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## A Broke(n) System: Comment on the Supreme Court's Decision to Rule on the Equal Access Provision in *Douglas v. Independent Living Center*, and its Potential Impact on the Affordable Care Act

Megan Waugh

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**A Broke(n) System: Comment on the Supreme Court’s  
Decision to Rule on the Equal Access Provision in  
*Douglas v. Independent Living Center*, and its Potential  
Impact on the Affordable Care Act**

**By Megan Waugh\***

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## I. INTRODUCTION

Medicaid recipients are disadvantaged by the Medicaid system. *Even children* on Medicaid are extremely deprived of health care access compared to their privately insured counterparts.<sup>1</sup> For example, providers denied seeing sixty-six percent of sick children on Medicaid versus eleven percent of children with private insurance.<sup>2</sup> An eight-year-old seizure victim, a thirteen-year-old with severe depression, and a fourteen-year-old with severe asthma were among those sixty-six percent of children on Medicaid who were denied health care.<sup>3</sup> Even those children on Medicaid that the provider accepted to see had to wait an extra twenty-two days to see a provider versus those children with private insurance.<sup>4</sup> The silver lining in this sad story is that these sick children were fictitious.<sup>5</sup> Research assistants posed as parents calling in on behalf of their sick children.<sup>6</sup> Nevertheless, the providers on the other end of the phone thought the callers were real parents.<sup>7</sup> The Illinois Department of Healthcare and Family Services funded this study due to allegations that providers were denying young Medicaid recipients equal access to care.<sup>8</sup> This study ultimately demonstrated the reality of the broken Medicaid system and its adverse effects on recipients' health care access.<sup>9</sup>

Curious about this unfortunate reality, I began researching the general process of the Medicaid system particularly in California. I found that the general sentiment of Californian doctors is that they want to help people in need, but they simply cannot afford it. Many

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\* Special thanks to Issa Azat and Patrick Nichols for their support and feedback.

<sup>1</sup> Monifa Thomas, *Medicaid Kids Suffer*, CHI. SUN-TIMES (June 17, 2011), available at 2011 WLNR 12094985.

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> Thomas, *supra* note 1.

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

doctors who accept Medicaid patients, risk delayed or no payments, which often results in providers closing practices. The Medicaid system makes it difficult for doctors to accept Medicaid patients because reimbursement rates are about half of what a doctor would normally receive from an insurance company.<sup>10</sup> Troubled by this lose-lose situation, I decided to investigate the underpinnings of the Medicaid system in relation to provider reimbursements and recipients' health care access.

The recession has severely impacted the medical world.<sup>11</sup> Many people who once had health insurance lost their insurance during layoffs or can no longer afford private health insurance, which in turn has led to more dependents on Medicaid.<sup>12</sup> Concurrently, states are also experiencing financial difficulties and, as a result, are cutting state spending in programs such as Medicaid.<sup>13</sup> Medicaid is targeted for budget cuts because it is spending for poor, and the poor are not as politically powerful to fight the inequalities arising from legislative action regarding Medicaid.<sup>14</sup> Strategically, budget cuts to Medicaid are not immediately apparent; typically cuts occur through "restricting eligibility, trimming benefits, raising copayments, and reducing provider reimbursement rates."<sup>15</sup> When a state cuts

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<sup>10</sup> Rosemary B. Guiltinan, Note, *Enforcing A Critical Entitlement: Preemption Claims As an Alternative Way to Protect Medicaid Recipients' Access to Healthcare*, 51 B.C. L. REV. 1583, 1592–93 (2010). "Physicians frequently cite low Medicaid reimbursement rates as their principle reason for refusing to accept Medicaid patients." *Id.*; VERNON SMITH ET AL., KAISER COMMISSION ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUNDATION, THE CRUNCH CONTINUES: MEDICAID SPENDING, COVERAGE AND POLICY IN THE MIDST OF A RECESSION; RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2009 AND 2010, 7 (2009), available at <http://www.kff.org/medicaid/upload/7985.pdf> (last visited Jan. 10, 2013).

<sup>11</sup> SMITH ET AL., *supra* note 10, at 7.

<sup>12</sup> Ana Gorman, *California Gets OK for Large Cuts to Medi-Cal*, L.A. TIMES (Oct. 28, 2011), available at <http://articles.latimes.com/2011/oct/28/local/la-me-medicare-20111028> (last visited Jan. 10, 2013); Pauline Vu, *Medicaid Programs Feel Weight of Recession*, STATELINE (Feb. 6, 2009), available at <http://www.stateline.org/live/details/story?contentId=374699> (last visited Jan. 10, 2013).

<sup>13</sup> SMITH ET AL., *supra* note 10, at 30.

<sup>14</sup> Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983 and Medicaid Entitlement*, 42 U.C. DAVIS L. REV. 413, 419 (2008).

<sup>15</sup> Guiltinan, *supra* note 10, at 1584.

providers' reimbursement rates, the providers cannot afford to help additional dependents on Medicaid, which leaves those relying on Medicaid without any form of access to medical care,<sup>16</sup> and their health needs go unaddressed.<sup>17</sup> By cutting provider reimbursements, the states contradict the goal of Medicaid program to provide health care to the poor and disabled.<sup>18</sup>

Medicaid is crucial to the United States' healthcare system.<sup>19</sup> It provides health insurance coverage to "sixty million people and accounts for roughly 17% of all healthcare spending and 7% of the total federal budget."<sup>20</sup> The spending on Medicaid is only second to education.<sup>21</sup> In 2008, California reacted to its budgetary crisis by cutting providers' reimbursements by ten percent.<sup>22</sup> Providers sued, which resulted in a case heard by the Supreme Court on October 3, 2011, *Douglas v. Independent Living Center*.<sup>23</sup> Despite California and other states' financial inabilities to handle Medicaid, the system is ridden with more uncertainties due to the Supreme Court's recent decision in *Douglas* and the *Affordable Care Act* cases.<sup>24</sup> In *Douglas*, the court never addressed whether providers or beneficiaries can bring suit to challenge provider reimbursements under Medicaid, and in the *National Federation of Independent Business v. Sebelius* (*Affordable Care Act Case*), the Court held that the Medicaid expansion under the Patient Protection and Affordable Care Act (PPACA) is constitutional but with an asterisk.<sup>25</sup> The Court

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<sup>16</sup> Sean Jessee, Comment, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 EMORY L.J. 791, 797 (2009).

<sup>17</sup> Guiltinan, *supra* note 10, at 1584.

<sup>18</sup> *Id.* at 1585.

<sup>19</sup> SMITH ET AL., *supra* note 10, at 9.

<sup>20</sup> Guiltinan, *supra* note 10, at 1519; SMITH ET AL., *supra* note 10, at 9.

<sup>21</sup> Guiltinan, *supra* note 10, at 1519; SMITH ET AL., *supra* note 10, at 9.

<sup>22</sup> Guiltinan, *supra* note 10, at 1519.

<sup>23</sup> *Douglas v. Indep. Living Ctr. of S. Cal.*, 132 S. Ct. 1204 (2012); *see also Douglas v. Independent Living Center of Southern California*, THE OYEZ PROJECT AT IIT CHICAGO-KENT COLLEGE OF LAW, [http://www.oyez.org/cases/2010-2019/2011/2011\\_09\\_958](http://www.oyez.org/cases/2010-2019/2011/2011_09_958) (last visited Jan. 10, 2013) [hereinafter OYEZ PROJECT].

<sup>24</sup> *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

<sup>25</sup> *Id.* at 2607–09.

found that the provision which mandated Medicaid-providing states to expand Medicaid or lose *all* Medicaid funding as unconstitutional.<sup>26</sup> As a result, the Medicaid expansion remains, but now, states may choose to adopt the expansion without any penalty.<sup>27</sup> This was not how Congress drafted the PPACA. A state's ability to choose the Medicaid expansion will make the future of Medicaid and goal of universal health insurance coverage more uncertain and unrealistic.

This comment first provides a historical and legal backdrop of the Medicaid system, the Equal Access Provision and private individuals' enforcement of the Equal Access Provision through litigation in order to analyze the outcome of *Douglas* in light of the Supreme Court's decision in the *Affordable Care Act Case*. Then taking that analysis, this article recommends an approach to handle either a cause of action or no cause of action under the Supremacy Clause upon the implementation of PPACA.

## II. MEDICAID PROGRAM

In 1965, Congress ratified Medicaid under title XIX of the Social Security Act.<sup>28</sup> Medicaid "is a cooperative federal-state program that provides federal assistance to participating states to reimburse providers for covered health services rendered to Medicaid-eligible individuals."<sup>29</sup> A state's participation in Medicaid is voluntary.<sup>30</sup> Once a state is a part of the program, then that state must comply with the Medicaid Act.<sup>31</sup> The Center for Medicare and

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<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at 2608.

<sup>28</sup> Guiltinan, *supra* note 10, at 1590.

<sup>29</sup> Brief for Petitioner at 6, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, Nos. 09-958, 09-1158, 10-283 (9th Cir. Jan. 18, 2011), 2011 WL 2062344.

<sup>30</sup> Jon Donenberg, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 YALE L.J. 1498, 1500 (2008).

<sup>31</sup> Brief for Petitioner, *supra* note 29, at 6. Although Medicaid is a voluntary program, all fifty states participate in the program. Donenberg, *supra* note 30, at 1500. "Over time, state budgets have become so inextricably linked with federal Medicaid funding that withdrawal from the program on the part of any state seems politically and financially untenable." *Id.* See also Bruce J. Casino, *Federal Grants-In-Aid: Evolution, Crisis, and Future*, 20 URB. LAW. 25, 40 (1988).

Medicaid Services (CMS), a federal agency within the United States Department of Health and Services (HHS), supervises the program of participating states.<sup>32</sup>

Before a state may participate, a state is required to submit a plan for medical assistance to the Secretary of Health and Human Services.<sup>33</sup> Every participating state must codify its Medicaid program in its state plan.<sup>34</sup> A state plan is a public document that remains on file with the CMS and includes a full record of the state's Medicaid programs since its commencement.<sup>35</sup> The plan indicates which services a state intends to provide as well as any supplemental regulation.<sup>36</sup> The plan must comply with the Medicaid Act and provide the "scope and nature of the state's Medicaid program."<sup>37</sup> The Secretary is authorized to revoke federal funding if the state does not comply with Medicaid's requirements.<sup>38</sup>

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(contending that participation in Medicaid is in effect obligatory because of the financial strains of states).

<sup>32</sup> Donenberg, *supra* note 30, at 1500.

<sup>33</sup> See Guiltinan, *supra* note 10, at 1590.

<sup>34</sup> The State Plan, 42 C.F.R. § 430.10 (2012).

<sup>35</sup> Donenberg, *supra* note 30, at 1506.

<sup>36</sup> 42 C.F.R. § 430.10. Generally, the HHS requires participating states to provide certain benefits to everyone on Medicaid. Donenberg, *supra* note 30, at 1505. These benefits include "physicians' services, laboratory and x-ray services, inpatient hospital services, and comprehensive early and periodic screening, diagnostic, and treatment services for children." *Id.* See also 42 U.S.C. § 1369d(a) (2000) (summarizing traditional benefits) as well as "nursing facilities for adults." Donenberg, *supra* note 30, at 1505. States can also provide optional services in addition to the mandatory services, such as, "prescription drugs and targeted case management services." *Id.* See also 42 U.S.C. § 1396(a)(12)–(19) (2000). "Despite their discretionary status, optional service account for a significant portion of most states' Medicaid expenditures." Donenberg, *supra* note 30, at 1505. Once a state accepts an optional benefit, that state must provide that benefit as if it were mandatory. *Id.*

<sup>37</sup> Guiltinan, *supra* note 10, at 1590.

<sup>38</sup> 42 U.S.C. § 1396c (2006). "[T]he Secretary shall notify such State agency that further payments will not be made to the State . . . until the Secretary is satisfied that there will no longer be any such failure to comply." *Id.* There are three basic federal statutory requirements that apply for all types of services. MARK MERLIS, CONG. RESEARCH SERV., RL32644, MEDICAID REIMBURSEMENT POLICY 2–3 (2004). First, "methods and procedures for making payments must be such as to assure that payments are 'consistent with efficiency, economy, and quality of care.'" *Id.* at 2. Second, "providers cannot bill a beneficiary when

The states and the CMS's lenient modification process of a state's Medicaid program aids inequalities that arise from provider reimbursement rates and the Equal Access Provision. States may subsequently modify its Medicaid program through a State Plan Amendments (SPA) or a waiver.<sup>39</sup> If a state wishes to modify its program beyond "those options specifically authorized under current law," the state must petition to the HHS Secretary for a waiver approval.<sup>40</sup> If a state makes a "*material change* to the law, organization, policy or operation"<sup>41</sup> within the Medicaid program, a state must file an SPA with the CMS.<sup>42</sup> An SPA is required to be filed with the CMS if there is a change in reimbursement and payment methodologies.<sup>43</sup> Then, the HHS Secretary must approve the SPA.<sup>44</sup> Typically, approval of a SPA by the CMS is not demanding and the CMS usually grants it.<sup>45</sup> In addition, a state can seek a waiver for filling a state plan amendment.<sup>46</sup> The purpose of a waiver of a state plan amendment is "to allow states flexibility [in its] Medicaid programs."<sup>47</sup> Essentially, waivers are meant to encourage

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Medicaid's allowed payment is less than the provider's charge for a service." *Id.* at 3. Third, "[t]here [are] an additional set of basic rules for payment of institutional services including hospitals, nursing facilities, and intermediate care facilities for the mentally retarded." *Id.* Then, rates are made public so that providers can comment. *Id.*

<sup>39</sup> Donenberg, *supra* note 30, at 1506.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* (emphasis added) (citations omitted).

<sup>42</sup> *Id.*

<sup>43</sup> *Financing & Reimbursement*, CTR. FOR MEDICAID & CHIP SERVS., <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html> (last visited Jan. 10, 2013). "Regulations provide guidance for state on implementing Medicaid state plan payment rates consistent with the Act (the Code of Federal Regulations (CFR) at 42 C.F.R. 430 and 42 C.F.R. 447)." *Id.*

<sup>44</sup> Donenberg, *supra* note 30, at 1506.

<sup>45</sup> *Id.* "In some cases, CMS even provides 'preprint' sheets—skeleton forms that state administrators can fill in containing boxes that they can check off to indicate the options they have chosen to implement—to streamline the process." *Id.*

<sup>46</sup> *Waivers*, CTR. FOR MEDICAID & CHIP SERVS., <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html> (last visited Mar. 17, 2012).

<sup>47</sup> *Financing & Reimbursement*, *supra* note 43.



states to try or test theories so that states can deliver the most efficient access to medical care. There are four types of waivers.<sup>48</sup> The pertinent waiver for provider reimbursements is a Section 1115 waiver. Section 1115 waivers deal with Medicaid payment schemes.<sup>49</sup> States use Section 1115 waivers to experiment with payment options for program coverage.<sup>50</sup> A state will usually informally apply for a waiver by submitting a concept paper with a proposal.<sup>51</sup> If a waiver is approved by the CMS, that waiver is valid for five years.<sup>52</sup> After the five-year period, states may seek a renewal waiver for an additional three years.<sup>53</sup>

Often cuts to reimbursement rates are a result of the CMS's administrative enforcement of the Equal Access Provision. Even though every participating state has to comply with the Medicaid Act and submit changes to the CMS and Secretary of HHS through SPAs and waivers, reimbursements nevertheless vary from state to state<sup>54</sup> because of the modification process,<sup>55</sup> and the CMS's unwillingness to enforce non-compliance by suspending funds.<sup>56</sup> The CMS is unwilling to withhold funds because it is so detrimental to Medicaid

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<sup>48</sup> *Financing & Reimbursement*, *supra* note 43. Section 1115 waivers are for research and demonstration projects. *Id.* Section 1915(b) is for managed care waivers. Section 1915(c) is for home and community-based service waivers. *Id.* Finally, concurrent section 1915(b) and 1915(c) waivers are for states that want "to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities." *Section 1115 Research & Demonstration Projects*, CTR. FOR MEDICAID & CHIP SERVS., <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html> (last visited Dec. 24, 2012).

<sup>49</sup> *Section 1115 Research & Demonstration Projects*, *supra* note 48.

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Section 1115 Research & Demonstration Projects*, *supra* note 48.

<sup>54</sup> MERLIS, *supra* note 38, at 2.

<sup>55</sup> See Guiltinan, *supra* note 10, at 1590. The Medicaid Act provides flexibility in its wording so that states, to an extent, determine reimbursement rates. Donenberg, *supra* note 30, at 1506.

<sup>56</sup> See Donenberg, *supra* note 30, at 1506.

recipients that it is “rarely, if ever, invoked.”<sup>57</sup> If the CMS does decide to cut funding, a hearing is required to determine non-compliance.<sup>58</sup> The burdens and amount of time spent toward these hearings are an additional deterrent for enforcement.<sup>59</sup> Finally, it is hard for the CMS to cut funding to states with which they frequently interact.<sup>60</sup> Administrators deal primarily with states rather than those on Medicaid and may value a good working relationship with the states over the interest of the Medicaid patients.<sup>61</sup> A combination of the vague wording of the Medicaid Act, administrative enforcement problems, and the recession has resulted in cuts to provider reimbursements and those cuts are most likely in violation Medicaid’s Equal Access Provision.

### III. THE EQUAL ACCESS PROVISION AND ITS ENFORCEMENT

When Congress first enacted Medicaid, the federal government rarely reviewed states’ reimbursements rates.<sup>62</sup> Then, in 1972, Congress had HHS set reimbursement rates.<sup>63</sup> But by 1980, Congress let states set reimbursement rates again. Congress wanted to provide the states with more flexibility in setting reimbursement rates, and as a result it passed the Boren Amendment.<sup>64</sup> The Boren Amendment provided that states *must* reimburse providers “according to rates the State finds are reasonable and adequate.”<sup>65</sup> Nine years later, Congress enacted the Equal Access Provision (EAP).<sup>66</sup> The EAP, like the Boren Amendment, regulates state

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<sup>57</sup> *Id.* at 1501 (citing Lisa E. Key, *Private Enforcement of Federal Funding Conditions Under § 1983: The Supreme Court's Failure to Adhere to the Doctrine of Separation of Powers*, 29 U.C. DAVIS L. REV. 283, 293 (1996)).

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.* at 1501–02.

<sup>61</sup> *Id.* See also Key, *supra* note 57, at 293.

<sup>62</sup> Matthew McKennan, *Medicaid Access after Health Reform: The Shifting Legal Basis for Equal Access*, 7 SETON HALL CIR. REV. 477, 489 (2011).

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> *Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498, 512 (1990) (quoting 42 U.S.C. § 1396a(A)(12)(A) (1982 ed., Supp. V)).

<sup>66</sup> McKennan, *supra* note 62, at 489.

Medicaid rates.<sup>67</sup> However, unlike the Boren Amendment, EAP focused on access rather than cost.<sup>68</sup> Congress repealed the Boren Amendment in 1997, while the EAP still remains.<sup>69</sup> The EAP mandates that a state Medicaid program must:

[P]rovide such methods and procedures relating to the utilization of, and the payment for, care 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 unavailable under the plan at least to the extent that such care and services are available to the general population in the geographic area.<sup>70</sup>

The language in the EAP guards against states cutting reimbursement rates to providers during economic difficulties.<sup>71</sup> As discussed in the previous section, because of the SPA modification process and the CMS's unwillingness to enforce violations of the EAP, provider reimbursement rates are not usually in check.<sup>72</sup> Provider reimbursement rates that are inconsistent with the Medicaid Act are even more common during an economic crisis, and during these economic downturns, it is usually the providers or recipients that act as enforcers and bring suit against states that cut provider rates.<sup>73</sup> But Congress did not explicitly include a private right of action under the EAP, thus providers and recipients have historically brought suit under 42 U.S.C. § 1983.<sup>74</sup>

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<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> 42 U.S.C. § 1396a(a)(30)(A) (2006) (emphasis added) (amended 2010).

<sup>71</sup> Guiltinan, *supra* note 10, at 1594; *see also* Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in the Health Care Regulation: The Federalism Failures of the ACA*, 20-SPG KAN. J.L. & PUB. POL'Y 267 (2011).

<sup>72</sup> Huberfeld, *supra* note 14, at 446.

<sup>73</sup> Guiltinan, *supra* note 10, at 1595.

<sup>74</sup> *See also* 42 U.S.C. § 1983 (2006). Section 1983 provides that

A. Section 1983

Under section 1983, individuals may bring civil suits against state officials for a violation of federal rights.<sup>75</sup> Federal rights under section 1983 also include federal statutory rights, as interpreted by the Supreme Court in *Maine v. Thiboutot*.<sup>76</sup> In *Thiboutot*, the Court held that Maine violated section 1983 by depriving Lionel and Joline Thiboutot welfare benefits that they were entitled to under the Social Security Act, 42 U.S.C. section 602(a)(7).<sup>77</sup> In the same year of the *Thiboutot* decision, Congress enacted the Boren Amendment.<sup>78</sup> As discussed above, the Boren Amendment provided that states *must* reimburse providers “according to rates the State finds reasonable and adequate.”<sup>79</sup> In *Wilder v. Virginia Hospital Association*, the Court analyzed whether the Boren Amendment created an enforceable right under section 1983 when a group of hospitals sued Virginia arguing that its reimbursement rates were not “reasonable and adequate” as required by the Boren Amendment.<sup>80</sup> The Supreme Court held that the Boren Amendment was a source of a federal

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[e]very 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.

42 U.S.C. § 1983 (emphasis added).

<sup>75</sup> *Id.*

<sup>76</sup> See 448 U.S. 1, 10 (1980). Just a year later, the Supreme Court began to whittle away at the holding of *Thiboutot* through *Pennhurst Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981). Sayles, *infra* note 83, at 127. In *Pennhurst*, the Court determined that in order to bring section 1983 suits, the statute had to have language that conferred mandatory not merely precatory rights. *Id.* See also *Pennhurst*, 451 U.S. at 18.

<sup>77</sup> *Thiboutot*, 448 U.S. at 4.

<sup>78</sup> *Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498, 502 n. 2 (1990).

<sup>79</sup> *Id.* at 502 (quoting 42 U.S.C. § 1369a(A)(13)(A) (1982 ed., Supp. V) (amended 2010)).

<sup>80</sup> *Wilder*, 496 U.S. at 512.

statutory right under section 1983 because it imposed mandatory compliance upon the states to the beneficiaries.<sup>81</sup> As a result of *Wilder* and the Boren Amendment, individuals brought private causes of action to enforce cuts to reimbursement rates through section 1983.<sup>82</sup>

*B. The End of Section 1983: Boren Amendment, Blessing, and Gonzaga*

In 1997, Congress repealed the Boren Amendment.<sup>83</sup> Thus, the Boren Amendment and its mandatory language was no longer available to help ensure state compliance with reimbursement rates through section 1983. In that same year, the Supreme Court answered whether legislation enacted under Congress' Spending Clause<sup>84</sup> was enforceable under section 1983.<sup>85</sup> In *Blessing v. Freestone*, the Court held a statutory right *may* be enforced under section 1983 if it met three conditions: (1) The plaintiff must be an intended beneficiary; (2) the plaintiff must have actual affected interest; and (3) the statute must "impose a binding obligation on the State."<sup>86</sup> Nevertheless, according to *Blessing*, a federal statutory

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<sup>81</sup> *Id.* at 512.

<sup>82</sup> See, e.g., *Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 1005 (1st Cir. 1996) (holding that providers have a cause of action under section 30(A) via section 1983); *Methodist Hosp., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996).

<sup>83</sup> Bradley J. Sayles, *Preemption or Bust: A Review of the Recent Trends in Medicaid Preemption Actions*, 27 J. CONTEMP. HEALTH L. & POL'Y 120, 129 (2010) ("Repeal of the Boren Amendment removed the 'reasonable' payment rate requirements and put the Supreme Court's holding in *Wilder* in question. Although, *Wilder* is still considered 'good law', its applicability is questionable because of the Boren Amendment's repeal . . .").

<sup>84</sup> Medicaid was enacted under the Spending Clause. 42 U.S.C. § 1396(a) (2012).

<sup>85</sup> *Blessing v. Freestone*, 520 U.S. 329, 332–33 (1997). However, in the specific facts of *Blessing*, the Court held that the mothers who brought suit under title IV-D of Social Security Act did not give the mothers individual right to sue the state because it did not fit within the three criteria. *Id.* at 342. Yet, the Court did not foreclose the idea that federal statutory rights could be brought under title IV-D of the Social Security Act. *Id.* at 348.

<sup>86</sup> *Id.* at 338–41.

right is simply a rebuttable presumption.<sup>87</sup> A court may dismiss a case if Congress intentionally or implicitly prevented a remedy under section 1983.<sup>88</sup>

Despite the test in *Blessing*, there was still ambiguity as to whether there was or was not an implied private cause of action under section 1983. In 2002, the Court settled this confusion in *Gonzaga University v. Doe*.<sup>89</sup> In *Gonzaga*, the Court held, “[w]e now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983.”<sup>90</sup> The Court reasoned that section 1983 provides a remedy for *rights*—not benefits or interests.<sup>91</sup> The Court further held that in order to enforce a right under section 1983, a court must first determine whether Congress intended to create a private right of action.<sup>92</sup> If Congress did not intend to do so, then that party may not bring a suit under section 1983.<sup>93</sup> If there is Congressional intent, the courts must then determine whether Congress also created a private remedy.<sup>94</sup> As a result of *Gonzaga*, absent specific language,

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<sup>87</sup> *Id.* at 341.

<sup>88</sup> *Id.*

<sup>89</sup> 536 U.S. 273, 283 (2002).

<sup>90</sup> *Id.* The State of Washington required students to obtain an affidavit of good moral character from the student’s university in order to become a public elementary school teacher. *Id.* at 277. The plaintiff was a student at Gonzaga University, a private institution. *Id.* The plaintiff was seeking an affidavit of good moral character. *Id.* The person in charge of issuing the affidavits overheard that the plaintiff was involved in sexual misconduct and denied the student’s application. *Id.* at 276. The student sued under section 1983 alleging a violation of the Family Educational Rights and Privacy Act of 1974 (FERPA). *Id.* The FERPA “prohibit[s] the federal funding of educational institutions that have a policy or practice of releasing education records to unauthorized persons.” *Id.* See also 20 U.S.C. § 1232g (2006). The Court held that the FERPA created no personal rights to the student in order to bring suit under section 1983. *Gonzaga*, 536 U.S. at 273.

<sup>91</sup> *Gonzaga*, 536 U.S. at 273.

<sup>92</sup> *Id.*

<sup>93</sup> *Id.*

<sup>94</sup> *Id.* at 284. However, “[p]laintiffs suing under §1983 do not have the burden of showing an intent to create a private remedy because §1983 generally supplies a remedy for the vindication of rights secured by federal statutes.” *Id.* If a plaintiff demonstrates the statute conferred a right of action, then the right is presumptively enforceable. *Id.* However, “[t]he State may rebut this presumption by showing that Congress ‘specifically foreclosed a remedy under §1983.’” *Id.* at

individuals cannot bring suit for violations of their rights unless Congress explicitly creates a right and provides a remedy. Since the EAP contains no explicit private cause of action, courts have interpreted *Gonzaga* as barring providers and recipients from bringing suit under the EAP.

Despite the repeal of the Boren Amendment and the Supreme Court's holding in *Gonzaga*, federal circuit courts are still split as to whether an individual may bring suit under the EAP via section 1983.<sup>95</sup> Those circuit courts, except the Eighth, that have considered whether the EAP creates a private action to providers or recipients have rejected it under *Gonzaga*.<sup>96</sup> The Supreme Court has not spoken to the issue, and in light of *Gonzaga*, it appears that section 1983 is not a viable method to get into court. This area of law has changed greatly over the years and as a result, the Court and Congress seemed to have successfully shut the courthouse door to section 1983 suits for the EAP, and essentially any spending program, absent specific intent. However, the Ninth Circuit was the first circuit court to circumvent the problems posed by the EAP and section 1983 by suggesting that there may be an implied cause of action in the Supremacy Clause.<sup>97</sup>

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284 n. 4 (quoting *Smith v. Robinson*, 468 U.S. 992, 1005 n. 9 (1984)). The State may show that the statute expressly forecloses a remedy or implicitly. *Gonzaga*, 536 U.S. at 284 n. 4. For an implicitly foreclosed remedy, a State can show that Congress created "a comprehensive enforcement scheme that is incompatible with individual enforcement under §1983." *Id.* at 284 n. 4 (quoting *Blessing v. Freestone*, 520 U.S. 329, 341 (1997)) (internal citation omitted).

<sup>95</sup> Sayles, *supra* note 83, at 129.

<sup>96</sup> Guiltinan, *supra* note 10, at 1600. *See, e.g.*, *Westside Mothers v. Olszewski*, 454 F.3d 532, 542–43 (6th Cir. 2006) (concluding that the EAP is too broad and non-specific for a judicial remedy); *Sanchez v. Johnson*, 416 F.3d 1051, 1059 (9th Cir. 2005) (holding that there is no enforceable right for providers because the EAP does not focus on recipients or providers as individuals to receive a private remedy); *Long Term Pharm. Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004) (finding that the EAP has "no 'rights creating language'"); *Mandy R. ex rel. Mr. R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006) (concurring with the sixth, ninth and first district that the language of the EAP is too ambiguous to create a right of private action for recipients and providers). *But see* *Pediatric Specialty Care, Inc v. Arkansas Dep't of Human Servs.*, 443 F.3d 1005, 1015–16 (8th Cir. 2006) (concluding that despite of *Gonzaga* the EAP created private rights for providers and recipients).

<sup>97</sup> *See Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, (Independent Living I) 543 F.3d 1047, 1048–49 (9th Cir.), *opinion issued by* (Independent Living II), 543



### C. Supremacy Clause

The Supremacy Clause, contained in Article VI of the Constitution, provides that the Constitution, laws and treaties made pursuant to it are the supreme law of the land, and it is from that concept that the doctrine of preemption is derived.<sup>98</sup> In *Gade v. National Solid Waste Management Association*, the Court held that “under the Supremacy Clause, from which our pre-emption doctrine is derived, ‘any state law, however clearly within a State’s acknowledged power, which interferes with or is contrary to federal law, must yield.’”<sup>99</sup> Thus, if there is a conflict between state and federal law, federal law is controlling.

Preemption can be either expressed or implied.<sup>100</sup> If a statute does not contain explicit language of preemption then it may be implicit through either 1) field preemption or 2) conflict preemption.<sup>101</sup> Field preemption is “where the scheme of federal regulation is ‘so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it.’”<sup>102</sup> In contrast, conflict preemption is where “‘compliance with both federal and state regulations is a physical impossibility . . . or where state law stands as an obstacle to the accomplishments and execution of the full purposes and objectives of Congress.’”<sup>103</sup>

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F.3d 1050 (9th Cir. 2008), *cert. denied*, 129 S. Ct. 2828 (2009), *and on remand to* No. CV 08-3315, 2008 WL 3891211 (C.D. Cal. Aug. 18, 2008), *aff’d sub nom.* Indep. Living Ctr. Of S. Cal., Inc. v. Maxwell-Jolly (Independent Living III), 572 F.3d 644 (9th Cir. 2009), *motion to vacate denied*, 590 F.3d 725 (9th Cir. 2009), *petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb 16, 2010) (No. 09-958).

<sup>98</sup> ERWIN CHEMERINSKY, CONSTITUTIONAL LAW PRINCIPLES AND POLICES 402 (Aspen Student Series 4th ed. 2011).

<sup>99</sup> *Gade v. Nat’l Solid Waste Mgmt. Assn.*, 505 U.S. 88, 108 (1992) (quoting *Free v. Bland*, 369 U.S. 663, 666 (1982)); *see also* CHEMERINSKY, *supra* note 98, at 402.

<sup>100</sup> *Gade*, 505 U.S. at 98.

<sup>101</sup> Sayles, *supra* note 83, at 132.

<sup>102</sup> *Gade*, 505 U.S. at 98 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

<sup>103</sup> *Gade*, 505 U.S. at 98 (quoting *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142–43 (1963)).



## 1. Supremacy Clause and Cause of Action

The Supreme Court has never stated that the Supremacy Clause is a source of any federal right.<sup>104</sup> However, based on the Court's precedent, it may be inferred that the Court permits an *implied cause of action* under the Supremacy Clause when there is an express or implied preemption issue before it.<sup>105</sup> Nevertheless, the Supreme Court has never overtly stated that position.<sup>106</sup> The Court has skirted around the issue by either dismissing the case because there was no express right of action, or more commonly deciding the case on the merits without considering whether there is an express or implied right of action.<sup>107</sup>

*Shaw v. Delta Air Lines, Inc.* is an example of the Court solving a case on the merits without considering whether the Supremacy Clause creates a private right of action.<sup>108</sup> In *Shaw*, a group of employees claimed that the New York law, which prohibited discrimination on the basis of pregnancy in the work place, violated the Employee Retirement Income Security Act of 1974 (ERISA).<sup>109</sup> The employees sought an injunction based on the notion that federal law *preempted* New York's law.<sup>110</sup> The Court found federal law preempted.<sup>111</sup> The Court only *briefly* addressed the plaintiff's ability to bring the suit in federal court by stating:

It is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights. A plaintiff who seeks injunction relief from state regulation, on the ground

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<sup>104</sup> See *Golden State Transit Corp. v. L.A.*, 493 U.S. 103, 107 (1989); *Chapman v. Hous. Welfare Rights Org.*, 441 U.S. 600, 613 (1979); see also Guiltinan, *supra* note 10, at 602; Sayles, *supra* note 83, at 133.

<sup>105</sup> David Sloss, *Constitutional Remedies for Statutory Violations*, 89 IOWA L. REV. 355, 377–78 (2004). See *infra* notes 104, 198–199 and accompanying text.

<sup>106</sup> Sloss, *supra* note 105, at 378.

<sup>107</sup> *Id.* at 365; Guiltinan, *supra* note 10, at 1602–03.

<sup>108</sup> *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983).

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

<sup>111</sup> *Id.* at 86.

that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve.<sup>112</sup>

Nevertheless, there is a set of cases where plaintiffs sued to enjoin state action that conflicted with federal law and the Court did not consider the merits of the case because there was no expressed private right of action.<sup>113</sup> For example, in *Alexander v. Sandoval*, Martha Sandoval brought a class action to enjoin the Alabama Department of Public Safety from administering state driver's license examinations in English.<sup>114</sup> Sandoval argued that the driver license examination *violated* section 601 of title VI of the Civil Rights Act of 1964, which prohibits funding to recipients that discriminate.<sup>115</sup> The Court refused to decide the case on its merits because neither title VI nor its corresponding regulations created a private right of action.<sup>116</sup> *Sandoval* and *Shaw* demonstrated the

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<sup>112</sup> *Id.* at 96 n. 14. See also *Ex parte Young*, 209 U.S. 123, 160–62 (1908); *Louisville & Nashville R.R. Co. v. Mottley*, 211 U.S. 149, 152 (1908); *Smith v. Kansas City Title & Trust Co.*, 255 U.S. 180, 199–200 (1921).

<sup>113</sup> Sloss, *supra* note 105, at 367. See also *Calderon v. Ashmus*, 523 U.S. 740 (1998) (holding that the district court lacked jurisdiction because plaintiff's declaratory judgment action was not a justiciable cause within the meaning of Article III). David Sloss described the difference between *Shaw* and *Sandoval* in that *Shaw* is a case that challenges state or local legislation or administrative regulations, whereas *Sandoval* challenges state or local executive action. Sloss, *supra* note 105, at 365. Sloss terms the cases like *Shaw* as *Shaw*-preemption cases and the second set of cases, like *Sandoval*, as *Shaw*-violation cases. *Id.* According to Sloss, the Court, absent an explicit cause of action will hear a case on its merits if it is a *Shaw*-preemption case; whereas the Court will refuse to hear the case if it is a *Shaw*-violation. *Id.* at 365–70. According to Sloss, the distinction between *Shaw*-violation and *Shaw*-preemption cases is merely linguistic. *Id.* at 370. The linguistic theory proposes that the Court will reach the merits if the case is phrased in the terms preemption whereas the Court will require an explicit cause of action for those cases that claim a violation. *Id.* “All twenty *Shaw* cases that the Supreme Court decided between October 1996 and June 2003 are consistent with the linguistic theory.” *Id.* at 371.

<sup>114</sup> *Alexander v. Sandoval*, 532 U.S. 275, 278–79 (2001).

<sup>115</sup> *Id.* at 279.

<sup>116</sup> *Id.* at 278.

Court's inconsistencies as to whether it will consider a private right of action implied in the Supremacy Clause versus requiring an explicit right of action.<sup>117</sup>

## 2. Medicaid Cases and the Supremacy Clause

Since *Gonzaga*, the Court has decided two cases regarding preemption and Medicaid. In *Pharmaceutical Research & Manufacturers of America v. Walsh*, a drug manufacturer challenged Maine's practice of negotiating rebates with drug manufacturers arguing that the Medicaid Act preempted it.<sup>118</sup> The Court, like in *Shaw*, did not consider the source of the private cause of action and decided *Walsh* on its merits.<sup>119</sup> In 2006, in *Arkansas Department of Health and Human Services v. Ahlborn*, Heidi Ahlborn was involved in a serious car accident, which resulted in permanent injuries.<sup>120</sup> In order to receive Medicare payments through the Arkansas Department of Human Services (ADHS), she had to consent to give the ADHS "a claim to reimbursement from 'any settlement, judgment or award.'"<sup>121</sup> Ahlborn received a settlement from the accident, and ADHS demanded that Ahlborn repay the medical expenses afforded to her by ADHS.<sup>122</sup> The Court considered whether the Medicare Act preempted state action without considering the source of the private cause of action,<sup>123</sup> and held that the Medicaid Act preempted the ADHS's claim.<sup>124</sup> Although the Court has heard preemption cases regarding the Medicaid Act and the Supremacy Clause, none of these cases have focused on the EAP. The Ninth Circuit, through *Douglas*,

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<sup>117</sup> See *supra* text accompanying note 113.

<sup>118</sup> *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 649 (2003).

<sup>119</sup> *Id.*

<sup>120</sup> *Arkansas Dept. of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 273 (2006).

<sup>121</sup> *Id.*

<sup>122</sup> *Id.* at 274.

<sup>123</sup> *Id.* at 272–73.

<sup>124</sup> *Id.* at 292.

was the first court to use the Supremacy Clause to bring a private cause of action based on a state's violation of the EAP.<sup>125</sup>

In sum, states are cutting reimbursement rates to providers to salvage their suffering budgets. Medicaid providers and beneficiaries are suffering from these reimbursement cuts without a clear venue to enforce state compliance with the EAP. Section 1983 suits seem futile after *Gonzaga*, however the Eighth Circuit has ruled that section 1983 is still applicable to challenge violations of the EAP. The Supreme Court could still speak to this issue, but it seems unlikely since it has not since the coming down of *Gonzaga* in 2002. Instead, the Supreme Court decided to hear whether there is a private cause of action for the EAP through the Supremacy Clause. Unfortunately, on February 22, 2012, the Supreme Court remanded the case without even addressing the Supremacy Clause issue.<sup>126</sup> “*Douglas* raises more questions than it answers, and adds a measure of uncertainty to the law applicable in resolving . . . substantive claims.”<sup>127</sup> Still with no answer as to the enforceability of the EAP and the shaky holding as to the Medicaid Expansion, “the courts will continue to be at the center of the controversy, namely the enforceability and interpretation of Medicaid’s guarantees.”<sup>128</sup>

#### IV. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

On March 23, 2010, President Obama signed the PPACA into law.<sup>129</sup> Through the PPACA, Congress aimed to have all Americans covered by health insurance, which in return would reduce the cost of health care.<sup>130</sup> Twenty-six states, several individuals and the

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<sup>125</sup> After *Gonzaga*, the circuits that have considered the Equal Access Provision held that it is not enforceable under section 1983 with the exception the Eighth Circuit. See *supra* note 96 and accompanying text.

<sup>126</sup> *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1210–11 (2012).

<sup>127</sup> *Dartmouth-Hitchcock Clinic v. Toumpas*, 856 F. Supp. 2d 315, 321 (2012).

<sup>128</sup> McKennan, *supra* note 62, at 487.

<sup>129</sup> Douglas A. Bass, *Validity of the Minimum Essential Medical Insurance Coverage, or “Individual Mandate,” Provision of § 1501 of the Patient Protection and Affordable Care Act of 2010*, 60 A.L.R. FED. 2d 1 (Originally published in 2011).

<sup>130</sup> *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012).

National Federation of Independent Business challenged the constitutionality of two provisions of the PPACA.<sup>131</sup> They challenged the individual mandate and the Medicaid expansion.<sup>132</sup> The individual mandate requires most Americans to have “minimum essential” health insurance coverage.<sup>133</sup> Individuals who do not have minimum essential health insurance coverage will have to pay a tax for non-compliance.<sup>134</sup> Under the PPACA, Congress extends the current Medicaid program by increasing the number of individuals a Medicaid-participating state must cover.<sup>135</sup> If a Medicaid-participating state does not comply with the expansion, that state will lose all Medicaid funding.<sup>136</sup> The expansion will provide Medicaid coverage to adults with incomes up to 133% of the federal poverty level, adding approximately sixteen million people.<sup>137</sup> The Supreme Court, in the *Affordable Care Act Case*, decided on whether these two provisions of the PPACA were constitutional.<sup>138</sup>

On June 28, 2012, the Supreme Court held that the individual mandate was a tax and was a valid exercise of Congress’ taxing power.<sup>139</sup> As for the Medicaid expansion, Chief Justice Roberts with Justices Scalia, Kennedy, Thomas, Breyer, Alito and Kagan concluded that the Medicaid expansion was unduly coercive and an overstep of Congress’s spending power.<sup>140</sup> However, Chief Justice Roberts, joined by Justices Ginsburg, Breyer, Sotomayor and Kagan held that the severability clause in the Medicaid Act saved the Medicaid expansion, and essentially severed the unconstitutional coercive portion which allowed the Secretary of the Department of Health and Human Services to withdraw all Medicaid funding for

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<sup>131</sup> *Id.* at 2572.

<sup>132</sup> *Id.*

<sup>133</sup> *Id.* at 2580.

<sup>134</sup> *Id.*

<sup>135</sup> *Sebelius*, 132 S. Ct. at 2581–82.

<sup>136</sup> *Id.* at 2582.

<sup>137</sup> *Id.*

<sup>138</sup> *Id.* 2580–82.

<sup>139</sup> *Id.* at 2600.

<sup>140</sup> *Sebelius*, 132 S. Ct. at 2601–07.

refusing to adopt the Medicaid expansion.<sup>141</sup> Thus, all states now have the option of adopting the Medicaid expansion.<sup>142</sup>

As illustrated throughout this paper, many of the states' Medicaid programs are suffering from budget cuts. To assist states, the PPACA provides that the federal government will help the states pay for the Medicaid expansion through the Federal Medicaid Assistance Percentage (FMAP).<sup>143</sup> FMAP will cover up to 100% of the *newly eligible* individuals on Medicaid from 2014 to 2016.<sup>144</sup> In 2017, FMAP coverage will drop to ninety-five percent, ninety percent in 2020 and thereafter.<sup>145</sup> Further, the PPACA assures that providers be reimbursed at Medicaid rates for the first two years for primary care services.<sup>146</sup> Through the FMAP coverage and providers reimbursements, Congress provided financial incentives to adopting the Medicaid Expansion."

The Supreme Court's rulings on *Douglas* and the *Affordable Care Act Case* will have huge implications on the Medicaid system. The uncertainties of not having a means of redress for states' violation of provider reimbursements coupled with the uncertainty of whether a state will expand Medicaid leaves those reliant on Medicaid in a lose-lose situation. The PPACA requires all citizens, with some exceptions, to have health insurance or that person will be "taxed." In order to provide insurance to those under the 133% federal poverty level, Congress expanded Medicaid. But the Court has left the option to expand Medicaid to the states. So now, certain citizens may be in a situation where they are required to have health insurance, but they cannot afford it because the state that they reside in does not expand Medicaid coverage to them, subjecting them to a

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<sup>141</sup> *Id.* at 2607–08.

<sup>142</sup> *Id.* at 2566, 2608.

<sup>143</sup> Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in the Health Care Regulation: The Federalism Failures of the ACA*, Kan. J.L. & PUB. POL'Y 267, 282 (2011).

<sup>144</sup> *Id.*

<sup>145</sup> *Id.* See also Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1201, 124 Stat. 1029, 1051 (2010).

<sup>146</sup> Deborah Bachrach, *Medicaid Payment Reform: What Policymakers Need to Know About Federal Law*, CTR. FOR HEALTH CARE STRATEGIES, INC. (Nov. 2010), available at [http://www.chcs.org/usr\\_doc/CHCS\\_Payment\\_Reform\\_FINAL.pdf](http://www.chcs.org/usr_doc/CHCS_Payment_Reform_FINAL.pdf).

tax for failing to obtain health insurance. On the other hand, Medicaid beneficiaries of states that do adopt the Medicaid expansion are essentially forced into a health care system that is financially struggling. Also, there is no reliable legal mechanism for these new beneficiaries to ensure that the provider reimbursements meet the standards of the Equal Access Provision. In essence, this group of people is either left without a viable health care option, or forced into a deficient health care system with little legal redress.

## V. DOUGLAS V. INDEPENDENT LIVING CENTER

### A. Background

This section describes *Douglas*'s background, and the Justices' reactions to *Douglas* in oral argument in order to analyze the Supreme Court's decision to remand *Douglas*. *Douglas* is a compilation of five different cases that all deal with the California legislature enacting laws that cut reimbursements to Medicaid providers.<sup>147</sup> In 2008 and 2009, the California legislature passed three statutes changing its Medicaid plan.<sup>148</sup> In February 2008, the California Assembly passed Assembly Bill 5 (AB 5), which added two new sections to the California Welfare and Institution Code.<sup>149</sup> Under these sections, the Assembly lowered payments to healthcare providers by ten percent.<sup>150</sup> The justification behind the cuts were as follows: "The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measure to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of health, safety,

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<sup>147</sup> *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1209 (2012).

<sup>148</sup> *Id.* at 1208.

<sup>149</sup> CAL. WELF. & INST. CODE §§ 14105.19, 14166.245 (2009). Section 14105.19 cut payments to "physicians, dentists, pharmacies, adult health care centers, clinics, health systems, and other providers." *Indep. Living Ctr of S. Cal, Inc. v. Maxwell-Jolly*, 572 F.3d 644, 649 (9th Cir. 2009). Section 14166.245 cut payments regarding hospital care not under contract with the State Department of Health Care and services. CAL. WELF. & INST. CODE § 14166.245 (West 2011).

<sup>150</sup> CAL. WELF & INST. CODE §§ 14105.19, 14166.245 (West 2011).



and welfare of the citizens of the State of California.”<sup>151</sup> A group of California Medicaid recipients and providers sued the Director of California’s Department of Health Care Services, Sandra Shewry, for the cuts in reimbursements, in a case named *Independent Living Center v. Shewry*, the case was later named *Douglas* when it was heard before the Supreme Court.<sup>152</sup> In *Shewry*, the plaintiffs argued that the rate cuts were preempted by the EAP, because the cuts would lead to less providers becoming involved in the State’s Medicaid Program.<sup>153</sup> This, in turn, would negatively impact recipients’ access to medical care.<sup>154</sup>

In *Shewry*, the district court denied the plaintiffs’ preliminary injunction relying on *Sanchez v. Johnson* holding that the plaintiff did not have enforceable rights or, in other words, a private cause of action.<sup>155</sup> Oddly, *Sanchez* did not deal with the Supremacy Clause but rather section 1983.<sup>156</sup> In *Sanchez*, the Ninth Circuit held that the Equal Access Provision did not create an enforceable right under section 1983.<sup>157</sup> The plaintiffs, in *Shewry*, appealed to the Ninth Circuit. The Ninth Circuit held that the plaintiffs could bring a suit, via the Supremacy Clause, despite not having an express cause of action in the EAP.<sup>158</sup> The court explained that in order to bring a claim under the Supremacy Clause, a plaintiff must only show: 1) that federal law allegedly preempts the state law and 2) that standing

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<sup>151</sup> *Id.*

<sup>152</sup> See *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1047, 1050, 1052 (9th Cir. 2008); Guiltinan, *supra* note 10, at 1606.

<sup>153</sup> 42 U.S.C. § 1396(a)(30)(A) (2006); Guiltinan, *supra* note 10, at 1606. Even prior to AB 5, payments were so low that “45% of primary care physicians, 50% of specialists, and 90% of dentists in California refused to accept Medi-Cal patients or participate in the Medi-Cal program.” Guiltinan, *supra* note 10, at 1606.

<sup>154</sup> *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005); *Indep. Living Ctr. of S. Cal. v. Shewry*, No. CV 08-3315 CAS (MANx), 2008 WL 4298223, at \*5 (C.D. Cal. June 25, 2008).

<sup>155</sup> *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005); *Shewry*, 2008 WL 4298223, at \*5.

<sup>156</sup> *Sanchez*, 416 F.3d at 1055.

<sup>157</sup> *Sanchez*, 416 F.3d at 1057, 1062.

<sup>158</sup> *Id.* The Ninth Circuit further explained its decision in a longer opinion issued in September of 2008. *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008).



is satisfied.<sup>159</sup> The Ninth Circuit Court relied on *Shaw* to conclude that the Supremacy Clause provides standing for a cause of action alleging preemption,<sup>160</sup> and that the district court wrongly applied the section 1983 test to determine whether a cause of action arises under the Supremacy Clause. The court ultimately justified the difference between section 1983 and the Supremacy Clause private cause of actions. The Ninth Circuit, relying on Supreme Court precedent, reasoned that the Supreme Court expressly made the test for bringing suits under section 1983 more difficult than that of the Supremacy Clause.<sup>161</sup> Therefore, the Supremacy Clause not section 1983 is the proper doctrine under which plaintiffs should seek redress for injury under the EAP, which resulted in the Ninth Circuit as the first circuit to hold that the Supremacy Clause creates a private cause of action for providers and recipients under the EAP.<sup>162</sup> The Ninth Circuit vacated the district court's ruling and remanded the case to be heard on its merits.<sup>163</sup> On remand, the district court held, in conjunction with the Ninth Circuit, that there was a private cause of action under the Supremacy Clause.<sup>164</sup>

The district court came down with its decision on August 8, 2008.<sup>165</sup> Shortly thereafter, the California legislature enacted a second statute in September of 2008 repealing the February 2008

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<sup>159</sup> *Shewry*, 543 F.3d at 1058.

<sup>160</sup> *Id.* at 1056.

<sup>161</sup> *Id.* at 1065–66. On remand the district court granted the injunction under *Orthopedic v. Belshe*. Gultinan, *supra* note 10, at 1611. In *Belshe*, the Ninth Circuit held that the EAP requires providers' reimbursements to be "consistent with efficiency, economy, and [the] quality of care" and "sufficient to enlist enough providers to provide access to Medicaid recipients," while also requiring the state Medicaid program to use "responsible cost studies" containing reliable data when setting those rates. *Id.* The Ninth Circuit upheld the injunction when the Director appealed. The Ninth Circuit found that *Belshe* was controlling and further stated that the Director violated the EAP because when he implemented the reimbursement rates he failed to rely on any data to justify cuts. *Id.* See generally *Orthopedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997).

<sup>162</sup> McKennan, *supra* note 62, at 502.

<sup>163</sup> *Shewry*, 543 F.3d at 1049.

<sup>164</sup> *Indep. Living Ctr. of S. Cal. v. Shewry*, No. CV 08-3315 CAS (MANx), 2008 WL 3891211, at \*11 (C.D. Cal. Aug. 18, 2008).

<sup>165</sup> *Id.* at \*1.

statute by reducing the amount of cuts.<sup>166</sup> Finally, the California legislature enacted its last statute in February 2009, which placed a limit on the State's "maximum contribution to wages and benefits paid by counties to providers of in-home supportive services."<sup>167</sup> The first statute that the California legislature enacted in February of 2008, the same statute that was argued in *Shewry* did not have a corresponding SPA, as required by the CMS.<sup>168</sup> This failure to file an SPA may have been the sole reason for the start of these lawsuits, as will be discussed later in this paper. After the district court ruled against the State in August of 2008, the State then submitted to the CMS a series of SPAs.<sup>169</sup> Once the State submitted its SPAs, the CMS reviewed them.<sup>170</sup> Yet, litigation had already begun before the agency had time to finish reviewing these statutes.<sup>171</sup> In November 2010, the CMS held that these statutes were not consistent with the EAP.<sup>172</sup> Thus, California appealed within the administrative agency.<sup>173</sup>

Meanwhile, on January 18, 2011, the Supreme Court granted *certiorari* of *Douglas v. Independent Living Center*, consolidating five cases into one.<sup>174</sup> The Supreme Court granted *certiorari* specifically as to whether "Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce §1396(a)(30)(A) by asserting that the provision preempts a state law

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<sup>166</sup> *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1208 (2012).

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> *Id.* at 1209.

<sup>171</sup> *Douglas*, 132 S. Ct. at 1209.

<sup>172</sup> *Id.*

<sup>173</sup> *Id.*

<sup>174</sup> UNITED STATES SUPREME COURT ACTIONS, *Certiorari Granted: Private Parties' Right to Seek Injunctive Relief Against Implementation of State's Allegedly Preempted Laws Reducing Medicaid Reimbursement Rates*, 01-21-2011 U.S. SUP. CT. ACTIONS 7 (2011); OYEZ PROJECT, *supra* note 23.

reducing reimbursement rates.”<sup>175</sup> The Supreme Court heard oral argument on October 3, 2011, which is summarized below.<sup>176</sup>

### B. Oral Argument

This section analyzes the Justices’ sentiment during oral argument to help predict the unclear holding of *Douglas* and to help determine, if the Court will one day decide the Supremacy Clause issue. The Supreme Court heard oral argument on October 3, 2011.<sup>177</sup> Chief Justice Roberts seemed concerned with the breadth of finding a private cause of action out of the Supremacy Clause, and thought it served merely as an “end run around” section 1983 suits.<sup>178</sup> He stated: “The answer is yes, [Congress] intended to deprive [plaintiffs] of the right to sue under the statute.”<sup>179</sup> Justice Breyer voiced similar concerns about the widespread implications of finding a cause of action.<sup>180</sup> He stated: “There must be a limit because if there is not a limit . . . I can go in my office and I look at the statute books . . . [and then] run right into court [with a state law that is contrary to federal law].”<sup>181</sup> He also expressed concern about the effect of a private cause of action on the judiciary, in that, inconsistencies that would arise by having judges across all jurisdictions interpreting the enforcement of the EAP.<sup>182</sup> Justice Scalia and Justice Thomas also seemed in favor of finding that there is no private cause of action, but on different grounds than Justice Breyer and Chief Justice Roberts. Justice Scalia, with little input in the oral argument, and Justice Thomas, with none, will arguably base

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<sup>175</sup> 09-958, *Douglas v. Independent Living Center of Southern California, Inc., Questions Presented*, SUPREME COURT OF THE UNITED STATES (2012), <http://www.supremecourt.gov/qp/09-00958qp.pdf>.

<sup>176</sup> OYEZ PROJECT, *supra* note 23.

<sup>177</sup> *Id.*

<sup>178</sup> Transcript of Oral Argument at 30, *Douglas v. Indep. Living Ctr. of S. Cal.*, 132 S. Ct. 1204 (2012) (Nos. 09-958, 09-1158, 10-283), *available at* [http://www.supremecourt.gov/oral\\_arguments/argument\\_transcripts/09-958.pdf](http://www.supremecourt.gov/oral_arguments/argument_transcripts/09-958.pdf) (last visited Jan. 10, 2013).

<sup>179</sup> *Id.* at 58.

<sup>180</sup> *Id.* at 47.

<sup>181</sup> *Id.* at 47–48.

<sup>182</sup> *Id.* at 36–37.

their opinion on their concurrences in *Blessing* and *Walsh*.<sup>183</sup> In those opinions, both Justices argued that there is no private cause of action under the spending context, without explicitly stated rights, because spending programs are like contracts between the State and the Federal Government.<sup>184</sup> Thus, like contract law, unintended third-party beneficiaries should not be able to enforce violations of a contract. Here, the Medicaid Act is essentially a contract between the State and the Government and third parties cannot enforce their rights unless explicitly stated otherwise.

The other Justices seemed to lean toward finding a cause of action. Justice Kennedy, relying on the brief of the former officials of HHS, noted the impracticality of the CMS to exclusively enforce the EAP and that a private cause of action may actually make the process more manageable and not terribly burdensome to the judicial system.<sup>185</sup> Justice Alito, Justice Kagan, and Justice Sotomayor kept on insisting for justifications as to why they should treat this case differently than any of the cases in the past.<sup>186</sup> These Justices seemed content on not addressing the Supremacy Clause issue and just hearing the case on its merits as they have done in the past.<sup>187</sup> Yet, later in the argument, Justices Kagan and Sotomayor seemed to be willing to limit a Supremacy Clause cause of action by requiring the parties to first exhaust administrative measures before a court may hear the case.<sup>188</sup> Justice Ginsburg appeared most sympathetic to supply a cause of action to the beneficiaries of the EAP.<sup>189</sup> She raised the points that the CMS does not have viable options to prevent injuries to those reliant on Medicaid and that the CMS can

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<sup>183</sup> *Blessing v. Freestone*, 520 U.S. 329, 349 (1997) (Scalia, J., concurring); *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 683 (2003) (Thomas J., concurring).

<sup>184</sup> *Blessing*, 520 U.S. at 349 (Scalia, J., concurring); *Walsh*, 538 U.S. at 683 (Thomas J., concurring).

<sup>185</sup> Transcript of Oral Argument, *supra* note 178, at 8. Justice Kennedy refuted the State's "the sky is falling" argument if there was a private cause of action by stating that there would not be thousands of judges hearing these cases, but only district court judges; and, in the case of California, there are only four districts. *Id.*

<sup>186</sup> *Id.* at 13–14.

<sup>187</sup> *Id.*

<sup>188</sup> *Id.* at 28–29, 50, 59.

<sup>189</sup> *Id.* at 5.

only withhold funds, which has an even more detrimental effect on Medicaid participants.<sup>190</sup> During drafts of this paper, the Supreme Court decided *Douglas*. Prior to its decision, this section predicted that the case would come down to a 5 to 4 decision. On February 22, 2012 it did.<sup>191</sup> However, Justice Alito joined the dissent, and Justice Breyer joined the majority. Based off oral argument, Justice Breyer raised some of the best points as to why there should not be a cause of action; nevertheless he joined the majority.

### C. Holding

A month after the Supreme Court heard oral argument, the CMS reversed its prior holding and held that California's statutes were consistent with the EAP and approved California's SPAs.<sup>192</sup> The Justices in the majority opinion believed that the CMS's approval changed the posture of *Douglas* as discussed in the Court's February 22, 2012 decision.<sup>193</sup> *Douglas* came down to a 5 to 4 decision, with the majority ignoring the Supremacy Clause issue.<sup>194</sup> The majority felt that the CMS's approval of California's statutes did not change the substantive question of whether there is a cause of action under the Supremacy Clause. However, now that the CMS approved the rates, the providers and beneficiaries are required to take a different legal course through sections 701–706 of the Administrative Procedure Act (APA).<sup>195</sup> Thus, the majority remanded the case so that the Ninth Circuit could decide if there is still a private cause of action available under the Supremacy Clause once the administrative agency has spoken.<sup>196</sup>

Justice Breyer delivered the majority opinion, despite his appearance in oral argument that he was against addressing the Supremacy Clause issue. In the opinion, he explained that because the CMS approved California's reimbursement cuts, the CMS's

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<sup>190</sup> Transcript of Oral Argument, *supra* note 178, at 5–6.

<sup>191</sup> *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1209 (2012).

<sup>192</sup> *Id.*

<sup>193</sup> *Id.* at 1210.

<sup>194</sup> *Id.* at 1207.

<sup>195</sup> *Id.* at 1210.

<sup>196</sup> *Douglas*, 132 S. Ct. at 1209.

approval does not make these cases moot, but it does put them “in a different posture,” since “[t]he federal agency charged with administering the Medicaid program” has now found that the “rate reductions comply with federal law.”<sup>197</sup> Thus, now that the administrative process was exhausted, the providers and beneficiaries could bring suit under sections 701–706 of the Administrative Procedure Act versus the Supremacy Clause.<sup>198</sup> The majority further elaborated on the importance of the use of the administrative agencies’ procedures and stressed that utilizing the Supremacy Clause post-administrative decision could usurp the power of the CMS.<sup>199</sup> Nevertheless, the Court still remanded the case, so that the parties could argue the Supremacy issue post-administrative decisions, versus mid-administrative proceedings, as it was originally granted.<sup>200</sup> The majority position is unclear. The Court seems to be trying to convey that once administrative procedures are exhausted, the way to get into court is through the APA, not the Supremacy Clause, but the Court still wants the Ninth Circuit to address the Supremacy Clause issue on remand.

Chief Justice Roberts delivered the opinion of the dissent.<sup>201</sup> The Chief Justice clearly stated, “I believe, there is no private right of action under the Supremacy Clause to enforce [the EAP], that is the end of the matter.”<sup>202</sup> Justice Roberts argued that since Congress did not explicitly state a cause of action under the EAP, then it makes no sense to claim that the Supremacy Clause itself must provide one.<sup>203</sup> By holding that if there was a private cause of action under the Supremacy Clause, the Court would contravene Congress’s intent to not provide a private cause of action.<sup>204</sup> Further, Chief Justice Roberts argued that if the Court held there was a private cause of action under the Supremacy Clause it would impinge on the separation of powers because the Court cannot create a remedy under

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<sup>197</sup> *Id.* at 1210.

<sup>198</sup> *Id.*

<sup>199</sup> *Id.* at 1210–11.

<sup>200</sup> *Id.* at 1211.

<sup>201</sup> *Douglas*, 132 S. Ct. at 1211.

<sup>202</sup> *Id.* at 1214.

<sup>203</sup> *Id.*

<sup>204</sup> *Id.* at 1212–13.

the law where Congress did not expressly create one.<sup>205</sup> Justice Roberts seemed confused as to why the majority provided ample support that the Supremacy Clause is no longer applicable because there is the possibility to bring suit under the APA but nevertheless remanded the Supremacy Clause issue to the Ninth Circuit.<sup>206</sup> Using the majority's and his own arguments, Justice Roberts pondered why *Douglas* should have been in front of the Court in the first place when the agency did participate in the administrative process.<sup>207</sup>

*D. Administrative Process for the Equal Access Provision and the Administrative Procedure Act*

Congress can provide for administrative hearings and remedies that must be exhausted before plaintiffs can bring legal action.<sup>208</sup> The purpose of exhausting the administrative process is to prevent "premature inference with agency processes, so that the agency may . . . have an opportunity to correct its own errors, to afford the parties . . . the benefits of its experience and expertise, and to compile a record which is adequate for judicial review."<sup>209</sup> Once an agency action is final—where there is no other adequate remedy—that decision may be subject to judicial review.<sup>210</sup> The APA allows a person suffering from an adverse final agency decision to seek judicial review of the agency's action.<sup>211</sup> The reviewing court must resolve, "all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of

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<sup>205</sup> *Id.* at 1213.

<sup>206</sup> *Douglas*, 132 S. Ct. at 1214–15.

<sup>207</sup> *Id.*

<sup>208</sup> *Bowen v. City of New York*, 476 U.S. 467, 482 (1986).

<sup>209</sup> *Bowen*, 476 U.S. at 484 (citation omitted). The administrative exhaustion doctrine applies only to remedies *mandated* by statute or agency rule. *Id.* It does not require parties to exhaust remedies that are merely an option. *Darby v. Cisneros*, 509 U.S. 137, 143 (1993). However, where Congress has not explicitly required administrative exhaustion, courts must decide whether it was Congress's intent to exhaust administrative remedies. *Id.*; *DSE, Inc. v. United States*, 169 F.3d 21 (D.C. Cir. 1999); *Moncrief v. United States*, 43 Fed. Cl. 276, 284 (1999). Congress seems to have intended to enforce the EAP disputes through the administrative proceeding. See *infra* text Part C.i.

<sup>210</sup> The Amendment Procedure Act, 5 U.S.C. § 704 (2006).

<sup>211</sup> *Id.* § 702.



the terms of an agency action.”<sup>212</sup> In addition, the reviewing court must set aside agency action that is “arbitrary, capricious, an abuse of discretion, *or otherwise not in accordance with law* . . . .”<sup>213</sup> While an agency action is under review, the reviewing court may postpone the agency’s action.<sup>214</sup> Further, the court may be required to postpone the agency’s decision “to prevent irreparable injury.”<sup>215</sup>

It is evident from the Medicaid Act that Congress intended for the CMS administrative process to be utilized before parties tried to enforce the EAP in court. Under 42 C.F.R. § 430.3, Congress provides three types of disputes that might arise under Medicaid, and provides appeals for those disputes.<sup>216</sup> The appeal pertinent to this article is under 42 C.F.R. § 430.3(a), this statute permits appeals regarding compliance with federal requirements.<sup>217</sup> Congress

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<sup>212</sup> *Id.* § 706.

<sup>213</sup> 5 U.S.C. § 706(2)(A) (emphasis added). The statute in full:

The reviewing court shall—

(1) compel agency action unlawfully withheld or unreasonably delayed; and

(2) hold unlawful and set aside agency action, findings, and conclusions found to be—

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) contrary to constitutional right, power, privilege, or immunity;

(C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D) without observance or procedure required by law;

(E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

*Id.* § 706(1)–(2)(F).

<sup>214</sup> *Id.* § 705.

<sup>215</sup> *Id.*

<sup>216</sup> Appeals under Medicaid, 42 C.F.R. § 430.3 (2012).

<sup>217</sup> 42 C.F.R. § 430.3(a).



provides that if there is a dispute “to whether a State’s plan or proposed plan amendments, or its practice under the plan meet or continue to meet Federal requirements are subject to [a] hearing provisio[n] . . . .”<sup>218</sup> Sections 430.6 –.104 lay out the requirements for this type of hearing.<sup>219</sup> Congress requires that the CMS and the State be parties to the hearing.<sup>220</sup> Other individuals may join as parties if the issues at the hearing have caused them injury and the issues are within their interest as to be protected by the federal statute.<sup>221</sup> Once the hearing is decided upon, that decision “is the *final decision* of the Secretary, and constitutes ‘*final agency action*’ within the meaning of 5 U.S.C. 704 . . . .”<sup>222</sup> Through these statutes, it is clear that if there is a conflict between federal and state law as to a state plan amendment or state’s compliance with federal law, Congress intended for the administrative agency to handle the inconsistency first, and once the agency has decided, then an aggrieved party could seek judicial review under the APA.

However, the CMS also has the ability to waive state plan amendments as discussed in *supra* Part II. If the CMS permits a waiver, it is unlikely that 42 C.F.R. § 430(a) will become an issue because the state will not bring a hearing to contest a granted-waiver in its favor. Since only a state or the CMS can bring a hearing as to inconsistent state action, providers and beneficiaries are left without a hearing. But, if the Secretary approves of a waiver, providers and beneficiaries can still seek judicial review under the APA.<sup>223</sup>

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<sup>218</sup> *Id.*

<sup>219</sup> Hearings on Conformity of State Medicaid Plan and Practice to Federal Requirements, 42 C.F.R. § 430.6 (2012).

<sup>220</sup> Parties to the Hearing, 42 C.F.R. § 430.76(a) (2012).

<sup>221</sup> 42 C.F.R. § 430.76(b)(1). If a party wishes to join the hearing, then that party must file a petition within fifteen days after notice of hearing is published. 42 C.F.R. § 430.76(b)(2). The petition must state the petitioner’s interest, the issues to which the petitioner wishes to participate, which will be appearing for the petition, and whether the petitioner wishes to present witness. 42 C.F.R. § 430.76(b)(2)(i)–(iv).

<sup>222</sup> Decisions Following Hearing, 42 C.F.R. § 430.102(c) (2012) (describing the effect of the administrator’s decision) (internal citations omitted) (emphasis added).

<sup>223</sup> *Beno v. Shalala*, 30 F.3d 1057, 1066 (9th Cir. 1994) (“[t]he district court also correctly found that § 1315(a) waivers are subject to APA review.”). See also *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011).

However, as of March 23, 2010, Congress required that the Secretary shall provide for waivers “a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input . . . .”<sup>224</sup> Through the PPACA, Congress is trying to have the public become more involved in the Medicaid decision-making process. However, Congress has not provided a specific remedy or appeals process for providers or beneficiaries under the EAP.

#### VI. THE AFFORDABLE CARE ACT AND *DOUGLAS*’S POTENTIAL IMPACT ON THE EQUAL ACCESS PROVISION

This section discusses the holding in *Douglas* and how it is exemplified in the light of the PPACA. This section then recommends an approach to help manage the comingled problems of the Equal Access Provision and the PPACA.

##### A. *Interpreting Douglas*

“*Douglas* raises more questions than it answers . . . .”<sup>225</sup> As the dissent adequately pointed out, “it is difficult to see what would be left of the original Supremacy Clause suit. Or, again, why one should have been permitted in the first place, when agency review was provided by statute . . . .”<sup>226</sup> This section analyzes the Supreme Court’s decision to remand the case.

First, the Supreme Court could want the providers and beneficiaries to exhaust administrative venues first before bringing a cause of action. If the providers and beneficiaries do that, then there

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<sup>224</sup> 42 U.S.C. § 1315(d)(2)(A) (2006). 42 U.S.C. § 1315(d)(2)(C) (2006) further requires “a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input.” *Id.* Congress also requires periodic evaluation by the Secretary to ensure compliance with the demonstration projects, and the Secretary must report to Congress any actions taken by the Secretary in respect to demonstration projects. 42 U.S.C. § 1315(d)(2)(C); 42 U.S.C. § 1315(E); 42 U.S.C. § 1315(d)(3).

<sup>225</sup> *Dartmouth-Hitchcock Clinic v. Toumpas*, No. 11-CV-358-SM, 2012 WL 683502, at \*6 (D.N.H. Mar. 2, 2012).

<sup>226</sup> *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1215 (2012) (Roberts, C.J., dissenting).

will be no Supremacy Clause issue because there will be means of redress via the APA. This seems to be the holding that the Supreme Court advances and is most consistent with Congress's intent. Congress provided administrative procedures for the state, the CMS, and those reliant on Medicaid to use first before running into court. If there is a reimbursement cut, a state should file an SPA with the CMS, and the CMS should review or waive it. Once the CMS makes a decision as to waive or review, there are opportunities for providers and beneficiaries to seek judicial review under the APA. Thus, if the CMS and the State adhere to the administrative procedures of the SPAs, then cases like *Douglas* should be irrelevant because there will be a cause of action under the APA. The problem, as was in *Douglas*, is when the State does not file an SPA and the CMS does nothing to enforce state compliance. At that point, the providers and beneficiaries are left without a way to enforce the state's non-compliance, because the CMS has made no administrative decision that the providers and beneficiaries could challenge under the APA. If there is no administrative enforcement, then an implicit cause of action under the Supremacy Clause might be necessary.

The second possible interpretation of the Supreme Court's holding is that the Supremacy Clause is a viable cause of action regardless of the parties' ability to get into court via the APA. Under this view, the Supreme Court could mandate the providers and beneficiaries to exhaust administrative venues first before bringing a cause of action, while there still remains court access via the Supremacy Clause. Thus, the Supremacy Clause remains as an option regardless of the administrative process. Under this view, by leaving the Supremacy Clause open resolves the problem when there are no administrative remedies available because the state did not file an SPA and the CMS did nothing to enforce state action. However, leaving the Supremacy Clause action open could lead to inconsistencies between the APA and the Supremacy Clause as recognized by both the majority and the dissent. To permit a different result under the APA and the Supremacy Clause "would subject the States to conflicting interpretations of federal law by several different courts (and the agency), thereby threatening to defeat the uniformity that Congress intended by centralizing administration of the federal program in the agency and to make

superfluous or to undermine traditional APA review.”<sup>227</sup> Essentially, leaving both avenues open could lead to inconsistencies and might result in the judiciary overstepping its powers by usurping the administrative process intended by Congress.

Third, the Supreme Court’s action to remand and re-argue the Supremacy Clause issue, despite their recognition that APA would be the proper course of action for providers and beneficiaries, might imply that the Supreme Court recognizes that there is a cause of action under the Supremacy Clause. The Supremacy Clause issue is difficult to resolve because it is politically charged in light of PPACA, and it could disrupt precedent. That being said, the Court may have intended to leave this Supremacy Clause issue open so that there is some avenue for the providers and beneficiaries to get into court, if the state does not file a SPA and the CMS does not monitor the state’s actions. This implicit cause of action serves as an additional check to ensure that the administrative process is working and the state legislature is conforming to federal law.

On balance, the Court seems ready to solve this Supremacy Clause issue because the Court specifically granted *certiorari* as to “whether Medicaid providers and recipients can maintain a cause of action under the Supremacy Clause . . . by asserting that the provision preempts state laws,”<sup>228</sup> but it seems that the Court may want to wait until the PPACA goes into full effect and see how the PPACA functions before extending any private cause of action under the Supremacy Clause, specifically in regards to the EAP. In addition, by temporarily evading the Supremacy Clause issue, the Court seems to be trying to speak to Congress as to whether the EAP has enforceable rights for providers and beneficiaries. But Congress actually seems to be moving in the opposite direction by repealing the Boren Amendment and not including right-creating language in the EAP once the Court ruled on *Gonzaga*. In *Gonzaga*, the Supreme Court could have resolved the circuit split as to whether the EAP has enforceable rights under section 1983. But it has chosen to address the Supremacy Clause issue, which is perplexing because there are many other methods that the Court could use to find or deny

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<sup>227</sup> *Id.* at 1211.

<sup>228</sup> UNITED STATES SUPREME COURT ACTIONS, *supra* note 174.

enforceable rights under the EAP, without disrupting every case heard on federal preemption.

But in the end, by evading the Supremacy Clause issue, the Court does not have to address or disrupt its precedent. The Supreme Court has heard many suits that have sought injunctive relief based on federal preemption without requiring section 1983's conditions to be met.<sup>229</sup> The Supreme Court's precedent demonstrates the Court's preference for solving these cases on its merits without considering its source of cause of action.<sup>230</sup> Nevertheless, the Court's precedent is not consistent.<sup>231</sup> The Court has refused to hear "preemption" cases on its merits without an express right to bring suit.<sup>232</sup> However some academics describe this inconsistency as merely linguistic.<sup>233</sup> In those cases where there was not an explicit cause of action but the Court resolved the case on the merits, the plaintiffs sought an injunction because state law was inconsistent with federal law and thus *preempted*. Whereas, in those suits that were declined on the merits for not having a private cause of action, the plaintiffs sought injunctions because state law *violated* federal law.<sup>234</sup> Thus, the contradicting precedent is not extremely detrimental to the Court if it decides to rule on the Supremacy Clause issue. It can simply be distinguished that the Supremacy Clause arises under preemption, *not* violations. Despite political and precedent issues, the Court may decide in the near future whether there is a cause of action under the Supremacy Clause. The following section discusses the implications of finding a private cause of action under the Supremacy Clause.

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<sup>229</sup> See generally *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 649 (2003); *Shaw v. Delta Airlines, Inc.* 463 U.S. 85 (1983); *Ray v. Atlantic Richfield Co.*, 435 U.S. 151 (1978); *City of Burbank v. Lockheed Air Terminal Inc.*, 411 U.S. 624 (1973).

<sup>230</sup> See *supra* text accompanying note 113.

<sup>231</sup> See *Alexander v. Sandoval*, 532 U.S. 275, 278–79 (2001); *Calderon v. Ashmus*, 523 U.S. 740 (1998) (holding that the district court lacked jurisdiction because plaintiff's declaratory judgment action was not a justiciable cause within the meaning of Article III).

<sup>232</sup> See *supra* text accompanying note 113.

<sup>233</sup> Sloss, *supra* note 105, at 370–71.

<sup>234</sup> *Id.* "All twenty Shaw cases that the Supreme Court decided between October 1996 and June 2003 are consistent with the linguistic theory." *Id.* at 371.

*B. Will there be an implicit private cause of action?*

This section analyzes the disadvantages to both sides of (1) finding a cause of action or (2) not finding a cause of action, while demonstrating how the drawbacks of each position are further exemplified in light of the constitutionality of the PPACA. If the Supreme Court, at some time in the future, decides that the Supremacy Clause creates an implicit cause of action for individuals it (1) may lead to excessive litigation, (2) impact other spending programs, and (3) discourage the CMS restructure.

If there is a cause of action, there would be more lawsuits due to the economic state of the country because states are making more cuts to Medicaid reimbursements. States are cutting Medicaid reimbursement rates, while more people are turning to Medicaid for healthcare assistance as their own financial affairs suffer. Thus, the increase in the amount of beneficiaries and the decrease in the amount of money to fund Medicaid will lead to the states trimming funds. Further, the more beneficiaries, the more likely that one will bring a lawsuit. Ultimately, a cause of action for these beneficiaries would eliminate the legal hurdle of section 1983, making it easier to get into court.

Assuming all states accept the Medicaid expansion under the PPACA, litigation would most likely increase because the Medicaid expansion would add sixteen million people to Medicaid. Also, as the CMS's responsibilities increase, it will have even less time to regulate compliance with the EAP, which may lead to more noticeable inconsistencies, and thus, to more suits by the increased number of beneficiaries. In sum, pumping more people into the Medicaid program that is already struggling with financial and administrative enforcement, while arming providers and beneficiaries with a cause of action, will result in more lawsuits.

If the Court finds a private cause of action under the EAP, it could lead to a broad application of enforcement of the other spending provisions that do not provide an explicit cause of action. Those beneficiaries would now be able to bring suit under the Supremacy Clause any time state law is inconsistent with federal law. This too would contribute to an overall increase in litigation, because any beneficiaries of a spending program who were denied the right to bring a suit for non-compliance in the past now could bring suit. No one is really sure as to how many federal programs there are,

according to Hill, a researcher in Washington D.C.<sup>235</sup> Hill spent a week searching through various sources in Washington to see if anyone knew.<sup>236</sup> No one knew. No one even guessed.<sup>237</sup> His guess of 10,000 “was met with varying degrees of ‘Sounds about right!’ or ‘Who knows? It could be 10,000 times 10,000!’”<sup>238</sup> This is concerning because the Court could rule on a case without realizing its full potential to reach across all federally-funded programs.

The breadth of this holding impacts the PPACA as well. The PPACA’s purpose is to remedy the nation’s healthcare system by mandating that all citizens have healthcare. If individuals have the opportunity to bring lawsuits, it would contradict the uniformity and social benefits that PPACA is trying to promote. If there is a private cause of action, different lawsuits could create inconsistencies among jurisdictions and states. Without uniformity in this regard it will be difficult to implement this massive Act. Also, the Supreme Court’s decision as to the Medicaid expansion creates even more uniformity because some states may or may not adopt Medicaid expansion. Based on the uncertainty as to which states will adopt the Medicaid expansion and whether there is a cause of action, it may make the next few years extremely litigious and potentially cripple Medicaid because now groups of people may be left in a situation where: 1) they must be insured but cannot afford insurance because their state of residence did not adopt the Medicaid expansion, or 2) they are insured under the Medicaid expansion, but cannot access healthcare because there is no legal redress for inconsistent provider rates.

The CMS is underfunded and short-staffed.<sup>239</sup> It does not have the resources, power or desire to enforce the EAP.<sup>240</sup>

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<sup>235</sup> Frank Hill, *Just How Many Federal Programs Are There Anyway?* TELEMACHUS (Sep. 27, 2009), <http://www.telemachusleaps.com/2009/09/just-how-many-federal-programs-are.html>. Frank Hill was the Chief of Staff to former Congressman Alex McMillan (R-NC-9), 1985–1995; budget associate on the House Budget Committee, 1991–1995; member of the Commission on Entitlement and Tax Reform, 1994; and Chief of Staff to former Senator Elizabeth Dole. *Id.*

<sup>236</sup> *Id.*

<sup>237</sup> *Id.*

<sup>238</sup> *Id.*

<sup>239</sup> 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) (Nos. 09-958, 09-1158, 10-283), 2011 WL 3706105, at \*19–20.

<sup>240</sup> *Id.*



Regardless if the Court finds that there is or is not a cause of action, the CMS needs to restructure its administrative enforcement—especially in light of the holding in *Douglas* that might require exhausting the administrative process. If there is a cause of action, the CMS will continue to rely on individuals to enforce EAP while it concentrates on other matters, such as fraud detection.<sup>241</sup> Here, adoption of Medicaid expansion might actually help to encourage restructure of the administration enforcement of the CMS, because upon its implementation, the CMS's responsibilities will greatly increase, and it will need to implement a system of effective administrative enforcement.<sup>242</sup> However, since states have the option to adopt the Medicaid expansion, there may arise problems where some states adopt the expansion and others do not. This inconsistency among states will most likely increase the burden on states that have adopted Medicaid expansion, because those individuals who cannot afford health insurance without this Medicaid expansion may have to relocate to states that provide for Medicaid under the PPACA. Thus, states that adopt Medicaid expansion may see an increased burden by accepting those individuals to whom Medicaid expansion was supposed to cover but did not.

On the contrary, if the Supreme Court finds that the Supremacy Clause does not create an implicit cause of action, (1) the CMS would not have the resources to enforce exclusive compliance with the EAP; and (2) it would eradicate beneficiaries' opportunity to prevent injury through the legal system when states do not comply with federal law. If there is no cause of action, then the CMS will have *sole* enforcement of the EAP. The CMS has typically relied on beneficiaries to bring suit when states are not complying with the EAP. However, if there is no cause of action, the CMS will have to

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<sup>241</sup> *Id.* at \*19.

<sup>242</sup> *Id.* The CMS already seems to be predicting potential administrative difficulties in light of *Douglas* and *Florida*—in May 2011, the CMS drafted a set of proposed rules focusing on the administrative enforcement of the EAP. See 42 C.F.R. § 477 (2012); 76 Fed. Reg. 26342-01 (May 6, 2011). The rule encourages transparency, better utilization of information, and communication between states, providers, and recipients to achieve more realistic results. *Id.* The rule proposes a state-level implementation system where the state would have to continually report to ensure that it is remaining in compliance. *Id.* Nevertheless, the rule still does leave a lot of leeway and interpretation to the states on how to help ensure the EAP is followed. *Id.*



replace the role of the private litigant. The CMS does not have the manpower, finances, or effective deterrents to ensure states are complying with the EAP.<sup>243</sup> The CMS's enforcement staff for the *entire* Medicaid program consists of 500 people for all the states, and the staff oversees other provisions aside from the EAP.<sup>244</sup> In addition, the CMS lacks the effective enforcement remedies to prevent states from acting inconsistent with the EAP. The CMS has only two enforcement options. It can disprove an SPA or cut funding for non-compliance. The CMS does not want to cut funding altogether because it is much more detrimental to providers than a state not complying with the EAP. Further, the CMS does not have any remedies for injured beneficiaries; all the CMS can do is prevent the state from acting inconsistently. Thus, beneficiaries could be injured by state action, but if the CMS does not see it as an injury, those beneficiaries cannot seek retribution or prevent injury. Also, the administrative procedure to cut funds is time-consuming, which serves as another deterrent to enforcing the EAP. If there is no cause of action when the PPACA is implemented, the Medicaid expansion by those states who accept the expansion will only add increased burdens in the form of responsibilities and recipients that will weigh down an administrative agency that is already stretched at its seams.

There are two concerning issues that arise if there is no cause of action upon the PPACA's full implementation. First, individuals at the 133% poverty level would essentially be forced into Medicaid but left without a cause of action to alert states of reimbursement cuts which impact the overall access to healthcare. Thus, those individuals' healthcare would essentially be left exclusively in the hands of the CMS and the state with little or no opportunity to oppose either state or CMS action. This seems contrary to the underlying theme of the PPACA—the idea of healthcare for all. Without private litigation as a check on the states, it seems that states could undermine the PPACA—because without a cause of action it would be easier for the states to successfully cut reimbursement rates. Second, states can also undermine the PPACA by not adopting Medicaid expansion. States can choose not to adopt the expansion and shift the burdens of those who need Medicaid expansion onto

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<sup>243</sup> Brief of Former HHS Officials, *supra* note 239, at \*19–21.

<sup>244</sup> *Id.* at \*19.

other states. Also, by not adopting the expansion, there will be less Medicaid beneficiaries for a state's administrative agencies to handle.

However, the drafters of the PPACA must have analyzed the states' present inability to comply with the Medicaid Act. Thus, the PPACA provides for financial breaks for Medicaid expansion. The federal government will cover up to 100% of *newly eligible* individuals on Medicaid from 2014 to 2016.<sup>245</sup> In 2017, coverage will drop to ninety-five percent, then ninety percent in 2020 and thereafter.<sup>246</sup> This provision seems to be helpful to providers, recipients and the Medicaid program overall. However, this provision applies *only to newly eligible* individuals *not* those who are *already* on Medicaid.<sup>247</sup> Those who are currently on Medicaid, once the PPACA goes through, will not receive the federal payment, but rather still be under the states' reimbursement rates. Therefore, a situation could arise where providers choose to only see newly eligible individuals because they know that the federal government will pay for those individuals. Thus, if the Court decides to bar all individual causes of action under the Supremacy Clause, existing Medicaid recipients could be in a situation where they cannot command state compliance of a spending program, and may be treated differently from newly eligible individuals because their reimbursement rates are guaranteed by the federal government. Under this scenario, the access to healthcare does not sound so equal. In light of these potential issues, regardless of whether a state chooses to adopt Medicaid expansion or whether a future case holds that there is an implicit cause of action under the EAP, the Medicaid program has inefficiencies that need to be addressed.

*C. Recommendations: Breathing Life into the Equal Access Provision through Cooperative Enforcement*

In light of *Douglas*, the Supreme Court has expressed reliance on the administrative agency. Despite the Supreme Court's ruling in *Douglas*, there is still the possibility that the Court will hear whether or not there is an implicit cause of action under the Supremacy

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<sup>245</sup> Moncrieff & Lee, *supra* note 143, at 282.

<sup>246</sup> *Id.*

<sup>247</sup> *Id.*

Clause. Regardless if there is or is not a cause of action, either scenario has flaws, and those flaws become more apparent in light of the PPACA. *Douglas* demonstrated the flaws within the Medicaid system, specifically the enforcement capacity of the CMS. The most apparent notion that could be drawn from *Douglas* is that there is going to be greater reliance on the CMS. The CMS will inevitably still have to oversee enforcement of the EAP, and this section suggests structural changes to help.

CMS enforcement is here to stay. The biggest issue is funding, and the following proposed recommendations would require more funding. It would be wise to invest in the money up front in order to strengthen the administrative workings versus spend money later on in unpredictable costly litigation. Nevertheless, these recommendations are made on the notion that the federal government will be willing to shell out more than .04% of its total expenditures on Medicaid to help the CMS enforce Medicaid and the potential Medicaid expansion.<sup>248</sup>

This recommendation focuses on what a state can do when it decides to cut reimbursement rates. The state could not reduce reimbursement rates until it (1) receives approval from the CMS—if the CMS does not recognize state non-compliance, then there should be a way that providers and beneficiaries can get into court or use the administrative process to alert the CMS of a violation of the EAP; (2) provides data specifically demonstrating the states' need to cut reimbursement rates; (3) encourages discussion with providers and recipients as to the reimbursement rates; and (4) upon approval, the state must provide an annual report justifying reimbursement rates.

The reason why *Douglas* came about was because the state cut reimbursements prior to the CMS's approval. Under *Douglas*, had a plan been submitted or waived, or there was some prior action by the CMS, there most likely would not have been a lawsuit because there would have been access to the courts through the APA. By requiring the state to wait until the CMS decides will prevent suits like *Douglas* and will prevent injury to beneficiaries while the CMS is considering the SPA. However, issues arise when neither the state nor the CMS acts in accordance with the Medicaid Act. To solve this problem, Congress should provide a way for providers and

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<sup>248</sup> Brief of Former HHS Officials, *supra* note 239, at \*21.

beneficiaries to alert the CMS of states' nonconforming actions either through the administrative process or in court. This would hopefully mitigate the high expenses of litigation. Under this "cause of action", the CMS should provide remedies for injured individuals. The administrative agency could provide remedies for those that are injured when a state fails to comply with the EAP. Remedies would serve as an effective deterrent to the state since the CMS's current enforcement tools are limited to cutting Medicaid funds all together or denying the SPA. Through remedies, the CMS can penalize the state, but not to the extent of taking away all of its funding. Further, under a Supremacy Clause cause of action, there are no remedies for a plaintiff, just injunctive relief. Thus, by providing a proceeding with available remedies, more beneficiaries and providers will be encouraged to enforce state compliance than under the Supremacy Clause.

Next, if a state wants to cut reimbursement rates, it should have to show sufficient data to justify cutting those rates. This will prevent states from arbitrarily or hastily cutting rates. The data should be collected over an extended period of time to preserve against a state trying to quickly cut rates based on a recent change in the economic market. It also will encourage more experts to look at the finances of the state and analyze where the states can adequately place its money.

Before a state cuts reimbursements rates, it should be required to speak to recipients and providers to gather information on how a cut in reimbursement rates would impact them, because essentially the whole Medicaid program is for the benefit of the recipient's health. By gathering input and encouraging discussion early, this will hopefully mitigate against lawsuits and result in effective solutions that do not need to be decided by a court.

Finally, to ensure that a state files an SPA that is consistent with the Medicaid Act, the CMS should require that a state provide an annual update of its compliance and finances to see if the rate is adequate. This will safeguard the states from arbitrarily cutting reimbursement rates. Although this may seem tedious, it will provide a state with insight of its rates and economic health in regard to Medicaid, which will in turn hopefully benefit the program. This type of oversight will be particularly beneficial especially if a state chooses to expand Medicaid. These recommendations are not

inclusive, but may be essential to help advance both the Medicaid system as is and under the PPACA.

## VII. CONCLUSION

The medical world in the United States has dramatically changed. What *Douglas* and the *Affordable Care Act* Cases have demonstrated is that there needs to be a change in the United States' healthcare system. Currently, the system seems broken. The Medicaid program struggles between funding and making sure that recipient have adequate health care. In light of these bleak economic times, it has been a difficult balance for states and the CMS to handle. In addition, the means of enforcement to ensure this balance between funding and healthcare is in jeopardy and *Douglas* does not help to clarify whether beneficiaries or providers may be able to bring a private cause of action to help the CMS enforce state compliance with the Equal Access Provision.

This paper concludes that leaving exclusive enforcement to the CMS would not necessarily be catastrophic, nor would finding a private cause of action in the EAP via the Supremacy Clause. Whether the Supreme Court finds that there is a cause of action under the Supremacy Clause for the EAP is manageable *if* the CMS's administrative enforcement of the EAP is more transparent, and it supplements a private cause of action. Although the suggested recommendations require more CMS involvement; in theory, these recommendations are workable. The problem is putting these recommendations into practice. And, at the end of the day, it comes down to this: What do you do with a broke state, broke citizens and a broken system?