Enforcing Medicaid's Entitlement Still Uncertain in the Wake of the Supreme Court's Douglas Decision

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The Medicaid statute begins with seven words: "A state plan for medical assistance must," and the statute then proceeds to list 83 requirements that a state Medicaid plan is required to meet.[1] Absent from the statute, however, is any remedy for Medicaid beneficiaries or providers who are harmed by a state's failure to satisfy any one of those requirements. An aggrieved party can always petition the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees the program, for relief when a state fails to comply with its obligations. But since CMS views itself as a partner with the states in overseeing the Medicaid program, aggrieved parties may want to secure independent judicial enforcement of Medicaid's entitlements. The lack of an enforcement mechanism in the statute has stymied these efforts.

In 1990, the Supreme Court seemed to have resolved the issue in favor of providers and beneficiaries in *Wilder v. Virginia Hospital Association*.[2] In *Wilder*, a divided Supreme Court ruled that providers could use the federal civil rights statute as a means to enforce a then-existing Medicaid requirement that a state Medicaid plan provide "reasonable and adequate" reimbursement rates.[3] According to Justice Brennan, writing for the majority, one could infer that the Medicaid statute created "enforceable rights" to reasonable and adequate Medicaid reimbursement because of the lack of an effective administrative enforcement mechanism through CMS.[4] Moreover, the federal Medicaid statute itself did not foreclose a challenge to the then-existing Medicaid requirement.[5] Therefore, because a state official - Governor Wilder, acting through his Medicaid commissioner - had deprived Virginia hospitals of a right guaranteed under federal law - access to "reasonable and adequate" reimbursement rates - the federal civil rights statute was an appropriate vehicle to vindicate that right.

In the intervening years, three things changed that called into question the continuing vitality of the *Wilder* decision. First, in 1997, Congress repealed the statute upon which the *Wilder* decision relied.[6] In its place, Congress imposed a much weaker requirement on the states: namely, that a state plan merely provide for a public process before setting rates for providers.[7] The second was a change in the make-up of the Supreme Court itself; Justice Marshall, who had been in the majority in *Wilder*, was replaced on the Court by Justice Thomas, who seemed less inclined to support a broad, sweeping interpretation of a right to judicial enforcement of the Medicaid entitlement. Finally, the Supreme Court's decision in *Gonzaga University v. Doe* seemed to drastically curtail the sweeping holding in *Wilder*.[8] In *Gonzaga*, the Supreme Court addressed the requirements necessary to maintain an action under the federal civil rights statute. Whereas *Wilder* had inferred a private right of enforcement of the federal Medicaid statute, Gonzaga seemed to suggest the need for a specific, individually enforceable right in order to maintain an action against a state official for a violation of the federal civil rights act.[9]

In the wake of these developments, all circuit courts that addressed the issue of a private right of enforcement of the Medicaid statute concluded that most Medicaid requirements failed to contain the specific, rights-creating language that the Supreme Court had envisioned in *Gonzaga* and supporting Supreme Court precedent, including *Suter* and *Blessing*.[10] In most of these cases, the circuit courts had addressed another requirement of federal law: that a state Medicaid plan "provide … that payments are … sufficient to enlist enough providers so that care and services are available under the plan."[11] For example, in a Massachusetts Medicaid case, the United States Court of Appeals for the First Circuit ruled that "If *Gonzaga* had existed prior to [our earlier decision], the panel could not have come to the same result."[12]

This history laid the groundwork for the Supreme Court's *Douglas v. Independent Living Center of Southern California* recently issued decision. In *Douglas*, providers had objected to a California amendment to its state Medicaid plan to reduce reimbursement rates for some

providers by as much as 10%. These providers believed that, with the proposed rate reductions, California would not be able to "provide … that payments are … sufficient to enlist enough providers so that care and services are available under the plan," in contravention of the federal Medicaid requirement. However, attempting to bring this argument in federal court in the Ninth Circuit using the federal civil rights statute as a means of enforcement would have meant that the providers were squarely confronted with the *Gonzaga*, *Suter* and *Blessing* trilogy, as well as adverse precedent in the Ninth Circuit itself.**13** Thus, the providers proceeded on a different track.

Because using the federal civil rights statute was now foreclosed as an option, the providers tried a new approach: the U.S. Constitution and the laws executed under it, they argued, are "the supreme law of the land."**14** Thus, if the federal Medicaid statute - a law enacted under the Constitution's Spending Clause authority - requires "sufficient" payments to providers, and a state statute provides arguably insufficient payments to providers, the state law, under traditional Supremacy Clause pre-emption analysis, must yield to the federal law. The Ninth Circuit accepted this argument, and struck down the California rate statute in 2009.**15** On February 22, 2012, in a somewhat surprising, and divided, decision, the United States Supreme Court vacated and remanded the Ninth Circuit's holding.**16**

In doing so, the Supreme Court noted that "since we [accepted this case for review], the relevant circumstances have changed." **17** In particular, after the Supreme Court had granted review in *Douglas*, CMS approved a modified version of the California rate plan. As a result of CMS' action, the Supreme Court questioned whether the Supremacy Clause action against the state plan could be maintained; after all, according to Justice Breyer, review of the federal agency's decision (i.e. CMS' decision to accept California's modified rate plan) was now available under the Administrative Procedure Act.**18** Accordingly, aggrieved providers had another means of challenging the rate reductions. Moreover, deciding the question now risked "inconsistency or confusion" in the lower courts.**19** As a result, the Supreme Court vacated the Ninth Circuit's judgment and remanded it in light of its decision and the CMS approval of the California rate plan.

Douglas, like *Wilder*, was a 5 - 4 decision. Of interest is the composition of that 5 - 4 majority. Whereas Justice Kennedy was in the minority in *Wilder* - suggesting that he disagreed that the federal civil rights statute provided a means of individual enforcement of the Medicaid entitlement - he was in the majority in *Douglas*. One has the sense that the Supreme Court was inclined to reject the Ninth Circuit's Supremacy Clause reasoning in its entirety, but that Justice Breyer was able to cobble together a 5 - 4 majority by attracting Justice Kennedy to a relatively narrow opinion that avoided the major Constitutional question. The tone of Chief Justice Roberts' dissent - joined by Justices Alito, Scalia and Thomas - suggests that this may be precisely what happened.

Thus, the availability of an individual means of enforcement of the Medicaid entitlement remains unanswered. Of additional interest is what Justice Kennedy's position may mean for the far larger health care cases pending Supreme Court review this term: i.e., the Constitutional challenges to the Patient Protection and Affordable Care Act, which will be heard by the Court at the end of this month.**20** Justice Kennedy's apparent reluctance to join a sweeping rejection of a means of challenging a purported violation of the Medicaid entitlement may suggest a similar reticence to striking down a major piece of Spending Clause legislation this Term.

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1 Social Security Act § 1902(a), 42 U.S.C. § 1396a(a).

2 496 U.S. 498 (1990).

3 The federal civil rights statute, enacted in the aftermath of the Civil War, provides a cause of action for any individual who has been deprived of their rights, guaranteed by the Constitution or federal law, by the action of any state official acting under color of state law. 42 U.S.C. § 1983.

4 496 U.S. at 521.

5 *Id.* at 521 - 22.

6 Balanced Budget Act of 1997, Pub. L. No. 105 - 33 § 4711(a), 111 Stat. 251, 507 - 508 (Aug. 5, 1997).

7 Social Security Act § 1902(a)(13)(A), 42 U.S.C § 1396a(a)(13)(A).

8 *Gonzaga*, 536 U.S. 273 (2002).

9 *Id*. at 280 - 83, citing *Suter v. Artist M*, 503 U.S. 347 (1992) and *Blessing v. Freestone*, 520 U.S. 329 (1997).

10 *See Sanchez v. Johnson*, 416 F.3d 1051, 1058 - 59 (9th Cir. 2005) (compiling cases).

11 Social Security Act § 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A).

12 *Long-Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 59 (1st Cir. 2004).

13 *Sanchez, supra* n. 10.

14 U.S. Const. Art VI cl. 2.

15 *Douglas v. Independent Living Center of Southern California*, 572 F.3d 644 (2009).

16 *Douglas v. Independent Living Center of Southern California*, 565 U.S. ___ (2012) (hereafter, Douglas slip op.).

17 *Douglas* slip op. at 2.

18 *See id.* at 6 - 7 (noting that although the question had not changed, the answer may).

19 *Id.* at 7.

20 Pub. L. No. 111 - 148 as amended by Pub. L. No. 111 - 152, and collectively referred to as the Affordable Care Act. The oral arguments on the constitutionality of the Affordable Care Act will be heard on March 26, 27, and 29, 2012.

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