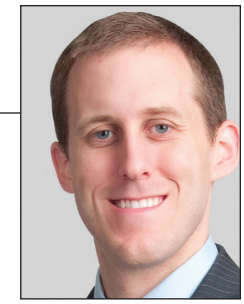
by Matt Wolfe



Salvaging a Remedy

How Medicaid Providers Can Challenge Rate Cuts in the Wake of *Armstrong v. Exceptional Children's Center*

Health law scholars, U.S. Supreme Court watchers, polit-ical pundits, and policymakers have been consumed with the Court's recent decision in *King v. Burwell*.[1] But an earlier decision by the Court in the 2015 term has substantially altered the playing field for health care providers, state Medicaid agencies, and equity jurisprudence. Although *King* has taken most of the attention, as we look back at the Court's 2015 health care-related decisions, *Armstrong v. Exceptional Children's Center*[2] potentially will have a more significant impact on health care providers and, more generally, federal court jurisdiction both in and outside of health law.

In *Armstrong*, the Court held that Medicaid providers lacked the right to challenge in federal court a state's failure to increase the Medicaid reimbursement rate based on a methodology that had previously been approved by the federal government. The case centered around whether the supremacy clause in the U.S. Constitution or the Medicaid Act affords Medicaid providers a private right of action to enforce 42 U.S.C. § 1396a(a)(30)(B), often known as the Medicaid equal access provision. Now that the Court has determined that providers do not have such a right of action, providers must consider their next steps in determining how to challenge inadequate Medicaid reimbursement rates.

Medicaid and Provider Rates

Medicaid is a federal–state health care program for the poor. Enacted under Congress' Spending Clause authority, Medicaid is a program that states can elect to participate in and thereby draw down federal dollars. As a practical matter though, every state in the union participates in Medicaid—despite perennial discussions of abandonment.[3]

The Medicaid Act creates a complex, byzantine structure with myriad requirements for each state. The complexity of the Medicaid Act and its ensuing regulations once led Judge Henry Friendly to call it "unintelligible to the uninitiated."[4] The federal government—through the Centers for Medicare & Medicaid Services (CMS)—is responsible for ensuring that each state's Medicaid plan meets the many requirements of the federal-state health care program for the poor.

On average, the federal government provides approximately two-thirds of the funding in the Medicaid program, but this percentage varies greatly from a low of 50 percent in some states to a high of 74.1 percent in another state.[5] This funding comes with certain strings attached. When a state wants to change its Medicaid program, it needs approval from the federal government—more specifically, CMS. States engage in this approval process through an extensive state plan and waiver documents.

Even with the federal combinations, states spend a lot of their budgets on the Medicaid program. According to the Pew Charitable Trusts, Medicaid consumes an average of 16 percent of state budgets. Analysts expect that this percentage will increase, particularly in states that have expanded Medicaid under the Affordable Care Act (ACA)—and even in those states that did not, due to the ACA's woodwork effect.

Enforcement of the Equal Access Provision in Federal Court

The CMS approval process includes the approval of payment rates and methodologies. This approval is critical, because Medicaid provider payments tend to be less than that of Medicare and private health coverage. According to the Kaiser Family Foundation, the average Medicaid payment is just 66 percent of Medicare rates. If Medicaid reimbursement is inadequate, providers will choose not to treat and care for Medicaid recipients. Without providers, Medicaid recipients will not have access to health care.

An amicus brief submitted by the American Hospital Association in *Armstrong* noted that the actual cost of providing care to Medicaid recipients exceeded reimbursements by 11 cents for every

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dollar—or $13.7 billion in 2012 alone. Particularly when states are struggling through budget crunches, Medicaid providers have seen these already low rates cut even further.

Section 30(A) of the Medicaid Act requires every state's Medicaid plan to:

> 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.[6]

Because this is a federal requirement, CMS is obligated to consider whether rates are adequate before approving them. But CMS has limited tools for forcing states to pay adequate Medicaid rates. The first step that CMS takes after a state submits a state plan amendment including a rate change is to ask the state for additional information, both formally and informally. These requests can encourage states to reconsider rate changes, particularly after examining data that may show access issues.

As this back-and-forth process between CMS and states occurs, however, states are not prevented from moving forward with imposing the rate cuts. Federal regulations actually permit rates to be imposed at the beginning of the quarter in which a state plan amendment is submitted.

Thus, if providers are facing down the barrel of a rate cut, they have turned to federal court for injunctive relief. Initially, providers sought judicial relief under 42 U.S.C. § 1983. As the Section 1983 jurisprudence began to make clear that providers could not challenge a violation of the federal Medicaid law without "rights creating language,"[7] providers turned to a different legal theory to get into federal court and challenge low Medicaid rates.

A Supremacy Clause "Right of Action"?

The supremacy clause, Art. VI, cl. 2, reads:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

Medicaid providers had argued (successfully) that they could challenge state actions that violated federal law, drawing upon a long line of cases starting with *Ex Parte Young.*[8] The question of whether the supremacy clause provides a Medicaid provider the right to challenge a state's compliance with the Medicaid Act has been an issue percolating in federal courts for several years.

In a prior case, the Court had considered this issue but only remanded the case to the Ninth Circuit to consider whether the federal government's approval of the rate cut at issue changed the analysis.[9] (It did not.) In that decision, however, four justices dissented, concluding that the provider did not have a right to sue under the

access-to-care requirement in federal court. Thus, when certiorari was granted in *Armstrong,* four dissenting justices only needed to persuade one of their colleagues to cut off this channel for providers to challenge Medicaid rate cuts in federal court.

Oral argument was held in *Armstrong* on Jan. 20, 2015. None of the four dissenting justices appeared to have changed his position on the supremacy clause preemption question, nor was it clear that they had been able to convince any of their colleagues to join them.

The *Armstrong* Decision

On March 31, 2015, the Court issued its decision in *Armstrong*, holding that neither the supremacy clause nor federal Medicaid law gave providers a cause of action to challenge a state's reimbursement standards. In an opinion written by Justice Antonin Scalia, a five-person majority of the Court held that Medicaid providers cannot sue to enforce the equal access provision. The majority and the minority opinions appeared to agree that the supremacy clause did not provide a right of action but instead created a "rule of decision."[10] The Court stated that a right to sue must come from somewhere else.

This is where the majority and minority parted ways. The majority held that the Medicaid Act implicitly precluded private enforcement of the equal access provision. Justice Scalia's opinion went further to suggest that providers lack enforcement rights under any provision of the Medicaid Act. Justice Stephen Breyer reasoned that, because the equal access provision involves a broad and vague standard for complex rate setting, CMS was in a better position to resolve the complex question than a federal judge. Because Justice Breyer's concurrence is specific to the equal access provision, Justice Scalia's opinion as to the federal Medicaid Act as a whole does not represent the Court's holding. Instead, the Court's ruling is limited to the equal access provision.

Justice Sonia Sotomayor's dissent, joined by justices Ruth Bader Ginsburg, Elena Kagan, and Anthony Kennedy, argued that the equitable cause of action ought to be available in this case. Justice Sotomayor explained that the administrative remedy emphasized by Justice Breyer was too limited.

Unresolved Questions After *Armstrong*

Much has been written on the case's impact in the wake of the decision. Although it cut off a provider's right to challenge a Medicaid rate in federal court by claiming violation of the federal Medicaid Act as a preemption theory, other questions remain. Importantly, for Medicaid advocates, the *Armstrong* decision does not clarify whether providers, recipients, or other affected parties could sue in federal court over other provisions of the Medicaid Act. Although the Court did not create any general prohibition on plaintiffs seeking injunctions on state officials for violations of federal law, the *Armstrong* decision would appear to limit those types of actions to violations of federal law that do not preclude a judicial remedy. The Court also did not address larger questions about equitable causes of action.[11]

Fallout for Providers

Setting these large questions aside, the *Armstrong* decision was devastating for health care providers who serve Medicaid recipients. It was also a perceived victory for states that have had to fight challenges to their Medicaid rates. The impact on the federal government is harder to read. Although the U.S. solicitor general sided with the states in *Armstrong*, several former officials from the U.S. Department of Health and Human Services filed an amicus brief in support of the providers' position:

> Every aspect of [HHS's] administration of the Medicaid program—from its regulations to its annual budget—is premised on the understanding that private parties will shoulder much of the enforcement burden. CMS [the part of HHS in charge of Medicaid] lacks the logistical and financial resources necessary to be the exclusive enforcer of the equal access mandate, and it is highly unlikely to receive the necessary resources in the future.[12]

More curiously, the current officials at the department did not take a stance.

But providers have already cast doubt on the ability of CMS to enforce the equal access provision. As many have explained, if CMS determines that a state is violating the Medicaid Act, CMS' only recourse is to threaten to cut off the federal matching funds. This tool is a radioactive option and one that has rarely been employed and, to my knowledge, never actually been done in a rate-making context.

The *Armstrong* decision may put pressure on CMS to revisit standards that would give more teeth to the equal access provision.[13] In 2011, CMS proposed federal rules that would set standards for CMS in determining whether proposed rate reductions would limit access to care. They would require states to study and analyze data on rate changes before obtaining approval on rate cuts. Importantly, the proposed rules would prohibit implementation of the rate cuts prior to implementation. The *Armstrong* decision should also encourage providers, recipients, and advocates to develop procedures for input into the state plan amendment process. Currently, CMS does not have a formal process for accepting and considering comments.

All of these efforts, however, are poor substitutes for the ability to seek and obtain an injunction in federal court.

Another Path to Federal Court

During oral arguments and in both Justice Scalia's and Justice Breyer's opinions, the Court discussed an alternative judicial remedy. Justice Breyer first advanced the view that a cause of action may exist under the Administrative Procedure Act (APA) against CMS in *Douglas v. Independent Living Centers of Southern California*.[14] He reiterated this view in his concurrence in *Armstrong.* During oral arguments, the attorney representing the state Medicaid agency and Justice Scalia both acknowledged such a remedy.

Such an action would have to be filed against CMS, the federal agency, not the state that is actually seeking or implementing a rate cut. The theory is that CMS is failing to enforce a federal requirement against the state or is improperly approving a state plan amendment. The provider or providers would first have to ask CMS to take some action. If the agency refused, as Justice Breyer notes, the injured party could seek judicial review of the refusal and claim that the refusal was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. §§ 702, 706(2)(A). Further, the APA permits an injured party to "compel agency action unlawfully withheld or unreasonably delayed." 5 U.S.C. §§ 702, 706(1).

The APA is by no means a panacea or substitute for the right of action pursued in *Armstrong* and rejected by the Court. The plaintiff would have to show an exhaustion of remedies and prove that he is entitled to relief under the APA as an injured party. Under the APA, the federal court would be inclined to pursue a more deferential standard. Combined with more stringent requirements on state Medicaid rate-making processes (as proposed by CMS in 2011), however, the APA petition for judicial review may allow providers to ensure reimbursement is sufficient to allow them to continue to care for Medicaid recipients. Although the Court clearly slammed a door in providers' faces, other doors may still be open. ⊙

Endnotes

[1]U.S.S.C. No. 14-114, 576 U.S. (2015).

[2]135 S. Ct. 1378 (2015).

[3]*See, e.g.,* Janet Adamy and Neil King, *Some States Weigh Unthinkable Option: Ending Medicaid,* The Wall Street Journal (Nov. 22, 2010).

[4]*Friedman v. Berger,* 547 F.2d 724 (2d Cir. 1976).

[5]79 Fed. Reg. 71426 (Dec. 2, 2014). Some Medicaid expenditures qualify for an enhanced matching percentage.

[6]42 U.S.C. § 1396a(a)(30)(A).

[7]*Gonzaga Univ. v. Doe,* 536 U.S. 273 (2002).

[8] 209 U.S. 123 (1908).

[9]*Douglas v. Independent Living Centers of Southern California Inc.,* U.S.S.C. No. 09-958, 565 U.S. ___ (Feb. 22, 2012).

[10]*Armstrong,* 135 S. Ct. at 1383.

[11]For an excellent discussion of these broader, unresolved questions, *see* William Baude, "Foreclosing Equitable Relief Under Medicaid Act," SCOTUSblog (Apr. 1, 2015, 9:53 AM), www.scotusblog.com/2015/04/foreclosing-equitable-relief-under-medicaid-act/.

[12]Brief for Former HHS Officials as Amici Curiae in Support of Respondents at 6, *Armstrong*.

[13]*See* Medicaid Program: Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (May 6, 2011).

[14]*Supra* note 8.