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Administrative Oversight of State Medicaid Payment Policies: Giving Teeth to the Equal Access Provision

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ADMINISTRATIVE OVERSIGHT OF STATE MEDICAID PAYMENT POLICIES: GIVING TEETH TO THE EQUAL ACCESS PROVISION

*Julia Bienstock**

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INTRODUCTION

After enrolling in the Illinois Medicaid program, the public health insurance program for poor and disabled Americans, Tessinia Rodriguez and Elissa Bassler both sought a physician referral from the Medicaid hotline.¹ The hotline gave Rodriguez the names of approx-

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imately ten doctors, all of whom practiced more than thirty miles from her home; not one accepted Medicaid.² Bassler received the names of eight doctors, none of whom accepted Medicaid.³ Benita Branch had difficulty finding a doctor to treat her children on Medicaid, and when she finally did, the doctor did not schedule appointments.⁴ Branch had to bring her children into the doctor's office and take a number, often waiting more than an hour—and sometimes several hours—before being seen.⁵ Sara Mauk was able to find a doctor that would see her daughter; however, the doctor required Medicaid patients to wait until after all privately insured patients had been seen.⁶

Over sixty million low-income individuals rely on Medicaid for their health insurance coverage.⁷ The majority of Medicaid beneficiaries are parents and children.⁸ The most medically needy and costly are the elderly and disabled.⁹ For both groups, however, Medicaid is intended to be a lifeline to essential health and medical care.¹⁰ Although Medicaid patients have freedom of choice to select among par-

1. *Memisovski ex rel. Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332, at *18–19 (N.D. Ill. Aug. 23, 2004) (finding that the children in Cook County, Illinois were unable to secure Medicaid covered care, in part because of low reimbursement rates).

2. *Id.* at *18.

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.* at *19.

7. *See* MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC), REPORT TO THE CONGRESS ON MEDICAID AND CHIP 26 (2011) [hereinafter MACPAC REPORT], (noting that today, the Medicaid program “finances health coverage for an estimated 68 million people, about half of whom are children”). In 2009, Congress created the Medicaid and CHIP Payment and Access Commission (MACPAC) specifically to study and make recommendations on beneficiary access to care in Medicaid and the Children's Health Insurance Program (CHIP). *See* 42 U.S.C. § 1396 (2006).

8. *See* MACPAC REPORT, *supra* note 7, at 29.

9. *Id.* at 30. Disabled individuals and individuals age sixty-five and older make up less than one-third of the Medicaid population, yet account for about two-thirds of Medicaid spending. *Id.*

10. *See* Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the “Equal Access” Provision*, 73 U. CHI. L. REV. 673, 675 (2006) (citing *Medicare and Medicaid, Hearings Before the Senate Committee on Finance*, 91st Cong. 57 (1970) (statement of Honorable John G. Veneman, Under Secretary, Department of Health, Education, and Welfare) [hereinafter Moncrieff, *Payments to Medicaid Doctors*] (testifying that providing “mainstream medical care for all the people of this country” was “[t]he whole purpose of the 1965 act”)).

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ticipating providers,¹¹ physicians also have freedom of choice to participate in Medicaid.¹² Congress has recognized that “without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program.”¹³ In fact, low reimbursement rates have led many physicians and particularly specialists to stop treating Medicaid patients.¹⁴

Despite the well-established correlation between Medicaid provider payments and physicians’ willingness to treat Medicaid recipients, states continue to make budget-driven cuts to their Medicaid provider reimbursement rates.¹⁵ Although the economy is improving slowly, states still face a dire fiscal situation and growing Medicaid costs are a key contributor to state budget gaps.¹⁶ As a result, nearly every state has proposed or implemented cuts to Medicaid in their 2011–2012 budget year, reducing payments to doctors, hospitals and other health care providers that treat Medicaid patients.¹⁷ As the stories of

11. The Medicaid Act’s “freedom of choice” provision requires states to ensure that “any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services . . .” 42 U.S.C. § 1396a(a)(23) (2006).

12. See BARRY R. FURROW, ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 562 (3d ed. 1997) (citing 42 U.S.C. § 1396a(a)(23)).

13. OMNIBUS BUDGET RECONCILIATION ACT OF 1989, H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2116.

14. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-11-624, *MEDICAID AND CHIP: MOST PHYSICIANS SERVE CHILDREN BUT HAVE DIFFICULTY REFERRING THEM FOR SPECIALTY CARE* 18 (2011), <http://www.gao.gov/new.items/d11624.pdf>. GAO estimates that for providers who choose not to participate in Medicaid and CHIP, 95% are influenced by low provider reimbursement rates. *Id.*

15. Public scientific studies consistently confirm that access to health care and dental services is generally poor for Medicaid recipients when compared to access enjoyed by the privately insured population, whose provider reimbursement rates are notably higher. See, e.g., Joanna Bisgaier et al., *Disparities in Child Access to Emergency Care for Acute Oral Injury*, 127 *PEDIATRICS* 1428 (2011); Joanna Bisgaier & Karin V. Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance*, 364 *NEW ENG. J. MED.* 2324 (2011); Medical Access Study Group, *Access of Medicaid Recipients to Outpatient Care*, 330 *NEW ENG. J. MED.* 1426 (1994); Asheley C. Skinner & Michelle L. Mayer, *Effects of Insurance Status on Children’s Access to Specialty Care: A Systemic Review of the Literature*, 7 *BMC HEALTH SERV. RES.* 194 (2007).

16. See NAT’L GOVERNORS ASS’N & NAT’L ASS’N OF STATE BUDGET OFFICERS, *FISCAL SURVEY OF STATES: AN UPDATE OF STATE FISCAL CONDITIONS* 28 (2011), <http://www.nga.org/files/live/sites/NGA/files/pdf/FSS1111.PDF>.

17. See VERNON K. SMITH ET AL., *KAISER COMM’N ON MEDICAID AND THE UNINSURED, MOVING AHEAD AMID FISCAL CHALLENGES: A LOOK AT MEDICAID SPENDING, COVERAGE AND POLICY TRENDS* 7 (2011), <http://www.kff.org/medicaid/upload/>

Tessinia Rodriguez, Elissa Bassler, Benita Branch, and Sara Mauk exemplify, cuts to state Medicaid programs can make it difficult, and sometimes impossible, for Medicaid patients to find a doctor who will see them.¹⁸ Cuts in reimbursement rates for providers can and have resulted in dramatic consequences for Medicaid patients.¹⁹ For example, in a highly publicized case, a hospital in Clare, Michigan closed its obstetrical unit in direct response to the state's inadequate Medicaid payments.²⁰

Congress enacted Medicaid in 1965 to ensure that poor and disabled Americans had access to "mainstream" and often life-saving medical services.²¹ The goal was to provide beneficiaries with meaningful access to medical services, not merely a Medicaid card.²² Title XIX of the Social Security Act, 42 U.S.C. § 1396 (Medicaid Act) gives individuals who meet Medicaid eligibility requirements a legal right to have payments made to their providers for their needed medical services.²³ The federal government and states jointly fund services rendered to Medicaid-eligible individuals.²⁴ States receive federal

8248.pdf. A total of thirty-nine states restricted provider rates in FY 2011 and forty-six states reported plans to do so in FY 2012. *Id.*

18. See Moncrieff, *supra* note 10, at 674 (noting that although cutting providers' reimbursements may seem like the best option, it causes providers to refuse Medicaid patients, "leaving program recipients with a welfare entitlement that buys them nothing"); see also Memisovski *ex rel.* Memisovski v. Maram, No. 92-C-1982, 2004 WL 1878332, at *43 (N.D. Ill. Aug. 23, 2004) (finding that "the rates Illinois Medicaid pays simply do not entice medical providers to participate in Medicaid").

19. See Shannon McCaffrey, *State Medicaid Cuts Hit Patients, Doctors*, FISCAL TIMES (Dec. 27, 2011), <http://www.thefiscaltimes.com/Articles/2011/12/27/AP-Medicaid-Cuts-Hit-Patients-Doctors.aspx#page1> (noting that Arizona, for a time, eliminated life-saving transplants for Medicaid patients, and hospital officials in the state blame at least one death on the halt in coverage); see also Robert Pear, *As Number of Medicaid Patients Goes Up, Their Benefits Are About To Drop*, N.Y. TIMES, June 15, 2011, at A24.

20. See Kevin Sack, *As Medicaid Payments Shrink, Patients are Abandoned*, N.Y. TIMES, Mar. 15, 2010, at A1.

21. See *supra* note 10 and accompanying text.

22. See H.R. REP. NO. 89-213, at 66 (1965) (noting that Congress' purpose in establishing the Medicaid program was to provide comprehensive health benefits to "the most needy in the country").

23. See ELICIA J. HERZ, CONGRESSIONAL RESEARCH SERVICE (CRS) 7-5700, MEDICAID: A PRIMER 1-4 (2012) (listing who must receive Medicaid services from the state).

24. 42 U.S.C. § 1396b (2006); see 42 C.F.R. § 430 (2011) (explaining that Medicaid is jointly funded by the states and federal government and administered by the states).

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matching payments for all state spending on covered services.²⁵ To receive federal payments, however, states must implement their Medicaid programs consistent with minimum federal requirements.²⁶ For example, 42 U.S.C. § 1396a(a)(30)(A) requires states to adopt payment rates that “are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”²⁷ This provision is often referred to as the “equal access provision.”²⁸ Today, the Center for Medicare and Medicaid Services (CMS), a subdivision of the United States Department of Health and Human Services (HHS), is charged with the administration of the Medicaid program at the federal level.²⁹ CMS oversees state Medicaid programs to ensure that they comply with the minimum federal requirements promulgated under the Medicaid Act, including the equal access provision.³⁰

This Note discusses Medicaid beneficiaries’ access to health care in the context of the federal Medicaid Act’s equal access provision.³¹ After examining state Medicaid payment policies and legal challenges to state rate cuts specifically, this Note finds that states have failed to comply with and the federal government has failed to enforce the equal access provision of the Medicaid Act.³² This Note concludes

25. See 42 U.S.C. § 1396d(a) (2006) (defining services that qualify as “medical assistance” and therefore receive funding).

26. 42 U.S.C. § 1396a (2006). State participation in the program is voluntary, but states that choose to participate must comply with the provisions of the Medicaid Act and its implementing regulations, 42 C.F.R. §§ 430.0–456.725, which set the program’s parameters and establish its basic requirements. *Harris v. McRae*, 448 U.S. 297, 301 (1980).

27. 42 U.S.C. § 1396a(a)(30)(A) additionally requires that a state provide “methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care.”

28. 42 U.S.C. § 1396a(a)(30)(A).

29. MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *THE LAW OF HEALTH CARE FINANCE AND REGULATION* 186 (2004); see CMS, <http://www.cms.hhs.gov> (last visited Feb. 6, 2012).

30. See HALL, *supra* note 29, at 186.

31. 42 U.S.C. § 1396a(a)(30)(A).

32. Although this Note brings to light many of the shortfalls of the Medicaid program, it is not intended to suggest that Medicaid has not been extremely beneficial. In fact, shortcomings aside, Medicaid has provided health insurance to millions of low-income Americans and markedly improved the position of the poor in the American health care system. See, e.g., JONATHAN ENGEL, *POOR PEOPLE’S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965* xvii (2006) (“Medicaid, although imperfect, has eased access, provided prophylaxis, and delivered procedures.

with policy recommendations that will enhance CMS' oversight of states' payment policies, thereby ensuring that Medicaid beneficiaries have access to meaningful care, as required by the Medicaid Act.

Part I of this Note reviews the history and structure of Medicaid and describes the Medicaid provider payment system in the context of the requirements, history, and rationale of the equal access provision of the Medicaid Act. Part II analyzes administrative tools available to CMS to ensure state compliance with the equal access process, highlighting the limitations of the administrative system. Part III proposes alternative administrative mechanisms by which CMS could hold states accountable where they fail to adopt rates that are adequate to ensure that Medicaid beneficiaries have sufficient access to care, as required by the equal access provision.

I. DECONSTRUCTING MEDICAID

To provide the necessary background and context for the discussion of the limitations of the current Medicaid enforcement scheme discussed in Part II, this Part describes the federal-state partnership in which Medicaid is grounded, providing an overview of both the development and operation of the Medicaid program. First, this Part explains Medicaid's current role in the American health care system and how it grew from a small welfare program to a significant health insurer. Next, this Part focuses on the operation of the Medicaid program, specifically, looking at how the state and federal governments interact to administer state Medicaid programs and set provider reimbursement rates. This Part concludes with a description of litigation challenging Medicaid provider payment policies.

A. The History and Development of Medicaid

Enacted as part of the Social Security Amendments of 1965, Medicaid was created to provide medical care to the poor, blind, and disabled.³³ When first created, most government officials and legislators viewed Medicaid as a welfare program, not health insurance, as Med-

Despite its underfunding and large eligibility gaps, Medicaid has brought the rates of poor people's interactions with private doctors and hospitals up to, and sometimes beyond, the rates posted by the middle class. And despite bizarrely inconsistent reimbursement rates among the various states, Medicaid has improved the life expectancy for all America's poor, regardless of residence.").

33. *See id.* at 48.

icaid eligibility was tied to cash assistance.³⁴ Since its inception, welfare (cash assistance to the poor) has faced forceful opposition, and Medicaid did not escape the welfare stigma.³⁵ Significantly, Medicaid was “de-linked” from welfare in 1996.³⁶ The 1996 Welfare Reform Act ended the federal entitlement to cash benefits for the poor by creating separate welfare programs administered by each state.³⁷ Eligibility for welfare now had no bearing on eligibility for Medicaid.³⁸ By “de-linking” Medicaid and cash assistance, states had greater flexibility in their Medicaid decision-making and Medicaid began to shift out of the welfare frame and into the health insurance frame.³⁹

Today, Medicare and Medicaid are the two largest components of public health care spending in the United States.⁴⁰ Medicare is a federal program that provides health coverage to about forty-seven million Americans, primarily individuals age sixty-five and older but also including several million younger adults with permanent disabilities.⁴¹ Medicaid provides health coverage and long-term care services and supports for sixty million low-income Americans including nearly thirty million low-income children, eleven million persons with disabilities, and six million elderly individuals.⁴² Medicare is financed en-

34. *See id.* at 111 (Medicaid “was essentially a welfare program, not an insurance program, and thus needed to be tightly wedded to existing welfare programs within the statute bureaucracies, lest eligibility standards diverge.”). Medicaid was housed within the existing state welfare departments and Congress described Medicaid beneficiaries as “recipients.” *Id.* at 48–49. By contrast, Medicare beneficiaries were referred to as “beneficiaries,” the usual term describing holders of private insurance policies. *Id.* at 49.

35. *See* Sandra K. Schneider, *The Impact of Welfare Reform on Medicaid*, 28 *PUBLIUS: J. FEDERALISM* 161, 163 (1998).

36. *See id.* at 169.

37. *See* NAT’L HEALTH POLICY FORUM, *ISSUE BRIEF: WELFARE REFORM AND ITS IMPACT ON MEDICAID: AN UPDATE* 5–6 (Feb. 26, 1999), http://www.nhpf.org/library/issue-briefs/IB732_WelfRef&Mcaid_2-26-99.pdf. Immediately following the enactment of welfare reform, Medicaid enrollments declined. But the initial drop in Medicaid was soon followed by remarkable increases in the Medicaid population. *Id.*

38. *Id.*

39. *See id.*

40. *See* JENNIFER JENSEN, CONGRESSIONAL RESEARCH SERVICE, *GOVERNMENT SPENDING ON HEALTH CARE BENEFITS AND PROGRAMS: A DATA BRIEF 2* (2008) (explaining that 77% of public funds allocated to health spending in 2007 was spent on Medicare and Medicaid).

41. *See* KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *THE HENRY J. KAISER FAMILY FOUNDATION, MEDICAID: A PRIMER 1* (2010), <http://www.kff.org/medicaid/upload/7334-04.pdf>.

42. MACPAC REPORT, *supra* note 7, at 10.

tirely with federal money; by contrast, the federal and state governments jointly fund Medicaid.⁴³

In 2002, Medicaid surpassed Medicare for the first time as the largest government health care program, providing benefits to more people than any other public or private insurance program.⁴⁴ Nationally, Medicaid accounts for roughly 17% of all health care spending and 7% of the total federal budget.⁴⁵ During the current economic recession, the number of Medicaid enrollees has grown as the number of Americans affected by loss of work or declining income has risen.⁴⁶ For federal fiscal year 2010, Medicaid spending totaled \$406 billion, with a federal share of \$274 billion and a state share of \$132 billion.⁴⁷ For states, Medicaid represents a major budget item and the largest source of federal revenues.⁴⁸ The majority of spending is to reimburse hospital, physician, and other acute care providers, as well as nursing home and other long-term care services.⁴⁹

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, will significantly expand the Medicaid program in 2014, requiring that states provide Medicaid coverage to all non-disabled adults under age 65 with incomes up to 133% of the federal poverty level.⁵⁰ As a result of expanded eligibility, Medicaid is expected to

43. See CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICAID REIMBURSEMENT AND FINANCE OVERVIEW, available at <https://www.cms.gov/medicaidrf/>; see also *infra* Part I.B.

44. See CENTERS FOR MEDICARE AND MEDICAID SERVICES, *supra* note 43.

45. VERNON K. SMITH ET AL., THE HENRY J. KAISER 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 9 (2009), <http://www.kff.org/medicaid/upload/7985.pdf>.

46. Since the start of the recession more than seven million people have enrolled in Medicaid. See THE HENRY J. KAISER FAMILY FOUNDATION, TOP 5 THINGS TO KNOW ABOUT MEDICAID Fig. 8 (2011), <http://www.kff.org/medicaid/upload/8162.pdf>.

47. MACPAC REPORT, *supra* note 7, at 38.

48. See THE HENRY J. KAISER FAMILY FOUNDATION, KEY QUESTIONS ABOUT MEDICAID AND ITS ROLE IN STATE/FEDERAL BUDGETS AND HEALTH REFORM 1–2 (Jan. 2011), <http://www.kff.org/medicaid/upload/8139.pdf>. Densely populated states spend significantly more money on Medicaid than smaller states. Although differences in population account for some of this variation, payments per enrollee also vary widely by state. *Id.*

49. See *id.* at 2 (“In fiscal year 2009 . . . about three-fifths of federal and state Medicaid spending was on hospital, physician, drugs, and other acute care services; about a third was on nursing home and other long-term care services.”). For example, Medicaid accounts for 17% of all hospital spending. Medicaid Cost-Savings Opportunities, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES (Feb. 3, 2011), available at <http://www.hhs.gov/news/press/2011pres/02/20110203tech.html>.

50. Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 109 (2010). Un-

cover up to eighty million Americans by 2019.⁵¹ It will be the largest payer of health care in the United States, providing health insurance to about sixty million Americans.⁵² Although the ACA dramatically expands Medicaid eligibility, it does little to assure that Medicaid beneficiaries have access to the care and services they require.⁵³ Therefore, this Note argues that HHS, through CMS, must implement additional administrative remedies to ensure state compliance with the equal access provision, which will in turn ensure that Medicaid beneficiaries have access to medical care and services “at least to the extent” they are available to the “general population” in the same geographic area.⁵⁴

B. The Operation of Medicaid: A Federal and State Partnership

Medicaid is entangled in a complex web of relationships between the federal government and the states. As noted above, the federal and state governments jointly fund Medicaid.⁵⁵ In return for agreeing to implement Medicaid according to federal standards, all states receive “federal financial participation” (FFP) for their Medicaid expenditures based on their Federal Medical Assistance Percentage (FMAP).⁵⁶ In other words, the higher a state’s FMAP, the higher the

der the ACA, starting in 2014, twenty million more people will become eligible to enroll in Medicaid. Andrea M. Sisko, et al., *National Health Spending Projections: The Estimated Impact of Reform Through 2019*, HEALTH AFFAIRS 5 (Oct. 2010). Provisions of the ACA, however, have been challenged, and on November 14, 2011, the Supreme Court granted certiorari to consider several questions relating to the constitutionality of the law. See *Florida ex rel. Atty. Gen. v. HHS*, 648 F.3d 1235, 1241 (11th Cir. 2011), *cert. granted*, No. 11-393, 2011 WL 5515162 (U.S. Nov. 14, 2011), *cert. granted*, No. 11-398, 2011 WL 5515164 (U.S. Nov. 14, 2011), *cert. granted in part*, No. 11-400, 2011 WL 5515165 (U.S. Nov. 14, 2011). Among other questions for review, the Court will decide whether the Medicaid expansion amounts to an unconstitutional coercion of state governments. See N.C. Aizenman, *Supreme Court’s Planned Review of Health-Care Law Shocks Medicaid Advocates*, WASH. POST (Nov. 16, 2011), http://www.washingtonpost.com/national/health-science/court-review-of-medicare-expansion-could-have-massive-consequences/2011/11/15/gIQA1LwkSN_story.html (explaining that supporters of the law were surprised and disappointed that the Supreme Court agreed to review the constitutionality of the extension of Medicaid to cover a greater number of the poor).

51. Sisko, *supra* note 50, at 4.

52. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 41, at 1.

53. See Bisgaier & Rhodes, *supra* note 15, at 2324 (“Health care reform has expanded eligibility to public insurance without fully addressing concerns about access.”).

54. 42 U.S.C. § 1396a(a)(30)(A) (2006).

55. See *supra* note 44.

56. 42 U.S.C. § 1396b (2006) (describing the amount of federal funds to which a state is “entitled”).

percentage of a state's Medicaid costs borne by the federal government.⁵⁷ A state's FMAP is based on its per capita income, with no state receiving less than 50%.⁵⁸ Mississippi has the highest FMAP at 74%, meaning that for every twenty-six cents Mississippi spends on Medicaid, the federal government contributes seventy-four cents.⁵⁹ Nationally, the average federal share of Medicaid (i.e. FMAP) is 57% and the states' share is 43%.⁶⁰

In order to receive federal matching dollars, the Medicaid Act requires states to implement their Medicaid programs according to federal standards laid out in the law and corresponding regulations.⁶¹ For example, states are required to abide by the statutory eligibility criteria.⁶² Although states must operate within federal guidelines, the Medicaid Act and its regulations provide states a degree of flexibility in determining eligibility standards, benefits packages, and provider payment rates.⁶³ As discussed in more detail below, a state must submit a State Plan Amendment (SPA) to CMS whenever it makes a "material change" to its Medicaid program.⁶⁴ CMS then reviews the SPA to ensure that the State is complying with the Medicaid law and regulations.⁶⁵ Therefore, even though states retain some flexibility in setting provider reimbursement methodologies, all payment policies must be set forth in the state's Medicaid plan and any payment changes must be reflected in a SPA.⁶⁶

57. See generally ALISON MITCHELL & EVELYNE P. BAUMRUCKER, CONGRESSIONAL RESEARCH SERVICE 7-5700, MEDICAID: THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) (2012).

58. Federal Financial Participation in State Assistance Expenditure, 75 Fed. Reg. 69082, 69082 (Nov. 10, 2010).

59. *Id.* at 69083.

60. *Id.*

61. See MACPAC REPORT, *supra* note 7, at 13.

62. Enrollment is based on categorical and financial eligibility and state residency/citizenship. 42 U.S.C. § 1396a.

63. *Id.*; see Moncrieff, *Payments to Medicaid Doctors*, *supra* note 10, at 675–76 (noting that even as the list of federal requirements has grown, "states still retain a large degree of flexibility in determining requirements for eligibility, in establishing the scope of benefits covered, and in setting rates for reimbursement").

64. 42 C.F.R. § 430.12(c)(ii) (2011).

65. 42 C.F.R. § 430.10 (2011) ("The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program."); see *Alexander v. Choate*, 469 U.S. 287, n.1 (1985) (explaining that state must agree to comply with the federal Medicaid law to receive federal funds).

66. The CMS website explains that CMS reviews State plan amendment reimbursement methodologies for services provided under the State plan for consistency with Section 1902(a)(30)(A) of the Social Security Act and other applicable federal

1. State Medicaid Plans

The Secretary of HHS, through CMS, monitors state Medicaid programs to ensure that states implement their Medicaid programs consistent with minimum federal requirements promulgated under the federal Medicaid Act.⁶⁷ To participate in Medicaid, a state must submit a “plan for medical assistance”⁶⁸ that explains how it will spend its funds.⁶⁹ Although participation is optional, all states have elected to participate in the Medicaid program for the past thirty years, and therefore have submitted State Plans that were originally approved by CMS.⁷⁰

A state must file a SPA with CMS when it seeks to enact a “[m]aterial change [] in State law, organization, or policy” to the state Medicaid program.⁷¹ The SPA must include a comprehensive written statement containing all information necessary for CMS to determine whether the plan can be approved.⁷² CMS reviews SPAs to ensure that any changes to state Medicaid programs comply with a long list of federal statutory and regulatory requirements.⁷³ If the State Plan with the proposed amendment satisfies these criteria, it is approved and the states may receive FFP for any new Medicaid expenditures consistent with the SPA.⁷⁴

When a State submits a proposed SPA to CMS, CMS has ninety days to determine whether the amendment complies with the Medicaid Act.⁷⁵ If CMS does not respond within the ninety days, the amendment is deemed approved and FFP for any additional Medi-

statutes and regulations. *Medicaid Reimbursement & Finance*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.cms.gov/MedicaidRF/>.

67. 42 U.S.C. § 1396a(b) (2006) (“The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) . . .”).

68. 42 U.S.C. § 1396a.

69. *See* Community Health Center v. Wilson-Coker, 311 F.3d 132, 134 (2d Cir. 2002) (“States electing to participate in Medicaid must submit a plan detailing how the State will expend its funds.”). At the state level, Medicaid is administered by a single state agency charged with establishing and complying with a state Medicaid plan that must comply with federal Medicaid law. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 430.10, 431.10 (2011).

70. *See* THE HENRY J. KAISER FAMILY FOUNDATION, *supra* note 48, at 1.

71. 42 C.F.R. § 430.12(c)(1)(ii)

72. 42 C.F.R. § 430.10.

73. *See* 42 C.F.R. § 430.15(a)–(b).

74. 42 C.F.R. § 430.12(c)(2)(ii).

75. 42 C.F.R. § 430.16(a)(1).

caid spending is forthcoming.⁷⁶ If CMS asks for more information, the clock stops until CMS receives the requested information.⁷⁷ After receiving all requested information, CMS has another ninety days to make a decision.⁷⁸ If CMS rejects a proposed SPA, the State is entitled to petition CMS for reconsideration of the issue, and CMS is required to hold a hearing.⁷⁹

In addition and distinct from the SPA approval process, the Secretary of HHS, through CMS, has discretion to withhold FFP from a State if the State does not act in compliance with an approved plan, or if an approved plan no longer complies with the requirements of the Medicaid Act.⁸⁰ Prior to withholding funding, CMS must initiate a compliance action against a State, alleging that the State has failed to abide by Medicaid rules and regulations.⁸¹ When this occurs, CMS must notify the state that

no further payments will be made to the State (or that payments will be made only for those portions or aspects of the program that are not affected by the noncompliance), and [t]hat the total or partial withholding will continue until the Administrator is satisfied that the State's plan and practice are, and will continue to be, in compliance with Federal requirements.⁸²

Federal funding may resume only when CMS is “satisfied that there will no longer be [a] failure to comply” with the requirements imposed by the Medicaid Act.⁸³

76. *Id.*; see *New York ex rel. Perales v. Bowen*, 811 F.2d 776, 779–80 (2d Cir. 1987) (finding that even if amendment to New York's Medicaid plan were “deemed accepted” by failure of the Secretary of Health and Human Services to reject amendment until ninety days after amendment's submission, the Secretary had continuing authority to determine approvability of state Medicaid plans; therefore, Secretary's official rejection of amendment would serve to revoke any implied acceptance of amendment by Secretary's delay in officially rejecting the amendment).

77. 42 C.F.R. § 430.16(a)(2).

78. *Id.*

79. 42 U.S.C. § 1396a(a)(3) (2006).

80. See 42 U.S.C. § 1396c; 42 C.F.R. § 430.35(a); see also CENTER FOR MEDICARE & MEDICAID SERVICES, MEDICAID REIMBURSEMENT & FINANCE, <http://www.cms.gov/MedicaidRF/> (ensuring that [FFP] for the Medicaid program is paid consistently with Federal requirements by reviewing State funding requests and claims); Letter from Timothy M. Westmoreland, Director, Center for Medicaid & State Operations, Health Care Financing Admin., U.S. Dept. of Health & Human Servs., to State Medicaid Directors (Jan. 2, 2011), <http://www.cms.gov/SMDL/downloads/SMD010201.pdf> (explaining that the agency will not provide federal funds for any state plan amendment until the agency approves the amendment).

81. 42 U.S.C. § 1396c; 42 C.F.R. § 430.35(a), (d).

82. 42 C.F.R. § 430.35(d)(1)(i)–(ii).

83. 42 U.S.C. § 1396c.

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Medicaid regulations provide that if a State is dissatisfied with a CMS final determination on a SPA or compliance with Federal requirements, the State may file a petition for judicial review.⁸⁴ The Administrative Procedure Act (APA) additionally provides for judicial review of final agency action.⁸⁵ The APA permits any person adversely affected or aggrieved by agency action to seek judicial review of the lawfulness of that action.⁸⁶ The reviewing court is required to set aside agency action if it finds it to be “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.”⁸⁷ A final determination by CMS regarding the approval of a SPA or a State’s compliance with Federal requirements must be upheld if it was based upon a permissible construction of the relevant Medicaid state.⁸⁸

2. *Provider Payment Rates*

A SPA must be submitted to CMS for approval and must describe the policies and methods to be used to set payment rates for each type of service included in the State Plan.⁸⁹ Although States have flexibility in determining their provider payment policies, including their reimbursement rates, they must receive approval from CMS.⁹⁰

84. 42 C.F.R. § 430.38(a).

85. 5 U.S.C. § 704 (2006).

86. 5 U.S.C. § 702.

87. 5 U.S.C. § 706(2)(A); *see* *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (“[A]n agency rule [is] arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.”).

88. *See* *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984). “[I]f a statute is silent or ambiguous with respect to a specific issue, the question for the court is whether the agency’s answer is based on a permissible construction of the statute.” *Id.* at 843. *Chevron* deference is required “when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and . . . the agency interpretation claiming deference was promulgated in the exercise of that authority.” *United States v. Mead Corp.*, 533 U.S. 218, 226–27 (2001). The Supreme Court has also held that informal agency interpretations of a statute such as those contained in an opinion letter, policy statement, agency manuals, or enforcement guidelines, are not entitled to *Chevron*-style deference. *Christensen v. Harris Cnty.*, 529 U.S. 576, 586–87 (2000); *cf.* *Cal. Hosp. Ass’n v. Douglas*, No. CV 11-9078 CAS, 2011 WL 6820229, at *5 (C.D. Cal. Dec. 28, 2011) (holding that Secretary’s approval of SPA is not entitled to *Chevron* deference).

89. 42 C.F.R. §§ 430.10, 447.201(b) (2011).

90. *See supra* notes 61–63 and accompanying text. In addition to securing federal approval for reimbursement rates and rate cuts, one commentator notes that Section 30(A) of the Medicaid Act sets a ceiling and a floor on payments. That is, “payments

CMS bases its approval on the state Medicaid agency's assurances that the State has complied with all Medicaid payment law and regulations.⁹¹

CMS typically has approved Medicaid payment rate reductions,⁹² although Medicaid reimbursement rates historically have been notably less than those of private payers and Medicare.⁹³ On average, States pay Medicaid providers about 72% of what Medicare pays, which is already below market rate.⁹⁴ Many providers lose money for each Medicaid beneficiary they treat, as reimbursements are on average considerably lower than the costs of providing Medicaid beneficiaries with care.⁹⁵ For example, CMS recently approved a 5% rate

[can] be no more than the cost of providing medical services efficiently and economically, but no less than the cost of providing recipients with access to the same quality of services to which private-market and Medicare patients have access." See Moncrieff, *Payments to Medicaid Doctors*, *supra* note 10, at 677.

91. 42 C.F.R. § 447.256(a)(2); see Jon Donenberg, Note, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 YALE L.J. 1498, 1506 (2008) ("Given the statutory enumeration of the grounds upon which states can modify their Medicaid programs through the SPA process, approval of amendments is generally straightforward and fairly predictable. In some cases, CMS even provides 'preprint' sheets—skeleton forms that state administrators can fill in . . .").

92. See Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) it Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2340 (2010) [hereinafter Moncrieff, *The Supreme Court's Assault*] (noting that CMS has failed to serve a "gatekeeping function" and instead, CMS tends to "rubber-stamp" state plans); Mary K. Reinhart, *Arizona Medicaid Cut Approved by Feds*, ARIZ. REPUBLIC (Nov. 26, 2011), <http://www.azcentral.com/news/election/azelections/articles/2011/11/25/20111125arizona-medicaid-cut-approved-by-feds.html>.

93. See TRICIA M. MCGINNIS, JULIA BERENSON & NIKKI HIGHSMITH, CENTER FOR HEALTH CARE STRATEGIES, INC., INCREASING PRIMARY CARE RATES, MAXIMIZING MEDICAID ACCESS AND QUALITY 2 (2011) (noting that "Medicaid has long reimbursed physician services at a lower rate than private payers and Medicare," which discourages physician participation); Stephen Zuckerman et al., *Trends: Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation*, 4 HEALTH AFFAIRS 374, 379 (2004), <http://content.healthaffairs.org/content/early/2004/06/23/hlthaff.w4.374.full.pdf+html> (noting that nationwide, the average Medicaid reimbursement rate is 69% of Medicare reimbursement).

94. Phil Galewitz, *A Dozen States Slice Medicaid Payments to Doctors, Hospitals*, KAISER HEALTH NEWS (July 6, 2011), <http://www.kaiserhealthnews.org/Stories/2011/July/06/states-cut-medicaid-payments-doctors-hospitals.aspx>. Although different, both Medicare and Medicaid payment systems are prospective rather than retrospective. These prospective payment systems set a fixed rate in advance that does not vary according to the nature or extent of treatment given. See Hall, *supra* note 29, at 300.

95. See WILL FOX & JOHN PICKERING, MILLIMAN, HOSPITAL & PHYSICIAN COST SHIFT: PATIENT LEVEL COMPARISON OF MEDICARE, MEDICAID, AND COMMERCIAL PAYERS 6 (2008), <http://publications.milliman.com/research/health-rr/pdfs/hospital->

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reduction for Arizona health care providers, which means Arizona hospitals will now be paid 70% of what it costs to care for a Medicaid patient.⁹⁶ Many providers have left the Medicaid program due to inadequate payment rates.⁹⁷ So long as state Medicaid programs underpay doctors and hospitals, the poor will face major barriers in accessing essential health care under the program, and will likely suffer worse health outcomes as a result.⁹⁸

Prior to 1980, Medicaid and Medicare rates were determined based on a “reasonable cost” methodology.⁹⁹ States thus had little flexibility in setting payment rates. In the early 1980s, various acts of Congress, including the Omnibus Budget Reconciliation Acts of 1980 and 1981, provided states with enhanced flexibility in setting Medicaid payment

physician-cost-shift-RR12-01-08.pdf (noting that the hospital industry has found Medicaid margins to be on average almost 15% lower than hospital costs).

96. See Reinhart, *supra* note 92. Pete Wertheim, vice president of the Arizona Hospital and Healthcare Association stated that the “cumulative effect of all of these cuts have really begun to take their toll on hospitals.” *Id.* On November 29, 2011, Arizona hospitals filed suit in the U.S. District Court in Phoenix, arguing that “the rate cut will reduce patient access to health care providers, in violation of federal law.” Mary K. Reinhart, *Arizona Hospitals’ Lawsuit Aims to Block Medicaid Cut*, ARIZ. REPUBLIC (Nov. 29, 2011), <http://www.azcentral.com/news/election/azelections/articles/2011/11/29/20111129arizona-hospitals-lawsuit-aims-block-medicare-cut.html>. The President and CEO of the Arizona Hospital and Healthcare Associations stated that “[w]e’re asking the court to prevent . . . cut[s] that will otherwise force hospitals to attempt to shift costs to purchasers of private health insurance The cost shift amounts to a hidden health-care tax on all consumers.” *Id.*

97. See *supra* note 20 and accompanying text (discussing the highly publicized case where a hospital in Michigan was forced to close its obstetrical unit due to the state’s inadequate Medicaid payments, which reimbursed only 65% of the hospital’s costs).

98. Roughly 17% of states reported problems with access to primary care for Medicaid beneficiaries; 36% reported problems with access to specialty care; and 39% reported problems with access to dental care. VERNON K. SMITH ET AL., THE HENRY J. KAISER FOUNDATION, HEADED FOR A CRUNCH: AN UPDATE ON MEDICAID SPENDING, COVERAGE AND POLICY HEADING INTO AN ECONOMIC DOWNTURN; RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2008 AND 2009 55 fig.29 (2008), <http://www.kff.org/medicaid/upload/7815.pdf>.

99. 42 U.S.C. § 1396a(a)(13)(E) (1979) (“reasonable cost related basis”), § 1396a(a)(30) (1976) (“reasonable charges”); see Rosemary H. Ratcliff, Note, *The Mistakes of Medicaid: Provider Payment During the Last Decade and Lessons for Health Care Reform in the 21st Century*, 35 B.C. L. REV. 141, 143 (1993) (“Prior to 1981, states were required to pay all [M]edicaid providers on the basis of uniform [M]edicare “reasonable charges,” which were determined by the Secretary of [HHS].”). For an in depth discussion of “reasonable cost” methodology, see Stephen M. Weiner, “Reasonable Cost” Reimbursement for Inpatient Hospital Services Under Medicare and Medicaid: The Emergence of Public Control, 3 AM. J.L. & MED. 1 (1977).

rates.¹⁰⁰ The key aspect of this change was the adoption of the Boren Amendment, which allowed states to provide payment based on methods and standards, that the state developed, so long as the rates were “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.”¹⁰¹ The Boren Amendment provided states flexibility in payment of providers, but also resulted in significant judicial oversight and scrutiny of states’ Medicaid reimbursement rates.¹⁰² For example, in 1990, the Supreme Court, in *Wilder v. Virginia Hospital Association*,¹⁰³ affirmed that under the Boren Amendment institutional providers had a private cause of action under 42 U.S.C. § 1983, which permitted them to challenge states’ low Medicaid reimbursement rates.¹⁰⁴ Thus, for a period of time, the Supreme Court in *Wilder* and *Wilder’s* progeny¹⁰⁵ held that the Boren Amendment created a cause of action for providers.¹⁰⁶ But as the “burden of covering Medicaid costs grew, States began to ‘clamor’ for the right to run their own programs.”¹⁰⁷ And in 1997, Congress responded by repealing the Boren Amendment, which effectively reduced the likelihood that providers and beneficiaries could raise successful challenges to states’ reimbursement rates.¹⁰⁸

100. See Pub. L. No. 95-499 § 962(a), 94 Stat. 2650 (1980) (Boren Amendment); Pub. L. No. 97-35 § 2173, 95 Stat. 808 (1981) (expanding Boren Amendment to apply to hospitals); Pub. L. No. 97-35 § 2174(a), 95 Stat. 809 (1981) (removing “reasonable charges” language from section 30(A)).

101. Pub. L. No. 96-499, 94 Stat. 2650, § 962(a) (amending Section 1902(a)(13)(E) of the Social Security Act).

102. See Dayna Bowen Matthew, *The “New Federalism” Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973, 983 (2002); see also Ratcliff, *supra* note 99, at 143 (“Recognizing the inherently inflationary nature of these payments, Congress amended the federal Medicaid statute in 1980 and 1981 to allow states flexibility and creativity in payment of providers, within general federal guidelines.”).

103. 496 U.S. 498 (1990).

104. *Id.* at 509–10.

105. See *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997); *Methodist Hosp. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996); *Visiting Nurse Ass’n of N. Shore v. Bullen*, 93 F.3d 997 (1st Cir. 1996); *Ark. Med. Soc’y v. Reynolds*, 6 F.3d 519 (8th Cir. 1993).

106. See Matthew, *supra* note 102, at 983.

107. *Id.*

108. See *id.* at 984.

a. The Equal Access Provision

Repeal of the Boren Amendment meant that federal regulation of state payment policies was left to 42 U.S.C. 1396a(a)(30)(A) (Section (30)(A)).¹⁰⁹ Section (30)(A) requires States to ensure that their payment policies (1) safeguard against unnecessary utilization of care; (2) ensure that payments are consistent with efficiency, economy, and quality of care; and (3) “are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”¹¹⁰ The second requirement sets a ceiling on provider payments, whereas the third requirement, often referred to as the equal access provision, sets a floor.¹¹¹

Medicaid regulations preventing States from setting provider reimbursement rates above the Upper Payment Level (UPL) are derived from the “efficiency” and “economy” language in Section (30)(A).¹¹² The general rule that applies to each category of institutional providers is that “aggregate Medicaid payments to a group of facilities within one of the categories” may not exceed the maximum amount the providers would have received under Medicare.¹¹³ As a result of these regulations, FFP will not be available to states for payments to classes of providers in excess of the UPL.¹¹⁴ Thus, UPL is the federal

109. See 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) (explaining that the repeal of the Boren Amendment “left § 1396a(a)(30) . . . as the primary federal guideline for state reimbursement rates”).

110. 42 U.S.C. 1396a(a)(30)(A) (2006).

[A state plan for medical assistance must] . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. . . .

Id.

111. See *Orthopaedic Hosp.*, 103 F.3d at 1497 (“Congress intended payments to be flexible within a range; payments should be no higher than what is required to provide efficient and economical care, but still high enough to provide for quality care and to ensure access to services.”).

112. See 42 C.F.R. §§ 447.271, 447.272(b), 447.321(b), 447.325 (2011).

113. 42 C.F.R. § 447.321(b)(2).

114. See DEBORAH BACHRACH, CENTER FOR HEALTH CARE STRATEGIES, PAYMENT REFORM: CREATING A SUSTAINABLE FUTURE FOR MEDICAID 7 (2010).

government's tool to ensure that States do not pay too much for Medicaid-covered services.¹¹⁵

The equal access provision of Section (30)(A) is the federal government's tool to ensure that States do not pay too little, thereby impeding Medicaid beneficiaries' access to services. The equal access provision was originally added by amendment in 1989, although it had been implemented previously through federal regulation.¹¹⁶ In codifying the equal access regulation, Congress stated that Medicaid payments must be at a level that "ensures that Medicaid beneficiaries in . . . [a particular geographic] area have at least the same access to physicians as the rest of the insured population in that area."¹¹⁷

Some commentators suggest that in codifying the equal access provision Congress foresaw the temptation States would face to set low reimbursement rates for healthcare providers, particularly when state budgets were tight.¹¹⁸ Even with the enactment of the equal access provision, however, States retain flexibility to establish their own reimbursement rate setting and payment systems. Although the process for setting Medicaid reimbursement rates varies from state to state, across the board state rates have been "significantly lower than those of both Medicare and private insurers."¹¹⁹ This discrepancy is problematic as reimbursement rates are an important determinant of provider participation and access to services for Medicaid beneficiaries.¹²⁰ Generally, there is little incentive for physicians to participate in Medicaid if their payments are too far below market levels.¹²¹

115. ANDY SCHNEIDER & DAVID ROUSSEAU, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, UPPER PAYMENT LIMITS: REALITY AND ILLUSION IN MEDICAID FINANCING 3 (2002), <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14122>.

116. See 42 C.F.R. § 447.204 (2011) ("The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.").

117. OMNIBUS BUDGET RECONCILIATION ACT OF 1989, H.R. REP. NO. 101-247, at 390 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2116.

118. See, e.g., Moncrieff, *Payments to Medicaid Doctors*, supra note 10, at 677.

119. See Rosemary B. Guiltinan, *Enforcing a Critical Entitlement: Preemption Claims as an Alternative Way to Protect Medicaid Recipient's Access to Healthcare*, 51 B. C. L. REV. 1583, 1592 (2010). Frequently, state reimbursement rates are set in a state's budget proposal, and the state agency that administers Medicaid will submit its reimbursement methodology to CMS through a SPA. Alternatively, some states have enacted statutes that prescribe a particular methodology for rate setting or a specific rate for specific medical services. *Id.*

120. See supra notes 13–15 and accompanying text.

121. See Sara Rosenbaum, *Medicaid and Access to the Courts*, 364 N. ENG. J. MED. 1489, 1490 (2011) (suggesting that the equal access provision was included in the Medicaid Act to ensure that the right to Medicaid is more than an "empty prom-

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Thus, low reimbursement rates can impede access to health care for Medicaid beneficiaries.¹²²

On average, states pay 43% of all Medicaid expenditures, and with the exception of Vermont, all States must produce annual balanced budgets (unlike the federal government).¹²³ Thus, States have strong incentives to manage carefully their Medicaid programs' cost growth.¹²⁴ States look to cut Medicaid spending in order to close their budget gaps.¹²⁵ During an economic recession, the economy goes down, while Medicaid enrollment goes up.¹²⁶ "Historically, for every

ise of care"); Bruce C. Vladeck & Stephen I. Vladeck, *Killing Medicaid the California Way*, N.Y. TIMES, Oct. 13, 2011, at A31; see also Andrew R. Gardella, *The Equal Access Illusion: A Growing Majority of Federal Courts Erroneously Foreclose Private Enforcement of § 1396A(A)(30) of the Medicaid Act Using 42 U.S.C. § 1983*, 38 U. MEM. L. REV. 697, 756 (2008) ("When states fail to set economically rational reimbursement rates, providers have no economic incentive to treat Medicaid patients, thus leaving Medicaid beneficiaries without access to medical care."); Guiltinan, *supra* note 119, at 1592–93 ("Physicians frequently cite low Medicaid reimbursement rates as their principal reason for refusing to accept Medicaid patients.").

122. See Guiltinan, *supra* note 119, at 1593; Peter J. Cunningham & Len M. Nichols, *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*, 62 MED. CARE & RES. 676 (2005).

123. Whether all states require a balanced budget can be disputed, depending on the way the requirements are defined. The National Conference of State Legislatures (NCSL) has traditionally reported that forty-nine states must balance their budgets, with Vermont being the exception. Other authorities add Wyoming and North Dakota as exceptions, and some authorities in Alaska contend that it does not have an explicit requirement for a balanced budget. See NATIONAL CONFERENCE OF STATE LEGISLATURES, NCSL FISCAL BRIEF: STATE BALANCED BUDGET PROVISIONS 2 (2010) ("Two points can be made with certainty, however: most states have formal balanced budget requirements with some degree of stringency, and state political cultures reinforce the requirements.").

124. THE HENRY J. KAISER FAMILY FOUNDATION, *supra* note 48, at 2.

125. See NAT'L GOVERNORS ASS'N & NAT'L ASS'N OF STATE BUDGET OFFICERS, *supra* note 16, at 28 (noting that "cost containment in Medicaid is a dominant theme" and "nearly every state implemented at least one new Medicaid policy to address costs in fiscal year 2011." "[A]s in previous years, provider rate restrictions were the most commonly reported cost containment strategy."). For recommendations on containing Medicaid costs without cutting provider rates, see MICHELLE LILIENFELD & JANE PERKINS, NATIONAL HEALTH LAW PROGRAM, FACT SHEET: MEDICAID COST CONTAINMENT WITHOUT HARMING BENEFICIARIES (2011), http://www.healthlaw.org/images/stories/FS_Medicaid_CC_Sept_2011_NHeLPv2.pdf.

126. Therefore, it is not surprising that provider rate reductions and restrictions was the most commonly reported cost containment strategy reported for FY 2011–2012. SMITH ET AL., *supra* note 17, at 7. "A total of 39 states [reduced or] restricted provider rates in FY 2011 and 46 states reported plans to do so in FY 2012." *Id.*; see also THE NATIONAL ASSOCIATION OF STATE BUDGET OFFICERS, MEDICAID COST CONTAINMENT: RECENT PROPOSALS AND TRENDS 2 (2011) ("39 states in Fiscal Year 2010 implemented a provider rate cut or freeze compared to 33 states in FY 2009. In FY 2011, 37 states planned provider rate restrictions."). Increased federal assistance

1% increase in the national unemployment rate, state revenues decline an average of 3 to 4% and enrollment in Medicaid increases by one million new recipients.”¹²⁷ As unemployment rises, more people enroll in state Medicaid programs, but States have less tax revenue to pay for them.¹²⁸ The countercyclical nature of the Medicaid program results in greater Medicaid expenditures, when States can least afford it.¹²⁹ In response, States must look for ways to contain Medicaid expenditures, and reducing provider payments is often seen as the only or best option.¹³⁰

b. Enforcing the Equal Access Provision

State payments policies are under increasing scrutiny. Providers are vociferously opposing budget-driven rate cuts, and policy makers are taking note of the opposition, especially in light of the forthcoming expansion of the Medicaid program under the health reform law. The equal access provision provides a standard by which to judge payment adequacy in Medicaid.¹³¹ On May 6, 2011, CMS issued a proposed amendment to the Medicaid regulations to clarify states’ obligations under the equal access provision and “create a standardized, transparent process for States” to assess whether their rates are

through the American Recovery and Reinvestment Act’s (ARRA) enhanced FMAP helped support state budgets and their Medicaid programs and reduced the state share of Medicaid costs in FY 2009 and FY 2010, but the expiration of these funds means that a large increase in state funding will be necessary for state Medicaid programs in FY 2012. SMITH ET AL., *supra* note 17, at 16.

127. Randy Edwards, *The Medicaid Trap*, H&HN MAGAZINE (Jan. 2010).

128. See NAT’L GOVERNORS ASS’N & NAT’L ASS’N OF STATE BUDGET OFFICERS, *supra* note 16, at 28 (“Medicaid spending, similar to health care spending is projected to increase faster than the economy as a whole.”).

129. See Shefall S. Kulkarni, *Puzzling Out How to Help States with Hard-Hit Medicaid Budgets*, KAISER HEALTH NEWS (Nov. 18, 2011), <http://capsules.kaiserhealthnews.org/index.php/2011/11/puzzling-out-how-to-help-states-with-hard-hit-medicaid-budgets/>.

130. See THE NAT’L ASS’N OF STATE BUDGET OFFICERS, *MEDICAID COST CONTAINMENT: RECENT PROPOSALS AND TRENDS 2* (2011) (“Provider rates are linked to economic conditions and under budget pressure states are often forced to reduce rates until economic conditions improve.”).

131. See *supra* note 14 and accompanying text (noting that Section 30(A) of the Medicaid Act sets a ceiling and a floor on payments). But Section 30(A) does not explicitly mention provider costs or cost studies and three circuit courts have determined that CMS need not consider provider costs in deciding whether or not to approve a State Plan Amendment. See *Rite Aid v. Houstoun*, 171 F.3d 842, 853 (3d Cir. 1999); *Minn. Homecare Ass’n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam); *Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996).

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sufficient.¹³² Prior to the proposal of this rule, states had very little guidance from CMS on how to assess whether state payment policies provide for sufficient access to beneficiaries under Section (30)(A).¹³³ Moreover, even though CMS has the authority to enforce the federal statute against state agencies, “it has never created an enforcement scheme that [has worked] to police state failures.”¹³⁴

Until the rule proposed in 2011, CMS provided little guidance to states on rate-setting and rarely found rates too low, instead focusing its attention on ensuring that rates were not too high.¹³⁵ Historically, Medicaid providers and beneficiaries challenged rate cuts by bringing judicial action against state Medicaid agencies to enjoin states from reducing provider reimbursement rates that allegedly violated the Medicaid Act’s equal access provision.¹³⁶ The federal circuit courts split in their analysis of the substantive requirements of the equal access provision.¹³⁷ But this circuit split on the merits has been put on

132. 76 Fed. Reg. 26342 (May 6, 2011). For further discussion of CMS’ proposed rule see *infra* Part II.A.1.

133. See Rosenbaum, *supra* note 121, at 1490 (explaining that despite the fact that the federal government has had the power to provide oversight of states’ reimbursement rates and compliance with the equal access provision under the federal Medicaid statute for twenty-two years, HHS has “never issued detailed compliance standards, much less enforced them”).

134. Moncrieff, *The Supreme Court’s Assault*, *supra* note 92, at 2341.

135. See Nicole Huberfield, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 462 (2008) (noting that CMS “is notoriously uninterested in enforcing the terms of State plans against the states; instead it seeks cooperation, when it makes demands at all”); see also Matthew, *supra* note 102, at 989–90 (“Researchers have documented the fact that disparity among the states’ Medicaid coverage and expenditures increases as federal oversight of the program decreases.”).

136. See, e.g., *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498 (1990) (allowing private enforcement of a Medicaid Act provision concerning payment for institutional services).

137. The Eighth and Ninth Circuits addressed the procedures a state undertook before setting rates, while the Third and Seventh Circuits focused on the effects of a state’s payment rate. See *Rite Aid v. Houston*, 171 F.3d 842, 851–52, 856 (finding that although the equal access provision only requires a “result,” not a “process,” the process cannot be arbitrary and capricious, but the court noted that “although budgetary provisions may not be the sole basis for a rate revision, they may be considered given that [Section (30)(A)] mandates an economical result”); *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997) (finding that the equal access provision specifically requires that state payment rates “bear a reasonable relationship” to the cost of providing service and that states cannot set payment rates without “responsible cost studies”); *Methodist Hosp. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding that the equal access provision does not require states to conduct access studies in advance of modifying their rates); *Ark. Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 529, 530 (8th Cir. 1993) (finding that the lack of procedural safeguards (i.e. cost studies) combined with the fact that the only apparent justification for the reimbursement

hold. In 2002, the Supreme Court issued a decision that called into question whether Medicaid providers and beneficiaries even have standing to seek judicial relief.¹³⁸ Ten years later, the Supreme Court has yet to take a definitive stance on the standing issue, but the Court's most recent decision in *Douglas v. Independent Living Center of Southern California* undoubtedly suggests that the right of beneficiaries and providers to challenge rate cuts in the courts is dubious at best.¹³⁹

The Medicaid Act, unlike the statute underlying Medicare, does not expressly address the question of whether private parties have access to the courts to prevent injury resulting from state action.¹⁴⁰ Prior to 2002, Medicaid providers and beneficiaries enforced the equal access provision by bringing suit against states pursuant to a civil rights statute, 42 U.S.C. § 1983 (Section 1983).¹⁴¹ In *Gonzaga University v. Doe*,¹⁴² however, the Supreme Court held that a federal law is not privately enforceable unless Congress has unambiguously manifested its intent to confer individual rights on the beneficiary of a statute.¹⁴³ Following this decision, a majority of the circuit courts

cuts was budgetary, meant that the Arkansas Department of Human Services was in violation of the equal access provision).

138. See generally *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002).

139. 132 S. Ct. 546, No. 09-958, 2012 WL 555204 (Feb. 22, 2012). The Court granted certiorari to decide whether Medicaid providers and recipients may maintain a cause of action under the Supremacy Clause to enforce a federal Medicaid law, which providers and beneficiaries argued conflicted with and therefore preempted state Medicaid statutes that reduce payments to providers. *Id.* at *2. In a five to four decision, the Supreme Court remanded the case to the Ninth Circuit to determine whether the plaintiffs' case on the Supremacy Clause can move forward in light of the federal government's post-oral argument approval of the challenged rate reductions. *Id.*; see also Jason Millman, *SCOTUS Punts on Calif. Medicaid Suit*, POLITICO (Feb. 22, 2012), <http://www.politico.com/news/stories/0212/73165.html> (noting that even though the lawsuit is still valid, the Court's opinion suggests that the Supremacy Clause is not the right way to challenge [Medicaid] rate cuts).

140. See Rosenbaum, *supra* note 121, at 1489.

141. See *Rite Aid*, 171 F.3d 842; *Minn. Home Care Ass'n v. Gomez*, 108 F.3d 917; *Orthopaedic Hosp.*, 103 F.3d 1491; *Methodist Hosp., Inc.*, 91 F.3d 1026; *Visiting Nurse Ass'n of N. Shore v. Bullen*, 93 F.3d 997 (1st Cir. 1996); *Ark. Med. Soc'y*, 6 F.3d 519; see also *supra* notes 104–06 and accompanying text (discussing the Supreme Court's judicial enforcement of the now-repealed Boren Amendment in *Wilder* and its progeny). For further discussion of the lawsuits challenging low or reduced Medicaid provider payment rates under 1983, see CALIFORNIA HEALTHCARE FOUNDATION, *MEDICAID PAYMENT RATE LAWSUITS: EVOLVING COURT VIEWS MEAN UNCERTAIN FUTURE FOR MEDI-CAL* (Oct. 2009).

142. 536 U.S. 273 (2002).

143. See *id.* at 280.

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have found the equal access provision unenforceable under Section 1983.¹⁴⁴

Without a cause of action under Section 1983, Medicaid providers and beneficiaries turned to the Supremacy Clause of the Constitution, seeking relief based on a preemption claim.¹⁴⁵ That is, plaintiffs have argued that state laws “interfere with, or are contrary to” federal law.¹⁴⁶ In *Douglas*, a consolidation of several legal challenges,¹⁴⁷ California Medicaid providers and beneficiaries challenged cuts to California’s Medicaid reimbursement rates.¹⁴⁸ Plaintiffs, including pharmacies, health care providers, and senior citizens’ groups, argued that the cuts violated the equal access provision of the Medicaid Act and therefore were preempted by the Supremacy Clause of the U.S. Constitution.¹⁴⁹

144. See *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 702–03 (5th Cir. 2007), *cert. denied* 129 S. Ct. 34 (2008); *N.Y. Ass’n of Homes & Servs. for the Aging, Inc. v. DeBuono*, 444 F.3d 147 (2d Cir. 2006); *Mandy R. v. Owens*, 464 F.3d 1139, 1146–48 (10th Cir. 2006), *cert. denied* 535 U.S. 1305 (2007); *Westside Mothers v. Olszewski*, 454 F.3d 532, 541–43 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 56–59 (1st Cir. 2004); see also SARAH SOMERS, NATIONAL HEALTH LAW PROGRAM, SUPREME COURT GRANTS REVIEW OF MEDICAID CASES 3 (Jan. 2011). For further discussion of the judicial enforcement of the equal access provision following *Gonzaga*, see generally JANE PERKINS, NATIONAL HEALTH LAW PROGRAM, UPDATE ON PRIVATE ENFORCEMENT OF THE MEDICAID ACT PURSUANT TO 42 U.S.C. § 1983 (Nov. 2011); Gardella, *supra* note 121; Brian J. Dunne, *Enforcement of the Medicaid Act Under 42 USC § 1983 After Gonzaga University v. Doe: The “Dispassionate Lens” Examined*, 74 U. CHI. L. REV. 911 (2007).

145. See *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal.*, 572 F.3d 644, 650 (9th Cir. 2009); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006).

146. *Lankford*, 451 F.3d at 509–10 (quoting *Wisc. Pub. Intervenor v. Mortier*, 510 U.S. 597 (1991)).

147. The consolidated cases encompassed five lawsuits and produced seven decisions of the Court of Appeals for the Ninth Circuit. See *Santa Rosa Memorial Hosp. v. Maxwell-Jolly*, 380 F. App’x. 656 (9th Cir. 2010); *Dominguez v. Schwarzenegger*, 596 F.3d 1087 (9th Cir. 2010); *Cal. Pharm. Ass’n v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010); *Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly*, 374 F.App’x 690 (9th Cir. 2010); *Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly*, 342 F. App’x. 306 (9th Cir. 2009); *Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009); *Cal. Pharm. Ass’n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009).

148. 132 S. Ct. 546, No. 09-958, 2012 WL 555204 (Feb. 22, 2012).

149. Brief for Petitioners, *Douglas*, 2012 WL 555204 (No. 09-958), 2011 WL 2062344, at *26. For an in depth discussion of whether providers and beneficiaries can enforce the equal access provision through the Supremacy Clause, see Matthew McKennan, *Medicaid Access After Health Reform: The Shifting Legal Basis for Equal Access*, 7 SETON HALL CIRCUIT REV. 477, 499–503 (2011); Guiltinan, *supra* note 119, at 1601–22; Sayles, *supra* note 109, at 136–48.

The lawsuits were filed after California lawmakers in 2008 and 2009 passed three statutes reducing reimbursement rates.¹⁵⁰ Medicaid providers and beneficiaries filed a series of lawsuits seeking to enjoin the rate reductions on the ground that they conflicted with and therefore were preempted by federal Medicaid law, specifically, the equal access provision.¹⁵¹ The Ninth Circuit ultimately affirmed or ordered preliminary injunctions that prevented the State from implementing its statutes.¹⁵²

While these cuts were being challenged in the courts, California was also seeking approval from CMS.¹⁵³ Although the cuts were effective July 1, 2008, California did not submit SPAs regarding the rate cuts until September 30, 2008.¹⁵⁴ Over two years after California had implemented its rate cuts, CMS denied the SPA on November 18, 2010, for lack of adequate information.¹⁵⁵ California sought reconsideration of CMS' disapproval and a hearing to reconsider was held on February 10, 2011.¹⁵⁶

Meanwhile, California appealed the Ninth Circuit's decision to enjoin California's rate cuts and the Supreme Court granted certiorari to decide whether Medicaid providers and recipients may maintain a cause of action under the Supremacy Clause to enforce a federal Medicaid law.¹⁵⁷ On October 27, 2011, less than a month after the

150. See *Douglas*, 2012 WL 555204.

The first statute, enacted in February 2008, reduced by 10% payments that the State makes to various Medicaid providers, such as physicians, pharmacies, and clinics. See 2007–2008 Cal. Sess. Laws, 3d Extraordinary Sess. Ch. 3, §§ 14, 15. The second statute, enacted in September 2008, replaced the 10% rate reductions with a more modest set of cuts. See 2008 Cal. Sess. Laws ch. 758 §§ 45, 57. And the last statute, enacted in February 2009, placed a cap on the State's maximum contribution to wages and benefits paid by counties to providers of in-home supportive services. See 2009–2010 Cal. Sess. Laws, 3d Extraordinary Sess. Ch. 13 § 9.

Id. at *3.

151. See *id.*

152. See *id.*

153. See *id.* at *4.

154. See Brief of Intervenor Respondents, *Douglas*, 2012 WL 555204 (No. 09-958), 2011 WL 3288335, at *6.

155. See Notice of Hearing: Reconsideration of Disapproval of California State Plan Amendments (SPAs) 08-009A; 08-009B1; 08-009B2; 08-009D; and 08-019, 75 Fed. Reg. 80058-01 (Dec. 21, 2010).

156. *Id.*

157. See *Douglas*, 2012 WL 555204, at *2.

Supreme Court heard oral argument in the *Douglas* case,¹⁵⁸ CMS approved some of California's rate cuts.¹⁵⁹ In light of CMS' decision, the Supreme Court in *Douglas*, in a five to four decision, vacated the Ninth Circuit's judgments and remanded the cases.¹⁶⁰ Justice Breyer, writing for the majority, found that although the case was not moot, the lower courts would have to determine whether the plaintiffs could continue to proceed under the Supremacy Clause or should instead challenge CMS' approval of California's rate cuts under the APA, noting the deference generally given to agency decision-making.¹⁶¹ The majority opinion notes that "to allow a Supremacy Clause action to proceed once the agency has reached a decision threatens potential inconsistency or confusion."¹⁶² Although the majority declined to decide whether the Supremacy Clause provides a cause of action to enforce the requirements of the Medicaid Act, the opinion casts doubt on the availability of a cause of action under the Supremacy Clause.¹⁶³

According to both California¹⁶⁴ and the federal government,¹⁶⁵ HHS, through CMS, is responsible for enforcing the equal access pro-

158. Oral argument took place on October 3, 2011. See Transcript of Oral Argument, at 2, *Douglas*, 2012 WL 555204, http://www.supremecourt.gov/oral_arguments/argument_transcripts/09-958.pdf.

159. See *Department of Health Care Services (DHCS) Announce Federal Approval of Medical Budget Reductions*, CALIFORNIA DEP'T OF HEALTH CARE SERVICES (Oct. 27, 2011), <http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/11-06%20SPA%20Approvals.pdf>. CMS based its decision to ultimately approve many of California's cuts on a study submitted by the state to CMS indicating that cuts would not curtail access to care and that DHCS would also set up a data collection and monitoring plan "to ensure that access to care is not compromised as the reductions are implemented." CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, MONITORING ACCESS TO MEDI-CAL COVERED HEALTHCARE SERVICES (2011), <http://www.dhcs.ca.gov/Documents/Rate%20Reductions/Developing%20a%20Healthcare%20Access%20Monitoring%20System.pdf>.

160. See *Douglas*, 2012 WL 555204, at *6.

161. *Id.* at *5.

162. *Id.*

163. *Id.* at *6. Instead, the majority suggests that the changed circumstances may require the respondents to proceed by seeking review of the agency determination under the Administrative Procedure Act (APA). *Id.* at *5.

[The] agency decision does not change the underlying substantive question, namely whether California's statutes are consistent with a specific federal statutory provision But it may change the answer. And it may require respondents now to proceed by seeking review of the agency determination under the Administrative Procedure Act (APA), 5 U.S.C. § 701 *et seq.*, rather than in an action against California under the Supremacy Clause.

Id.

164. See Brief for Petitioners, *supra* note 149, at *26 (arguing that the purposes of Section (30)(A) reflected in the statute's text and structure and the legislative history is to preserve and enhance "the States' flexibility to control and reduce costs and in-

vision, not the courts.¹⁶⁶ Although Medicaid law and regulations create an administrative enforcement scheme to ensure that states' reimbursement rates do not violate the equal access provision, many have argued, including former HHS officials, that exclusive enforcement by the federal agency is "logistically, practically, legally and politically unfeasible."¹⁶⁷ By contrast, others suggest that shifting enforcement of the equal access provision from judicial forums to executive agencies may be wise.¹⁶⁸ Part II of this Note examines the administrative compliance mechanisms available to and utilized by CMS, considering whether the administrative processes established under the Medi-

crease the efficiency of Medicaid," and to centralize "enforcement authority in HHS," and to protect the "States from private lawsuits that drive up the cost of Medicaid").

165. Brief for the United States as Amicus Curiae Supporting Petitioner, *Douglas*, 2012 WL 555204 (No. 09-958), 2011 WL 2132705, at *31-*32 (arguing Section 30)(A)'s language suggests that a nonstatutory private right of action should not be recognized and that the "administrative process brings to bear 'the expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decisionmaking'" (citing *Gonzaga Univ. v. Doe*, 536 U.S. 273, 292 (2002) (Breyer, J., concurring))). *But see* Brief of Former HHS Officials as Amici Curiae Supporting Respondents, *Douglas*, 2012 WL 555204 (No. 09-958), 2011 WL 3706105, at *5 ("Private enforcement . . . provides a means for meaningful statutory enforcement both until and unless the Secretary has the opportunity to exercise her discretion, and to ensure that the Secretary is acting within her discretion.").

166. *See* Rosenbaum, *supra* note 121, at 1490 (noting that the state argues that enforcement of Medicaid law by the federal government is sufficient); Vladeck, *supra* note 121.

167. Brief of Former HHS Officials, *supra* note 165, at *3.

First, because the Medicaid Act contemplated—and has historically been understood to allow—direct redress by beneficiaries, neither CMS nor HHS has the resources to provide comprehensive oversight of state-by-state compliance with the equal access provision. Second, because funds for the administration of Medicaid are provided by appropriation, they are subject to far greater congressional budget constraints than Medicaid benefits. Third, as CMS itself has repeatedly conceded, it is limited both practically and legally in its authority to both enforce § 30(A) and provide remedies for violations thereof. Fourth, and finally, even in the absence of such constraints, the "cooperative federalism" behind Medicaid means that the Executive Branch is under far more political pressure from states than from private parties.

Id. at *3-*4.

168. *See* Moncrieff, *The Supreme Court's Assault*, *supra* note 92, at 2382 (noting that judges are bad at understanding, evaluating, and creating health care regulations and suggesting that "we should embrace the reallocation of regulatory authority" because "federal executive agencies are significantly better positioned" than the courts). *See generally* Timothy Stoltzfus Jost, *Health Law and Administrative Law: A Marriage Most Convenient*, 49 ST. LOUIS U. L.J. 1 (2004) (suggesting that there are advantages to having the executive branch regulate health care over both the judiciary and the market).

caid law and regulations provide a sufficiently powerful tool to enable CMS to ensure compliance with the equal access provision.

II. ASSESSING THE ADMINISTRATIVE ENFORCEMENT SCHEME WITH RESPECT TO THE EQUAL ACCESS PROVISION

As discussed in Part I, there are two primary administrative remedies available to CMS to ensure state compliance with the federal Medicaid Act, including the equal access provision.¹⁶⁹ First, through the SPA process, CMS is able to review and approve or disapprove a state's payment policies and any amendments thereto.¹⁷⁰ If CMS disapproves a state plan or plan amendment, the state may seek reconsideration from the agency.¹⁷¹ If the agency subsequently upholds the decision, the state may petition for judicial review under Medicaid regulations and private parties, and states may challenge final agency action under the APA.¹⁷² Second, and separate and apart from the SPA process, the Secretary has the discretion to deny federal funds if the state's payment policies do not comply with the equal access provision.¹⁷³

Neither the SPA process nor the authority to withhold federal funds, however, appear to be effective tools for ensuring state compliance with the equal access provision.¹⁷⁴ This procedural shortfall is because states do not require additional federal matching dollars when they decrease rates and therefore often act before the federal government has completed the SPA procedure.¹⁷⁵ And, as noted above, aggrieved parties have previously sought injunctive relief under Section 1983 of the Civil Rights Act, and more recently, under the Supremacy Clause; however, the Supreme Court's decisions in *Gonzaga* and *Douglas* strongly suggest that these judicial avenues are no longer viable, highlighting the need for an effective and timely administrative remedy.¹⁷⁶

169. See *supra* Part I.B.

170. See *supra* notes 71–73 and accompanying text.

171. See *supra* note 79 and accompanying text.

172. See *supra* notes 84–88 and accompanying text.

173. See *supra* note 80 and accompanying text.

174. See *supra* notes 132–35 and accompanying text. The U.S. Government Accountability Office has criticized CMS for poor oversight of the states, emphasizing holes in the data provided by the states. See George France, *The Form and Context of Federalism: Meanings for Health Care Financing*, 33 J. HEALTH POL. POL'Y & L. 649, 689 (2008).

175. See *infra* notes 180–188 and accompanying text.

176. See *supra* notes 143–44, 163 and accompanying text.

A. SPA Process

Requiring states to seek approval from CMS through the SPA process gives CMS the opportunity to review a state Medicaid plan to determine whether the state is in compliance with federal Medicaid laws and regulations.¹⁷⁷ When states seek to increase reimbursement rates, they submit a SPA describing the planned increase in order to receive federal approval before they implement.¹⁷⁸ States will delay implementation pending approval because they want to be certain that federal matching dollars will be forthcoming with respect to the increased payment amount.¹⁷⁹ There is no comparable incentive to delay implementation with respect to a rate decrease. In fact, states do not always submit a SPA when decreasing reimbursement rates. States do not need more federal matching dollars in this situation; they need less. In addition, states are anxious to reap the budgetary relief connected with rate cuts.

CMS often withholds approval of SPAs that seek to increase reimbursement rates in violation of Section (30)(A) and the UPL;¹⁸⁰ however, there are few examples of CMS denying SPAs that cut reimbursement rates.¹⁸¹ Given its financial participation, the federal government has a strong incentive to provide substantial oversight of states' efforts to increase provider rates, as approval would result in the federal government having to pay more money to the states.¹⁸² By contrast, CMS has less incentive to deny a SPA that seeks to cut reimbursement rates in a way that may violate the equal access provi-

177. See *supra* notes 65–69 and accompanying text.

178. See *supra* note 89 and accompanying text (explaining that federal funds will not be provided for any state plan amendment until the agency approves the amendment).

179. Without federal funds, state budget expenditures would rise by 22.5%, which one commentator suggests would create an unbearable burden for any state, especially in the midst of a nationwide fiscal crunch. See Peter Suderman, *ObamaCare's Medicaid Mandate*, WALL ST. J. (Feb. 10, 2012), http://online.wsj.com/article/SB10001424052970203824904577213642801222230.html?mod=googlenews_wsj.

180. See Moncrieff, *Payments to Medicaid Doctors*, *supra* note 10, at 682 n.43 (noting that the federal government commonly relies on a state's violation of Section (30)(A) and the regulatory UPL to justify a disallowance of FFP).

181. See CALIFORNIA HEALTHCARE FOUNDATION, MEDICAID PAYMENT RATE LAWSUITS: EVOLVING COURT VIEWS MEAN UNCERTAIN FUTURE FOR MEDI-CAL 4 (2009) (“In practice, federal agency oversight and action primarily has been focused on restricting state payments to providers, while enforcement of beneficiary safeguards has been relatively limited.”).

182. See Moncrieff, *The Supreme Court's Assault*, *supra* note 92, at 2341 (“On the occasion that CMS does reject state plans or insist on amendments thereto, it almost always does so to protect its own funds from perceived state raids.”).

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sion.¹⁸³ Former HHS officials point out that there is no realistic financial incentive for CMS to enforce aggressively the equal access provision against states' cutting rates, since violations of the provision would save the federal government money.¹⁸⁴ Instead, since CMS has discretion to take action against non-compliant states, the federal government often prefers to seek "cooperation"¹⁸⁵ from states that want to cut reimbursement rates rather than disapproving SPAs or withholding federal funds. In the past, CMS has focused almost exclusively on ensuring that payment rates are not too high and do not exceed the UPL. More recently, CMS has expanded its focus to include rate reductions in light of state budget-driven rate cuts that threaten to reduce provider capacity just as millions more Americans will become eligible for Medicaid in 2014.¹⁸⁶

Until recently, CMS had "sought to monitor and promote access through informal processes, principally by raising the issue of the adequacy of rates in meetings and correspondence with state authorities."¹⁸⁷ Even the proposed rule CMS published in May 2011 reflects this approach, creating new means of promoting adherence to Section (30)(A) short of federal disapproval or compliance proceedings.¹⁸⁸

183. *See id.*

184. Brief of Former HHS Officials, *supra* note 165, at *25-*26 ("If anything, because poorer states tend to have the highest percentage of their Medicaid outlays reimbursed by the federal government, the states under the greatest pressure to cut costs will be those in which the federal government spends (and stands comparatively to save) the highest proportion of funds.").

185. Huberfield, *supra* note 135, at 462 (explaining that CMS monitors states' compliance with federal rules through informal processes).

186. *See* Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342, 26348 (proposed May 6, 2011) (noting that since 2008, CMS has asked states to provide more information "to help the agency determine that the changes to rates resulting from State plan amendments will continue to provide for access to care consistent with the Act and the implementing regulations").

187. Brief of Former HHS Officers, *supra* note 165, at *25 (citing Brief of Amicus Curiae Secretary of Health & Human Services at 12, *Clark v. Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990) (No. 87-1700)). States may be more inclined to "cooperate" with the federal government when they are in need of federal matching funds, but may be less inclined where they simply want to cut Medicaid funding. For example, after California submitted a SPA to HHS regarding rate cuts on September 30, 2008, CMS requested that California provide additional information, but California never responded. Instead, California continued to implement the rate cuts without CMS approval. *See* Brief of Intervenor Respondents, *supra* note 154, at *6.

188. *See* Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342, 26345 (proposed May 6, 2011). At the time this Note was written, CMS had not issued a final rule. Unfortunately, there is no way of knowing whether the final rule will look anything like the proposed rules. Moreover, proposed rules take a long time to be finalized as they often face enormous political

The proposed rule seeks to clarify and reinforce that beneficiary access must be considered in setting and adjusting payment methodologies for Medicaid services and emphasize that payment rate changes are not in compliance with the equal access provision if they result in a denial of sufficient access to covered care and services.¹⁸⁹

The proposed rule provides a framework for states to assess access to care.¹⁹⁰ States would be required to conduct medical assistance access reviews¹⁹¹ for every covered Medicaid service.¹⁹² Under the proposed rule, if a state Medicaid agency seeks to reduce or restructure Medicaid payment rates, the agency would be required to submit, along with the SPA, an access review for the service in question that has been completed within the prior twelve months and that demonstrates sufficient access.¹⁹³ Finally, the agency would have to develop procedures to monitor continued access to care after implementation of the payment rate reduction or restructuring.¹⁹⁴ The rule's access framework, CMS contends, is intended to provide additional guidance to states on the standards the states must follow to demonstrate that their Medicaid beneficiaries have sufficient access to medical services.¹⁹⁵

pressures from states and other stakeholders. See THE HENRY J. KAISER FAMILY FOUNDATION, PROVIDER PAYMENT AND ACCESS TO MEDICAID SERVICES: A SUMMARY OF CMS' MAY 6 PROPOSED RULE 3, (2011) ("Given the high level of interest in the proposed rule . . . and the different perspectives . . . on . . . whether it goes far enough or too far, it is difficult to anticipate what shape the final rule will take."); Sara Rosenbaum, *Medicaid and Access to Health Care—A Proposal for Continued Inaction?*, 365 N. ENGL. J. MED. 102, 103 (2011).

189. See Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342, 26,343 (proposed May 6, 2011); THE HENRY J. KAISER FAMILY FOUNDATION, *supra* note 188, at 1.

190. See THE HENRY J. KAISER FAMILY FOUNDATION, *supra* note 188, at 1.

191. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342, 26345 (proposed May 6, 2011).

192. Such reviews are not currently required. The state Medicaid agency would have to review access to a subset of Medicaid-covered services every year, and review access to every Medicaid-covered service at least once every five years. Each state would have discretion as to the measures it uses to analyze access to care and the services it reviews in any given year.

THE HENRY J. KAISER FAMILY FOUNDATION, *supra* note 188, at 2.

193. Along with the SPA, the agency would also have to submit an analysis reflecting its consideration of beneficiary and stakeholder input on the impact of the proposed rate change on continued access to the affected service. *Id.*

194. *Id.*

195. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342, 26348 (proposed May 6, 2011).

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Notably, the proposed rule does not specify what, if any, consequences states would face if they failed to comply with the new requirements.¹⁹⁶ Although the proposed rule acknowledges that states have previously failed to take access determinations seriously,¹⁹⁷ the rule notes that rather than disapproving state rate cuts or instituting compliance actions against states whose cuts violate the equal access provision, CMS' strategy "is designed to allow for State and Federal review of beneficiary access to evolve over time and for States to implement effective and efficient approaches and solutions that are appropriate to their local and perhaps changing circumstances."¹⁹⁸ Several comments to the proposed rule argue that the rule "does not go far enough in establishing a mechanism for measuring access to care that is . . . enforceable."¹⁹⁹ Although the proposed rule may provide a useful framework for states to assess whether provider reimbursement rates comply with the equal access provision and are sufficient to ensure access to services, it does not provide a clear remedy to compel compliance when state resources are sparse.²⁰⁰

Significantly, the Medicaid Act and regulations are unclear as to whether CMS approval is required before states may implement rate cuts.²⁰¹ In *Exeter Memorial Hospital Ass'n v. Belshe*,²⁰² the Ninth

196. See Rosenbaum, *supra* note 188, at 103 (describing the proposed rules as a "model of inaction").

197. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342, 26348 ("When asked for additional detail on the methodology that States used to determine compliance with the access requirement, only a few States indicated that they relied upon actual data to make a determination.").

198. *Id.* at 26344. The proposed rule, however, goes on to clarify that at § 447.204(b) CMS "may disapprove a proposed rate reduction or restructuring SPA that does not include or consider the data review and a public process." *Id.* at 26352. Alternatively, CMS can take compliance action in accordance with regulation at 42 C.F.R. § 430.35 in these instances. *Id.*

199. Comment of Center on Budget and Policy Priorities at 1 (July 5, 2011), in response to Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342.

200. See Rosenbaum, *supra* note 188, at 103 (noting that "because the rule specifies neither standards for adequate access nor an independent evidentiary process, it would be nearly impossible for the federal government to enforce the rule."); see also Comment of Greater New York Hospital Association, at 3 (July 5, 2011), in response to Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (noting that states must have flexibility to develop measures to demonstrate compliance with the access measurement framework "given the limited resources that many state Medicaid programs have to devote to such analyses.").

201. See 42 C.F.R. § 430.12(c)(2) ("Prompt submittal of amendments is necessary . . . [s]o that CMS can determine whether the plan continues to meet the requirements for approval, [and] to ensure the availability of FFP.").

202. 145 F.3d 1106 (9th Cir. 1998).

Circuit held that California's Medicaid agency could not implement a SPA that was submitted to CMS but not yet approved.²⁰³ California argued that the rate cuts were in compliance with the (now repealed) Boren Amendment, and thus could be implemented.²⁰⁴ The Court found that to permit implementation before a SPA is approved would put "a reimbursement rate in place for a considerable time period that had never been approved, that may not be approved, and that may be inadequate under the standards set in the statute and regulations."²⁰⁵ The legal impact of the *Exeter* decision, however, is unclear. Some courts have recognized its legal authority,²⁰⁶ while others argue that the case does not apply to post-Boren Amendment rate setting.²⁰⁷ Another court recognized the *Exeter* holding but found that the courts are split on the issue.²⁰⁸

Arguably consistent with the holding in *Exeter*, CMS issued guidance in October that suggests that implementation is not permitted prior to SPA approval.²⁰⁹ The letter to all State Medicaid Directors (SMD) stated that "[f]ederal statute and regulations require CMS to review and approve [plan amendments] . . . before a state may implement Medicaid program modifications."²¹⁰ At least one court,

203. *Id.* at 1108; see *AGI-Bluff Manor, Inc. v. Reagen*, 713 F. Supp. 1535, 1552 (W.D. Mo. 1989) ("The Medicaid Act and HHS regulations require that a state Medicaid plan or an amendment to the plan receive federal approval from [CMS] prior to implementation.").

204. *Exeter Mem'l Hosp. Ass'n*, 145 F.3d at 1108.

205. *Id.* at 1124 (quoting *Exeter Mem'l Hosp. Ass'n v. Belshe*, 943 F. Supp. 1239, 1243 (E.D. Cal. 1996)).

206. See *Cal. Hosp. Ass'n v. Maxwell-Jolly*, 776 F. Supp. 2d 1129, 1136 (E.D. Cal. 2011) ("Any amendment to the State Plan, including changes in the methodology for determining reimbursement rates, cannot be implemented until the amendment has been approved by CMS.").

207. See Appellants Joint Opening Brief, *Cal. Ass'n of Health Facilities v. Douglas*, No. 11-558851 (9th Cir. June 23, 2011), 2011 WL 2617609 at *10-*11.

208. *Compare* *Cnty. Pharmacies of Ind. v. Ind. Family & Soc. Servs. Admin.*, No. 1:11-cv-0893-TWP-DKL, 2011 WL 4102804, at *6 (S.D. Ind. Sept. 14, 2011) (finding that the Seventh Circuit has maintained the position that proposed amendments may be implemented before approval is received), with *Exeter Mem'l Hosp. Ass'n*, 145 F.3d at 1108 ("[A]pproval is required before implementation of amendments to the Plan.").

209. See Letter from Cindy Mann, Director, Ctrs. for Medicare & Medicaid Services to State Medicaid Director & State Health Official 1 (Oct. 1, 2010), http://www.dmh.ca.gov/services_and_programs/medi_cal/docs/SMD10_020SPARReviewProcess.pdf.

210. *Id.* The letter also states that although "[i]n the past, the review process has required that any issue identified during the review of SPA must be resolved . . . States will now have the option to resolve the issues related to State plan provisions that are not integral to the SPA through a separate process." *Id.* Cuts to reimburse-

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however, refused to give this letter “considerable weight” in determining whether approval was required before states implement rate reductions because “CMS has not exactly been a model of consistency on this issue.”²¹¹ Additionally, the proposed rule, which was published after the SMD letter, contains no language even suggesting that CMS requires approval prior to states’ implementation of rate cuts.

As CMS has failed to state explicitly whether prior approval is required, states have continued to implement rate reductions before CMS review. For example, as noted above, California enacted²¹² and implemented²¹³ its 2008 and 2009 rate cuts before California even submitted its SPA to CMS and continued even after HHS originally disapproved them.²¹⁴ California has specifically taken the position

ment rates, however, are integral to any SPA. The argument could also be made that approval is required only when states are seeking to qualify for additional federal funds. See Brief for the United States as Amicus Curiae, *supra* note 165.

211. *Cnty. Pharmacies of Ind. v. Ind. Family & Social Servs. Admin.*, No. 1:11-cv-0893-TWP-DKL, 2011 WL 4102804, at *7 (S.D. Ind. Sept. 14, 2011).

212. California’s Assembly Bill 5 was chaptered on Feb. 16, 2008. Assembly Bill No. 5, 2007–2008 Leg., 3d Ex. Sess. (Cal. 2008), An act to amend Section 95004 of the Government Code and to amend Sections 4640.6, 4643, 4648.4, 4681.3, 4681.5, 4691.6, 4781.6, and 4783 of, and to add Sections 4681.6, 4689.8, 4691.9, 14041.1, 14105.19, and 14166.245 to, the Welfare and Institutions Code, relating to health, and declaring the urgency thereof, to take effect immediately.

213. California’s Assembly Bill 5 reduced provider reimbursement rates by 10% “on and after July 1, 2008.” *Id.*

214. See Transcript of Oral Argument, *supra* note 158, at 6 (Justice Kagan questioned whether California made an “end-run” around the administrative process by putting “new rate schedules [] into effect even before [California] submitted them to HHS, and continued them in effect while HHS was considering them, and continued them in effect to the extent [California was] allowed to do so by injunction, even after HHS disapproved them.”); see also *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002); *supra* notes 155–59 and accompanying text (explaining that California sought reconsideration of CMS’ disapproval, a hearing to reconsider was held on February 10, 2011, and CMS ultimately approved California’s rate cuts on October 27, 2011). In light of CMS’ approval of California’s rate cuts, the Supreme Court asked the parties in *Douglas* to submit briefing on the effect of CMS’ action. See *Douglas v. Indep. Living Ctr. of S. Cal.*, 132 S. Ct. 546, No. 09-958, 2012 WL 555204 (Feb. 22, 2012). In their briefs, the Solicitor General and California Attorney General asked the Court to decide the case, see Letters from Donald B. Verrilli, Jr., Solicitor Gen. U.S. Dep’t of Justice, and Karin S. Schwartz, Dep. Attorney Gen. Cal. Dep’t of Justice, to Hon. William K. Suter, Clerk, U.S. Supreme Court (Nov. 18, 2011), while the providers and beneficiaries argued that the Court should dismiss certiorari as improvidently granted based on the intervening events. See Letters from Carter G. Phillips, Sidley Austin LLP, and Lynn S. Carmen to Hon. William K. Suter, Clerk, U.S. Supreme Court (Nov. 18, 2011). More recently, the California Hospital Association (CHA) petitioned a federal district court to grant a preliminary injunction against the California’s Medicaid program, to prevent it from making 10% reimbursement cuts primarily affecting hospital-based skilled nursing facilities. See Melanie Evans, *Injunction Sought Against Calif. Medicaid Rate Cut*, MODERN HEALTHCARE (Nov. 22,

that the *Exeter* decision does not apply to post-Boren Amendment rate setting and therefore it is free to go ahead and implement rate reductions prior to CMS approval.²¹⁵

The proposed rule fails to resolve this ambiguity. Many commentators argued that the final rule should state explicitly that CMS prohibits states from implementing any SPA that reduces or restructures payment rates until CMS approval is obtained.²¹⁶ Even if the final rule, however, were to specify that CMS approval is required before states may implement reimbursement rate cuts, there is limited action that can be taken against states for non-compliance. The provisions of the Medicaid Act that allow CMS to withhold some or all of a state's federal matching dollars if they are out of compliance are the intended mechanism for holding states accountable for their Medicaid obligations.²¹⁷ Neither the proposed rule nor the current Medicaid rules specify an alternative penalty and as discussed below, CMS almost never withholds federal matching funds.

B. Compliance Action

To qualify for federal matching funds, a state plan must comply with the requirements of the equal access provision.²¹⁸ The Secretary of HHS, through CMS, may withhold funding from a state where its Medicaid payment policies do not so comply.²¹⁹ In fact, some argue that withholding federal funds is the only remedy available to CMS

2011), <http://www.modernhealthcare.com/article/20111122/NEWS/311229968/injunction-sought-against-calif-rate-cuts>. And on January 31, 2012, the U.S. District Court Judge issued an injunction blocking the rate cuts, noting that the "state's fiscal crisis does not outweigh the serious irreparable injury plaintiffs would suffer absent the issuance of an injunction." See Chris Megerian, *Judge Issues Injunction Blocking Healthcare Cuts; State to Appeal*, L.A. TIMES (Feb. 1 2012), <http://latimesblogs.latimes.com/california-politics/2012/02/california-budget-healthcare.html>.

215. Appellants Joint Opening Brief, *Cal. Ass'n of Health Facilities v. Douglas*, No. 11-558851, 2011 WL 2617609, at *10-*11 (9th Cir. June 23, 2011).

216. See Comment of National Health Law Program, at 3, in response to Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (proposed May 6, 2011) ("CMS should amend the regulations to absolutely clarify that SPAs that include rate reductions cannot be implemented until CMS has an opportunity to review and make a decision. . . ."); Comment of Greater New York Hospital Association, *supra* note 200, at 4 ("In the final rule, CMS should clearly identify the consequences of non-compliance. At a minimum, we recommend that CMS prohibit states from implementing any SPA that reduces or redistributes funding until CMS approval is obtained.").

217. See *supra* notes 80-83 and accompanying text.

218. See *supra* note 61 and accompanying text.

219. See *supra* notes 80-83 and accompanying text.

for state violations of the Medicaid Act, including the equal access provision.²²⁰ In a brief to the Supreme Court opposing certiorari in the *Douglas* case, however, the United States argued that “programs in which the drastic measure of withholding all or a major portion of federal funding if the only available remedy would be generally less effective than a system that also permits awards of injunctive relief in private actions.”²²¹ In other words, since withholding all or a major portion of federal funding is an extreme and arguably draconian remedy,²²² other remedies are necessary to complement and make meaningful CMS’ enforcement powers.

The United States reiterated this point in *Planned Parenthood of Indiana, Inc. v. Commissioner of Indiana State Department of Health*.²²³ The Indiana legislature passed legislation prohibiting providers that furnish abortion services from participating in the Medicaid program.²²⁴ This provision went into effect on May 10, 2011, and Indiana subsequently submitted a SPA to CMS.²²⁵ CMS disapproved the SPA on June 1, 2011, explaining that the CMS Administrator was “unable to approve” the defunding provision amendment because the Indiana law violated the Medicaid Act’s “freedom of choice”²²⁶ provision.²²⁷ Despite CMS’ disapproval, Indiana continued to enforce the provision, and CMS did not withhold FFP from Indiana. Instead,

220. See, e.g., *PhRMA v. Walsh*, 538 U.S. 644, 675 (2003) (Scalia, J., concurring in the judgment) (“I would reject petitioner’s statutory claim on the ground that the remedy for the State’s failure to comply with the obligations it has agreed to undertake under the Medicaid Act is set forth in the Act itself: termination of funding by the Secretary of the Department of Health and Human Services, see 42 U.S.C. § 1396c.”) (internal citations omitted).

221. Brief for the United States as Amicus Curiae, *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal.*, 572 F.3d 644 (9th Cir. 2010) *on petition for cert.*, 2010 WL 4959708, at *19. Note that this statement is inconsistent with subsequent statements made by the United States in the *Douglas* case after the Supreme Court granted certiorari. See *supra* note 165 and accompanying text (noting that the United States opposed a nonstatutory private right of action).

222. See, e.g., Consolidated Brief of American Medical Association et. al., *Douglas v. Indep. Living Ctr. of S. Cal.*, 132 S. Ct. 546, No. 09-958, 2012 WL 555204 (Feb. 22, 2012), 2011 WL 3488986, at *5 (“Federal administrative enforcement provisions provide no viable solution to the access crisis because Congress delegated only limited, and draconian, enforcement powers.”).

223. No. 1:11-CV-630, 2011 WL 2532921, at *10 (S.D. Ind. June 24, 2011).

224. IND. CODE § 5-22-17-5.5(b)–(d) (2011).

225. “On May 13, 2011, FSSA submitted a Medicaid plan amendment to account for the defunding provision—to ‘make changes to Indiana’s State Plan in order to conform to Indiana State Law.’” *Planned Parenthood of Ind., Inc.*, 794 F. Supp. 2d at 905.

226. 42 U.S.C. 1396a(a)(23).

227. *Planned Parenthood of Ind., Inc.*, 794 F. Supp. 2d at 905.

CMS and the federal government supported Planned Parenthood's complaint, urging the federal district court to enjoin implementation of the Indiana law, which violated the freedom of choice provision of the Medicaid Act.²²⁸ According to the Statement of Interest Brief submitted by the United States in this case, the request for "injunctive relief [was] particularly necessary . . . [because] Indiana has expressed its view that operating a 'non-compliant program' is a 'lawful option for the State under the [Medicaid] statute,' so long as the State is willing to 'risk that the Secretary will turn off the funding spigot.'"²²⁹ The Court ultimately granted injunctive relief.

Planned Parenthood may be distinguished from *Douglas* because the Indiana law was found to be in violation of the freedom of choice provision of the Medicaid Act, not the equal access provision.²³⁰ The United States' reason, however, for supporting an alternative mechanism to enforce the Medicaid Act rather than withholding federal funds in *Planned Parenthood* does not seem to turn on the specific provision of the Medicaid Act, but rather the need for an effective response to a State's operation of a non-compliant program.

Although the Supreme Court sent the *Douglas* case back to the Ninth Circuit, the Court strongly suggested that the providers and beneficiaries do not have a cause of action under the Supremacy Clause.²³¹ Instead, providers and beneficiaries must wait until final agency action, which in the case of *Douglas* took more than 3 years, and bring suit under the APA.²³² Therefore, withholding all or a major portion of federal matching funds seems to be the most immediate

228. Statement of Interest of the United States at 1, *Planned Parenthood of Ind., Inc.*, 794 F. Supp. 2d at 892 (No. 11-CV-630) (explaining why injunctive relief is both necessary and appropriate to prevent a state from continuing to violate the Medicaid Act until HHS has the opportunity to formally reject a plan amendment).

229. *Id.* at 21–22.

230. *See Planned Parenthood of Ind., Inc.*, 794 F. Supp. 2d at 905.

231. *See supra* notes 161–62 and accompanying text. In providing support for its finding that there is no private right of action under the Supremacy Clause, the *Douglas* dissent highlights the fact that the majority "provides a compelling list of reasons" to decide that there is no cause of action directly under the Supremacy Clause to enforce the equal access provision. *Douglas*, 132 S. Ct. 546, No. 09-958, 2012 WL 555204, at *10 (Feb. 22, 2012) (Roberts, C. J., dissenting).

The majority itself provides a compelling list of reasons for such a result: "The Medicaid Act commits to the federal agency the power to administer a federal program"; "the agency is comparatively expert in the statute's subject matter"; "the language of the particular provision at issue here is broad and general, suggesting that the agency's expertise is relevant"; and APA review would provide "an authoritative judicial determination." *Id.*

232. *Id.* at *5.

penalty CMS may impose on states that fail to comply with the federal Medicaid law and regulations, and the only penalty so long as CMS has failed to make a final decision. As noted above, however, CMS rarely withholds federal funding because it would have perverse effects on the very people the remedy is intended to protect.²³³ As Justice Ginsburg pointed out during oral argument in the *Douglas* case, loss of federal funds is “a very drastic remedy that is going to hurt the people that Medicaid was meant to benefit.”²³⁴ Ultimately, the revocation of federal funding would likely result in even lower reimbursement rates, meaning that many Medicaid recipients may either lose some of the services they currently receive or lose their coverage altogether.²³⁵ In fact, the federal government has been candid about its unwillingness to withhold federal funds because of the “potentially detrimental effects” it would have on Medicaid recipients.²³⁶ A less drastic and more targeted remedy is needed to penalize non-

233. See *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 52 (1981) (White J., dissenting) (“[A] funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act.”); Mark H Gallant, *Federal Remedies for Noncompliance by States*, 2 HEALTH L. PRAC. GUIDE § 27:7 (2011) (describing the suspension or reduction of payments to states as an “atomic bomb” remedy that is rarely used by DHHS); Moncrieff, *The Supreme Court’s Assault*, *supra* note 92, at 2341 n.83 (noting that termination of federal funding “would have perverse effects if CMS’s goal were to force state to provide more generous—rather than less generous—coverage; the withdrawal of federal funding would obviously harm the states’ capacity to be generous.”).

234. Transcript of Oral Argument, *supra* note 158, at 5.

235. See Brief of Respondents Santa Rosa Memorial Hospital et al., *Douglas*, 2012 WL 555204 (No. 09-958), 2011 WL 3288334, at *2 (“This draconian sanction is rarely sought, however, because it would lead to a result that is contrary to the primary purpose of the Medicaid Act—*i.e.*, to facilitate the provision of health care services to those otherwise unable to obtain them.”).

236. Brief for the United States as Amicus Curiae at 13 n.11, *Exeter Mem. Hosp. Ass’n v. Belshe*, No. 96-693, 943 F. Supp. 1239 (E.D. Cal. 1996).

A compliance action, which results in the withholding of FFP, has a potentially detrimental effect on Medicaid recipients and providers. If [CMS] were to withhold FFP pursuant to a compliance action, recipients may well be deprived of medical assistance because the State may no longer be able to provide certain services.

Id.; *cf.* Brief for the United States as Amicus Curiae, *supra* note 165, at *31–*32 (“[I]f the State plan does not comply with [Section (30)(A)], the Secretary can also undertake a compliance action and withhold federal funds. That administrative process brings to bear ‘the expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decisionmaking.’” (citing *Gonzaga Univ. v. Doe*, 536 U.S. 273, 292 (2002) (Breyer, J., concurring in judgment))).

compliant states because withholding federal funds is a draconian enforcement mechanism that is hardly ever used.²³⁷

III. STRENGTHENING CMS' OVERSIGHT OF STATES' MEDICAID PROVIDER PAYMENT RATES

As discussed above, the current administrative mechanisms for ensuring state compliance with the equal access provision are of limited value. States do not wait for CMS approval before implementing rate cuts; indeed, sometimes states do not even submit a SPA to CMS when making a change to their payment policies. Although CMS has the authority to withhold federal matching dollars when states are out of compliance with the Medicaid Act or the equal access provision specifically, they rarely do so, viewing it as a draconian remedy. And, without the benefit of the administrative review of the proposed cut, it is difficult for CMS to determine if a rate cut will in fact deny Medicaid beneficiaries equal access to care. The backup to the administrative enforcement has heretofore been the courts, with consumers and providers seeking judicial review and injunctive relief of rate cuts they believed violated the equal access provision. After the Supreme Court's decision in *Douglas*, that avenue is now in doubt.²³⁸

Congress, however, could write an explicit private cause of action into the Medicaid Act.²³⁹ Some argue that a private right of action is essential to ensure that states comply with Medicaid's requirements.²⁴⁰ But others have argued that administrative enforcement may work better than private litigation because a thorough understanding of Medicaid payment policies is needed to determine whether state rate cuts violate the equal access provision, and courts do not have the expertise or resources to determine whether a given reimbursement rate reduction will cause Medicaid recipients to lose access to needed services.²⁴¹ Regardless of whether providers and benefi-

237. See Brief of Amici Curiae, AARP et al., 2012 WL 555204 (No. 09-958), 2011 WL 3584753, at *20 ("Termination of federal funding is a draconian remedy, one that DHHS rarely uses.").

238. See *infra* note 261 and accompanying text.

239. See, e.g., Guiltinan, *supra* note 119, at 1624; McKennan, *supra* note 149, at 503.

240. McKennan, *supra* note 149, at 503-04 ("A private right action encourages provider participation by creating a mechanism to recoup financial damages incurred as a result of accepting patients at below-cost rates. The private cause of action is a safety net for those contemplating participation in the [Medicaid] program.").

241. See Jost, *supra* note 168, at 18 (arguing that the judiciary can make only a limited contribution to setting the rules for governing the health care industry or for resolving disputes that arise within it, leaving administrative oversight to carry out the-

ciaries have standing to bring judicial action challenging state action, an effective administrative remedy is needed to ensure expeditious review of states' Medicaid payment policies.

Although CMS has the authority to enforce federal standards against states, it has failed for the most part to use this authority with respect to the equal access provision. Part III proposes policies to enhance the oversight of state payment policies and ensure compliance with the equal access provision. As a first step, CMS should clarify that states must secure federal approval *before* making changes to provider payment policies. States that implement changes in advance of federal approval should be held accountable if their rate cuts are ultimately found to violate the equal access provision. Second, CMS could provide that where states benchmark their Medicaid rate levels to Medicare rate levels, CMS would presume the states' reimbursement rates to be consistent with the equal access provision without prior review.

A. Require and Enforce Prior Approval of Medicaid Rate Cuts

CMS should amend the Medicaid regulations to explicitly require CMS approval before implementation of rate cuts.²⁴² As discussed above, CMS' proposed rule sets forth a framework by which states can demonstrate compliance with the equal access provision.²⁴³ The proposed rule requires that any SPA "that [would] reduce provider payment rates or restructure provider payments in circumstance[s] when the resulting changes could create access issues" must include an access review that is conducted prior to the submission of a SPA implementing a rate reduction.²⁴⁴ The proposed rule does not specify the consequences of failing to submit a SPA or implementing a rate reduction prior to CMS approval of the SPA. CMS' final rule should clarify that *any* rate cut or reduction must be accompanied by an ac-

se tasks); Moncrieff, *The Supreme Court's Assault*, *supra* note 92, at 2324 (suggesting that a shift of regulatory authority from judicial forums to federal executive forums may be good for health care).

242. See CALIFORNIA HEALTHCARE FOUNDATION, *supra* note 181, at 12 (suggesting that Congress "could require that HHS make specific findings of fact regarding the effects of rates on access because a state may be permitted either to increase or reduce provide payment rates").

243. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342, 26344 (May 6, 2011) ("[W]e are proposing federal guidelines to frame alternative approaches for States to demonstrate consistency with the access requirement using a standardized, transparent process, rather than setting nationwide standards.").

244. *Id.* at 26349.

cess review.²⁴⁵ Further, CMS should make clear that states may not implement provider reimbursement rate cuts until they have complied with the access framework in the rule and received CMS approval.²⁴⁶

If a state implements rate cuts in advance of federal approval, it should be held accountable if CMS ultimately denies the rate cut SPA. Specifically, federal funding must be withheld if CMS bars the rate cut barred. Unlike the current system, which gives the federal government discretion to withhold all or some federal funding after a state has failed to comply with federal requirements, this rule would impose a mandatory and discrete penalty on states that implement rate cuts without CMS approval.

For whatever reason, if states go ahead and implement rate cuts before receiving CMS approval, they should be penalized if CMS thereafter denies their SPA cutting reimbursement rates. CMS should amend the Medicaid regulations to include a provision that if states implement rate cuts prior to receiving CMS approval, states risk the loss of FFP for any retroactive payments that they are found to owe providers for the time that the disapproved rate cuts were in effect. This penalty imposes a risk that is comparable to the risk states face if they implement rate increases prior to receiving CMS approval. If a state increases provider rates prior to CMS approval, and CMS subsequently disapproves the rate increase, the state will be liable for the full cost of the increased payment. This scenario rarely occurs, however, because states are unwilling to risk the loss of FFP for payment increases and therefore wait for federal approval of rate increases. By contrast, the current system does not put states at risk of losing FFP if they implement rate cuts before receiving CMS approval. Therefore, this new rule would discourage states from implementing rate cuts before receiving CMS approval, as they would be liable for 100% of the retroactive reimbursement if CMS ultimately disapproves the rate reduction.

For example, hypothetical State A passed legislation that reduced hospital provider rates by 10%. State A implemented the legislation on July 1, 2010. Two months later,²⁴⁷ on September 1, 2010, State A

245. *Id.*

246. Letter from Rick Pollack, Executive Vice President, American Hospital Assoc., to Donald Berwick, Admin., Centers for Medicare & Medicaid Services (June 30, 2011).

247. Although regulations require that, when making changes to “advance directive requirements,” amendments must be submitted no later than sixty days from the effective date, the regulations do not specify a specific time when all other

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submitted a SPA to CMS seeking approval for the reduction in hospital provider rate cuts. Under Medicaid regulations, CMS has ninety days to render a decision on State A's SPA. But CMS requested additional information from State A regarding the proposed rate reductions and State A provided CMS with the additional information on December 1, 2010. CMS notified State A that the SPA had been disapproved on February 1, 2011 and State A immediately sought reconsideration of the disapproval. A hearing to reconsider the disapproval of State A's SPA was scheduled for April 1, 2011 and the disapproval was affirmed on September 1, 2011.

For fourteen months, from July 1, 2010 until September 1, 2011, State A had implemented a 10% rate reduction despite the fact that CMS never approved their SPA. Prior to this reduction State A paid approximately \$200 million a month for hospital payments.²⁴⁸ With a 10% reduction, State A paid approximately \$20 million less than it had previously paid. This decrease in payment persisted for fourteen months before CMS finally affirmed its decision to disapprove State A's SPA. State A now must reimburse the hospital providers for the reduction over the last fourteen months—approximately \$280 million. State A normally would have received federal matching funds for this payment; however, based on the penalty proposed, State A would be required to pay this amount in full. State A's FMAP is 57%, the national average.²⁴⁹ That is, State A would have received approximately \$160 million from the federal government for this hospital payment, but due to its implementation of the payment reduction prior to receiving CMS approval, under the proposed approach, State A would not receive the \$160 million in matching funds from the federal government.

amendments must be submitted. 42 C.F.R. § 430.12(c)(1)(ii). Instead, the regulations state "prompt submittal of amendments is necessary (i) so that CMS can determine whether the plan continues to meet the requirements for approval and (ii) to ensure that availability of FFP in accordance with § 430.20." 42 C.F.R. § 430.12(c)(2)(i)–(ii).

248. Although this example is purely hypothetical, these numbers are not unreasonable. For example, in 2007, Pennsylvania spent approximately \$12 billion on Medicaid. About 18.5% of Pennsylvania's Medicaid spending was on hospital payments. That is, Pennsylvania spent approximately \$226 million on hospital payments per month in 2009. See TOTAL MEDICAID SPENDING, THE URBAN INSTITUTE & KAISER COMMISSION ON MEDICAID AND THE UNINSURED (2010). View interactive table at statehealthfacts.org.

249. See *supra* note 60 and accompanying text (noting that the average FMAP for states is 55%).

States are already struggling to find the state funds to reimburse providers.²⁵⁰ Losing tens of millions of dollars for failing to follow federal regulations should be more than sufficient to incentivize states to follow the administrative procedures when enacting significant rate reductions. This Note previously acknowledged the detrimental effects that withholding federal funds could have on providers and Medicaid beneficiaries. But, unlike the current system, where the threat is both too great and too amorphous, under this proposal the penalty is mandatory and the amount is limited.

Finally, a requirement of prior approval imposes an obligation on CMS to review proposed rate cuts expeditiously. Assuming that CMS enacts a final rule, expeditious review should be possible since CMS has provided states with a “standardized, transparent process” to set reimbursement rates in compliance with the equal access provision.²⁵¹ In fact, the proposed rule recognizes that CMS has the regulatory authority “to make SPA decisions based on sufficiency of beneficiary service access” and that “this proposed rule merely provides a more consistent and transparent way to gather and analyze the necessary information to support such reviews.”²⁵² If this new rule, in fact, provides states with a process for determining access, then CMS should be able to make determinations on state SPAs that cut reimbursement rates rather expeditiously and states should not have to wait months (or years) for CMS to make a determination on their rate cuts.

B. Benchmark Medicaid Rates to Medicare

An alternate approach by which states could comply with the equal access provision would be to benchmark Medicaid rates to Medicare rate levels.²⁵³ This option would relieve states of the obligation to conduct an access review and enable the expeditious implementation of rate cuts.

In opposing CMS’ proposed rule, many states have argued that the access review process proposed by CMS imposes “extremely burden-

250. See, e.g., Melissa Westphal, *Illinois Has Area Hospitals Playing ‘Balancing Game’ with Late Money*, ROCKFORD REGISTER STAR (Oct. 22, 2011), <http://www.rrstar.com/news/x1872805880/Illinois-has-area-hospitals-playing-balancing-game> (“Illinois is far behind in paying bills owed to health care providers.”).

251. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342, 26344 (May 6, 2011).

252. *Id.*

253. Mckennan, *supra* note 149, at 505.

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some . . . data collection obligations on states as a precondition to demonstrating compliance with the vague rate-setting standards.”²⁵⁴ The States argue that the effort to conduct a study like the access study required in the proposed rule “would be nothing short of Herculean.”²⁵⁵ The states also contend that the requirements under the proposed rule “would leave states in a state of perpetual uncertainty . . . of their provider reimbursement rates.”²⁵⁶ Allowing states to set their Medicaid rates based on federal standards would relieve states of the responsibility to conduct a costly access study, and would provide states with the certainty that their rates are compliant with federal requirements.

Linking Medicaid rates to Medicare rates is not a radical solution to the problem of unreasonably low Medicaid rates. As discussed above, based on Section (30)(A)’s requirement that state payment policies are consistent with efficiency and economy, states cannot set reimbursement rates that exceed the UPL.²⁵⁷ “[The] UPL [is] calculated based on what could reasonably be estimated would . . . be paid under Medicare payment principles to an entire class of providers.”²⁵⁸ In addition, the ACA includes a provision, often referred to as the “PCP bump,” which requires state Medicaid agencies to increase primary care provider (PCP) reimbursement rates to reach parity with Medicare rates in 2013 and 2014.²⁵⁹ By benchmarking Medicaid rates to Medicare, the PCP bump “enables Medicaid programs to sustain and potentially expand its primary care network . . . and creates a critical opportunity to drive improvements in primary care access and quality.”²⁶⁰

Similar to the UPL and the ACA’s PCP bump provision, states may opt-in to set rates based on federal standards benchmarked at Medicare rates. By giving states this option, states can decide to retain flexibility in designing payment methodologies or decide to set rates based on federal standards. This alternative option would allow states to avoid penalties for setting rates not in compliance with fed-

254. Joint Comments of 17 States and State Medicaid Agencies at 2 (July 5, 2011), in response to Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (May 6, 2011).

255. *Id.* at 3.

256. *Id.* at 4.

257. See BACHRACH, *supra* note 114, at 7 and accompanying text.

258. See SCHNEIDER & ROUSSEAU, *supra* note 115 and accompanying text.

259. See MCGINNIS, BERENSON & HIGHSMITH, *supra* note 93, at 1.

260. *See id.* at 2.

eral rules and relieve states having to comply with the “burdensome” access review process.²⁶¹

CONCLUSION

The Medicaid law vests CMS with the responsibility and authority to review state payment policies to ensure compliance with the equal access provision; it also establishes a SPA review process to effectuate CMS oversight of state Medicaid programs. Due both to the lack of financial incentives for states to comply with the SPA process and the perverse effects of a federal compliance action— withholding federal matching dollars — the federal government lacks effective tools to ensure compliance with the equal access provision. In short, the current administrative remedies for non-compliance are without teeth. This Note proposes two approaches whereby CMS could facilitate state compliance with the equal access provision and penalize non-compliance. States that implement changes in advance of federal SPA approval would be held accountable if their rate cuts are ultimately found to violate the equal access provision. In addition, states that benchmark their Medicaid rate levels to Medicare rates would be presumed to be in compliance with the equal access provision. These policy changes will not only streamline the state rate-setting process, but will also give the federal government the tools to provide effective oversight of state payment policies.

Enforcement of the equal access provision is central to Medicaid’s goal of providing low-income Americans with meaningful access to needed medical care. Tens of millions of people rely on Medicaid for their health insurance. Without access to services that coverage is meaningless. If states are permitted to disregard the equal access provision with impunity, not only will violations of federal law go unchecked, but millions of Americans will be without adequate access to needed medical services. The lack of access puts them at unnecessary risk of harm or even death. For all these reasons, CMS must adopt procedures to ensure that state Medicaid payment policies enable Medicaid beneficiaries to access medical services to the same extent as the general population in their communities.

261. See Joint Comments of 17 States and State Medicaid Agencies, *supra* note 254, at 2. (“[T]he Commenting States are deeply concerned that the access review process proposed by CMS fails to advance those objectives, instead subjecting states to unnecessarily burdensome requirements . . .”).