NOTES

At Risk Patients and Doctors: Why Increased Agency Enforcement and Private Causes of Action Under the Supremacy Clause are Needed to Protect Medicaid Providers and Beneficiaries

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INTRODUCTION

Two recent developments have raised important questions about the ability of the Medicaid program to continue to pursue meaningfully its goal of providing health care services to the nation's most impoverished people. First, on May 6, 2011, the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services (HHS) which is responsible for oversight of state Medicaid provider payment rate-setting, invoked its rulemaking power for the first time to propose regulations aimed at helping CMS fully implement the Equal Access provision of the Medicaid Act.[2] Second, on February 22, 2012, the Supreme Court decided *Douglas v. Independent Living Center of Southern California*, a case in which Medicaid providers challenged California state budget cuts reducing the amount of Medicaid reimbursement.[3] The providers argued that California's budget cuts violated the Equal Access provision of Medicaid ("§ 30(A)")[4] which requires that providers be paid well enough to ensure that Medicaid beneficiaries have "care and services" equivalent to "the general population in the geographic area."[5] The providers further urged that these state budget cuts were in violation of federal law under the Supremacy Clause.[6]

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2 Medicare Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (proposed May 6, 2011) [hereinafter Covered Medicaid Services] (to be codified at 42 C.F.R. pt. 447).

3 *See* Douglas v. Indep. Living Ctr. of S. Cal., Inc., 132 S. Ct. 1204, 1208 (2012).

4 Brief of Respondents at 18, *Indep. Living Ctr.*, 132 S. Ct. 1204 (No. 09-958), 2011 WL 3319553.

5 42 U.S.C. § 1396a(a)(30)(A) (2006).

6 *See* Brief of Respondents, *supra* note 4, at 41, 45.

The Equal Access provision of Medicaid is essential to Medicaid's goal of providing health care to America's poorest and most needy citizens—the chronically ill, pregnant women, seniors, and children.[7] A failure to enforce the Equal Access provision would have resulted in continued state budget cuts to Medicaid provider reimbursement rates, which would have in turn led to providers limiting the number of Medicaid patients they see or even opting out of treating Medicaid patients altogether.[8]

This note will focus on how best to ensure the continued viability of Medicaid's Equal Access provision, thereby preserving adequate health care for America's sickest and most vulnerable citizens. Part I provides a brief history of the Medicaid program and its purposes. Part II will examine private causes of action to enforce the Equal Access provision under § 1983 and the Supremacy Clause. Part III will focus on the Obama Administration's newly proposed access regulations and ways to improve their deficiencies.

Finally, Part IV will argue that although the proposed regulations are a positive step, much more is needed to ensure that they are effective in providing equal access to Medicaid beneficiaries. The regulations should be revised to afford less discretion to the states in their methods of measuring equal access and to increase agency enforcement to ensure state compliance with the regulations. Further, the courts should continue to allow private causes of action under the Supremacy Clause to aid agency enforcement by helping to identify unlawfully low provider reimbursement rates that threaten Medicaid providers' and beneficiaries' equal access rights.

I. MEDICAID BACKGROUND

A. The History and Purpose of Medicaid

Prior to 1965, America suffered from a "dual-track" system of health care.[9] The wealthy were able to afford a high standard of care, while the

7 *See* Diane Rowland, *Medicaid at Forty*, 27 HEALTH CARE FIN. REV., Winter 2005–2006, at 63, *available at* https://www.cms.gov/HealthCareFinancingReview/downloads/05-06WinpG63.pdf (describing Medicaid's purpose to provide care for the "medically indigent"); *see also* Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 418–19 (2008) (explaining that Medicaid was intended to provide healthcare only for the Nation's "deserving poor").

8 See Kevin Sack & Robert Pear, *States Consider Medicaid Cuts as Use Grows*, N.Y. TIMES, Feb. 19, 2010, at A1, *available at* http://www.nytimes.com/2010/02/19/us/politics/19medicaid.html, for the story of Dr. John Beck, a Wichita ophthalmologist who treated Medicaid patients for years before Kansas's latest state budget cuts lowered his payment rates to where he could no longer afford to treat Medicaid patients.

9 John V. Jacobi, *Mission and Markets in Health Care: Protecting Essential Community Providers for the Poor*, 75 WASH. U. L.Q. 1431, 1435 (1997); Abigail R. Moncrieff, Comment, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 673–75

poor were left at the mercy of "poor clinics and charity hospitals."[10] The Medicaid Act, enacted in 1965 as Title XIX of the Social Security Act, was viewed as a remedy to "dual-track" health care and was intended to provide health care services to the nation's poorest and most needy citizens.[11] Over its forty-seven years, Medicaid grew into the nation's largest health care program.[12] While remaining a program for impoverished people, Medicaid expanded its coverage beyond simply the poorest segments of the population to include many working class families.[13] In fact, due to the current economic recession, Medicaid enrollment recently exceeded fifty million individuals for the first time in the program's history.[14] The program's average monthly enrollment was expected to exceed fifty-five million in 2011.[15]

Medicaid is a cooperative program between the federal government and the states.[16] Such joint federal-state programs are commonly referred to as "cooperative federalism."[17] Through Medicaid, the federal government provides funds to states to facilitate "medical care to needy individuals."[18] Essentially, a state voluntarily agrees to enact a "state plan" that conforms to the strictures of the Medicaid Act; if these requirements are met, the government then subsidizes a majority of the state's plan.[19] The shared administrative and funding duties of the federal and state governments in Medicaid have been considered a "source of tension" since the program's inception.[20]

(2006).

10 Jacobi, *supra* note 9, at 1435.

11 *See* Rowland, *supra* note 7, at 63; *see also* Huberfeld, *supra* note 7, at 418–19.

12 *See* Rowland, *supra* note 7, at 63.

13 *See Medicaid Matters: Understanding Medicaid's Role in Our Health Care System*, KAISER FAMILY FOUND. (Mar. 2011), http://www.kff.org/medicaid/upload/8165.pdf.

14 *See Medicaid Enrollment: December 2010 Data Snapshot*, KAISER FAMILY FOUND. (Dec. 2011), http://www.kff.org/medicaid/upload/8050-04.pdf.

15 John K. Iglehart, *Expanding Eligibility, Cutting Costs—A Medicaid Update*, 366 NEW ENGL. J. MED. 105, 105 (2012).

16 *See* 42 U.S.C. § 1396b(p)(1) (2006).

17 *See* King v. Smith, 392 U.S. 309, 316 (1968).

18 *See* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); *see also* Harris v. McRae, 448 U.S. 297, 308 (1980).

19 42 U.S.C. § 1396b(a)(1) (2006); *see also* Michael A. Platt, Comment, Westside Mothers *and Medicaid: Will this Mean the End of Private Enforcement of Federal Funding Conditions Using Section 1983?*, 51 AM. U. L. REV. 273, 298–99 (2001) (analogizing a state's Medicaid plan to a contract between the state and the federal government).

20 Iglehart, *supra* note 15.

B. Medicaid's Equal Access Provision

The federal government has given the states considerable flexibility to administer their Medicaid programs.[21] Through Medicaid demonstration waivers,[22] states may determine delivery systems for health care, enact methods for enrolling providers, and modify provider payments.[23] However, this flexibility afforded to the states does not go unchecked. Whatever changes a state may make to its Medicaid program, that program must still meet the "equal access" provision of the Medicaid Act.[24]

Section 30(A) requires that a state Medicaid plan:

> [P]rovide 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 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.[25]

Section 30(A) should not be viewed as a particularly harsh rule or one that handcuffs the states. As long as a state meets the requirements of § 30(A), it will be given significant leeway to maximize the value of its Medicaid spending through its rate policies.[26]

1. *History of Medicaid's Equal Access Provision.*—The Medicaid Act has long realized the importance of provider payment levels sufficient to assure access, quality, and efficiency.[27] Shortly after the law's enactment

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21 *See* Alexander v. Choate, 469 U.S. 287, 303 (1985).

22 Section 1115 of the Social Security Act allows the Secretary of HHS to waive certain requirements of the Medicaid Act in order to allow states to use federal Medicaid funds in ways typically not allowed under the Medicaid Act. *See Five Key Questions and Answers About Section 1115 Medicaid Demonstration Waivers*, KAISER FAMILY FOUND. (June 2011), http://www.kff.org/medicaid/upload/8196.pdf. Section 1115 demonstration waivers are required to remain budget neutral. *Id.*

23 *See id.*; *see also* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 447–48 (2011) (describing the different waiver variations and the flexibility they provide states). Huberfeld explains that so many different forms of waivers exist "because the states are always seeking more flexibility in Medicaid." *Id.*

24 42 U.S.C. § 1396a(a)(30)(A) (2006).

25 *Id.*

26 *See* Covered Medicaid Services, *supra* note 2, at 26,342. Although Covered Medicaid Services are proposed regulations, the general information section of the regulations explains that under the current rule of § 30(A), states are free to seek best value through payment rate and access strategies. *Id.*

27 *See* DeGregorio v. O'Bannon, 500 F. Supp. 541, 549 n.13 (E.D. Pa. 1980) (explaining that Medicaid equal access language first appeared in 1966 in the HHS Handbook of Public

in 1965, early statements of provider payment policies contained equal access language.[28] In 1979, equal access assurance was incorporated into program regulations.[29] Throughout this early period in Medicaid's history, the Secretary of the Department of Health and Human Services was responsible for determining whether a "state plan" satisfied federal standards.[30]

In 1980, due to concern over rising health care costs, Congress passed the Boren Amendment.[31] This amendment to the Medicaid Act was meant to address waste in hospital and nursing home care.[32] It facilitated state experimentation with payment models for the purpose of cost–containment. States became free to set rates on a statewide basis, or on an institutional basis, and Medicaid rates no longer had to abide by Medicare rate–setting principles.[33] Boren also shifted the responsibility of determining whether "state plans" satisfied federal standards, including that reasonable provider rates were in place to ensure equal access, from the Secretary to the states.[34] Under Boren, the Secretary could only reject a "state plan" if it was clear on its face that the state's assurance of reasonable provider rates was false. Essentially, the Secretary's role in ensuring equal access was rendered nugatory.

The Boren Amendment proved successful in its goal of facilitating state experimentation with cost reduction; however, it also spurred legal challenges from hospitals and nursing homes contesting the rate–setting methods states employed under Boren.[35] Boren was aimed at increasing state flexibility in order to encourage efficiency and economy, but providers and beneficiaries were still supposed to be protected from arbitrary

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Assistance Administration, Supplement D, § D–5320.1).

28 Sara Rosenbaum, *Medicaid Payment Rate Lawsuits: Evolving Court Views Mean Uncertain Future for Medi–Cal*, CAL. HEALTHCARE FOUND. 1, 3 (Oct. 2009), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalProviderRateLitigation.pdf.

29 Encouragement of Provider Participation, 42 C.F.R. § 447.204 (2011).

30 *See* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 527 (1990).

31 Omnibus Reconciliation Act of 1980, Pub. L. No. 96–499, § 962(a), 94 Stat. 2599, 2623–65 (1980) (repealed 1997).

32 *See* Brietta Clark, *Medicaid Access, Rate Setting and Payment Suits: How the Obama Administration Is Undermining Its Own Health Reform Goals*, 55 How. L.J. 771, 797–98 (2012).

33 *See id.* at 798–99. Although the Medicaid Act did not create a uniform system of rate–setting, the U.S. Department of Health, Education, and Welfare, a precursor to HHS, instituted a "de facto parity standard that deemed Medicare rates presumptively reasonable for Medicaid." *Id.* at 796–97.

34 *See Wilder*, 496 U.S. at 527.

35 Clark, *supra* note 32, at 799; *see* Malcolm J. Harkins III, *Be Careful What You Ask For: The Repeal of the Boren Amendment and Continuing Federal Responsibility to Assure that State Medicaid Programs Pay For Cost Effective Quality Nursing Facility Care*, 4 J. HEALTH CARE L. & POL'Y 159, 159 (2001).

budget cuts.[36] Legislative history shows that the Boren Amendment was not intended to allow states to set rates "solely on the basis of budgetary appropriations."[37] Furthermore, Boren was "not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care."[38] Boren did not alter the expectation that states would set rates sufficient to ensure equal access.

The Boren Amendment's intention of avoiding state cuts based on budgetary concerns was undercut by the broad discretion it allowed states in determining provider payment levels. States were free to formulate whatever rate-setting policy they wanted so long as they made "findings" and assured the Secretary that their rates were sufficiently "reasonable and adequate" to cover the costs of providers.[39] However, states were also allowed to establish their own criteria for evaluating the reasonableness of their methodologies, which were subject to no real oversight. It was not uncommon for states to set provider payment rates without conducting any analysis whatsoever to ensure that the rates were sufficient for providers to be able to maintain quality of care and thus ensure equal access for beneficiaries.[40]

In 1989, in response to low provider participation in Medicaid partially caused by deficient provider payment rates, Congress was forced to take legislative action to abate a growing access problem.[41] The result was the codification of § 30(A), Medicaid's Equal Access provision, into the Medicaid Act itself.[42] Ironically, the equal access language employed in § 30(A) was taken from the same ineffectual Health and Human Services regulatory fabric that had been in existence since 1966.[43]

2. *The Failure of § 30(A).*—Whereas the Boren Amendment only covered the rate-setting procedures of hospitals and nursing homes, § 30(A) was not limited to specific services or providers.[44] Under § 30(A), the states were no longer required to make the perfunctory findings that their payment levels

36 *See* Harkins III, *supra* note 35, at 203.

37 *See* Clark, *supra* note 32, at 799.

38 *See* Harkins III, *supra* note 35, at 173.

39 *See* Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, §962(a), 94 Stat. 2599, 2650-51 (1980) (repealed 1997).

40 *See* Clark, *supra* note 32, at 800.

41 *See id.* at 785; *see also* Moncrieff, *supra* note 9, at 686. Rep. Henry A. Waxman stated that "the one complaint [Congressman] hear most is the rate of payment." *Medicare and Medicaid Initiatives: Hearings Before the Subcomm. on Health and the Env't of the H. Comm. on Energy and Commerce,* 101st Cong. 113 (1989).

42 42 U.S.C. § 1396a(a)(30)(A) (2006).

43 *See* Encouragement of Provider Participation, 42 C.F.R. § 447.204 (2011); *see also* Sara Rosenbaum, *Medicaid and Access to Health Care—A Proposal for Continued Inaction?*, 365 NEW ENG. J. MED. 102, 102-04 (2011).

44 *See* Clark, *supra* note 32, at 800.

were consistent with quality of care mandated by the Boren Amendment.[45] Section 30(A) did, however, require the states to submit assurances to the Secretary that their rates were sufficient to enlist providers.[46]

Medicaid's latest equal access mandate failed to gain any significant ground over its failed regulatory predecessors.[47] Although § 30(A) required assurances from the states to the federal government, it failed to require any meaningful presentation by the states of the findings and data that formed the basis of their assurances.[48] Additionally, the Secretary was not required to review the reasoning behind state assurances.[49] At least some of the blame for the ineffectiveness of § 30(A) can be attributed to Congress for its failure to provide for significant enforcement of the provision.[50]

Subsequent administrations' inability (or unwillingness) to enforce the statute has further contributed to the ineffectiveness of § 30(A).[51] These administrations have declined to make efforts to firmly implement § 30(A). The equal access question is complex and a number of variables must be considered in determining whether provider payments are sufficient. Despite the heightened need for guidance due to the complexity of the issue, until recently, no administration had issued regulations aimed at providing any metrics to ensure that the statute would be enforced.[52] Lacking any meaningful metrics or research, CMS has no means to ascertain whether Medicaid beneficiaries are receiving access to the quality of care to which they are entitled.

A recent report to Congress by the Medicaid and CHIP Payment and Access Commission laments that "there is no easily accessible source of state payment methods, no comprehensive analysis of which are more or less effective, and no uniform data that permit meaningful comparisons of payment levels."[53] To summarize, "[M]eaningful federal enforcement . . . has been utterly absent."[54]

3. *Negative Effects of Inadequate Federal Enforcement of § 30(A).*—The recent economic recession has led many states to consider or to enact significant cuts

45 *See id.*

46 42 U.S.C. § 1396a(a)(30)(A).

47 *See* Rosenbaum, *supra* note 43, at 102 ("Congressional intervention did not, however, serve as a wake-up call.").

48 *See* Clark, *supra* note 32, at 801.

49 *See id.*

50 *See* Harkins III, *supra* note 35, at 216.

51 *See* Rosenbaum, *supra* note 43, at 102.

52 *See id.*

53 MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 158 (2011), *available at* http://www.gpo.gov/fdsys/pkg/GPO-MACPAC-2011-03/pdf/GPO-MACPAC-2011-03.pdf.

54 Rosenbaum, *supra* note 43, at 102.

to their Medicaid programs.[55] Furthermore, states facing budget deficits are increasingly likely to target cuts in Medicaid provider payments as a means of stretching their Medicaid dollars.[56] A lack of federal enforcement of § 30(A) makes it all too easy for states to cut provider reimbursement rates. In fact, states looking to reduce their Medicaid spending often find that the simplest cut they can make is to lower provider payment rates.[57] The quick fix of decreasing provider payment rates has the end result of impairing the ability of the Medicaid program to function effectively. Medicaid is already notorious for its low levels of provider reimbursement—it pays less than Medicare and private insurance (and often pays less than the actual cost to the provider).[58] The result of further cuts to the program is that many doctors simply decide they can no longer afford to treat Medicaid patients.[59] When health care providers decide to opt out of treating Medicaid patients, it poses the threat that states will fail in their duty to provide equal access under § 30(A).

II. Private Enforcement of § 30(A), Medicaid's Equal Access Provision

The paucity of federal enforcement of § 30(A) has led numerous beneficiaries and providers alike to seek recourse in the federal courts when states make cuts to provider payments that threaten the equal access provision in violation of federal law.[60] Problematically, Medicaid contains no enforcement procedure for providers and beneficiaries who do not receive the payments or benefits required under the program.[61] Therefore, private actions to enforce the equal access requirements of § 30(A) primarily take one of two more circuitous paths: either through 42 U.S.C. § 1983 ("1983")[62]

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55 *See* Sack and Pear, *supra* note 8.

56 *See* Rosenbaum, *supra* note 43, at 102–04 ("[S]tates are especially prone to cut Medicaid provider payments because of grim financial conditions.").

57 Bradley J. Sayles, *Preemption or Bust: A Review of the Recent Trends in Medicaid Preemption Actions*, 27 J. Contemp. Health L. & Pol'y 120, 121 (2010) (citation omitted).

58 *See* Sack and Pear, *supra* note 8.

59 *Id.*

60 *See, e.g.*, Methodist Hosps., Inc. v. Sullivan, 91 F.3d 1026, 1029 (7th Cir. 1996); Wood v. Tompkins, 33 F.3d 600, 601 (6th Cir. 1994); Miller v. Whitburn, 10 F.3d 1315 (7th Cir. 1993), Ark. Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519 (8th Cir. 1993).

61 *See* Huberfeld, *supra* note 7, at 416–17.

62 42 U.S.C. § 1983 (2006) now reads:

> 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, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.

or through the Supremacy Clause.[63] The following two sections of this note will briefly explore the contours of private actions to enforce § 30(A) through § 1983 and the Supremacy Clause while also exploring how recent jurisprudential trends threaten to nullify these causes of action altogether.

A. Private Enforcement of § 30(A) Through § 1983

Section 1983 was originally enacted as part of the Civil Rights Act of 1871.[64] It was, at its core, a reaction to the racial terrorism of the Ku Klux Klan in the post–Civil War Southern United States.[65] Although § 1983 was primarily intended to enforce civil rights in the postbellum South, its broad language helped lead to an eventual expansion of the statute's scope to a general civil rights statute.[66] In 1980, the Supreme Court decided *Maine v. Thiboutot*, which held that § 1983 creates a private cause of action for violation of federal law by state officials.[67] In the years following the Court's decision in *Thiboutot*, Medicaid providers and beneficiaries brought a "steady stream of litigation" into federal courts to challenge state Medicaid program limitations.[68]

However, recent decisions by the Court have threatened the viability of § 1983 as a means of enforcing Medicaid's "equal access" requirement.[69] Private causes of action under § 1983 were dealt a severe blow with the Supreme Court's ruling in *Gonzaga v. Doe*.[70] In *Gonzaga*, the Court narrowed the applicability of § 1983 as an enforcement mechanism to situations where Congress has created a new right in "clear and unambiguous terms."[71] This new focus on congressional intent has led the majority of circuit courts to find that § 30(A) creates no enforceable rights for Medicaid beneficiaries

63 U.S. CONST., art. VI, cl. 2. The Supremacy Clause provides that

> [t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority 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.

64 Also known as the Ku Klux Klan Act of 1871, § 1 (now known as § 1983), was introduced by Rep. Samuel Shellabarger (R., Ohio); it was passed with little debate and without amendment. Monell v. N.Y.C. Dep't of Soc. Servs., 436 U.S. 658, 665 (1978).

65 *Id.*

66 *See* Monroe v. Pape, 365 U.S. 167, 183 (1961).

67 Maine v. Thiboutot, 448 U.S. 1, 1 (1980).

68 Timothy Stoltzfus Jost, *The Tenuous Nature of the Medicaid Entitlement*, 22 HEALTH AFF., no. 1, Jan.–Feb. 2003, at 145, 145–48.

69 For an in depth account of the threats to the use of § 1983 to enforce Medicaid provisions, see Huberfeld, *supra* note 7, at 417–18. Huberfeld explains that current Supreme Court justices are critical of the use of § 1983 to enforce spending conditions and that the Court's decision in *Gonzaga University v. Doe* vitiates § 1983 enforcement. *Id.*

70 Gonzaga Univ. v. Doe, 536 U.S. 273 (2002).

71 *Id.* at 290.

under § 1983.[72] The Eighth Circuit seems to be the only circuit still willing to allow private causes of action under § 30(A) through § 1983.[73] Whatever heft remains in § 1983 for Medicaid beneficiaries, it seems clear that its use as an enforcement mechanism for § 30(A) stands on uneven ground—even a step as drastic as overruling *Thiboutot* is not out of the question.[74]

B. Private Enforcement of § 30(A) Through the Supremacy Clause

1. *The History of Private Actions Under the Supremacy Clause.*—Similar to the private cause of action to enforce § 30(A) through § 1983, the viability of a private cause of action for a preemption claim under the Supremacy Clause now stands on questionable ground. The vitiation of the private cause of action under § 1983 has caused many Medicaid providers and beneficiaries to seek judicial redress in federal courts for violations of § 30(A) through the alternative route of asserting a private cause of action under the Supremacy Clause.[75] The Ninth Circuit has explained that while the Supreme Court in *Gonzaga* limited private actions under § 1983, the Court has also "consistently reaffirmed the availability of injunctive relief" against state officials that would implement state legislation in violation of federal law.[76]

Ironically, the seeds of a private cause of action to enforce § 30(A) under the Supremacy Clause were sown during the same time period in which the conservative Justices of the Supreme Court sought to foreclose § 1983 actions aimed at the same purpose.[77] In 1983, the Court decided *Shaw v. Delta Airlines*, which noted that it was "beyond dispute" that injunctive relief could be sought under the Supremacy Clause to prevent the implementation of a state regulation that was preempted by federal law.[78] In *Shaw*, the Court granted relief to a group of plaintiffs that claimed that the New York statutes at issue in the case were preempted by federal law.[79] This decision strongly implied that the plaintiffs had a private cause of action.

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72 *See* Andrew R. Gardella, Note, *The Equal Access Illusion: A Growing Majority of Federal Courts Erroneously Foreclose Private Enforcement of § 1396a(A)(30) of the Medicaid Act Using 42 U.S.C. § 1983*, 38 U. MEM. L. REV. 697, 706 (2008).

73 *See* Huberfeld, *supra* note 7, at 448–50.

74 Lauren Saunders, *Are there 5 Votes to Overrule* Thiboutot*?*, 40 CLEARINGHOUSE REV. 380, 381 (2006).

75 *See* Indep. Living Ctr. of S. Cal., Inc. v. Shewry, 543 F.3d 1050, 1059–63 (9th Cir. 2008).

76 *Id.* at 1063.

77 *See* Rochelle Bobroff, *Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes*, 10 LOY. J. PUB. INT. L. 27, 45–46 (2008).

78 Shaw v. Delta Airlines, Inc., 463 U.S. 85, 96 n.14 (1983).

79 *Id.* at 108–09.

In 2002, the same year that the Court took some of the teeth out of § 1983 actions with its ruling in *Gonzaga*, it also lent further credence to preemption claims under the Supremacy Clause with its ruling in *Verizon Maryland, Inc. v. Public Service Commission*.[80] The Court reached a unanimous decision on the merits of the preemption claim at issue while expressly declining to offer an opinion on whether a private cause of action exists under the Supremacy Clause.[81] In fact, in nine different cases between 1996 and 2003, the Supreme Court reached the merits on private plaintiffs' preemption claims without ever holding that the federal statute at issue granted a private cause of action.[82]

Whatever the reason may be for the Supreme Court's reluctance to explicitly state that a private cause of action exists under the Supremacy Clause, its jurisprudence in this area has sent an unmistakable message to the lower courts that a private cause of action does, in fact, exist.[83] The Circuit Courts have "universally affirmed the right of private parties to seek injunctive relief under the Supremacy Clause regardless of whether the allegedly preemptive statute confers any federal 'right' or cause of action."[84] There is no shortage of appellate precedent favoring preemption claims by private parties.[85]

2. *The* Douglas *Cases: The Supreme Court Considers Private Actions Under the Supremacy Clause.*—However favorable circuit court precedent may be toward a private cause of action to enforce § 30(A) under the Supremacy Clause, the Supreme Court appears comparatively ambivalent to actions premised upon the Clause. One commentator has stated that the Supreme Court's refusal to explicitly acknowledge a private right of action in its Supremacy Clause cases is because "at least some of the Justices . . . do not want to encourage suits by individuals against the government."[86]

80 Verizon Md., Inc. v. Public Serv. Comm'n. of Md., 535 U.S. 635, 642–45 (2002).

81 *Id.*

82 Bobroff, *supra* note 77, at 60 (citing David Sloss, *Constitutional Remedies for Statutory Violations*, 89 IOWA L. REV. 355, 366–67 (2004)).

83 *See* Indep. Living Ctr. of S. Cal., Inc. v. Shewry, 543 F.3d 1050, 1058 (9th Cir. 2008) (explaining that it is a "well-established rule" in the circuits that an explicit conferral of a private right of action is not necessary to claim injunctive relief under the Supremacy Clause).

84 *Id.*

85 *See, e.g.*, Qwest Corp. v. City of Santa Fe, 380 F.3d 1258, 1266 (10th Cir. 2004) ("A party may bring a claim under the Supremacy Clause that a local enactment is preempted even if the federal law at issue does not create a private right of action."); Bud Antle, Inc. v. Barbosa, 45 F.3d 1261, 1269–72 (9th Cir. 1994) (citing Shaw v. Delta Airlines, 463 U.S. 85, 96 n.14 (1983)) (noting the "general rule that a private party may seek declaratory and injunctive relief against the enforcement of a state statutory scheme on the ground of federal preemption."); *see also* Local Union No. 12004, United Steelworkers of Am. v. Massachusetts, 377 F.3d 64, 75 (1st Cir. 2004) (holding that plaintiff may assert a claim for preemption even lacking an explicit statutory cause of action).

86 Bobroff, *supra* note 77, at 60–61.

Against this unfavorable backdrop, the Supreme Court recently decided a case challenging state budget cuts to provider payment levels that had the potential to foreclose private actions under the Supremacy Clause.[87] *Douglas v. Independent Living Center* consolidated three Ninth Circuit cases, each of which addressed a dispute between the state of California and its Medicaid providers.[88] The providers argued that the reimbursement cuts, enacted by statute in response to California's budget crisis, were preempted by § 30(A) and were in violation of federal law for threatening Medicaid beneficiaries' guarantee of "equal access" under § 30(A).[89] It appears that the plaintiffs in these cases—hospitals, physicians, pharmacists, and Medicaid beneficiaries—had particularly strong claims as California's provider payment rates "were already the lowest in the Nation on an average per-enrollee basis" at the time the cuts were made.[90] Despite California's low payment rates, the state legislature, facing a budget crisis, passed legislation reducing Medicaid provider reimbursement rates by ten percent.[91]

Any doubt that the Court would not address the private cause of action issue was erased when certiorari was granted and limited to the first question presented,[92] which framed the issue, "Whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce § 1396a(a)(30)(A) by asserting that the provision preempts a state law reducing reimbursement rates?"[93]

The Supreme Court's decision to grant certiorari produced some strange bedfellows in favor of, and against, a private cause of action under the Supremacy Clause. Most shockingly, the Obama Administration issued an amicus brief siding with the states and arguing against a private cause of action to enforce § 30(A).[94] Sara Rosenbaum explains, "[the administration] want[s] the prerogative of when and where to intervene in state conduct

87 *See* Douglas v. Indep. Living Ctr. of S. Cal., 132 S. Ct. 1204, 1205–06 (2012).

88 Sara Rosenbaum, *Equal Access for Medicaid Beneficiaries—The Supreme Court and the* Douglas *Cases*, 365 N. ENGL. J. MED. 2245, 2245 (2011).

89 *Id.*

90 Brief of the Chamber of Commerce of the United States of America as Amicus Curiae in Support of Respondents, *Indep. Living Ctr.*, 132 S. Ct. 1204 (No. 09–958), 2011 WL 3439920 at *3–4.

91 *Explaining* Douglas v. Independent Living Center: *Questions about the Upcoming United States Supreme Court Case Regarding Medicaid Beneficiaries and Providers' Ability to Enforce the Medicaid Act*, KAISER FAMILY FOUND., (Sep. 2011), http://www.kff.org/medicaid/upload/8240-2.pdf.

92 Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly, 572 F.3d 644 (9th Cir. 2009), *cert. granted*, 131 S. Ct. 992 (U.S. Jan. 18, 2011) (No. 09–958).

93 Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly, 572 F.3d 644 (9th Cir. 2009), *petition for cert. filed*, 2010 WL 599171 (U.S. Feb. 16, 2010) (No. 09–958).

94 Brief for the United States as Amicus Curiae Supporting Petitioner, *Indep. Living Ctr*, 132 S. Ct. 1204 (No. 09–958), 2011 WL 2132705 at *12.

matters."[95] The Administration's amicus brief pointed to proposed regulations aimed at greater enforcement of § 30(A) as a reason to derogate private actions under the Supremacy Clause.[96] Professor Rosenbaum writes that the new proposed access regulations were released "as if to bolster the solicitor general's arguments [in *Douglas*]."[97] However, the proposed regulations, as currently drafted, are insufficient to enforce § 30(A), as discussed in Part III.

In an amicus brief equally as surprising as the Obama Administration's, the Chamber of Commerce argued in favor of allowing a private cause of action for Medicaid beneficiaries.[98] As a conservative, free–market oriented group, its position in favor of low–income Medicaid beneficiaries' rights seems counterintuitive. However, Medicaid beneficiaries that bring private actions to enforce § 30(A) are also necessarily protecting the interests of private health organizations in receiving adequate payment rates.[99] Medicaid providers and beneficiaries are inextricably linked—spending cuts that hurt providers' abilities to provide effective care (or any care at all in some cases) affect beneficiaries by lowering their access to health care. It can be said that there is no bright line to differentiate cuts that affect only providers from those that impact patients.

Early developments in the *Douglas* case raised the possibility that the Supreme Court might never have to reach a decision in the case.[100] In its brief to the Court after oral arguments had been heard, the United States argued that California's spending cuts were being reviewed by federal officials and that this review might make it unnecessary for the Justices to hear the case.[101] In a letter to the Court, Solicitor General Donald B. Verrilli Jr. stated that CMS had approved California's spending cuts under § 30(A).[102] In response to the Solicitor General's letter, the Supreme Court

95 Pema Levy, *How the Obama Administration is Jeopardizing Health Care Reform*, THE NEW REPUBLIC (Oct. 3, 2011, 12:00 AM), http://www.tnr.com/article/politics/95631/supreme–court–case–medicaid–california–affordable–care–act.

96 Brief for the United States as Amicus Curiae Supporting Petitioner, Indep. Living Ctr, 132 S. Ct. 1204 (No. 09–958), 2011 WL 2132705 at *12.

97 Rosenbaum, *supra* note 42, at 103; *see Provider Payments and Access to Medicaid Services: A Summary of CMS' May 6 Proposed Rule*, KAISER FAMILY FOUND. (July 2011), http://www.kff.org/medicaid/upload/8207.pdf (stating that the proposed rule was offered in response to litigation by Medicaid providers and beneficiaries challenging state cuts to provider payment rates).

98 Brief of the Chamber of Commerce of the United States of America as Amicus Curiae in Support of Respondents, *Indep. Living Ctr.*, 132 S. Ct. 1204 (No. 09–958), 2011 WL 3439920 at *4.

99 *See id.* at *1–4 (explaining that § 30(A) cases raise "issues of vital concern to the Nation's business community").

100 Lyle Denniston, *New Briefs Due in Medicaid Cases*, SCOTUSBLOG (Nov. 4, 2011, 2:47 PM), http://www.scotusblog.com/2011/11/new–briefs–due–in–medicaid–cases/.

101 Brief for the United States as Amicus Curiae Supporting Petitioner, *supra* note 93, at *31–32.

102 Letter from Donald B. Verilli, U.S. Solicitor Gen., to William K. Suter, U.S. Supreme

issued an order directing the parties and the Solicitor General to file supplemental briefs addressing what effect CMS's approval of California's cuts should have on the case.[103]

3. *The* Douglas *Decision.*—On February 22, 2012, the Supreme Court issued an opinion in *Douglas.*[104] Justice Breyer authored the opinion of the Court which decided by a vote of five to four to vacate the Ninth Circuit's decisions and remand the cases for further proceedings.[105] The Court found that CMS's approval of the state Medicaid statutes at issue as consistent with federal law warranted remand of the Court of Appeals' judgments holding that federal law preempted the state statutes.[106] The Ninth Circuit will now determine whether the parties' dispute should be resolved under the Administrative Procedure Act (APA) and whether the cases can proceed directly under the Supremacy Clause though CMS has already sanctioned the state's actions.[107]

The narrow decision in *Douglas* did nothing to clarify whether Medicaid providers and beneficiaries can continue to rely on private rights of action under the Supremacy Clause to protect themselves from state budget cuts in violation of federal law; that issue has been left to the Ninth Circuit to decide. The Court's punting of the larger issue means that Medicaid providers and beneficiaries have not yet seen the courthouse doors slam completely shut, but they may not remain open much longer.[108]

Medicaid providers and beneficiaries are in danger of losing the ability to enforce Medicaid's Equal Access provision through the judiciary. As explained above, private causes of action under § 1983 and the Supremacy Clause are threatened by recent developments in the Supreme Court. Against the backdrop of the Court's proceedings in *Douglas*, the Obama Administration released new proposed regulations aimed at finally substantively defining the requirements and enforcement procedures for § 30(A), Medicaid's Equal Access provision.[109] The next part of this note will explore the contents of the proposed regulations and explain how they fall well short of protecting Medicaid providers and beneficiaries from inadequate state funding of Medicaid.

Court Clerk (Oct. 28, 2011), *available at* http://sblog.s3.amazonaws.com/wp-content/uploads/2011/11/SG-letter-re-Calif-Medicaid-10-28-111.pdf.

103 Opinion, Douglas v. Santa Rosa Mem'l Hosp., 132 S. Ct. 547 (2011) (No. 10-283).

104 Douglas v. Indep. Living Ctr. of S. Cal., 132 S. Ct. 1204 (2012).

105 *Id.* at 1204.

106 *See id.*

107 *Id.* at 2011.

108 *See* Denniston, *supra* note 100.

109 Covered Medicaid Services, *supra* note 2, at 26,342.

III. The Obama Administration's Newly Proposed Access Regulations

A. Background of the Proposed Regulations

The Obama Administration's newly proposed regulations were written to ensure that Medicaid patients have equal access to the kind of care § 30(A) and its predecessors have long promised. In particular, the proposed regulations are designed to assure that state reimbursement methodologies comply with § 30(A). The proposed regulations advance this objective by suggesting additional data that will help inform whether enrollees' needs are being met, providing access review timeframes, requiring public notice of significant statewide changes in provider payment rates, and mandating public input.

Both the Obama Administration's position in *Douglas* against a private cause of action to enforce § 30(A) under the Supremacy Clause and its support of CMS's proposed access regulations are closely related to its goals with the Affordable Care Act ("ACA").[110] In 2014, the ACA could expand Medicaid eligibility to 133% of the federal poverty level, possibly incorporating up to an additional sixteen million people into the Medicaid program.[111] The Obama Administration appears not to want private causes of action potentially interfering with its own exclusive enforcement of the ACA.[112] To that end, the Administration's amicus brief in *Douglas* argued that proposed federal regulations would provide the necessary guidance to ensure enforcement of § 30(A).[113]

As part of the new proposed regulations on Medicaid access, CMS solicited comments on the regulations' adequacy from the general public.[114] As a result of CMS's solicitation, the agency received 193 public submissions from various health care provider associations, hospitals, private health care

110 *See* Patent Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010).

111 *Provider Payments and Access to Medicaid Services: A Summary on CMS' May 6 Proposed Rule*, Kaiser Family Found., (July 2011), http://www.kff.org/medicaid/upload/8207.pdf (explaining that the ACA includes an unprecedented expansion of Medicaid services to individuals under age 65 with income below 133% of the federal poverty level). *But see* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012) (finding that the federal government could not expel states from Medicaid for refusing to comply with the Medicaid expansion). For a discussion of how this unprecedented expansion has marked a "major philosophical shift" in the Medicaid program from its traditional goal of providing assistance only to the "deserving poor," see Huberfeld, *supra* note 23, at 432–33.

112 *See* Levy, *supra* note 95.

113 *See* Brief for United States as Amicus Curiae Supporting Petitioner, supra note 94, at *31–32.

114 Covered Medicaid Services, *supra* note 2, at 26,342.

businesses, and state health care administrative agencies.[115] While the state Medicaid agencies decried the additional administrative burdens of the proposed regulations,[116] the majority of the submitted public comments called for several measures needed to give the proposed regulations more heft.[117]

B. Deficiencies in the Proposed Regulations

A review of submitted comments on CMS's new proposed regulations shows that a number of concerns repeatedly manifest themselves, reflecting the ways in which the proposed regulations are truly deficient. The most common critiques included that the regulations need to expand to review access for beneficiaries under Medicaid-approved managed care; that the regulations should require input from physicians and other Medicaid providers in addition to the required beneficiary input; that guidelines for how to use input data to determine if there is an access problem need to be defined; and that CMS require public notice of any state-enacted provider payment cuts, not just those termed "significant."

1. *The Proposed Regulations Do Not Cover Medicaid's Managed Care Plans.*— The most glaring deficiency in CMS's newly proposed "equal access" regulations is that they simply do not apply to Medicaid's managed-care arrangements.[118] Managed care is covered by a separate part of the Code of Federal Regulations.[119] The proposed regulations apply to Fee-For-Service Medicaid but will have no effect on managed care, which provides at least some level of medical care to over seventy percent of the nation's Medicaid beneficiaries.[120] Medicaid programs in South Carolina and Tennessee have fully implemented managed care, meaning that the proposed regulations would be inapplicable to those two states.[121] The omission of standards for managed care beneficiaries is an egregious error in the proposed regulations. Significant numbers of Medicaid enrollees will continue to be effectively deprived of the protection of § 30(A)'s "equal access" requirement.[122] The

115 *See* CMS-2011-0062 Docket Folder Summary, http://www.regulations.gov (search "CMS-2011-0062", click on "Docket ID CMS-2011-0062" hyperlink, then click on "View All" hyperlink.

116 *Id.*

117 *Id.*

118 *See Provider Payments and Access to Medicaid Services: A Summary on CMS' May 6 Proposed Rule*, KAISER FAMILY FOUND., (July 2011), http://www.kff.org/medicaid/8207.cfm.

119 *See* Nicole Huberfeld, *Post-Reform Medicaid Before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 ANNALS HEALTH L. 513, 523 (2012).

120 *Id.*

121 *Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, as of July 1, 2010*, KAISER FAMILY FOUND., http://www.statehealthfacts.org/comparemaptable.jsp?ind=217&cat=4.

122 *See* Medicaid Defense Fund Letter from Lynn S. Carmam, Esq., to Sec'y of U.S.

proposed regulations must be expanded to include Medicaid beneficiaries under managed care plans.

2. *The proposed regulations should require more concrete and relevant input from the public.*—The proposed regulations require Medicaid access reviews to include only perfunctory beneficiary input.[123] Under the regulations, the states would be required to have a mechanism for beneficiaries to provide input such as "hotlines, surveys, ombudsman or another equivalent mechanism."[124] Beneficiary input is certainly important in determining whether equal access exists, but the proposed regulations' nebulous input requirements do little to ensure that meaningful beneficiary input will be collected and imported into access reviews. In the proposed regulations, HHS suggests collection of useful beneficiary data such as provider turnover, distance from beneficiary home to provider, and beneficiary knowledge of Medicaid services by provider.[125] These suggestions should be fully implemented—having mere suggestions instead of concrete requirements would continue to allow states to skate by CMS with hollow assurances rather than true equal access.

Furthermore, an input mechanism for Medicaid providers and other stakeholders must be inserted into the proposed regulations. As it is currently drafted, CMS's proposed regulations only call for beneficiary input. HHS has acknowledged that provider costs are closely related to rate sufficiency,[126] yet the new regulations fail to consider provider input as an important element in rate-setting, despite data that shows that low Medicaid reimbursement rates cause providers to opt out of Medicaid.[127] Provider input is an efficient way for CMS to collect data on the sufficiency of the reimbursement rates that are so inextricably linked to equal access and it should be considered.

3. *The proposed regulations afford the states too much discretion.*—The proposed regulations purport that their purpose is to "create a standardized, transparent process for States to follow" as part of compliance with the Medicaid Access Requirement.[128] The new regulations would require

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Dep't of Health and Human Servs. (July 5, 2011) (on file at http://www.regulations.gov/#!documentDetail;D=CMS-2011-0062-0168).

123 *Id.*

124 Covered Medicaid Services, *supra* note 2, at 26,342 § 447.203(b)(4).

125 *See* Clark, *supra* note 32, at 839.

126 *See* Methodist Hosps. v. Sullivan, 91 F.3d 1026, 1029–30 (7th Cir. 1996).

127 One study has shown that the physician reimbursement rate is a statistically significant predictor of drop-out. *See* Benjamin D. Sommers, *From Medicaid to Uninsured: Drop-Out Among Children in Public Insurance Programs*, 40 HEALTH SERVICES RES. 59, 76 n.7 (2005), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361126/#fn7 (finding that a $1 increase in reimbursement correlates to a 5.8% decrease in the drop-out rate).

128 Covered Medicaid Services, *supra* note 2, at 26,342.

states to perform "medical assistance access reviews" of their Medicaid services.[129] Certain subsets of Medicaid services would have to be reviewed every year, while every single service would have to be reviewed at least once every five years.[130]

Under the proposed regulations, a state attempting to reduce Medicaid provider payment rates would be required to submit a State Plan Amendment to CMS and an access review demonstrating compliance with § 30(A).[131] States would have twelve months to complete this review.[132] The review would be required to reflect the state's consideration of beneficiary and stakeholder input in its study of the effects of the rate cut on the access required under § 30(A).[133] States would be required to make their access review data available to the public through public records or websites on a continuing basis.[134] Additionally, states would have to conduct ongoing reviews on the effects of implemented rate reductions.[135] Finally, states that discover deficiencies in access brought about by provider payment reductions would be required to remediate any deficiency within twelve months of its discovery.[136]

The proposed access reviews force states to once again make tangible "findings" that are similar, though greater in scope, than those formerly required by the now-repealed Boren Amendment.[137] The proposed regulations share the Boren Amendment's strengths, but they also incorporate its weakness of affording the states too much discretion in how they will satisfy procedural requirements. The proposed regulations' entire data collection and utilization procedure remains ill-defined and it continues to grant broad discretion to the states—the same problem that has plagued § 30(A) and its predecessors since the dawn of Medicaid.[138] The states are left to decide which data should be collected, what methods for assessing the data should be used in order to ascertain whether there is an access problem, when corrective action should be taken, and what level of public input is necessary.[139] The proposed regulations do little more than

129 *Id.*

130 *See Provider Payments and Access to Medicaid Services: A Summary on CMS' May 6 Proposed Rule*, KAISER FAMILY FOUND., (July 2011), http://www.kff.org/medicaid/upload/8207.pdf.

131 *Id.*

132 *Id.*

133 *Id.*

134 *Id.*

135 *Id.*

136 *Id.*

137 Omnibus Reconciliation Act of 1980 Pub. L. 96-499, § 962(a), 94 Stat. 2599, 2650-51 (1980) (repealed 1997).

138 *See* Clark, *supra* note 32, at 837-38.

139 *See* Covered Medicaid Services, *supra* note 2, at 26,345 (defining beneficiary procedures as "suggestions.").

reiterate the states' duty to make assurances to the Secretary that were previously required under § 30(A).

The procedures of the proposed regulations will have to be strengthened significantly if the regulations are to have any real impact on equal access. CMS can continue to afford substantive flexibility to the states to determine how best to administer their Medicaid programs. However, states should no longer be given such absolute freedom to decide the procedures used to measure equal access. As an administrative agency with considerable expertise, it should be CMS that decides the particulars of an access review.[140]

4. *The Proposed Regulations Only Require Public Notice of State Budget Cuts to Medicaid Providers that the State Deems "Significant."*—Finally, CMS should require public notice of any state budget cuts to Medicaid provider payment rates, not just those it considers "significant." As CMS's proposed regulations are currently drafted, public notice is required for state changes to provider payment rates that are termed "significant."[141] Obviously, such a vague standard as "significant" presents an easy run-around for states wishing to make cuts to provider payments. States could implement cuts deemed not "significant" enough in order to avoid public notice, which would in turn avoid other requirements of the regulations such as beneficiary input. The vague and ineffectual standards repeatedly employed in the proposed regulations create the general impression that the regulations were devised almost as a ruse or as a means of temporarily placating Medicaid beneficiaries and providers.

The aforementioned changes—the inclusion of access data for managed care plans, broader public input, less state discretion, and increased public notice of state cuts—must be made for the proposed regulations to have any real heft. However, these changes alone will not be enough; the federal government will have to make a greater effort to enforce its own regulations than it has done in the past. The final part of this note urges that improved agency enforcement combined with a private cause of action under the Supremacy Clause will best ensure that Medicaid providers' and beneficiaries' federal right to equal access is adequately protected.

140 *See* Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (And How) It Might Be Good For Health Law*, 90 B.U. L. REV. 2323, 2330 (2010).

141 *See* Covered Medicaid Services, *supra* note 2, at 26,347.

IV. The Need for Agency Enforcement and a Private Cause of Action Under the Supremacy Clause to Protect Medicaid Providers and Beneficiaries

A. Agency Enforcement

Amending CMS's proposed regulations to include the above-suggested improvements will be of little consequence if the regulations lack federal enforcement. Unfortunately, the histories of the Boren Amendment and § 30(A) reveal that the federal government has failed to enforce equal access requirements in the past.[142] Numerous suits were brought under the Boren Amendment because states failed to make the minimal findings required under the Amendment.[143] After the repeal of Boren, many courts interpreted § 30(A) to include a similar requirement and similar suits were brought under that statute. Regardless of whether § 30(A) requires states to make findings of equal access,[144] the APA sets a minimum requirement that agency determinations must at least meet an "arbitrary and capricious" standard.[145]

Successful suits under these provisions intimate that agency enforcement was deficient or, in some cases, nearly nonexistent. In *Arkansas Medical Society v. Reynolds*, the Eighth Circuit decided that HHS/CMS's approval of Arkansas's state budget cuts to Medicaid reimbursement rates failed the arbitrary and capricious standard.[146] This failure is especially troubling because the arbitrary and capricious standard is highly deferential to an agency's determinations.[147] All an agency must do to satisfy the standard is to articulate a "rational connection between the facts found and the choice made."[148] An agency decision is arbitrary and capricious when it "entirely fail[s] to consider an important aspect of the problem" or is "implausible."[149]

Amending the proposed regulations to require more concrete procedures and substantive findings rather than mere suggestions is a necessary first step toward ensuring greater federal enforcement.[150]

142 *See* Frederick H. Cohen, *An Unfulfilled Promise of the Medicaid Act: Enforcing Medicaid Recipients' Right to Health Care*, 17 Loy. Consumer L. Rev. 375, 378 (2005).

143 *See, e.g.*, Affiliates, Inc. v. Armstrong, 2009 U.S. Dist. LEXIS 37136 , at *9 (D. Idaho 2009).

144 *See* Methodist Hosps. v. Sullivan, 91 F.3d 1026, 1029–30 (7th Cir. 1996).

145 5 U.S.C. § 706(2)(A) (2006).

146 Ark. Med. Soc'y v. Reynolds, 6 F.3d 519 (8th Cir. 1993).

147 *See* Balt. Gas & Elec. Co. v. NRDC, Inc., 462 U.S. 87, 105 (1983).

148 *Id.*

149 O'Keefe's, Inc. v. U.S. Consumer Prod. Safety Comm'n, 92 F.3d 940, 942 (9th Cir. 1996) (quoting Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983)).

150 *See* Covered Medicaid Services, *supra* note 2, at 26,342.

Increased regulatory guidance would send a message to the states that they must actively demonstrate compliance. Furthermore, CMS would have increased authority to reject state plans that fail to comply with regulations. As it stands, so much discretion is granted to a state in its required access reviews that CMS is unlikely to reject a state plan for fear of stepping on a state's toes when, technically, the state has met the minimal procedures required under the regulations.[151]

Oral argument in *Douglas* highlighted another impediment to effective agency enforcement of equal access. In Justice Ginsburg's colloquy with California's attorney, it was revealed that if a state institutes payment cuts in violation of § 30(A) and no private cause of action exists for Medicaid providers and beneficiaries, the federal government's only remedies would be to seek an injunction in federal court or to terminate Medicaid funding to the state altogether.[152] This line of questioning also revealed the deficiencies inherent in both of these remedies. If injunction is sought, the state's inadequate payment rates will remain in place while the injunction is considered.[153] On the other hand, completely cutting a state off from Medicaid funding would be a drastic measure, one that the federal government has never taken.[154]

The proposed regulations incorporate these same severe remedies.[155] The regulations should be amended to provide CMS with more flexible and incremental remedies beyond these two options that hurt the beneficiaries the regulations are supposed to protect. For one, the proposed regulations should implement the remedial option of partial defunding. Furthermore, as discussed *infra*, solidifying the procedural requirements for state access reviews will facilitate consequential agency review of state plans that would temper the need for the federal government to seek injunctions, thereby preventing inadequate provider rates before they ever take effect and not allowing them to persist, harming beneficiaries, while injunction is sought.

B. The Continuing Need for a Private Cause of Action Under the Supremacy Clause

The Supreme Court has long recognized the value of agency expertise.[156] The intricacies of provider costs, beneficiary access, and rate–setting methodology fall more within the realm of CMS than that of the federal courts. Courts have long deferred to agency determinations

151 *See* Clark, *supra* note 32, at 834–35.

152 *See* Rosenbaum, *supra* note 88, at 2246.

153 *Id.*

154 *Id.*

155 *See* Covered Medicaid Services, *supra* note 2. at 26,342.

156 *See* Pennsylvania v. West Virginia, 262 U.S. 554, 623 (1923) (Brandeis, J., dissenting) (recognizing the value of "administrative machinery").

and policy judgments.[157] Strengthening agency enforcement is the best way to ensure that CMS's considerable expertise is put to good use. Still, increased agency enforcement of the proposed regulations will best protect the federal rights of Medicaid providers and beneficiaries if it is supported by private causes of action under the Supremacy Clause.

A private cause of action under the Supremacy Clause to enforce equal access requirements is still needed because of the natural limitations of CMS—it is an agency of limited resources.[158] The agency's limitations are best explained in an amicus brief submitted by former HHS officials in *Douglas*.[159] The brief contended that CMS simply does not have the staffing nor funding to fully ensure that states are meeting their equal access obligations.[160] In fact, the former officials stated that they welcomed and relied on private causes of action to identify states that were failing to provide adequate provider payment levels.[161]

C. An Example of How Agency Enforcement and a Private Cause of Action Might Work Together

If the deficiencies in the Obama Administration's proposed regulations are properly addressed, increased agency enforcement combined with a private cause of action will assure that Medicaid providers' and beneficiaries' rights are protected more ardently and efficiently. The consolidated *Douglas* cases involving California's budget cuts to reimbursement rates provide a suitable example for analysis of how the approach offered in this note might work in practice.

To begin with, under the proposed regulations, public notice would be required for California's provider rate cuts at issue in *Douglas*.[162] As explained above, the proposed regulations also contain the vague requirement that public notice must be given when a rate cut is "significant."[163] For ease of analysis, consider only the first reimbursement cut passed by the California legislature.[164] This first cut reduced California's payments to

157 *See, e.g.*, United States v. Mead Corp., 533 U.S. 218 (2001); Chevron v. NRDC, 467 U.S. 837 (1984).

158 *See* Brief of Former HHS Officials as Amici Curiae in Support of Respondents, Douglas v. Indep. Living Ctr. of S. Cal., Inc., 132 S. Ct. 1204 (2012) (No. 09–958) 2011 WL 3706105 at *4,.

159 *See* Brief of Former HHS Officials as Amici Curiae in Support of Respondents, *Indep. Living Ctr.*, 132 S. Ct. 1204 (No. 09–958), 2011 WL 3706105 at *21.

160 *See id.*

161 *See id.* at *16.

162 *See* Covered Medicaid Services, *supra* note 2, at 26,342.

163 *Id.*

164 *See* Act of Feb. 16, 2008, ch. 3, §§14, 15, 2007–2008 Cal. Stat, 3d Extraordinary Sess. 6003, 6017–19.

various Medicaid providers by ten percent.[165] The proposed regulation is not particularly helpful as written in determining whether public notice should be required for the ten percent cut; the question remains as to whether a ten percent cut is "significant." Now, suppose the proposed regulations were revised to quantitatively define "significant." In a state that already provided some of the lowest provider payment rates in the nation, a ten percent cut would almost certainly fail quantitative analysis and be deemed "significant."

The proposed regulations currently call for beneficiary input, but, as explained above, the regulations would be more effective if they also required meaningful provider input.[166] The combination of a quantitative definition of "significant" and additional public input would ease the strain currently on CMS to assess the impact of state budget cuts. CMS could quickly be alerted to the decreased access concerns of both providers and beneficiaries. Presumably, this input would include data that could save CMS some of its investigatory costs and make agency enforcement easier.

Douglas is an example of a lengthy and costly process that would be improved by greater agency enforcement and strengthened proposed regulations. A lack of agency enforcement ultimately failed the Medicaid providers and beneficiaries of California. The state's rate cuts were not meaningfully reviewed by CMS or the public before California attempted to enact them.[167] Instead, the providers and beneficiaries had no option but to engage in lengthy and costly litigation that eventually landed them in the United States Supreme Court.[168] Once the consolidated *Douglas* cases finally made it before the highest court, HHS determined that the cuts were in fact valid.[169] Had the proposed regulations been strengthened and their parameters more clearly defined, this agency action would have occurred much earlier, saving great time and expense.

Even if the proposed regulations are redrafted in a way that will increase their effectiveness and enhance agency enforcement, a private cause of action based on the Supremacy Clause is still necessary to supplement agency action. In the event that an unlawful state rate cut is not adequately detected by the agency, private causes of action serve as a backstop and the last resort for Medicaid providers and beneficiaries who would otherwise find their rights under the Medicaid Act violated.[170]

Clear procedural requirements for state plans are needed to ensure that CMS has the information and methodology it needs to more expeditiously

165 *See id.* at 6018.

166 *See supra* Part III.B.

167 *See* Douglas v. Indep. Living Ctr. of S. Cal., Inc., 133 S. Ct. 1204, 1208–09 (2012)..

168 *See id.*

169 *Id.* at 1209.

170 Brief of Former HHS Officials as Amici Curiae in Support of Respondents, *supra* note 158, at *16.

spot deficiencies in the states' suggested reimbursement rate cuts. A private cause of action is needed to bookend the agency's work by providing further oversight of provider payment and by helping to highlight issues that may not be clearly identifiable in the data states provide to CMS.

CONCLUSION

Similar to private causes of action for Medicaid beneficiaries under § 1983 and the Supremacy Clause, CMS's proposed access regulations face an uncertain future. Proposed regulations generally take a long time to be finalized and state Medicaid administrations typically fight provisions of the regulations that call for increased state accountability.[171] This means that the regulations as they currently appear may undergo substantial revision and their final form may end up being either more or less consequential than they currently appear.

CMS's proposed regulations need to be significantly strengthened if they are going to aid Medicaid beneficiaries at all. As it stands now, the proposed regulation is little more than a process to gather information. Additionally, a private cause of action is needed under the Supremacy Clause or Medicaid beneficiaries will be fully at the mercy of state budgets. In a time when state budget crises are prevalent, giving states effective control over Medicaid provider payments with no real mechanism to ensure access will provide the states with great leeway to cut payment rates. CMS's proposed regulations, as currently drafted, are terribly inadequate to ensure equal access to health care for our Nation's most poor and needy citizens, which is supposed to be the ultimate goal of Medicaid. If the proposed regulations are not revised to provide greater protections to Medicaid providers and beneficiaries and private causes of action to enforce beneficiary rights are further eroded, the Equal Access provision will be rendered inoperative. An inoperative Equal Access provision combined with the high cost of healthcare in this country will usher America into a "dual-track" system of healthcare more stratified than we have seen since Medicaid was enacted in 1965.

171 Rosenbaum, *supra* note 43, at 103.