Circuit dismissed this argument on several grounds.²²⁰ HHS recently issued a proposed rule clarifying the requirements of § 30(A) and potentially resolving the current circuit split.²²¹ The Supreme Court

²¹² 543 F.3d 1050 (9th Cir. 2008).

²¹³ *Id.* at 1052.

²¹⁴ *Id.* at 1054.

²¹⁵ *Id.* at 1055.

²¹⁶ *Id.* at 1063.

²¹⁷ *Id.* at 1066.

²¹⁸ *Pa. Pharm. Ass'n v. Houstoun*, 283 F.3d 531, 536 n.5 (3rd Cir. 2002) (Becker, C.J. dissenting) (noting that attorney fees are available to a successful § 1983 plaintiff).

²¹⁹ *Id.*

²²⁰ In *Independent Living Center v. Maxwell Jolly*, the Ninth Circuit adopted its pre-*Gonzaga* interpretation of the § 30(A), amid extensive challenges by the state. 572 F.3d 644, 653–57 (9th Cir. 2009). The court stated that "[t]he Director has not provided any coherent reason why the purpose underlying § 30(A) would be different for purposes of federal preemption than it was for direct enforcement under § 1983, and we see none." *Id.* at 653.

²²¹ 76 Fed. Reg. 26342, 26343 (May 6, 2011) The proposed rule requires states to consider access data prior and to collect input from patients and providers before

has granted certiorari to determine whether providers and beneficiaries can file suit under the Supremacy Clause to enforce § 30(A), which may significantly impact access to care.²²²

VI. THE LEGISLATIVE RESPONSE: HEALTH REFORM AND EQUAL ACCESS

The Affordable Care Act expands the role of states in providing health care to low-income populations, making it crucial that states administer Medicaid in compliance with federal law. States must adopt rates that assure access to care if the goals of the reform legislation are to be realized. The circuit split addressed *supra* demonstrates the difficulties faced by providers and patients as to whether Congressional demands under the Medicaid statute are even enforceable, due to the varying jurisdictional requirements and the statute's ambiguities. Moreover, the broad and undefined language of § 30(A) provides little guidance to state policy-makers which has in turn led to rate cuts and decreased access.

In response to the courts' retreat from § 1983, a legislative response is necessary to ensure that states comply with Medicaid's minimum requirements and to ensure that all citizens receive adequate access to care. If Congress fails to act, Medicaid's expansion will likely result in a large number of newly enrolled beneficiaries with limited access to care. Congress must expressly declare that the Medicaid Act affords both providers and beneficiaries rights that can be enforced against states that fail to comply with the statute's substantive requirements. Congress must also provide states with the option to adopt federal rates that are set by HHS, which will in turn relieve states of liability for rate-making decisions. Finally, Congress must provide incentives for states to monitor compliance and achieve quality and access similar to the framework provided used to implement accountable care organizations.

A. Private Enforcement

A private right of action is necessary to ensure that states comply with Medicaid's requirements. A private right of action encourages provider participation by creating a mechanism to recoup financial

reducing or restricting Medicaid rates. *Id.* at 26361–62. States must submit to CMS an analysis of Medicaid rates and their impact on access to care, which CMS can disapprove or take compliance action. *Id.* States must also conduct ongoing access reviews and when access issues are identified a corrective action plan with specific steps and timelines must be submitted to address the issue within 90 days of discovery. *Id.*

²²² Maxwell-Jolly v. Santa Rosa Mem. Hosp., No. 10-283, 2011 U.S. LEXIS 735, 735 (Jan. 18, 2011).

damages incurred as a result of accepting Medicaid patients at below-cost rates. The private cause of action is a safety net for those contemplating participation in the program. Currently, providers have no guarantee that they will not suffer tremendous financial loss by volunteering to participate in Medicaid.

Moreover, a private right of action provides security to Medicaid beneficiaries and in part, serves to eliminate the stigma of being enrolled in a welfare program. For example, under the current system, low-income patients face tremendous legal hurdles when seeking medical assistance. Unfortunately, neither the federal nor state governments are monitoring state compliance.²²³ Thus, patients are ignored with a bus ticket to nowhere and no recourse to recoup financial losses that may have occurred when states violate the law by limiting access to care. A private right of action sends the message that beneficiaries are important, and if their rights are ignored, the state will compensate those in need.

Furthermore, enacting a private cause of action is a fiscally conservative approach that will result in long-term savings for the federal government. The private cause of action, similar to a *qui tam* suit under the False Claims Act,²²⁴ empowers patients and providers to monitor the use of federal funds by financially strapped states. By allowing patients and providers to police state compliance, Medicaid must be administered efficiently in order to protect against watered-down programs that delay access resulting in costly care. The private cause of action puts the ability to help enforce the law in the hands of those affected by state decisions and forces states to pay attention to those who need care.

Although some plaintiffs have experienced success pursuing a cause of action under the Supremacy Clause, this too may deteriorate, as two Justices have stated that this path to compliance is not viable when enforcing Spending Clause legislation.²²⁵ Moreover, preemption claims do not allow recovery of legal damages or attorney's fees.²²⁶ Thus, when states cut Medicaid rates, resulting in extended wait or travel times to

²²³ According to a new rule proposed by HHS, states will be required to submit access data to CMS when restructuring or reducing Medicaid rates. 76 Fed. Reg. 26361–62 (May 6, 2011). The rule would also require states to consider input from beneficiaries and stakeholders. *Id.* Finally, the rule will require that states and the federal governments monitor access issues. *Id.*

²²⁴ 31 U.S.C. §§ 3729–3733 (2006).

²²⁵ *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 675, 683 (2003) (Scalia, J. concurring) (Thomas, J., concurring). Justice Scalia and Justice Thomas expressed serious doubts as to the availability of a cause of action under the Supremacy Clause when seeking to enforce Spending Clause legislation. *Id.* Accordingly, both Justices suggested that the only remedy available when states violate Spending Clause legislation is the withdrawal of federal funds. *Id.*

²²⁶ Bobroff, *supra* note 194. Somers, *supra* note 194.

access care, states are not financially liable to the affected beneficiaries. Under the preemption theory, rate cuts may be enjoined, but physicians and beneficiaries receive no compensation for filing suit, pursuing an appeal, or accepting Medicaid patients at unlawful rates. Thus, the Supremacy Clause cause of action does not encourage provider participation and provides little recourse for beneficiaries. Without a private cause of action, states are free to violate the law and restrict access with little to no consequence.

Congress should enact a private cause of action to allow providers and beneficiaries to enforce the Medicaid Act and its regulations. This private right would alleviate the legal burdens faced by patients and providers, and provide each a day in court. The private right should allow for attorney's fees and legal damages, to assure provider participation and guard against uncompensated time spent on waiting lists or travelling across the state to access care often experienced by Medicaid beneficiaries. Additionally, the threat of legal damages and attorney's fees deters unlawful state action and fosters a cooperative and attentive relationship among states, providers, and beneficiaries. Finally, and perhaps most importantly, the private cause of action ensures that federal money is spent according to federal guidelines, thus resulting in full-strength programs that live up to the goals of reform.

B. Universal Rates and Accountable Care

In addition to the private cause of action, Congress should provide states with the option of adopting rates set at the federal level. By adopting the federal rates, states would be relieved from liability incurred under the private cause of action. The federal Medicaid rates should be equal to Medicare rates for services reimbursed under Medicare. For those services not reimbursed under Medicare, such as certain types of costly long-term care, HHS should examine current state rates and adjust for quality and access measures. The universal rates should cut down on administrative inefficiencies and financial inequity, thus improving provider participation and beneficiary access. Moreover, rate consistency across public programs would help eliminate, to a certain extent, the ability to shift costs between public and private payers.

The Affordable Care Act contains numerous provisions that focus on payment strategies to reduce costs and improve access, and Medicaid and Medicare universal rates should be a primary focus. Under the Affordable Care Act, the Center for Medicare and Medicaid Innovation ("the Innovation Center") was created to "test innovative payment and service delivery models to reduce program expenditures . . . while

preserving or enhancing the quality of care furnished to individuals.”²²⁷ Like § 30(A), the Innovation Center also seeks to improve access, increase quality, and promote efficient care.

As part of its quality and efficiency studies, the Center should develop a universal rate system that ties Medicaid reimbursement to Medicare reimbursement, similar to the way in which the Affordable Care Act seeks to provide equal access to primary care physicians. Under such a system, access would improve and states would be relieved of financial liability under a private cause of action as they would no longer control rates. In addition to decreasing administrative obstacles at the provider level, such a system would promote efficiency by eliminating duplication among rate setting agencies. For example, under the new rule proposed by HHS, both the federal and state governments will be responsible for monitoring and adjusting rates to ensure access to care. If federal rates are adopted, states would no longer be required to adjust payments, eliminating an administrative cost at the state level.

Over time, additional costs could be eliminated by reducing duplication and administrative barriers experienced by providers participating in both Medicare and Medicaid. For example, program reform should focus on efficiency by streamlining conditions of participation, forms, codes, and additional administrative measures into a single administrative body. Such a system would eliminate current inefficiencies which require providers and beneficiaries to navigate the federal and state framework when seeking reimbursement for care. Finally, the system would promote equality between Medicare and Medicaid beneficiaries throughout the country, eliminating the stigma of Medicaid. Rather than focusing on setting rates to assure access to care, the legislative focus at the state level would turn toward improving efficiency and quality while decreasing costs.

The federal government should also provide states with a new incentive to manage and monitor the care provided across Medicaid programs. In order to do so, states should be rewarded or penalized based on their ability to administer the program efficiently and their ability to meet certain quality and access measures. Thus, states under this system will in essence become Accountable Care Organizations (ACO) as developed under the Affordable Care Act.²²⁸ An ACO is “an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries.”²²⁹ ACO

²²⁷ Affordable Care Act § 3021 (2010).

²²⁸ *Id.* § 3022.

²²⁹ CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICARE “ACCOUNTABLE CARE ORGANIZATIONS”

participants are eligible for a portion of shared savings payments attributed to increased efficiency and coordination of care provided that quality benchmarks are satisfied.²³⁰ The ACO concept should be expanded to include the coordination of care provided to Medicaid beneficiaries.

For example, when developing a statewide ACO, the federal government could provide incentives for states (based on federal benchmarks) which might include increased FMAP or funding for additional services or even the ability of the state to keep any cost savings due to efficiency efforts. Federal benchmarks would include access and quality goals similar to those imposed by § 30(A). States that meet these goals would be eligible for incentive payments, just like groups of providers would be eligible for shared savings as part of an ACO. The program would give states flexibility to implement their Medicaid programs but would also require close federal oversight to monitor the extent to which states achieve the goals of Medicaid and health reform. A statewide ACO would also eliminate many of the fraud and abuse issues and anti-trust concerns confronting providers under the current ACO program.

New Jersey has proposed an ACO demonstration project to encourage efficiency and decrease costs among Medicaid providers.²³¹ Under this program, Medicaid providers in an ACO would be eligible for shared savings payments similar to the payments distributed under the Medicare ACO program.²³² States across the country could adopt similar programs, or the federal government could expand its ACO program to include Medicaid providers. Ultimately, however, states (in addition to groups of providers) should be held accountable for providing access to quality care for Medicaid beneficiaries. A federal program that treats states as ACOs may be the best way to promote accountability for equal care.

In sum, a move towards federal rates may encourage the development of innovative programs among the states that focus on the efficiency and economy of care they provide. The option proposed here allows states to retain the flexibility they currently have when adopting Medicaid reimbursement rates. It also allows providers and beneficiaries to file suit against states if rates are not set within the parameters of federal law. State rate-setting decisions should be measured by

SHARED SAVINGS PROGRAM – NEW SECTION 1899 OF TITLE XVIII PRELIMINARY QUESTIONS & ANSWERS (2010).

²³⁰ *Id.*

²³¹ S2443, 214th Leg. (N.J. 2011).

²³² *Id.*

substantive results, which should be clarified by Congress or HHS in objective measurable terms. A state's ability to provide access to quality, economical, and efficient care should be measured according to similar, objective standards adopted by regulation for ACOs. Moreover, if states choose to adopt federal Medicaid rates, states should be relieved from future liability under a private cause of action by patients and providers seeking to enforce § 30(A). A system that seeks to streamline the provision of medical assistance under both federal and state programs may actually encourage provider participation and leaves open the option of rewarding states (as ACOs) for structuring Medicaid programs in order to achieve quality and efficiency goals.

VII. CONCLUSION

Medicaid has been widely out of favor according to many Americans due to its lack of quality and access. Medicare, on the other hand, is a sacred entitlement and private insurance is viewed by some as the ultimate path to accessible, quality care. Congress enacted Medicaid's Equal Access provision to ensure that states set rates so that inequities between private and public programs did not occur. Unfortunately, issues of quality and access have been left to the states and the federal courts. Although difficult, Congress must revise and enact measurable standards to fix its past shortcomings and to assure that states provide an accessible safety net.

Due to the economic recession and recent reform measures, Medicaid will play a larger role in providing care to low income Americans. The federal government has generously extended funds to encourage states to establish Medicaid programs, yet federal standards are either too flexible or states are not being held accountable for the care they are required to provide. Many states are taking advantage of this flexibility by cutting reimbursement rates to balance budgets. Additionally, the courts have had difficulty interpreting the language of the statute, which provides insufficient guidance. In turn, providers and beneficiaries have been required to overcome immense legal hurdles to assure that states provide medical assistance according to federal law.

In response, Congress should extend a private right of action to Medicaid providers and beneficiaries by clearly expressing its intent to create a right to access medical assistance. As a complementary alternative to requiring that states achieve substantive results, Congress should develop a universal rate system for its public programs. This option would relieve state liability under § 30(A) and move the nation one step closer towards equal access to care among both low-income and elderly populations. Finally, the Accountable Care Organization concept

should be expanded to include Medicaid providers as well as the states. The federal government should provide incentives for providing equal access to quality care and the states should do the same with respect to encouraging efficiency among Medicaid providers. These actions clarify multiple circuit splits and protect states, providers, beneficiaries, and the federal budget, and bolster the goals of health reform.